(Un)safe routes: Maternal mortality and Ethiopia’s development agenda

by Ruth Jackson, BA BLitt (Hons)

Submitted in fulfillment of the requirements for the degree of

Doctor of Philosophy

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I certify that the thesis entitled (Un)safe routes: Maternal mortality and Ethiopia's development agenda

submitted for the degree of Doctor of Philosophy

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

FULL NAME... Ruth Ethel Jackson...

Signed...

Date...
Acknowledgments

In Australia, my introduction to International Development Studies began when I chose a new focus for my electives as a third-year undergraduate at Deakin University. Since being captivated with this new line of study, I followed it through a Bachelor of Letters, Honours and then a Higher Degree by Research. Dr Max Kelly assisted me with my original application to the university and then became my primary supervisor. My other supervisors were Dr Liz Eckermann and Dr Rohan Bastin. In 2007, I was accepted as a visiting student at Addis Ababa University Population Studies and Research Centre, headed by Dr Assefa Hailemariam. Dr Assefa was my pivotal contact in Ethiopia, and he facilitated many contacts and documents that enabled me to travel to Ethiopia to conduct research.

Without naming everyone, but also to protect their privacy, people in the following organisations were prepared to give their time to be interviewed or to offer documents or reports in Ethiopia: Actionaid; Addis Ababa University; Apostolic Prefecture of Jimma-Bonga, especially the Social and Development Coordination Office in Jimma and other individuals who offered me great kindness and hospitality throughout my fieldwork in 2007; CARE International Ethiopia; Decha Woreda Health Desk; FAO; Lalmba Chiri Health Center; Ministry of Health Addis Ababa; Farm Africa; Kafa Development Association; Kafa Development Program; SOS Sahel; the Zonal Health Department and Statistics Office; and, many individuals at various health posts, health centres, clinics and Bonga Hospital in Kafa Zone. Thanks also to Habtamu Argaw from the WHO (previously from SUPAK).

Christian Grassini contacted many people he knew in Ethiopia who made my stay more enjoyable. His friendship near the end of my stay in Ethiopia was crucial to my sanity. Through Christian, a contact at FAO Addis Ababa accessed a number of maps which was a major achievement given the difficulties I had trying to access maps in Kafa Zone where the printer at the mapping and statistical office was ‘non-functional’ despite a new printer cartridge brought from Australia.

To the many women who graciously offered hospitality and allowed me to enter their homes to discuss their experiences of pregnancy and childbirth, I cannot express my gratitude in words. In almost all circumstances this was despite their poverty and difficult circumstances. Many of these women were coping on their own with their children. I will never forget their ability to smile and laugh despite their hardships. In spite of everything I had the feeling that life goes on and that we have much in common despite our cultural differences.

Mike Watters has exceptional coffee making skills, and Jo and Jack assisted with technical problems over many years. My parents David and Rose Jackson and my brother Philip also provided support. Other friends including Lisa Lillee, Michelle Keen, Tony Bazeley, Bernard Goldman and Ella Rosso have shared the highs and lows. Alganesh Argaw and her family welcomed me into their home in Adelaide on many occasions; Alganesh and Dr Tilahun Afrassa (then Secretary of the Ethiopian Community Association SA Inc) translated my ethics documentation in Amharic.

Other HDR students and the off-campus library staff at Deakin University have been wonderfully supportive. Thanks Glenda. Cheers Murray.
I met Elizabeth Reid at the ‘Africans in Australia and Outsiders in Africa’ Conference run by African Studies Association of Australasia and the Pacific in early 2008. Elizabeth’s longstanding commitment to the well-being of women and her thoughtful counsel really meant a lot to me.

The Australian Federation of University Women (AFUW) provided funding for a female interpreter throughout my research in Ethiopia through a William and Elizabeth Fisher Scholarship Ethel McLennan Bursary. Although there were a few occasions when I had to work with male interpreters, most of the time I worked with a young woman whose first language was Kafficho, her second was Amharic and the third was English. Azeb and her siblings had not long lost their father, and were still mourning the recent loss of their mother. At times I felt our relationship was like that of a mother and daughter. Nevertheless, over the months we became firm friends and I was grateful to know her and her extended family who did everything possible to ensure my stay was enjoyable. We did a lot of walking and talking together and I hope the experience gave her extra confidence to achieve her goals in the future. Azeb and her sister Genet are now studying nursing.
Abstract

Of all the health statistics monitored by the World Health Organization (WHO), maternal mortality has the highest discrepancy between developing and developed countries. Maternal mortality and disability levels in many developing countries are similar to those of the more developed regions of the world at the late nineteenth century. The reduction of maternal mortality by three quarters by 2015 was endorsed as a Millennium Development Goal. Starting with the theory of international development and the presumption that biomedical health interventions will reduce maternal mortality and disability if governments devote resources to health care and delivery assistance, the thesis documents the need to take a more comprehensive perspective to understand the problems of maternal mortality to include social, cultural, economic and political determinants of health in addition to the transfer of health service interventions. It draws on the Three Delays model which emphasises the importance of delays between the onset of obstetric complications and its outcome and proposes that most maternal deaths are preventable with prompt and adequate medical interventions. This study employed qualitative techniques to determine how reproductive health, in particular the goal of reducing maternal mortality, fits into Ethiopia’s development agenda. In Kafa Zone in south-west Ethiopia, most women give birth with the assistance of their neighbour, mother, mother-in-law, or husband. Less than five percent of women give birth in a health institution or with the assistance of a trained health worker or trained traditional birth attendant. Using semi-structured interviews with key personnel in government and non-government organisations, in health institutions, and with women in rural and semi-urban areas in Kafa Zone, the research juxtaposes women’s experiences of birth at home with that in a ‘modern’ health care setting. It is likely that women who give birth at home feel ‘safe’ because that is where birth normally takes place and where they are supported by close relatives and neighbours. Women always feel it is ‘unsafe’ to go to a health facility because of the very real possibility they will die on the way. For this reason, a picture emerges of ‘unsafe’ childbirth denoting those births that are transferred to a health facility. The study confirms that as maternal health has been identified as a key development goal in Ethiopia, there is a need to consider social and cultural issues alongside biomedical health interventions.
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<th>Description</th>
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<tbody>
<tr>
<td>ADLI</td>
<td>Agricultural Development Led Industrialization</td>
</tr>
<tr>
<td>AMDD</td>
<td>Averting Maternal Death and Disability</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CSA</td>
<td>Central Statistical Authority</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>E.C.</td>
<td>Ethiopian calendar</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization (UN)</td>
</tr>
<tr>
<td>GAD</td>
<td>Gender and Development</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HEP</td>
<td>Health Extension Program</td>
</tr>
<tr>
<td>HEW</td>
<td>Health Extension Worker</td>
</tr>
<tr>
<td>HSDP</td>
<td>Health Sector Development Plan</td>
</tr>
<tr>
<td>IAG</td>
<td>Inter-Agency Group for Safe Motherhood</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>FCI</td>
<td>Family Care International</td>
</tr>
<tr>
<td>FG C</td>
<td>Female Genital Cutting</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>KDA</td>
<td>Kafa Development Association</td>
</tr>
<tr>
<td>KDP</td>
<td>Kafa Development Program (previously SUPAK)</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MOFED</td>
<td>Ministry of Finance and Economic Development of the Federal Democratic Republic of Ethiopia</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>PASDEP</td>
<td>Plan for Accelerated and Sustained Development to End Poverty</td>
</tr>
<tr>
<td>PBS</td>
<td>Protection of Basic Services</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>RSDP</td>
<td>Road Sector Development Program</td>
</tr>
<tr>
<td>SIM</td>
<td>Sudan Interior Mission</td>
</tr>
<tr>
<td>SMI</td>
<td>Safe Motherhood Initiative</td>
</tr>
<tr>
<td>SNNPR</td>
<td>Southern Nations, Nationalities and Peoples’ National Regional State</td>
</tr>
<tr>
<td>SUPAK</td>
<td>Sustainable Poverty Alleviation Project Kafa Zone (now KDP)</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>TTBA</td>
<td>Trained Traditional Birth Attendant</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Fund</td>
</tr>
<tr>
<td>UN ECOSOC</td>
<td>United Nations Economic and Social Council</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WID</td>
<td>Women in Development</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>arek’e</td>
<td>distilled alcoholic drink</td>
</tr>
<tr>
<td>ammit</td>
<td>ground barley flour used to make a nutritious drink</td>
</tr>
<tr>
<td>awalaj</td>
<td>midwife</td>
</tr>
<tr>
<td>berberé</td>
<td>mixture of spices mainly comprising chilli pepper</td>
</tr>
<tr>
<td>birr</td>
<td>Ethiopian currency</td>
</tr>
<tr>
<td>chow duk et</td>
<td>iodised or ‘powdered’ salt</td>
</tr>
<tr>
<td>corrorima</td>
<td>false cardamom (Aframomum corrorima)</td>
</tr>
<tr>
<td>enset</td>
<td><em>Ensete ventricosum</em> popularly known as false banana. Extracts from the stem and root provide a widely consumed stable carbohydrate.</td>
</tr>
<tr>
<td>ferenji</td>
<td>popular term for foreigner</td>
</tr>
<tr>
<td>habesha</td>
<td>Ethiopian</td>
</tr>
<tr>
<td>iddir</td>
<td>Traditional meeting where people get together to support each other in case of funerals and other emergency situations</td>
</tr>
<tr>
<td>injera</td>
<td>staple flat bread made from <em>tef</em>, sometimes with sorghum or barley added</td>
</tr>
<tr>
<td>jebena</td>
<td>clay coffee pot</td>
</tr>
<tr>
<td>kebele</td>
<td>peasant association, neighbourhood or village level of administration</td>
</tr>
<tr>
<td>keranchimma</td>
<td>threefold and complementary state of equilibrium with religious and cosmic dimensions: physical health, moral integrity and spiritual holiness</td>
</tr>
<tr>
<td>kibbi</td>
<td>butter</td>
</tr>
<tr>
<td>kocho</td>
<td>staple food made from <em>enset</em>, baked like flat bread</td>
</tr>
<tr>
<td>mengist</td>
<td>government</td>
</tr>
<tr>
<td>shirro</td>
<td>ground chick pea flour mixed with berberé to make a spicy sauce</td>
</tr>
<tr>
<td>sini</td>
<td>tiny cup for serving coffee</td>
</tr>
<tr>
<td>tef</td>
<td>cereal from which a staple flat bread is made</td>
</tr>
<tr>
<td>tej</td>
<td>honey mead</td>
</tr>
<tr>
<td>tella</td>
<td>local beer, ideally brewed from barley</td>
</tr>
<tr>
<td>tena</td>
<td>harmonious well-being</td>
</tr>
<tr>
<td>timiz</td>
<td>wild black pepper, <em>(Piper capense)</em></td>
</tr>
<tr>
<td>woreda</td>
<td>‘district’ administration, nominally around 100,000 people</td>
</tr>
</tbody>
</table>
Chapter 1: The research background: Questions, objectives and theoretical considerations

1.1 The research background

Of all the health statistics monitored by the World Health Organization (WHO), maternal mortality has the highest discrepancy between developing and developed countries (WHO 1998; WHO et al. 2007). Maternal mortality and disability\(^1\) levels in many developing countries are similar to those of the more developed regions of the world at the late nineteenth century (Loudon 1992; De Brouwere et al. 1998). WHO, United Nations International Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) figures show that complications during pregnancy and childbirth are the main cause of death and disability in women of reproductive age in developing countries. An estimated 536,000 women died in childbirth around the world in 2005 and for each of these women around 20 more suffered injury, infection and disability during pregnancy or childbirth. This means at least 10 million women, or more than a quarter of women in the developing world are affected by maternal death or disability (WHO et al. 2007:1; UNICEF 2009:12-13)\(^2\).

In 2005 in sub-Saharan Africa there were 270,000 maternal deaths, there were 188,000 in south Asia, 15,000 occurred in Latin America and the Caribbean and 960 occurred in the more developed regions of the world (WHO et al. 2007:16)\(^3\). Eleven countries accounted for 65 per cent of deaths in 2005: India (117,000), Nigeria (59,000), the Democratic Republic of the Congo (32,000), Afghanistan (26,000), Ethiopia (22,000), Bangladesh (21,000), Indonesia (19,000), Pakistan (15,000), Niger (14,000), the United Republic of Tanzania (13,000), and Angola (11,000) (WHO et al. 2007:15). The

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\(^1\) “Maternal morbidity” includes a range of minor conditions of short duration to those which are severe and chronic. The term “disability” is used to describe ‘chronic, severe, morbidity that results from either pregnancy or childbirth’ (McCarthy and Maine 1992:24).

\(^2\) More recently, Hogan et al. (2010) constructed a database of 2651 observations of maternal mortality for 181 countries for 1980 – 2008, from vital registration data, censuses, surveys, and verbal autopsy studies. Their estimate is that there were 342,900 maternal deaths worldwide in 2008. They estimate that the MMR in Ethiopia was 590 in 2008 (2010:1618). See also footnote 16.

\(^3\) Includes Albania, Australia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Serbia and Montenegro (independent entities since 2006), Slovakia, Slovenia, Spain, Sweden, Switzerland, the former Yugoslav Republic of Macedonia, the United Kingdom and the United States of America (WHO et al. 2007:16).
countries with a Maternal Mortality Ratio (MMR)\(^4\) of 1,000 or more are in sub-Saharan Africa\(^5\). The adult risk of maternal death (the probability that a 15 year old female will die from a maternal cause) is highest in Africa as well (1 in 26), followed by Oceania (1 in 62) and Asia (1 in 120). In comparison, the adult lifetime risk of maternal death in the developed regions is 1 in 7300 (WHO et al. 2007:15).

Maternal and Child Health (MCH) has been one of the priorities of the WHO since its establishment in 1948 (WHO 1948) although the early focus was primarily associated with child health and family planning (FP) in developing countries (Rosenfield and Maine 1985). Table 1 summarises a number of the major milestones in maternal and reproductive health programs and strategies funded by governments and international agencies aimed at reducing maternal mortality and disability in developing countries since 1948. Notably, in the 1970s and 1980s attention focused on primary health care (PHC) in developing countries as a move away from the Western biomedical model\(^6\). PHC concentrated on decentralising health services to local communities; prevention and extensive community involvement, using Antenatal Care (ANC) and training traditional birth attendants (TBAs) rather than costly curative services (Lush and Campbell 2001).

In spite of this attention, international concern about the dimensions of the problems of maternal mortality grew in the 1980s and 1990s and a number of landmark conferences (see Table 1) gave substantial attention to the historical neglect of women’s health and needs (Thaddeus and Maine 1994; Mahler 1987; Rosenfield and Maine 1985; see also AbouZahr 2001; De Brouwere et al. 1998; Lush and Campbell 2001; Family Care International (FCI) in collaboration with Inter-Agency Group for Safe Motherhood (IAG) 1997; WHO 2005). Yet evidence suggested that the earlier approaches of training

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\(^{4}\) There are three statistical measures of maternal mortality: Maternal Mortality Ratio (MMR) measures the number of maternal deaths during a given time period per 100,000 live births during the same time period. Maternal Mortality Rate (MMRRate) measures the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time period. The adult lifetime risk of maternal death measures the probability of dying from a maternal cause during a woman’s reproductive lifespan (WHO et al. 2007:5).

\(^{5}\) These countries include Sierra Leone, Niger, Chad, Somalia, Angola, Rwanda, Liberia, Guinea Bissau, Burundi, the Democratic Republic of the Congo, Nigeria, Malawi and Cameroon. The exception is Afghanistan (WHO et al. 2007:15).

\(^{6}\) Following Kleinman (1995), I also use the term biomedicine, rather than ‘Western medicine’, ‘cosmopolitan medicine’, or ‘allopathic medicine’ because ‘it emphasizes the established institutional structure of the dominant profession of medicine in the West, and today worldwide, while also conjuring the primacy of its epistemological and ontological commitments’ (1995:25). Cf. Pigg (1996), who uses ‘modern medicine’ to ‘emphasize the symbolic connection between biomedicine and modernity’ (1996:194 note 4). Biomedicine has been exported from the West to developing countries since the late 19th century (Gaines and Davis-Floyd 2003).
TBAs and using the risk approach\(^7\) to reducing maternal mortality had limited success: the focus then shifted to skilled care during delivery and the availability of emergency obstetric care programmes (EmOC) (De Brouwere et al. 1998; Koblinsky et al. 1999; Lush and Campbell 2001; WHO and UNICEF 2004; Campbell and Graham 2006). The current imperative from international reproductive health policy makers is that high rates of maternal death and disability should be reduced through the transfer of modern health service interventions now referred to as a health centre intrapartum-care strategy (Campbell and Graham 2006:1291; see also Partnership for Maternal, Newborn and Child Health 2010). This means that all women should have access to skilled attendants at birth, referral for EmOC, and other strategies that complement those targeted at the intrapartum period including antenatal and postpartum care, FP, safe abortion, and treatment for pre-existing ill health particularly those causing indirect death such as infections, chronic disease or malaria.

So after more than 50 years of international health policies and strategies aimed at reducing maternal mortality and disability, and after the reduction of maternal mortality by three quarters by 2015 was endorsed as a major international development goal at the Millennium Summit in 2000 (UN 2000), data to monitor the progress of the Millennium Development Goals (MDGs) has drawn attention to sub-Saharan Africa. As the region with the highest levels of maternal mortality, there had been almost no progress towards the MDG Five Goal (United Nations 2009). A case in point is Ethiopia with an MMR of 720 per 100,000 in 2005 and a lifetime risk of maternal death of one in 27 (WHO et al. 2007:24)\(^8\).

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\(^7\) The risk approach to identify at-risk pregnancies during ANC has been shown to have limited success in reducing the risk of maternal mortality as most women who develop life-threatening complications have no apparent risk factors and those identified at risk generally have uneventful deliveries. ANC should now be used to improve maternal health (WHO, UNICEF et al. 2004:1).

\(^8\) The Ethiopian Central Statistical Authority (CSA) estimates the MMR at 673 maternal deaths per 100,000 live births. Data for the period 1994 - 2000 show the MMR was estimated to be 871 deaths per 100,000 live births. The DHS states that although maternal mortality may appear to be declining, the rates are both subject to a high degree of sampling error and it is not possible to conclude there has been a decline. The true MMR for 2000 ranges from 548 to 799 deaths per 100,000 live births (CSA and ORC Macro 2006:233).
Table 1: Selected milestones in international reproductive and maternal health policies and strategies for developing countries and Ethiopia

<table>
<thead>
<tr>
<th>Organisation/people involved</th>
<th>Key concepts/goals/strategies</th>
<th>Focus for developing countries</th>
<th>Comment and/or focus in Ethiopia</th>
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<tr>
<td>Prior to 1948</td>
<td>Health problems dominated by disease and parasitic models that viewed local populations as unhealthy and unclean.</td>
<td>Generally concentrated health services in urban areas or close to sites of colonial production (Packard 1997:94; Vaughan 1991).</td>
<td>European travellers, missionaries and doctors introduced Western biomedicine to Ethiopia and conducted scientific investigation of traditional Ethiopian medical practice. Their writings from the early 19th century included the descriptions of traditional surgery and medicinal plants and cures (Slikkerveer 1990; Pankhurst 2004a). Under Menelik II, the first modern hospitals were built and in 1907, the Public Health Department of the Ministry of Home Affairs took on the responsibility of modern health care although it was mainly restricted to Addis Ababa.</td>
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Medicalisation of childbirth. E.g. Coincided with colonial panic about depopulation and a falling birth rate and concerns about hygiene in the Congo (Hunt 1999). Missionaries used aspects of modernity, particularly technology and medicine, to propagate their Christianity (Donham 1999:82). Dr Lambie of the Sudan Interior Mission became a client of then ras Teferi (Haile Selassie) (1999:92), whose modernist goal, was 'to wring as many hospitals and schools as possible from the missionaries—not to mention threshing machines and Ford automobiles' (1999:94). |
<table>
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<tr>
<th>Year</th>
<th>Event</th>
<th>Description</th>
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<tr>
<td>1948</td>
<td>Formation of World Health Organisation (WHO)</td>
<td>Maternal and Child Health (MCH) identified in a list of “diseases” by the WHO so that the care of mothers and children, the most vulnerable members of the population, could be coordinated by obstetricians and pediatricians, nurses and midwives, nutritionists and health educators' (Williams et al. 1994:50). Early focus primarily associated with child health and FP (Rosenfield and Maine 1985). Tendency to link health interventions such as malaria control with social and economic development as health interventions viewed as a prerequisite to development because of economic and political benefits (Packard 1997:103-4). Development of new technologies made disease control relatively inexpensive. E.g. DDT developed for control or elimination of malaria (1997:99). Linkages between international health and development to entire populations not just productive workers as “the development of the so-called “underdeveloped world” was critical for the economic health of the industrialized world” (Packard 1997:97). After World War II, international action by WHO and the UN encouraged the development of a modern programme of health care and the founding of the Ministry of Health (MOH). A network of first aid post health centres and hospitals developed since then (Slikkerveer 1990:206), but these were still unable to supply the population with basic modern health care (1990:209).</td>
</tr>
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### 1970s-1980s

| Alma Ata Declaration on Health for All by the Year 2000 developed at the WHO/UNICEF conference in 1978. | Primary Health Care (PHC) focused on improving the health of people in developing countries. Essentially moved away from the Western biomedical model based on economic modernisation to a model of health care based on equitable distribution. The emphasis is on prevention; use of appropriate technology and a multi-sectoral approach that recognises that the requirements for good health cannot be met by the health sector (WHO and UNICEF 1978; Kloos 1998). It ‘is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable’ (WHO 1998). | PHC principles reflect the economic, sociocultural and political characteristics of each country. Includes aspects such as a) health is not the responsibility of the health sector alone, but is also affected by development activities such as education, housing, agriculture. Hence, a need exists to integrate all such development activities; b) development of self-reliance and social awareness through community participation; c) communities should define their needs and suggest ways of meeting them; d) decentralisation is necessary to meet needs and solve problems; e) community resources, financial and human can make an important contribution to health and development activities (Kloos 1998). One focus was maternal health through Antenatal Care (ANC) and training TBAs rather than costly curative services (Lush and Campbell 2001:181). | The focus of the socialist Dergue government was PHC. For the first time in Ethiopia, public health policy ‘gave priority to the development of rural health services, the prevention and control of the most common causes of morbidity and mortality and to the promotion of self reliance and community participation in health activities’ (Kloos et al. 1987:1004). Public health campaigns were run by secondary and university students and nearly 20,000 peasant associations were established along with a literacy, political and health education, vaccinations, training of rural midwives and the building of new health stations, latrines and wells (1987:1005). Under the Dergue population policy based on redistribution rather than fertility control (Kloos 1998:85). |

### 1976 - 1985

<p>| United Nations Decade for Women | Growing international interest in women’s rights and health including maternal health. | | |</p>
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<th><strong>1987</strong></th>
<th>Safe Motherhood Conference in Nairobi sponsored by WHO, the World Bank, UNFPA and UNDP. Safe Motherhood Initiative (SMI) launched also Safe Motherhood Inter-Agency Group (IAG): UNICEF, UNFPA, WHO, World Bank, International Planned Parenthood Federation, The Population Council, International Federation of Gynaecology and Obstetrics, International Confederation of Midwives, Safe Motherhood Network of Nepal, Regional Prevention of Maternal Mortality Programme (Africa), and Family Care International.</th>
<th>Safe Motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth (Safe Motherhood Initiative 2002). The objective was to reduce maternal deaths by half by the year 2000. Not achieved (FCI and IAG 1997).</th>
<th>Neo-liberal economic policies have also influenced policy makers at Ministries of Health in developing countries; two of the most cost-effective reforms addressed services for pregnancy-related care including preventing maternal mortality, and FP to prevent unwanted pregnancy and further reduce maternal mortality (World Bank 1993).</th>
<th>Maternal mortality in Addis Ababa estimated to be 566 per 100,000 live births (Kwast et al. 1986).</th>
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After 1991, Ethiopia began a process of reforming the health sector. Health policy was based on 'the fundamental principle that health constitutes physical, mental, and social well-being for the enjoyment of life and for optimal productivity' (CSA and ORC Macro 2001:2). In 1993/94 the government drafted an initial Health Sector Development Program (HSDP) designed for a period of 20 years with rolling five-year program periods.

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<th>1994</th>
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<td><strong>International Conference on Population and Development (ICPD) in Cairo</strong></td>
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<td>The ICPD focused on universal access (and a new definition) of reproductive health services which created 'an almost-feminist vision of reproductive rights and gender equality in place of the old population control discourse' (Petchesky 1995:152).</td>
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<tr>
<td>Highlighted high levels of maternal mortality in developing countries.</td>
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The new government's health policy was rural oriented with a decentralised political set up in place (Kloos 1998:100). Decentralisation of the MOH and State Health Bureaus run independently. New targets to reduce infant mortality, maternal mortality etc set by federal MOH.

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9 'Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases' (United Nations 1994). Programme of Action of the United Nations International Conference on Population & Development: Chapter VII - REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH: PROGRAMME OF ACTION OF THE UN ICPD: A. Reproductive rights and reproductive health: 7.2.5-13 September 1994. Paper read at United Nations International Conference on Population and Development (ICPD), at Cairo, Egypt.
WHO distinguishes three dimensions of reproductive health: as a human condition (including the level of health and related areas of well-being); as an approach (policies, legislation and attitudes); and as services (the provision of services, access to them, and their utilization) (Sadana 2002:407).

One PHC strategy for developing countries was the Three Delays Model for EmOC (Thaddeus and Maine 1994).

Ethiopia's first population policy (1993) emphasised reducing fertility from 7.7 children per woman to 4.0 children per woman; increasing the contraception rate from 4.0 percent to 44 percent; and, increasing the minimum age for marriage from 15 to 18 years by the year 2015 (Kloos 1998:85).

<table>
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<th>1995</th>
<th>Fourth World Conference on Women in Beijing</th>
<th>Highlighted high levels of maternal mortality in developing countries</th>
<th>Estimate that MM was 1,841 based on: the number of deliveries assisted by a skilled attendant (8 percent); general fertility rate (208 births per 1000 women); the number of deaths of women of reproductive age (120,145); number of live births (2,513,722); and predicted number of maternal deaths (46,268) (Hill et al. 2001:190).</th>
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<td>1997</td>
<td>Technical Consultation to review lessons learned from SMI held in Colombo, Sri Lanka</td>
<td>Highlighted lack of evidence that training TBAs or at-risk scoring at ANC reduces MM. Core message to ensure skilled attendance at delivery “having a health worker with midwifery skills present at childbirth, backed up by transport in case emergency referral is required” (FCI and IAG 1997).</td>
<td>Focus shifted to skilled care during delivery and the availability of emergency obstetric care programmes (EmOC) (De Brouwere et al. 1998; Kohlinsky et al. 1999; Lush and Campbell 2001; FCI and IAG 1997; WHO and UNICEF 2004; Shiffman 2003).</td>
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10 Selected quantitative studies on Safe Motherhood and Maternal Mortality not referred to in the thesis: Prolonged labour in rural Ethiopia (Berhane and Högberg 1999); Reasons for referrals and time spent from referring sites to arrival at Tikur Anbessa Hospital in emergency obstetric: A prospective study (Tadesse Kitilla 2003); A review of maternal mortality at Jimma Hospital, Southwestern Ethiopia found there had been no decrease in the overall rate from 1990 to 1999 with an overall rate for the period of 1,965 per 100,000 live births (Asheber Gaym 2000); Patterns of maternity care service utilization in Southern Ethiopia: Evidence from a community and family survey Assessment of rural and urban maternal health care utilisation: 21.4% of rural women and 73% of urban women received ANC. Only 1.2 per cent of rural deliveries were attended by trained medical personnel compared to 42.8 per cent for urban areas. Most health facilities lacked basic supplies and basic maternity equipment for delivery; basic consumable supplies; communication between health care facilities; and had inadequate management and procedures for resupply (Yared Mekonnen 2003); Obstructed labour in Adigrat Zonal Hospital, Tigray Region, Ethiopia (Amanuel Gessessew and Mengiste Mesfin 2003); Emergency obstetric performance with emphasis on operative delivery outcomes: Does it reflect the quality of care? (Yirfu Berhan and Ahmed Abdela 2004).
| **1999** | | | |
|---|---|---|
| Averting Maternal Death and Disability (AMDD) | Most obstetric complications that lead to maternal death cannot be predicted or prevented, but the vast majority of women can be saved through prompt emergency treatment. | Initially worked with developing countries to improve EmOC. Since 2006 AMD D recognized the critical role of health systems to achieve large-scale reduction in mortality, AMDD began to focus more intensively on the health systems barriers to equitable access to EmOC. New attention to the role of health systems and to addressing EmOC as a crucial part of the home-to-hospital continuum of care for women and newborns (AMDD 2010). |

| **2000** | | | |
|---|---|---|
| Millennium Summit (UN 2000). | Reduction of maternal mortality by three quarters by 2015 endorsed as a major international development goal. | Indicators to measure progress towards the MDG Five are the MMR and the proportion of births attended by skilled health personnel (United Nations Millennium Project 2002 - 2006). |

| WHO | Making Pregnancy Safer: A Health Sector Strategy for Reducing Maternal and Perinatal Morbidity and Mortality (WHO 2000). Focus is on improving the health system with attention on midwifery and health professionals throughout pregnancy, delivery and the postpartum period with referral to EmOC. Approaches safe motherhood from a humans rights perspective with a focus on equity. Seeks to keep Safe Motherhood high on the health and development agenda. | 2000 Ethiopian Demographic and Health Survey (DHS): Reasons women (with a child) did not seek health care: lack of money (over 70 per cent); no health facility nearby (27.0 per cent); not having permission to go (9.4 per cent); no transport (6.5 per cent); and not wanting to go alone (5.1 per cent) (CSA and ORC Macro 2001:126). MMR estimated to be 850 maternal deaths per 100,000 live births (range of uncertainty is from 500 to 1,200) (WHO, UNICEF and UNFPA 2004:23). DHS reported data from 1994 – 2000 and the estimated MMR is 871 (CSA and ORC Macro 2001:109). |
### 2001

UNICEF’s Eastern and Southern Africa Regional Office estimates Ethiopia’s MMR as 1400 with an estimated number of maternal deaths at 39,872 (UNICEF Eastern and Southern Africa Regional Office (ESARO) 2003:5).

### 2002/03

Health Services Extension Package (HSEP): health promotion and extension services to communities including MCH, FP, immunization, adolescent reproductive health, and nutrition. Two health extension workers HEWs assigned to each kebele (rural peasant association, neighbourhood or village level of administration) to promote prevention, hygiene and sanitation education, reproductive health information and services. HEWs liaise with PHC facilities for referrals, particularly for high risk pregnancies and EmOC. Ethiopian government also plans to upgrade existing health posts and construct new ones in 10,000 kebeles, employing a further 20,000 HEWs (World Bank and Ministry of Health Ethiopia 2005:85-6).

### 2004/05

SMI expanded to become the Partnership for Safe Motherhood and Newborn Health which aims to increase action through:
1. Political leadership and community engagement and mobilization
2. Effective health systems that deliver a package of high quality interventions in key areas along the continuum of care:
   - Comprehensive family planning

2005 DHS: Reasons women had problems accessing health facilities: concern there may not be a health provider (80.5 percent) or female provider (72.5 percent); concern about getting money for treatment (75.6 per cent); concern about transport (71.6 per cent); concern there would be no one to complete household chores (69.3 per cent); distance to a health facility (67.7), not
Skilled care for women and newborns during and after pregnancy and childbirth, including ANC, quality delivery care in a health facility, EmOC, postnatal care, and essential newborn care

- Safe abortion services (where legal)
- Improved child nutrition and prevention and treatment of major childhood diseases

3. Removing barriers to access, with services for women and children being free at the point of use where countries choose

4. Skilled and motivated health workers in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations

5. Accountability for credible results (Partnership for Maternal, Newborn and Child Health 2010).

| 2006 | High rates of maternal death and disability should be reduced through the transfer of modern health service interventions: health centre intrapartum-care strategy. All women should have access to skilled attendants at birth, referral for EmOC, and other strategies at the intrapartum period including antenatal and postpartum care, FP, safe abortion, and treatment for pre-existing ill health particularly from indirect causes such as infections, chronic disease or malaria (Campbell and Graham 2006). |

| National Reproductive Health Strategy (MOH 2006a)
Targets include:
- To increase proportion of births attended by skilled attendants to 60 percent.
- To reduce maternal mortality to 350 deaths per 100,000 live births by 2015 (MOH 2006a:18). |

| The Lancet published a series on maternal survival11. | wanting to go alone (61.4 per cent), and needing to get permission to go for treatment (34.5 percent) (CSA and ORC Macro 2006:121). Geographical access to modern health services in Ethiopia improved slightly with the average distance to the nearest health facility providing curative care decreasing from 8.8 to 7.7 km in 2000 (World Bank and Ministry of Health Ethiopia 2005:97). |

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11 Indicated that consensus had been building in the policy community about the need for both skilled attendants at birth and EmOC if needed. Called for deliveries to be attended by midwives in health centres, with other medical professionals present and higher levels of care available if needed (Shiffman and Smith 2007:1378).
<table>
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<th><strong>2007</strong></th>
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<td><strong>Women Deliver Conference in London</strong></td>
<td>Marked 20 years of the SMI and brought together education, health, development, equity, human rights, poverty reduction, and micro-finance sectors (Women Deliver: A global initiative 2007). Called for international policy and strategic attention and argued that maternal health impacts national economic productivity and development (Gill et al. 2007).</td>
</tr>
</tbody>
</table>
|  | HSDP III Objectives  
- To increase deliveries attended by skilled attendants from 12 to 32 percent  
- To increase family planning service coverage to 60 percent  
- To increase health post coverage from 20 to 100 percent.  
- To increase health centre coverage from 18 to 100 percent. |

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<th><strong>2008/09</strong></th>
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<td><strong>UNICEF/ UN FPA/ WHO/ AMD D/ MOH Ethiopia</strong></td>
<td>Draft National EmONC (EmOC with the addition of N for Newborn) baseline assessment to provide evidence for policy and planning to strengthen the health system using EmONC as a point of entry; to identify gaps and actions to be taken at the woreda (district administration, nominally around 100,000 people) and regional level.</td>
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<th><strong>2010</strong></th>
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<td><strong>The Lancet</strong></td>
<td>Argues for serious reflection on how the global health community responds to new data: when the paper by Hogan et al (2010) was submitted, &quot;we were invited to &quot;delay&quot; or &quot;hold&quot; publication because of: potential political damage to maternal advocacy campaigns; confusion among countries, policymakers, and the media, given the difference between this maternal mortality estimate and the previous UN number; undermining progress on global commitments to maternal health; and the risk of an unproductive academic debate while women continued to die&quot; (Horton 2010:1581-2).</td>
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<td></td>
<td>Hogan et al. (2010) constructed a database of 2651 observations of maternal mortality for 181 countries for 1980 – 2008, from vital registration data, censuses, surveys, and verbal autopsy studies and used robust analytical methods to generate estimates of maternal deaths and the MMR for each year between 1980 and 2008. Their estimate is that there were 342,900 maternal deaths world wide in 2008.</td>
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<tr>
<td></td>
<td>Estimate that the MMR in Ethiopia was 590 in 2008 (uncertainty interval 358 – 932) (Hogan et al. 2010:1618).</td>
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In accordance with international policy, Ethiopia’s National Reproductive Health Strategy 2006 - 2015 (MOH 2006a:16) states that a ‘key factor contributing to both high maternal and newborn mortality is the low rate of skilled care during pregnancy and delivery’ (2006a:16). Over 80 per cent of Ethiopia’s population live in rural areas with the vast majority of the population living more than 10 kilometres from the nearest health facility. According to the 2005 Demographic and Health Survey (DHS) (CSA and ORC Macro 2006), around seven in 10 mothers (72 percent) received no ANC for births in the five years prior to the survey. Of those who did receive ANC, 28 percent of mothers received it from a trained health professional (doctor, nurse or midwife), and less than one percent received ANC from a TBA (trained or untrained) (2006:111). Only 5.7 percent of births in Ethiopia are delivered with the assistance of a trained health professional and 28.1 percent are delivered by a TBA. The majority of births are attended by a relative or some other person (60.5 percent) and 5.4 percent of all births are delivered with no assistance at all (2006:118). In Kafa Zone in south-west Ethiopia, the results of a community-based baseline study showed that only 4.2 percent of women gave birth in a health institution or with the assistance of a trained health worker or trained traditional birth attendant (Habtamu Argaw 2002:19). The MMR was estimated at 738 per 100,000 live births using the sisterhood method\(^{12}\) and the lifetime risk of a mother dying in pregnancy or from complications related to pregnancy was estimated at 1 in 22 (2002:57). For Kafa Zone, the huge maternal health problems are not reflected in health service delivery data which show extremely low coverage and utilisation rates\(^{13}\).

\(^{12}\) The sisterhood method is an indirect method to assess MMR by using information from adults on the survival of their adult sisters.

\(^{13}\) More recent figures from the Zonal Health Department in 2007 (1999 E.C.), show delivery coverage for Kafa Zone as 28 percent and ANC coverage as 60.5 percent. I was told that the timing, completeness and reliability of these statistics was lacking. Combined with my observations in the field, I concluded that record keeping could be a hit and miss affair. Given that the majority of births are not attended by trained health professionals, this is a major shortcoming. I tend to agree that reliable and dependable information for decision making in health management is lacking in Kafa Zone (Habtamu Argaw 2002:1-2).
1.2 Research objectives

This thesis examines how reproductive health, in particular the goal of reducing maternal mortality and disability, fits into Ethiopia’s development agenda. Specifically, the four objectives of this study are:

1. To report the personal experiences of a group of women who are pregnant or have recently given birth in rural Ethiopia.
2. To identify the variables that influence their decision making when faced with the alternative options for the location of birth.
3. To compare the women’s experiences to the views of the staff at local health centres who provide ANC, normal delivery care and EmOC.
4. To examine maternal health within the broader development framework.

The thesis examines the impact of international reproductive health policies in rural Ethiopia. Following Hunt (1999:21), I started with three simple questions: Who is giving birth where, and why? Asking Who is the first key question because it is important to know Who are the women the National Reproductive Policy is intended to impact on if they are to have their births attended by skilled health personnel either at home or in a facility (MOH 2006a:18). Asking Where is an equally important question because although most women give birth at home it is important to understand where home is in relation to biomedical health facilities. Why do women give birth at home and only go to a health facility if there is a problem? To answer this question I attempt to look at some of the other factors that might influence birth location such as education and decision making about travelling to a health facility in the final chapter.

In stating these objectives, the focus of this study is on direct obstetric deaths, that is those arising from obstetric complications of the pregnant state and not indirect obstetric deaths that result from a previously existing disease or disease that developed during pregnancy. This is because the focus of the health systems approach is to provide skilled birth attendance and EmOC to reduce direct maternal deaths from conditions such as haemorrhage and sepsis.
1.3 The state of knowledge
1.3.1 Maternal health and reducing maternal mortality

The findings are clear: maternal death is preventable. Effective interventions are known. Investment in safe motherhood will reduce maternal and infant death and disability, contribute to the well-being of families and the community, and ultimately improve human development and enhance economic growth (World Bank 1999:v emphasis added).

Millennium Development Goal Five: To reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio (United Nations Millennium Project 2002 - 2006).

Much of the existing literature about maternal mortality and disability in developing countries focuses on describing the magnitude and causes of the problem; the difficulties in measuring maternal mortality\(^{14}\); the obstacles to Safe Motherhood; and the interventions needed to strengthen modern health systems. These 'health system factors' (Bullough et al. 2005) largely focus on 'levels of maternal mortality and morbidity [that] tell us about the risk attributable to pregnancy and childbirth as well as the performance of health systems in terms of access to health care and the quality of care provided' (Gülmezoglu et al. 2004:16; see also WHO et al. 2004:14). For example, in Malawi, maternal mortality is estimated to have nearly doubled to 1,120 per 100,000 live births between 1992 and 2004 (McCoy et al. 2004:2). HIV/AIDS partially explains the rise in maternal mortality, but 'the deplorable doubling of maternal mortality is as much a crisis of the entire health system as it is a crisis of maternal health services' (2004:24). Around 15 percent of live births are expected to develop serious obstetric complications (WHO 1994:18; Thaddeus and Maine 1994; see also Bang et al. 2004 which validates this percentage through an observational study in India; Khan et al. 2006; The Partnership for Maternal 2006:67). Of these, around 75 percent of maternal deaths arise from direct obstetric causes: haemorrhage, eclampsia, obstructed labour, infection, toxaemia and

\(^{14}\) A number of studies for the WHO, UN and UNFPA document the difficulties in measuring maternal mortality and conclude that reliable estimates of the dimensions of the problem are not generally available (WHO et al. 2007; WHO et al. 2004; AbouZahr and Wardlaw 2001; Hill et al. 2001). AbouZahr and Wardlaw (2001) describe some of the problems of using assistance of a skilled attendant at delivery as a process indicator. These include a lack of unequivocal epidemiological evidence; problems of definition to define skilled attendant; and a lack of trend data. The report by WHO, UNICEF and UNFPA (2004) stresses that the margins of uncertainty are so large and the strategies deriving the estimates between countries so varied that estimates should not be used to monitor short-term trends or cross-country comparisons (WHO et al. 2004:2). It concludes that the intention of the estimates is to draw attention to the existence and likely dimension of the problem of maternal mortality thus stimulating 'greater awareness of and attention to the challenge of measuring maternal mortality' (2004:13). This is clearly evident in the case of Ethiopia.
unsafe abortion\textsuperscript{15}; it is argued that the majority of deaths could be prevented with timely medical treatment (McCarthy and Maine 1992; Khan et al. 2006). In other words, the imperative has been to reduce maternal death and disability in developing countries through development based on the superiority of Western technology and its success with biomedicine and the transfer of these ‘techniques that were instrumental in reducing maternal mortality in industrialized countries’ (De Brouwere et al. 1998:771). A major consequence of the development of maternal health services means the location of birth must change: from home delivery where birth takes place without the assistance of trained health providers to facility based delivery and the medicalisation of maternity care (Koblinsky et al. 1999:404). It is for this reason the MMR implies a lot about the performance and functioning of health care systems and an increasing number of studies point to maternal health indicators being closely associated with key service delivery issues: because maternal health services depend on the functioning of the entire health system, they have been used to assess the functioning of health systems and proposed as a measure of the performance of a country’s health system (Graham 2002:703; Gill et al. 2007:1353-4; Gülmezoglu et al. 2004; WHO, UNICEF and UNFPA 2004:14; World Bank 1999:2). So despite the problems in measuring maternal mortality and the lack of vital registration systems in most developing countries (WHO 2004:4), the indicators to measure progress towards MDG Five are the MMR and the proportion of births attended by skilled health personnel (United Nations Millennium Project 2002 - 2006): where MMR is high, ‘one must conclude that the health care system is dysfunctional, either in terms of providing adequate access to care or in the quality of care provided, or as is most likely a combination of the two’ (WHO 2004:14).

Even though there has been international consensus about the need to prioritise maternal mortality as a health issue, there has not been consensus about what to do about it. The maternal and reproductive policy community has been driven by a relatively small set of actors with particular ideologies: FP policy, PHC, neo-liberal economic policies and women’s activist groups (Lush and Campbell 2001). From the start the various groups grappled with disagreements and tensions about strategies and

\textsuperscript{15} Around 13 percent of maternal mortality results from complications from abortion. This study examines the direct causes of maternal mortality (haemorrhage, eclampsia, obstructed labour, infection, toxaemia) after labour has started. According to Ipas (a leading provider of reproductive health services in Ethiopia), more than half of the annual 20,000 maternal deaths are caused from unsafe abortion and abortion with sepsis being the sixth leading cause of hospital admissions for Ethiopian women and girls (Ipas 2008).
interventions (Shiffman and Smith 2007): preventing maternal death is not as simple as it is for other conditions such as vaccine preventable diseases but ‘most argue that functioning health systems are crucial. Disagreement exists about the actual degree of complexity of the necessary interventions and the strength of the evidence base for these interventions and their cost’ (2007:1377), particularly when facility based interventions do not reach the poorest households. Nevertheless, the proponents of skilled attendance and EmOC have now attempted to bridge their differences (2007:1378)\textsuperscript{16}. While some researchers maintain that social, cultural and individual factors influence maternal mortality and others argue they ‘are beyond the control of an action program’ (Ross and Begala 2005:60); others question the focus on clinical health service strategies because they are poorly implemented or lack an evidence base... are based mostly on low-grade evidence derived from retrospective and observational studies... [and are] focused on providing evidence for clinical decision-making... Gender equity and traditional culture must be taken into account to improve maternal health... We must look beyond the difficulties that pregnant women may face in accessing health services to develop a broader framework that includes socio-cultural and political contexts as well as other structural boundaries such as access to health services (Gil-González et al. 2006:903 and 906-7).

There has been an increasing number of research studies that argue for a need to take a more comprehensive perspective to understand the problems of maternal mortality and include ‘the macrostructural— i.e. the social, cultural, economic and political— determinants of health’ (Gil-González et al. 2006:904) as service availability alone is not enough to increase utilisation and reduce maternal mortality (Barker et al. 2007:85). Some studies emphasise the need for allowing the macrostructural and health factors to be integrated into one analysis, starting with the premise that the expansion of modern scientific and technological ‘progress’ in developing countries will overcome particular problems such as population management, disease prevention and maternal health (Pigg and Adams 2005:1). The next section describes a number of these studies.

1.3.2 Structural factors that may shape maternal health outcomes

In the early 1990s, Thaddeus and Maine (1994) developed the Three Delays framework which remains influential today. Based on PHC principles, it focuses on the interval between the onset of an obstetric complication and its outcome and allows analysis of

\textsuperscript{16} On the disagreements and tensions about strategies and interventions, note the comments by Horton (2010) when The Lancet was invited to “delay” or “hold” publication of new data in 2010 (see Table 1).
the institutional and economic considerations that play in the decision to seek care (1994:1098). Delay is identified as a pertinent factor contributing to maternal deaths (1994:1092). The First Delay is the delay in deciding to seek care during an obstetric emergency; this decision is influenced by cultural and socio-economic factors such as who makes decisions at household levels, but also by factors that shape decision making such as cost, distance, and perceived quality of health care at the health facility. The Second Delay is the delay in reaching a medical facility which is related to accessibility and options for transport including time and cost. These delays are common in rural areas. Delay Three delineates delays in receiving appropriate treatment in a health facility. This is mainly related to the quality of care, adequacy of the referral system, and shortages of supplies and equipment. This framework also allows analysis of the commonalities in the women’s experiences rather than emphasising the unique and peculiar aspects of individual cases: for this reason the framework was used to examine maternal mortality in Haiti (Barnes-Josiah et al. 1998:990). I used the Three Delays as an early framework to conceptualise my fieldwork and prepare a report for local government and NGOs (Jackson 2007). The Three Delays are referred to in most chapters in the thesis but due to the overall importance of the Second Delay, location and distance are treated in detail in Chapter 3. Cultural and socio-economic factors that shape decision making (Delay One) are discussed in Chapter 4. The role of the health workers and the difficulties they experience providing adequate and appropriate care (Delay Three) are discussed in Chapter 5.

Shiffman (2000) analysed maternal mortality and disability change by focusing on health, wealth and empowerment perspectives. The ‘health perspective’ promoted by Safe Motherhood advocates was based on the presumption that targeted health interventions such as ANC, FP, skilled attendants at birth and EmOC will reduce maternal mortality and disability. Proponents of the health perspective do not believe that either broad-based socioeconomic change or the empowerment of women will significantly reduce

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maternal mortality. By comparison, the ‘wealth perspective’ is more pessimistic: if maternal mortality change lies in economic development, then poor countries will have to wait many years for this to happen (2000:276; see also Bulatao and Ross 2003). Because maternal deaths occur predominantly in poor countries, the standard-of-living argument that parallels classical economic demographic transition theory concerning fertility argues that the key to transition lies in socioeconomic progress: better nourished mothers are less likely to suffer delivery complications; resources will be devoted to public health systems that can address maternal health issues; educated women are more likely to seek appropriate medical care during pregnancy and delivery; higher women’s status means that women’s lives are valued during pregnancy and childbirth; and finally, wealthier women have less children and will have a lower lifetime risk of maternal mortality and disability (Shiffman 2000:276-7). Shiffman and del Valle (2005) further point out that economic development may influence government capacity to improve population health, establish Safe Motherhood programs and support transport infrastructures that enable women in remote areas to reach health facilities in the event of complications (2005:7-8).

The ‘empowerment perspective’ focuses on the position of women in society rather than appropriate health services or raising the general standards of living (E.g. Hogan et al. 1999; George et al. 2005). For example, Sen et al. (2006) reviewed trends and changes in the international policy environment to explain why progress has been slow and inconsistent. Drawing on historical and contemporary evidence, the study illustrates how many pregnant women, mothers, and their newborn children are treated poorly because they are poor, have lower social status in terms of caste or race/ethnicity and because they are women. It is argued that these root causes have been responsible for policy inattention despite pronouncements to the contrary at different times. Shiffman (2000) also argues that women’s status is seen as an important determinant of maternal mortality levels for three reasons. First, national leaders will devote more attention and resources to the health of women; second, women’s lives will be valued by the community and actions will be taken if complications arise during pregnancy or delivery; third, women will have access to education. This means they will be more likely to have skilled attendance at the birth of their babies, eat nutritious foods and practice healthier
behaviours during pregnancy. Finally, women are likely to have fewer children which reduces their lifetime risk of maternal mortality and disability (Shiffman 2000:277).

The health, wealth, empowerment analysis shows that devoting resources to health care and delivery assistance may make a difference to maternal mortality levels; the proportion of women receiving trained assistance at delivery and the percentage of GDP spent on health services are both statistically significant in reducing maternal mortality levels (2000:283). The conclusion is that the most critical interventions are educating women, prioritising health care and 'ensuring pregnant women have access to appropriate medical services' (2000:286). These issues are explored in Chapter 6.

Nevertheless, Shiffman and del Valle (2005) also argue that scholars need to consider history and social structure in their explanations concerning maternal mortality. Research directed towards health service interventions should also focus on factors more readily manipulated by government and human action. If our goals in maternal mortality research extend beyond intervention to include explanation, however, we must consider factors deeper in the causal chain that are not easily altered by human agency (Shiffman and del Valle 2005:2).

In Ethiopia, Yemane Berhane (2000) points out that health problems that are prevalent in low-income countries result from many complex and often inter-related adverse conditions; for interventions to succeed they must take these complex factors into account or they are bound to fail (2000:5). A study of rural women in Butajira in rural south central Ethiopia showed that women’s access to health services is restricted by distance and lack of transportation, poor social status, poor organisation of health services, lack of experienced health workers and inadequate equipment (Yemane Berhane et al. 2001:1537). Both Molesworth (2005) and Gil-González et al. (2006) argue that the cost and lack of transport have been found to be deterrents for poor rural women to access delivery in health facilities: if maternal death is directly related to the distance between women’s homes and health facilities, ‘other factors such as infrastructure, transport and social services’ should be examined to see how other ‘government departments, not only health, should also be involved in tackling the problem’ (Gil-González et al. 2006:907).

Given the interplay of complex structural factors in these studies, a key issue in the present study is how to frame reproductive health strategies and include the social, cultural, economic and political determinants of health in rural Ethiopia. Because most
women give birth at home, my approach has been to study a group of women who were pregnant or had recently given birth (Chapter 4), and where they live and work in semi-urban and rural Kafa Zone (Chapter 3). Chapter 5 describes how ‘normal’ birth generally starts at home and how women are assisted by close neighbours or relatives. Despite individual variations, women’s interaction with the biomedical health system during pregnancy and delivery is generally only through ANC or if there is a serious problem during birth. Yet the many challenges for staff in rural health facilities reveals the ‘distance’ between international policies, strategies, and realities on the ground. This is not only due to the physical distance but seemingly unambiguous concepts such as ‘the proportion of births attended by skilled health personnel’ which has its own empirical limitations for the women who seek care too late for the midwife or doctor to be able to provide life saving care. In fact, higher rates of maternal mortality are likely to be seen initially as the sickest women seek care, but over time as coverage increases, as more women who are less at risk seek care, the average mortality in those seeking care will decrease (Ronmans et al. 2010:292). Until then, the Reproductive Health Strategy which aims to ensure that reproductive health (and the goal of reducing maternal mortality and disability) is on the national development agenda is often limited by a number of complex structural factors that delay health seeking behaviour and the capacity of existing health care workers to assist or refer women with complications to appropriate health facilities (Chapter 3).

1.3.3 The economic context and international development

As a phenomenon of contemporary history, modern development theory was conceived after World War Two following the reconstruction of Europe by way of the Marshall Plan, along with the establishment of the International Bank for Reconstruction and Development (later the World Bank), the International Monetary Fund (IMF) and the UN. Before World War Two, what is now called development was dominated by colonial administrators, trading companies and missionaries. But the ‘concept of development became a framing device bringing together a range of interventionist policies and metropolitan finance with the explicit goal of raising colonial standards of living’ (Cooper and Packard 1997:7), thus creating the space for international development and official development assistance to be administered (Remenyi 2004:23). It was also
the best way for colonial, and then ex-colonial, states to accelerate national economic growth... the goal of development was growth; the agent of development was the state and the means of development were... macroeconomic policy instruments (Leys 1996:7).

The use of the word ‘underdeveloped’ by United States President Truman in his Inaugural Address euphemistically named ‘economically backward’ areas and invoked the need to escape from the condition of underdevelopment to one of development (Rist 2002:70-76; Esteva 1992:6-7). The semantics around the terms developed and underdeveloped were largely organised according to the dichotomy of coloniser and colonised (Rist 2002:73), and the new way of dividing up the world was based on the Cold War and the desire to save the newly decolonised nations from Communism. Large scale development assistance began based on a developing country’s commitment to either ideology. But the changes were much more than semantic. Underdevelopment was not the other side of the coin to development. Development was the new global strategy that would use ‘technical measures outside the realm of political debate, utilization of scientific knowledge, growth of productivity, expansion of international trade’ (2002:78), while at the same time relieving the suffering of half the people in the world who live in conditions of misery with inadequate food, disease, primitiveness and stagnation18 (2002:71). As countries in the developing world, which were seen to be simple, backward and unchanging, moved through stages of development to become complex and dynamic in their social, cultural and economic organisation like those of the developed world or the West (Tucker 1999), the process of change introduced a dichotomy between ‘traditional’ and ‘modern’ societies. Traditional societies which were generally agricultural in nature needed to become modern; the path to development and modernity involved moving through a set of staged changes to result in an industrialised urban based economy. If modernisation justifies capitalism, then one of main arguments of dependency theorists was that modernisation and capitalism created a situation where developing countries were dependent on foreign capital rather than on their own resources and citizens (Törnquist 1999:65).

Modernisation theory dominated development in the 1950s and 1960s and the emphasis for developing countries was on economic growth. Growth in Gross Domestic Product (per capita gross domestic product or GDP) and Gross National Product (GDP plus all net income earned abroad or GNP) was the measure of development that would

18 An extract from President Truman’s speech cited by Rist.
eventually ‘trickle-down’ to benefit entire populations in developing countries. Economic growth was equated to modernisation; it was to be achieved through capital investment, technology, urbanisation and industrialisation and large scale development projects such as dams and roads. Government planning to structure the economy, promote industrialisation and accelerate the rate of growth was seen in part as a solution to problems of low investment and slow industrialisation (Little 1982). From the Western point of view, modernisation would bring democracy as well as economic growth (Leys 1996:10). Other stated motivations for development now range from humanitarian interest to enlightened self-interest as development expands markets for the goods and services of industrialised donor countries (OECD 1996:6). Contemporary examples include the Royal Netherlands Embassy which cites the Ethiopian emerging markets as providing good opportunities for Dutch businesses (Royal Netherlands Embassy Addis Ababa n.d.), and United States Agency for International Development (USAID) which aims to achieve ‘a more secure, democratic, and prosperous world’ (USAID 2006:18). More recently, issues around regional and global security have been highlighted as violent conflict and state fragility have been identified as major development challenges. The 2011 World Development Report will focus on these issues (World Bank 2010).

Over time, the process of defining and measuring development has also undergone significant evolutionary change. By the 1970s it became clear that the benefits of modernisation had not trickled down to the rural poor and a new approach was needed. With a new focus on poverty alleviation, the new development path was defined by the International Labour Organization (ILO) and called for increased development assistance targeting essential human needs in literacy, numeracy and health:

Basic needs, as understood in this Programme of Action, include two elements. First, they include certain minimum requirements of a family for private consumption, adequate food, shelter and clothing, as well as certain household equipment and furniture. Second, they include essential services provided by and for the community at large, such as safe drinking water, sanitation, public transport and health, education and cultural facilities (ILO Office Bulletin 1977 cited in Rist 2002:164).

GNP and GDP per capita as measures of economic growth of a country are limited indices that do not reflect the social, cultural or political factors of a developing country. The Human Development Index (HDI) was devised in 1990 to measure three basic goals of human development: longevity (measured by life expectancy at birth); education
(measured by adult literacy and mean years of schooling); and, standard of living (measured by real income per capita in purchasing power parity dollars). Since then the Human Development Report (published annually by the UNDP) has included other variables such as gender and poverty related indices that can stimulate further debate about the process of human development. As Todaro and Smith (2009) note, the HDI allows nations to take a broad measure of their development performance and force economic and social policies more directly on those areas in need of improvement such as maternal or infant mortality, adult literacy or the percentage of the population with access to safe drinking water. The HDI also greatly improves understanding of which countries are succeeding and how significant groups within a country are participating in that development (2009:54-6).

In the early 1990s, the World Bank and the UN once again began to promote human development while remaining firmly committed to economic growth as the only way to achieve human development (Braidotti et al. 1994:17-20). But the early economic growth seen in the early 1990s came to a dramatic ‘bust’ in 1997 with the Asian economic crisis that brought recession to most of the developing world. Consequently, interest in the role of the state became a focus of development as the World Bank focused on good ‘governance’ along with minimal, efficient state institutions and an increased role for civil society including NGOs, transparency and accountability, decentralisation and participation in public life (World Bank 2000). The influence of these factors in Ethiopia is discussed in the next section.

Corbridge (2007) argues that ‘the most influential critique of development studies’ (2007:182) since 1980 has come from the neo-liberal Right or neo-liberal school of economics who questioned the agenda for development and gave rise to a free market management approach. The IMF and World Bank sponsored Structural Adjustment Packages (SAPs) were advocated as the new orthodoxy for debt ridden developing countries who now found themselves dealing with policies that forced them to remove external imbalances of payment and remove social services, including basic health and education, to their own people so the country could service overseas debt and create an environment conducive to foreign investment. As the role of governments became more clearly stated or dismissed, market failure was seen as the result of excessive government intervention in economies (McKay 2004:61-2). Other critics argue that this
process, along with the consortia of other agencies such as the UN High Commission for Refugees and the UN Food Programme, was a ‘de facto’ recolonisation of Africa (Leys 1996:195) because of the excessive power residing in the external financial institutions and donor agencies (Riddell 1992:68). Abbink (2000) points out that Ethiopia’s overdependence on external aid alongside the top down donor country pressures often results in ill-conceived development policies and an erosion of the sociocultural order and the neglect of local societies. He cites mass tourism with its commodifying approach and commercial farming at the expense of peasants and pastoralists’ land rights that makes the impact of globalising agents all the more pervasive (2000:8-9).

According to Schech and Haggis (2000), much of the research in development studies has been critical of development policy and its failure to provide practical alternatives to deal with the empirical problems of poverty and deprivation in developing countries (2000:79). For example, in the 2009 World Development Report (World Bank 2008b), per capita output increased in countries such as Australia and the United States by 65-fold over the past 500 years compared to only threefold in Africa. In the poorest countries (many in Africa) income declined by five percent in the 1990s (2008b:110). Since the adoption of the International Development Targets, and their successor the MDGs, a growing number of publications have presented estimates of development outcomes in 2015, the target year for most of the goals. What most these projections show is that the developing world as a whole is ‘off track’ with respect to most targets. They will not, in aggregate, be met and many countries will fall far short and the MDGs seem set to pass into history as another set of missed development targets (White and Blöndal 2007:1). Recent estimates show that Africa is overtaking South Asia as the region with the largest number of those living on less than a dollar a day, and by 2015 half of those below this poverty line globally will be in that region. The prospects for most of Africa meeting the MDG of halving income poverty seem remote (2007:7).

Some of the critique of development has been centred on the idea of post-development theory which argues that the development project is inherently a tool of Western hegemony based on the exercise of power over people in developing countries (Escobar 1992, 2006). The alternative that is suggested is that social movements should reject the Westernisation of development projects while encouraging people to determine their
own future. As Kiely (2006) points out, it is unclear if that means rejecting all social projects that expand basic needs or encourage political participation as ‘both the means (Westernise through technology, aspirational values or market forces) and the ends (the West as ideal) are problematic’ (2006:399). Moreover, ‘a commitment to development needs to be separated from a commitment to modernisation theories, and the debate continues to take place within rather than outside the discourse of development’ (2006:399 emphasis in original). Chapter 6 explores the meaning of development for government staff and the staff of NGOs in Kafa Zone.

1.3.4 The growth of the NGO sector

When optimism about economic growth and modernisation declined in the 1960s and 1970s, development theory began to focus on alleviating poverty and working directly with the poor using ‘bottom-up’ processes and focusing on ‘participatory development,’ ‘empowerment’ and ‘democracy’. The emphasis shifted to include social movements as the fundamental agents of social change and to include non-state actors including NGOs in the development process (Rugendyke 2007:6). The growth of NGOs, supported by bilateral and multilateral donors willing to finance development projects in health, education and economic development and so on, has resulted in their alignment with liberal democratic theory and neoliberal economics. This is not necessarily because NGOs promote capitalism and economic growth but because the neoliberal agenda supports minimal state intervention, and because markets and private enterprise are seen as more efficient for economic growth and service provision: ‘the state is a negative, and civil society equally a positive actor; that state-civil society relations are hostile and zero-sum; and that ‘genuine community’ action is sufficient for development, whilst political activity is to be avoided’ (Vaughan and Tronvoll 2003:62). For this reason, official agencies support NGOs to provide welfare services to those who cannot be reached by the markets; the result being that NGOs are now the preferred channel for providing services rather than the state (Hulme and Edwards 1997:6). Hulme and Edwards (1997) argue that the growth of NGOs and NGO funding has increased the likelihood for NGOs to implement donor policies. This conditionality means that ‘he who pays the piper calls the tune’ which means ‘entering into agreements about what is done, how it is to be reported and accounted for’ (1997:8).
As both donors and the state take a greater interest in the NGO activity and make efforts to influence it, whether directly or indirectly (1997:12), NGOs are also seen as a vehicle for democratisation which is an essential component of a thriving 'civil society' essential factor of the new economic agenda. This linkage between civil society and democratisation is seen as important for the creation of accountable systems of governance and the respect for human, political and economic rights (CRDA 2006:4). NGOs have the capacity to involve diverse groups of people and can be seen as a more legitimate system of governance as the broader the participation in the political process, the more legitimate the system of governance: a more pluralistic and diverse civil society will involve more people in the development process and reduce their dependence on the government (Clark 2000:15). Clark's (2000) report (on behalf of the World Bank), reiterates the complementarity of the priorities of the various NGOs with the strategies being pursued by the Ethiopian government and other official international development agencies including the World Bank. Poverty alleviation and international development are central to those strategies and to the work of the NGOs including the NGO sector in Ethiopia so 'it is virtually impossible to refute the basic orientation of their efforts around these objectives' (2000:16) as they focus on investment in education, health, population, food security, water supply and so on. Thus 'civil society' describes the positive aspects of NGOs and other organisations involvement in 'non-state associational life which can be mobilised for social political and economic development' (Vaughan and Tronvoll 2003:62).

Both the government and NGO sector in Ethiopia are concerned with development and provide service delivery in economic development, education and health at the grassroots. Some NGOs provide services or are directly involved in implementing government policy while others are more concerned with advocacy and the nature of development although there is not a strict division between service delivery and advocacy. There is a widely held view amongst NGOs and other institutions of civil society in Ethiopia that the government should not build civil society but create an enabling environment for civil society to thrive in as these groups should be independent of the state and promote diverse interests in society (Muir 2004:41). Yet community service organisations including NGOs are expected to provide more accountability around service provision as there is a widening space for civil society actors to support
continued democratic evolution in Ethiopia which is the rationale for the expanded partnership between the World Bank and the NGO sector (Clark 2000:16).

Despite the greater interest in the roles of NGOs, there is a long history of an uneasy, uncomfortable and suspicious relationship between NGOs and government in Ethiopia (Harrison 2002:596; Vaughan and Tronvoll 2003:64), characterised by the government’s suspicion of undesirable ‘inefficiency’ and ‘competition for hearts and minds’ and other concerns about NGO corruption, lack of understanding about social transformation and the need to work outside of major cities, and the ability of NGOs to pay higher salaries than the civil service (2003:64). This relationship does not appear to be getting ‘progressively better’ (CRDA 2006:36 emphasis in original)19. The number of NGOs has increased from 70 in the post-Dergue era in 1994 (Dessalegn Rahmato et al. 2008:12), to include many voluntary organisations and international and national NGOs ranging from civil society organisations, religious groups, adoption agencies and professional associations, many of whom are also engaged in activities concerning governance, human rights and advocacy. In sum, there were 2,305 registered civil society organisations and NGOs in 2008, but it is likely the number is closer to 3,000 as this data does not include organisations registered by regional and zonal authorities (2008:13). At the same time, a number of the Ethiopian NGOs are closely aligned with the government:

the political mobilization activities of the EPRDF have been aimed at the development of community-based structures which fed directly into the administrative and developmental systems of local government and party. They were not, per se, directed at the encouragement of independent associational life at local level, as is commonly understood (Vaughan and Tronvoll 2003:68).

Following the contested elections in 2005, there were public protests, mass arrests and ‘an increasingly polarized climate that created continuing risks for the country’s

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19 There was considerable apprehension about new levels of surveillance for NGOs in Ethiopia after the Ministry of Justice revised version of the Charities and Societies Proclamation of June 2008. For example, the Christian Relief and Development Association’s (CRDA) (an umbrella organisation with 283 members) June-July 2008 newsletter discussed at length their concerns about the classification of NGOs on the basis of their funding source (foreign/international or domestic) and the prohibition of foreign or foreign funded NGOs from local politics and advocacy (CRDA 2008). Amnesty International was also deeply concerned that the government’s ‘increasing intolerance of the work of human rights defenders and civil society organizations... would seem to be a ploy by the government to conceal human rights violations and prevent public protest and criticism of its actions’ and argued that this move aims not only to ‘undermine and frustrate the work of independent civil society organizations in Ethiopia but also to bar foreign non-governmental organizations (NGOs) such as Amnesty International from operating in the country’ (Amnesty International 2008). Given the limited funding opportunities in Ethiopia, local civil society organisations will find it difficult to exist without external funding. The Proclamation for the Registration and Regulation of Charities and Societies was passed on 6 January 2009.
development agenda’ (World Bank 2006), that challenged the relationship between NGOs and the Ethiopian government. Budget support to the Ethiopian government was suspended and key donors such as the World Bank withheld direct budget support to the federal government. Funds were to be transferred directly to the woreda level, to regional governments where some money would be spent on capital works, and then to the federal government: each woreda ‘will be allocated funding through a strict monitoring programme, under the supervision of the World-Bank-led PBS [Protection of Basic Services] project’ (OECD 2007:257).

The US$236 million World Bank PBS budget was supported by other development partners including the African Development Bank (ADB), the Irish and Netherlands governments, Canada International Development Agency (CIDA), Department of International Development UK (DFID), the German Development Bank and the European Commission. The PBS aims to protect basic services in health, education, agriculture and access to safe water20. In some sectors such as health, the NGO sector in Ethiopia provides considerable resources towards the government’s poverty reduction strategies: 44 percent of the health budget is funded by government and donors with 56 percent being funded by NGOs, the private sector and communities (although the community contribution is mainly in kind support) (Dessalegn Rahmato et al. 2008:65).

In total, a large number of bilateral and multilateral donors provide ODA to Ethiopia, with 25 averaging more than US$5 million per year in ODA from 2005 to 2008 (World Bank 2008a).

On the one hand, some feel that the ‘competition for resources’ has resulted in resentment towards NGOs as a ‘system of parallel (outside of government) resource provision’ (CRDA 2006:27). The PBS project also focuses on the improvement of citizens’ understanding of regional and woreda budgets to ensure services are more accountable to the citizens they serve and provides support for citizens and community service organisations to engage in social accountability and service delivery (CRDA 2006:17). On the other hand, the Ethiopian government accepts that NGO activity brings additional funding, but at the same time it does not want to see its legitimacy

20 The PBS in health are malaria control, reducing infant mortality through vaccines, improving the delivery of primary health services, family planning and strengthening the health system and will cover the shortfall in commodity support and system strengthening (World Bank 2007b:11).
weakened or undermined and is highly suspicious of outsiders providing state services that reduce state control over resources and services and strengthen the case for public sector reform (Hulme and Edwards 1997:14).

Chapter 6 examines the role of government and NGOs in Kafa Zone.

1.3.5 Economic development and development of the health sector in Ethiopia

After the collapse of the socialist Dergue in 1991, Ethiopia began to move to a market economy when the transitional government adopted a standard structural adjustment programme with a US$657 million World Bank economic recovery and reconstruction programme. This was followed later that year by structural adjustment credits (Economist Intelligence Unit (EIU) 1998:16) and with further disbursements in 1996 and 2001. In 2004 Ethiopia received debt relief from the Heavily Indebted Poor Countries Initiative (HIPC) (US$6 billion) and in 2006 the IMF cancelled Ethiopia’s debt amounting to about US$161 million (IMF n.d.). Private investment in Ethiopia has been slowly increasing but government investment accounts for about 60 percent of total investment much of which has been financed by donors (OECD 2007:256). In actual fact, Ethiopia is dependent on Official Development Assistance (ODA) from multilateral, bilateral and NGO sources. In 2008 this amount was US$3,327 million equating to 12.5 percent of net ODA/GNI (OECD n.d.). From 2005 - 09 the IMF did not give any financial assistance program to Ethiopia but was involved in yearly surveillance, balance of payments support and technical assistance. However, during the global recession of 2008 - 09 Ethiopia received US$106,960,000 from the IMF (IMF 2009).

At a national level, the absolute number of poor people declined from 28,063,909 in 1999/00 to 27,523,414 in 2004/05 (United Nations Economic and Social Council (UN ECOSOC) 2007:19). With the current growth rate of 3.0 percent, about 19.6 million people will be categorised as absolute poor in Ethiopia in 2015 (down from 40 to 23 percent from 2000 - 2015) but the persistent burden of poverty emphasises the need for reinforcing pro-poor sources of economic growth (Dorosh and Thurlow 2009:13). Ethiopia’s Plan for Accelerated and Sustained Development to End Poverty (PASDEP) 2005 - 2010 is the second phase of the Sustainable Development and Poverty Reduction
Plan (the first phase covered 2000/01 - 2003/04). PASDEP concentrates on seven sectors: agriculture and rural development (the Agricultural Development Led Industrialization (ADLI) strategy is the government’s key policy response to Ethiopia’s food security and agricultural productivity challenge); education; health; water and sanitation; roads; urban development; private sector and trade issues, as well as three cross-cutting areas: gender; HIV/AIDS; and population (UN ECOSOC 2007:xi).

The key areas relevant to this study are health (this chapter and Chapter 5); education (Chapter 6); and a number of the infrastructure projects designed to achieve ADLI’s objectives especially in roads, energy and water and sanitation. In particular, the Road Sector Development Programme (RSDP) which was designed to integrate isolated rural communities with regional and national markets has resulted in a significant increase in the total road network of the country and the proportion of roads in good condition. Of the RSDPII (2002/03 - 2004/05) targets, 5,561 kms of roads were built of which 1,276 were new rural roads. Road density rose from 32.3 km/1,000 sq/km to 33.6 km/1,000 sq/km (OECD 2007:262). The length of high voltage transmission power lines increased from 9,512.9 kilometres in 2001/02 to 13,798 kilometres in 2003/04 and 25,000 kilometres in 2004/05. The number of telephone users increased to 620,000 for regular fixed telephone lines, 410,630 for mobile phones and 17,375 for internet lines by the end of 2004/05 (OECD 2007:263) (Table 2).

**Table 2: Infrastructure Development**

<table>
<thead>
<tr>
<th></th>
<th>Base Line Achievements by end of 2004/05</th>
<th>PASDEP Target (2009/10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time taken to all-weather road (hours)</td>
<td>5.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Road density (km/1,000 km²)</td>
<td>33.2</td>
<td>54.1</td>
</tr>
<tr>
<td>Population with access to electricity (%)</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>Population with access to telecommunication center/services (within 5 km radius) (%)</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Number of kebeles with telephone access</td>
<td>3,000</td>
<td>15,000</td>
</tr>
</tbody>
</table>

Source: UN ECOSOC (2007:6)
Prior to 1974, modern health services in Ethiopia covered around 20 percent of the country and most of the care was curative (Kloos et al. 1987:1004). The focus of the Dergue was PHC following the Alma Ata Declaration on Health for All by the Year 2000 (Table 1). Under the Dergue, the MOH ‘formulated a policy that emphasized both disease prevention and control, priority to rural health services, self-reliance and community participation’ (Kloos 1998:92). The plan was to develop a six-tiered health service with 36,000 community health services each run by community health agents and a trained TBA (TTBA) but there were numerous problems over the next 17 years: the urban bias for health services continued; there was a lack of community support as the centrist and authoritarian bureaucratic traditions deterred community participation; health expenditure did not cover recurrent budgets; and utilisation rates of health services rapidly decreased away from hospitals, health centres and health stations (1998:92-99).

In 1991, the transitional (and then elected and still current government) began the ‘daring experiment of decentralisation and democratisation’ (Kloos 1998:88). Unlike the central, top-down approaches of previous governments in Ethiopia, the government’s stated health policies signaled a new political and social environment that incorporates democratisation, decentralisation, inter-sectoral collaboration, and the promotion of the private sector and NGOs in health care: decentralisation is a way to bring about democratisation by devolving decision making and enabling more people to be involved in the political process21. Many critics such as Poluha (2004), argue that the government ‘has not really broken with its historical past but continues to follow a tradition according to which all political and economic activities are controlled by the centre’ (2004:187). Nevertheless, in health, the priority was to reflect ‘the new political, economic and social environment’ (Kloos 1998:100) with rural oriented and decentralised policy based on PHC: ‘the fundamental principle that health constitutes physical, mental, and social well-being for the enjoyment of life and for optimal productivity’ (CSA and ORC Macro 2001:2). The MOH was to be responsible for ‘policy formulation, standard-setting, issuance of licenses and qualification of professionals, establishment of standards for

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21 However, if both decentralisation and democratisation are seen as prerequisites for development to occur (Salih and Markakis 1998:8), decentralisation is also seen as ‘a highly experimental move’ (Vaughan and Tronvoll 2003:53) because it was based on ethnic federalism ‘intended to harness ethnicity to the purposes of development’: therefore the focus on the relationship between ethnicity and the state in Ethiopia is a political matter (Salih and Markakis 1998:8).
research and training, coordination of external loans and grants’ (World Bank and MOH 2005:84). The decentralisation of functions from the Centre to the regions was designed to give the woredas block grants with responsibility for setting priorities, delivering services and determining budget allocations at the local level within the framework of the national policies. Health Sector Development Plan I (HSDP) (1997 - 2002) aimed to increase access to health care from 40 percent to 50 - 55 percent (World Bank and MOH 2005:86) by delivering PHC services throughout the country (Box 1 summarises the principles and goals of HSDP I). Woreda councils now have responsibility for planning and implementation of all woreda development programs including health services including the construction of health centres and health posts and for the procurement of drugs and equipment. However, in actual practice this process is still evolving because woredas still depend on regional and central levels for a number of health system related services such as the recruitment and allocation of health personnel and the procurement and distribution of supplies (World Bank and MOH 2005:84).

Reviews of the HSDP I indicated the challenges in achieving universal health coverage as basic health services had not reached people at the grass roots (Habtamu Argaw 2007). In response, the government introduced the Health Services Extension Program (HSEP) which coincided with HSDP II (2002-2005) (Box 2 summarises the principles and goals of HSEP). The HSEP aimed to improve equitable access to preventive essential health services through community (kebele) based services with strong focus on sustained preventive health actions and increased health awareness. Originally designed to promote prevention, hygiene and sanitation education, the plan now includes health extension workers (HEWs) who will provide reproductive health information and services including safe delivery at home. Two workers are to be assigned to each kebele to liaise with PHC facilities for referrals, particularly for high risk pregnancies and EmOC. To fully launch the HSDP, the government planned to upgrade existing health posts and construct new ones in 10,000 rural kebeles, employing a further 20,000 health extension workers (World Bank and MOH 2005:85-6).
In 1993/94 the government drafted an initial HSDP designed for a period of 20 years with rolling five-year program periods. The new policy had ten principles:

- Democratization and decentralization of the health system;
- Development of the preventive and promotive components of health care;
- Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources.
- Promoting and strengthening intersectoral activities.
- Promotion of attitudes and practices conducive to the strengthening of national self-reliance in health development by mobilizing and maximally utilizing internal and external resources.
- Assurance of accessibility of health care for all segments of the population.
- Working closely with neighboring countries, regional and international organizations to share information and strengthen collaboration in all activities contributing to health development, including the control of factors detrimental to health.
- Development of appropriate capacity, based on assessed needs.
- Provision of health care for the population on a scheme of payment according to ability, with special assistance mechanisms for those who cannot afford to pay.
- Promotion of the participation of the private sector and non-governmental organizations in health care (World Bank and MOH 2005:82).

HSDP I saw changes in the public health system from a six-tier to a simpler four-tier system. The main change was to replace the health stations (which covered approximately 45,000 persons) with primary health care units (PHCUs). PHCUs would have five satellite community health clinics or health posts each serving a population of 5,000; therefore, the PHCU is intended to serve a population of 25,000 located within a 10 km radius catchment area. PHCUs are expected to provide comprehensive, integrated and community based preventive and basic curative services in:

- Maternal and child health care, including immunisation, family planning advice and services, nutritional health, micronutrient supplementation;
- Curative services for common ailments such as parasitic infections, diarrhoea, acute respiratory infections and tuberculosis;
- Minor surgery: appendectomies, Caesarean sections;
- Technical assistance establishing and monitoring environmental and occupational health standards;
- Record keeping of basic vital statistics and disease surveillance
- Training of CHAs and TBAs.

The next tier is the district hospital serving a population of 250,000. The district hospital also acts as a referral and training centre for 10 primary health care units. Zonal hospitals provide specialised services and training to a population of one million (2005:89-90).
Box 2: Summary of principles and goals of HSEP (HSDP II)

- Hygiene and environmental sanitation: excreta disposal, solid and liquid waste disposal, water quality control, food hygiene, proper housing, arthropod and rodent control, and personal hygiene;
- Disease prevention and control: HIV/AIDS and other STDs prevention and control, TB prevention and control, malaria prevention, and first aid;
- Family health services: maternal and child health, family planning, immunization, adolescent reproductive health, and nutrition, and
- Health education (World Bank and MOH 2005:85).

HSDP III (2005-2010) coincided with the planning process of the Second National Development Plan and reiterates the government’s commitment to promote ‘decentralization and meaningful participation in local development activities’ with administration of public health occurring at the regional level and planning and political administration being done at the woreda level (Ministry of Health (MOH) 2005:3) (Box 3 summaries the principles and goals of HSDP III). The Ethiopian Government-led Sustainable Development and Poverty Reduction Program (SDPRP) aims to reduce poverty through economic growth, improve human development (including education, health, HIV/AIDS, water and sanitation), democratisation and governance, and improve public sector institutional performance (World Bank and MOH 2005:88-9). The major goals of HSDP III are to improve maternal health, reduce child mortality and combat HIV/AIDS, malaria, TB and other diseases with the ultimate aim of improving people’s health status and thus achieving the MDGs (MOH 2005:xii).
Box 3: Summary of principles and goals of HSDP III

- To increase family planning service coverage from 25% to 60%.
- To increase deliveries attended by skilled attendants from 12% to 32%.
- To provide Comprehensive EmOC in 87% of the hospitals and 20% of health centers.
- To provide Basic EmOC in 100% of the health centers.
- To reduce the prevalence of teenage pregnancy and unsafe abortion from 20% and 50% to 5% and 10% respectively.
- To increase DPT3 coverage from 70% to 80% and increase the proportion of fully immunized children from 45 to 80%.
- To increase the proportion of neonates with access to proper neonatal resuscitation and Ampicillin/Gentamycin for neonatal sepsis from 6% to 32%.
- To expand IMCI implementation from 36% to 90% of health facilities; C-IMCI implementation from 12% to 80% of the districts; and the pre-service IMCI training from 65% to 95% of health professionals teaching institutions (Ministry of Health (MOH) 2005:58).

In addition to the HSDP, the MOH also developed the National Reproductive Health Strategy 2006-2015 (MOH 2006a:18). The main targets are to:

- Increase to 60 percent the proportion of births attended by skilled health personnel either at home or in a facility (representing a six-fold increase from the current 9.7 percent).
- Increase national ANC coverage levels to 70 percent.
- Equip one health post per 5,000 population to provide essential obstetric and newborn care.
- Equip one health centre per 25,000 population to provide basic EmOC and newborn care.
- Equip one rural/district hospital (250,000 population coverage) to provide comprehensive EmOC.
- Reduce maternal mortality to 350 deaths per 100,000 live births by 2015.

While there is no doubt that the objectives of the HSDP are to develop a health system that provides PHC services primarily at the community health level, so far, the emphasis has been the construction of new health facilities. In actual fact, regional and woreda governments must choose between building facilities or improving the quality of existing facilities because of their limited budgets, with around 43 percent of the health budget being devoted to the construction of more facilities (Collier et al. 2002:22). And according to the World Bank’s Woreda Studies (2001), the obligation to provide basic service does not extend to the delivery of those services as the service delivery model is ‘based on area coverage and direct service provision by cadres of professional staff, whose salaries consume the bulk of the development budget’ (World Bank 2001: Section 7.57). In addition, the budgetary choice between quantity and quality of service is
complicated as the Ministry of Planning and Economic Development determines the capital budget, whereas the quality of services is determined by the Ministry of Finance which controls the recurrent budget (Collier et al. 2002:11). This means that the population potentially has better access to facilities but many health facilities in Ethiopia are not well utilised which may be related to shortages of drugs or inadequate staffing (World Bank 2007a:20). Following the Bamako Initiative in 1987 and subsequent health sector reforms, many African countries were forced to find alternate ways to finance health systems (Table 1). One of the core principles is that local communities should become more self-sufficient by paying for part of the drugs and services that they use. However, studies show that user fees generate around five percent of total revenue (Turshen 1999:50; James et al. 2006:8). In Ethiopia, PBS funding to HSDP III includes 2.1 percent from user fees (World Bank 2007a). Some new facilities are completed with no deployment of health staff or provision for the supply of equipment, furniture, water and so on (2007a:35). This was certainly the case with some health facilities I visited during my fieldwork. In May 2008, the HSDP mid-term review found that Ethiopia was moving in the right direction yet remains off-track for the health MDGs: the government remains committed to the MDGs but it is unlikely that Goal Five will be met (World Bank and MOH 2005:200). Estimates show that current total health spending of less than $10 per capita must be doubled to enable the health MDGs to be attained (World Bank 2009:50).

The fact that maternal mortality remains high is partly explained by the low percentage of births attended by skilled attendants (6 percent) and low levels of other reproductive health services such as FP (15 percent of married women) and ANC (28 percent) (CSA and ORC Macro 2006). According to the Maternal and Neonatal Program Effort Index (MNPI), Ethiopia has a relatively strong policy on Safe Motherhood but rates poorly on EmOC particularly in rural areas (MNPI 2002). The emphasis in this section has been on health but the provision of health services to the rural population must also involve other sectors such as the RSDP in Ethiopia. The following section focuses on women and gender within the discourse on development.

22 Collier et al. (2002) argues that ‘[m]aternal education and household income both affect usage quite substantially. Hence education and rural development policies may be even more important for health usage objectives than health care policy itself’ (Collier et al. 2002:28).
1.3.6 Women, gender and development

The first initiatives aimed at women in developing countries by international development agencies such as the WHO, the World Bank and the United Nations were based on the assumption that women were passive recipients rather than contributors to the development process; that motherhood was women’s most important role in society; and that child rearing was the most effective role for women to perform in economic development (Moser 2001 [1989]:137). International awareness also focused on the world’s rapid population growth for many years; development agencies argued that huge populations were a problem because they eroded the benefits of economic growth on developing economies. This awareness coincided with developments in fertility control and fears about rapid population growth that could further the growth of communism during the Cold War (Lane 1994:1307). Consequently, the key incentives to FP programmes from the 1950s to the late 1980s became birth control, nutrition for pregnant and lactating women, child health, and raising rural incomes (Campbell 2001:443-4).

The first feminist investigation of the impact of modernisation and development on women was pioneered by Ester Boserup. Women’s Role in Economic Development (Boserup 1970) was the first book to highlight the important productive role which women play, particularly in agriculture. She argued that women could also play a much more active role in industrial employment and the modern sector and that growth would be enhanced if this were encouraged. Importantly, she drew attention to the nature of different family and household systems and their land tenure arrangements, and stimulated a great deal of empirical research to explore such systems in different parts of the world. Until then, women had been viewed by most development planners as mothers and housewives, in need of welfare assistance perhaps, but not seen as subjects of development. In hindsight it can be seen why her work contributed to a strong movement for Women in Development (WID).

WID identified the exclusion of women from the development process and aimed to integrate women into existing development projects mainly through education, training and technology. WID emulated the existing sexual division of labour within modernisation and ignored the unequal value on women’s and men’s activities. Feminist
critics of the WID approach such as Warren and Bourque (1991) argue that although technology can be thought of as autonomous and neutral, it is because both development and technology transfer affect our understandings of the Third World and ‘reflexively reveal Western cultural and political preoccupations’ (1991:278). In particular, it perpetuates the view that women are passive targets of programs or receptors of technology rather than constructors of their own cultural understanding of change and technology. A further criticism is that international development agencies implementing WID have tended to perpetuate a view of women as being ‘ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized’ (Mohanty 1997 [1991]:80).

The Women and Development (WAD) perspective emerged as a critique of WID by Marxist feminists who questioned the development model itself rather than the policies aimed at integrating women into development (e.g. Mies 1986). The theoretical base was dependency theory which saw capitalist development as creating economic and social inequalities. The WAD objective was to transform international development structures to eliminate social inequalities. The renaming of the field as Gender and Development (GAD) was a reflection of theoretical changes during the 1980s as feminist scholars and activists led a shift in focus from women to gender relations. GAD reflected the notion of ‘gender’ pertaining to the social construction of men and women’s identities. It focused on the discrimination against women because of their sex, and the unequal power relations that prevent equitable development (Benería and Sen 2001 [1982]; Hunt 2002, 2008). For GAD, the state was an important actor to promote women’s emancipation: GAD questioned social, economic, political and cultural structures and aimed to understand the roles, responsibilities, resources and priorities of women and men in specific contexts and how these would be affected by and influence development activities (AusAID 2002). Although GAD’s recommendations were difficult to implement because they depended on structural change, its ‘multifarious approach distinguished between capitalism, patriarchy, and racism, and enabled feminists to identify places in official policies for strategic interventions’ (Peet and Hartwick 1999:188).

Feminist theorists and critics have succeeded in expanding the understanding of work as they showed how women are workers within the material and political constraints of
their household composition and location in the class system. Moreover, women’s visibility in the development process has increased and international development agencies now use gender empowerment terminology to integrate gender considerations into country assistance programs (Rai 2002) or into health programs (Stein 1997). However, the debate about population shows how critiques of coercive population control have been accepted under the pretext of women’s empowerment (Hartman 1995), or, under a humanitarian concern about the adverse health effects of frequent pregnancy to justify further population control interventions (Morsy 1995). Further, the call for social transformation through Safe Motherhood has brought attention and professional legitimacy to sociomedical interpretations of the social and economic determinants affecting the morbidity of women. These include women’s educational levels, economic activity and social support networks (1995:165) although Mikell (1997), argues that African feminism is quite different to Western feminism: it is ‘distinctly heterosexual, pro-natal, and concerned with many “bread, butter, culture, and power” issues… that has grown out of a history of a female integration within largely corporate and agrarian-based societies with strong cultural heritages’ (1997:4). Nevertheless, GAD is now a distinctive and plural field of enquiry with official status in the discourse of mainstream development. It has become institutionalised in advisory posts in donor agencies, NGOs, in university courses and training programmes and has a body of academic research (Cornwall et al. 2007:1).

While maternal health has been emphasised as a health issue, the reduction of maternal mortality is a key MDG so it is also important to assess it in development terms. In ‘Women Deliver for Development’, Gill et al. (2007) describe some of the key links between maternal health and development using three measurements of development: women’s status and empowerment; economic and social development at the family level; and economic and social development at the national level (2007:1347). Citing evidence from the past 20 years, women are described as mothers (who suffer high rates of maternal mortality and disabilities in developing countries); as individuals (where the enabling factors to improve women’s status such as education and employment affect a woman’s capacity to access and utilise health services along with the empowerment to make decisions about using health services); and as family members, where a woman’s contribution is important to ensure the health of her children who are less likely to be stunted or more likely to attend school. As citizens, the cumulative effect of women
dying in childbirth or suffering disability because of complication of birth or its management ‘probably affects national and global development outcomes’ (2007:1353). The costs of maternal death or illness can change patterns of consumption and increase debt and poverty. It is estimated that the annual loss of productivity from maternal mortality in Ethiopia costs around $95 million (2001 figures) (2007:1353) although research has not explicitly explored the effect of poor maternal health on economic growth, evidence suggests a positive relation between health overall and economic growth. Since estimates for the burden of disease show that maternal mortality and morbidity is one of the largest single causes of ill-health for women, it can reasonably be assumed to account for an important portion of the effect of overall adult health on economic growth (Gill et al. 2007:1353).

For this reason, the investment of resources in maternal health can at least partly address these issues through its positive effect on overall health service delivery and use. Maternal health indicators are so closely associated with key service delivery issues such as equity and efficiency that they have been used to assess the functioning of health systems and proposed as a measure of the performance of a country’s overall health system (Gill et al. 2007:1353-4).

The investments in maternal health fall short of requirements for achieving the MDG Five along with other development outcomes such as poverty reduction and the status of women. It is argued that the countries that have made the most progress have invested in the availability and quality of maternal health and other services including education and employment for women (Gill et al. 2007:1354).

While research in GAD generally reflects the criticisms and disciplinary differences among its scholars, gender inequality features worldwide especially in sub-Saharan Africa, South Asia and the Middle East (Hunt 2008:245). In Ethiopia, Pankhurst (1992) and Poluha (1995; 2002a; 2002b) reveal the traditional gendered world of rural women whose lives are socially constructed as mothers and whose activities in social and biological reproduction are not usually counted as work or labour. Gender is a principal aspect for describing the division of labour at home although the gendered division of labour extends to those women who have work outside the home (Chapter 4). In Chapter 4 I describe how women giving birth are not the key decision makers at times of critical decision making. Yet women are the major targets of many health interventions because of their ability to reproduce (Chapter 5). Chapter 6 discusses how all intervention activities including health, are in line with zonal, woreda and kebele government policies. This means that the top-down planning approach by government restricts planning and
development to the various pre-existing sector plans further restricting government staff and the staff of NGOs from paying ‘greater attention to the gendered effects of different policies and programmes’ (Hunt 2008:252). The following section will focus on childbirth as a prominent discourse within a sociocultural context.

1.3.7 The sociocultural context and development

Shiffman and del Valle (2005) accord a key position in research in reproductive health to the sociocultural context by citing medical anthropologists such as Obermeyer (2000) and Hay (1999), who research local beliefs and practices and have found ‘considerable differences across ethnic groups in attitudes and norms surrounding birth and medicine that have direct bearing on maternal mortality outcomes’ (Shiffman and del Valle 2005:7). Although there had been earlier cross-cultural studies of birth by anthropologists, Jordan (1993) instigated anthropological attention on childbirth as a topic worthy of in-depth field work and cross cultural comparison with the first edition of Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States. Since then there has been a burgeoning literature exploring the ‘historical transformation of birthing in Europe and North America’ (Jolly 2002a:1) motivated by feminist enquiry into birthing and motherhood alongside awareness of continuing high levels of maternal and infant mortality in many developing countries (e.g. Adams 1995; Ross 1995; Davis-Floyd and Sargent 1997; Lock and Kaufert 1998; Ram 1998; Lukere 2002). As the field expanded, an increasing number of contemporary studies pointed out that childbirth is ‘an arena within which culture is produced, reproduced and resisted; that should be situated ‘historically within the context of particular political and economic relations’ (Van Hollen 1994; see also Liamputtong 2007). Nonetheless, all cultures are concerned with the health and survival of a mother and her child during pregnancy and delivery (Liamputtong Rice and Manderson 1996:1). However, in Birthing in the Pacific: Beyond Tradition and Modernity? (Lukere and Jolly 2002) cross-cultural case studies from Tonga, Papua New Guinea, Fiji, New Caledonia and Vanuatu show how the binaries of ‘traditional’ and ‘modern’ birthing can be deeply problematic against the difficulties that beset maternal and infant health programs in developing countries.

23 There have been four successive editions since this book was first published in 1978. Robbie Davis-Floyd revised and expanded the fourth edition.
There has also been a significant attempt in medical anthropology to consider culture and history in the formation of biomedical knowledge and practice (e.g. Kleinman 1986, 1994, 1995; Obergmeyer 2001:2-3)\(^\text{24}\). For this reason, Obergmeyer (1999:S50), Pigg (1995:58), and others, point out that the concept of reproductive health that is being prescribed for developing countries is itself culturally constructed as it ‘emerged as a result of a particular historical, legal and ethical evolution’ (Obergmeyer 1999:S51) that reflects the social, political, demographic, and medical disciplinary areas (1999:S55) of those who formulate and implement policies for those who are the targets of these policies (1999:S50). In particular, people in developing countries have frequently been represented as backward, undeveloped and non-Western by those societies asserting to be the home of modernity. The solution inherent in the process of modernisation is portrayed in terms of industrialisation, urbanisation and so on which are effectively the result of Western values and beliefs (Schech and Haggis 2000:xii).

The public health perspective of safe motherhood considers pregnancy and birth as health conditions with potential risks; any problems that emerge are manageable within modern health care settings (Obergmeyer 1993:362). By promoting the use of biomedical services, the SMI ‘sought to overcome “cultural obstacles” to safer birth practices in developing countries by putting in place educational programs that ... would encourage women to have recourse to formal health services’ (Obergmeyer 2000:176):

[t]he notion that there may be cultural obstacles to the optimal use of health services appealed to many health professionals... who were convinced that geographical obstacles and problems of transportation could not fully account for the low use of health services. Other factors had to be involved, since many women gave birth at home even when there appeared to be no major obstacles to their seeking care at health facilities (2000:176)

Douglas (1990), Beck (1992), Turner (1994; 1995), Giddens (1999) Lupton (1999) and others accord different positions to the concept of risk but in general it is a concept that has changed over time and place; is best understood as a social construct; and, ‘crucial to any debate about modernity because the process of modernization involves an intensification and multiplication of social risk, both at the level of the individual and the level of social collectivitives’ (Turner 1995:219). In public health, the word risk is

\(^\text{24}\) Even though international development studies has been associated with examining economic and political terms since World War Two, it has been profoundly influenced by anthropology’s exploration of culture (Schech and Haggis 2000:xii). If ‘culture is nothing but a way to describe human behavior’ (Barth 1969:9), it remains ‘the anthropological keyword par excellence’ (Comaroff and Comaroff 1992:27) and one of the most contested words in the English language.
synonymous with danger whether it be at the environmental level (such as the risks to populations from pollution and other hazards) or the risks of lifestyle choice by individuals which places emphasis on self-control (Lupton 1999:426-7). In relation to childbirth, Lane (1995) argues that the risk category has been imposed on all women acting as a form of ‘micro-social regulation bringing about acquiescence to medical intervention’ (1995:59-60). Thus it is impossible to examine maternal mortality and disability without considering risk. For example:

The maternal mortality ratio is a measure of the risk of death once a woman has become pregnant (WHO et al. 2004:10 emphasis added).

Although it is clear that elevated risks exist at the extremes of reproductive performance, most births occur in low-risk groups (Winikoff and Sullivan 1987:132 emphasis added).

The risk approach, adopted as a way of identifying which women are most likely to develop serious complications, has been shown to have only limited effectiveness: most women who go on to develop life-threatening complications have no apparent risk factors; conversely, those identified as being at risk generally end up with uneventful deliveries (WHO and UNICEF 2004:1 emphasis added).

The assessment of risk assists in identifying the risk of maternal mortality and disability in the female population which plays an important role in helping identify how many pregnant women may need medical intervention during childbirth. However, the risk approach only has limited effectiveness in identifying which women actually need medical assistance. For the medical clinician, it means thinking about risk as being a statement about disease rates in a population and then translating that knowledge to the treatment of one patient (Gifford 1986:222). As a result the meaning of risk in epidemiology is used as ‘an objective, scientific concept which describes relationships within large populations’ (1986:238) usually bounded in geographic, demographic or administrative boundaries (Dunn and Janes 1986:7).

Risk is a topic worthy of its own research as it reveals that the biomedical discourse about birth is dominated by the perception of risks to life and health. It will not be dealt with in the present study but is referred to in Chapter 5 because it determines the public health strategy of prevention and medical care. According to Obermeyer (2000), the public health view of high obstetric risks is based on calculations that account for the multiple exposures of women over a lifetime and, ‘the conviction that these risks are easily preventable with current medical knowledge’ (Obermeyer 2000:186). And public
health discussions around safe motherhood frequently start with the notion that risk is absent in traditional societies: consequently, ‘traditional culture’ might be an ‘obstacle to health’. Yet ethnographic research reveals that ‘ideas about risk are found in local constructions of childbirth’ (Obermeyer 2000:176). There are a number of elements that indicate an awareness of risks in childbirth in Ethiopia which are discussed in Chapter 5.

Obermeyer (1999; 2000) advocates that universal access to reproductive health programs means policies must be applied in diverse locations; therefore, ‘a cultural perspective that clarifies the link between the global and the local must be developed’ (Obermeyer 1999:S50). Obermeyer (2001:2) describes three key concepts that define a cultural perspective to health. The first principle is that health care is not just about using health care services for specific purposes as ‘behaviours related to health and reproduction are everywhere, [and are] associated with symbolic meanings beyond their immediate instrumental effects’ (Kleinman 1986:32). The question then is, how does culture shape social reality and personal experience as ‘health beliefs and behaviour, illness beliefs and behaviour and health care activities are governed by the same set of socially sanctioned activities’ (1986:32). For example, Knutsson’s (2004) study of TBAs in Addis Ababa shows how knowledge and practice in pregnancy and childbirth is influenced by different knowledge systems. The TBAs knowledge system is based on cultural and religious norms and structures but also includes varying degrees of knowledge, practices and symbols from the modern biomedical knowledge system.

In Chapter 4 of this study I focus on a group of women who go about their everyday lives, especially the work they do in and around the house and the relationships they build with neighbours and the community. Giving birth to many children is still a priority for many women and most women give birth at home with the assistance of their neighbour, mother, mother-in-law, husband or sister. As I interviewed the women and sought to learn about their lives, it was essential to consider how their lives intersected with others around them, and how this was reflected in the ‘day-to-day life ways characteristic of a particular group of people’ (Keesing and Strathern 1998:24). I also sought to understand how walking defines an approach to living where all the activities and decisions are framed by time and distance. The action of walking links a woman’s activities between the home, the field, water and firewood collection, visiting neighbours, going to church and going to the market. It also affects decision making
about seeking biomedical health care. Most people in Kafa Zone are engaged in agricultural activities and the studied area consists of a mosaic of different land-use types (Chapter 3). As Keesing and Strathern point out, ‘what people do and say can be observed... the sharing of meanings in people’s daily life is a social process, not a private one’ (1998:20-1). In this study I wanted to learn what happens if a woman has problems during birth and needs to be carried to the health centre or hospital.

The second cultural perspective of health encompasses medical pluralism and the co-existence of other medical systems. For some Ethiopian groups, human well-being is conceived as a threefold and complementary state of equilibrium with religious and cosmic dimensions: physical health, moral integrity and spiritual holiness. This state of equilibrium known as kerandhima ‘can be violated by the onset of events of a physiological, environmental, magico-religious and social nature leading to ill-health’ (Vecchiato 1993:179). For other groups from the central and northern provinces, the Amhara, harmonious well-being, tena, comes from divine providence that ensures the body’s organs work together (Young 1986:146). This state of equilibrium is conceived as within the body and ‘between the body and the elements around it’ (Makonnen Bishaw 1991:194). As a result, healing is more than curing of disease as it is concerned with the protection and promotion of human physical, spiritual and material well-being. For this reason it is important to advocate a medical pluralist approach to classify different co-existing medical systems and sub-systems and to examine ‘all aspects of local knowledge, practices and behaviour in relation to health and illness’ (Slikkerveer 1990:21). It was obvious that the co-existence of other medical systems still exists in Kafa Zone as people referred to local knowledge, traditional practices and witchdoctors from time to time. These things are referred to as they arose but are not the focus of the present study.

For most Ethiopian communities, pregnancy is camouflaged and childbirth is not considered openly; women are most likely to believe that childbirth is a natural process and that their physical well-being is related to their supernatural and spiritual world: they must prepare themselves emotionally and spiritually as well as nutritionally by avoiding certain foods, cleansing the bowels, wearing the right clothes and moving in the correct way (Pankhurst 1992; Slikkerveer 1990; Vecchiato 1993; Knutsson 2004). Knutsson (2004) describes how women worry about dying in childbirth and about the health or
their child. The time of birth is a place or state between life and death; maintaining t'au during pregnancy describes the necessary emotional and spiritual preparations; birth is not just about physical well-being. TBA's place their belief in Maryam, the overall protector of labour and childbirth, the midwife of midwives and the one who gave birth to Jesus Christ to protect them.

Finally, health, particularly reproductive health, is increasingly defined, explained, and controlled through bio-medical knowledge and practice. Western biomedicine, like other forms of healing, is a cultural construct despite being based on empirical objectivity; it continues ‘to exist in dialectical relationship with its wider social context’ (Comaroff 1982:57). It has become dominant as our orthodox system of healing through formal mechanisms of control and the tacit hegemony of the conception of knowledge which it shares with our mainstream culture (1982:59). An overview of the biomedical health system was discussed earlier in the chapter and Chapter 3 focuses on the health system in Kafa Zone in 2007.
1.4 Synthesis and approach in this study

This section outlines the theoretical orientation of the thesis in international development. The brief review of the international development in Section 1.3.3 contends that it has been dominated by international economic affairs managed by the World Bank, the IMF, the World Trade Organisation (WTO) (which succeeded the General Agreement on Tariffs and Trade [GATT]), the UN specialised agencies and more recently Non-Government Organisations (NGOs). Early modernisation theory resulted in a form of linear thinking whereby developing countries, where social change was deemed to be too slow, needed to move through stages of development and modernisation to reach a point where they would be more like the developed or modern nations of the West. Since then, ‘mainstream’ development studies describes the various points of view that take for granted that there is a broadly positive relationship between economic growth and human development which suppose[s] that developmental states have some responsibility, and some capacity, for stimulating economic growth, and which implicitly acknowledge[s] that richer countries have a duty to help poorer countries. The mainstream defines development not just as an immanent process but as something that can be willed or sponsored—a development that is intentional as well as immanent (Corbridge 1998:34).

Similarly, Pigg and Adams (2005) express it as developmentalism that holds out ‘hope that greater health and well-being can be attained through rational planning, and development regimes [that] enlist people in efforts to carry out these plans by promoting technologies and educating them to modern consciousness’ (2005:22). While later studies identified the need to examine a broad range of perspectives and to consider connections between the economic, historical, geographical, political, sociological and anthropological perspectives of development, there is some debate about whether international development should be considered cross-disciplinary, multi-disciplinary, interdisciplinary or viewed as a discipline on its own (Clark 2006:xxvii - xxxv). Others emphasise that development studies should be based on real problems and ask: ‘What are the difficulties people encounter in their efforts to make (on the basis of their interests and ideas) the best possible use of their potential?’ (Törnquist 1999:24)25. In the end, whether the researcher is interested in economic theory or in anthropological or sociological modes of explanation, the multifaceted nature of development problems

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25 Törnquist (1999) is concerned with politics and development but a number of fruitful connections can be made with health and development.
appears to require a ‘blending of analysis and methods from different disciplines’ (Clark 2006:xxviii).

A key theme in this study is how international development (through international policies and strategies aimed at reducing maternal mortality and disability) has helped shape the health sector in Ethiopia which is now in the third phase of its HSDP. Ethiopia is committed to achieving the MDGs as a framework for measuring progress towards sustainable development and eliminating poverty and one of the major aims of Ethiopia’s Reproductive Health Strategy is to ‘ensure its place in the national development agenda’ (MOH 2006a:7). This means ‘assessment of the importance of improving maternal health as a development goal is essential’ (Gill et al. 2007:1347), requiring a development framework to examine the components of development interventions and strategies for improving health in the studied area. For example, maternal health services can monitor and treat preexisting conditions during pregnancy; treat serious complications that occur during delivery and the postpartum period; and, provide medical care for complications due to unsafe abortion (Vlassoff et al. 2004:55). Thus the benefits from maternal health services are reductions in maternal mortality and disability thus ensuring that more mothers are able to care for their children and families.

Improving survival and reducing the pregnancy-related disease burden also translates into increased time in productive work and less time lost to ill-health. The economic benefits from improving maternal health and survival means savings accrue to the public sector ‘as maternal health services reduce the resources spent on pregnancy-related morbidity’ (2004:58; see also Shiffman and del Valle 2005:7).

The thesis considers the relationship between health and the macrostructural determinants of health as it is assumed that stimulating the rural economy enables a greater proportion of the population to be able to afford preventive and curative health care, and that there are nonmedical benefits at the societal level that contribute to a range of development goals. Tied to notions of economic development and social change in previously isolated rural areas is the development of a transport infrastructure (Molesworth 2005) which is a key factor for rural communities to access preventative and curative services and the development of the referral system (Chapter 3). The emphasis in the present study is, however, not so much on economic development or even development activities such as the ADLI strategy (the Ethiopian Government’s
overarching policy response to Ethiopia’s food security and agricultural productivity challenge) or the RSDP both of which are seen as essential in Ethiopia’s strategy to accelerate economic growth and reduce poverty, but how the government staff and staff of NGOs who are engaged in development activities in the Bonga region perceive development and its implementation (Chapter 6). The main guiding principle for government staff and staff of NGOs is the national decentralisation policy. To examine maternal health within the broader development framework, I employ the decentralisation policy as a tool of analysis to investigate what are the factors that affect the social, cultural, economic and political determinants of health in rural Ethiopia. Details of how these factors influence women’s decision making when they are faced with the alternative options for the location of birth are examined in Chapter 4.

Childbirth in its literal sense is a little-studied topic in African history (Hunt 1999:9). There is little ‘unconventional’ literature on childbirth in Ethiopia26 and few studies using the ethnographic method where attention has been paid to both local practices and local knowledge (Lock and Kaufert 1998:3). Studies using qualitative techniques include Knutsson’s (2004) study of TBA’s in Addis Ababa; CARE Ethiopia’s assessment of their projects into Safe Motherhood and health seeking behaviour (Alemayehu Mekonnen 2005; Endale Workalemahu 2003); the Ministry of Health’s Report on Safe Motherhood Community-based Survey (MOH 2006b); and the Ethiopian Women’s Perspectives on Reproductive Health (Hemmings et al. 2008). The method I have chosen, to approach the subject of reproductive health, in particular the goal of reducing maternal mortality and disability in rural Ethiopia, has been to study a group of women who are pregnant or have given birth recently, as women can ‘methodologically, be used as a window onto the society of which they are a part’ (Poluha 2004:16) (see Chapter 4). Identifying the variables that influence their decision making when faced with the alternative options for the location of birth was important because the National Reproductive Strategy aims to increase the proportion of births attended by skilled health personnel either at home or in a facility (MOH 2006a:18). Skilled attendance is also a proxy indicator of progress towards the MDGs. In this study, I aimed to compare the women’s experiences to the views of the

26 Following Hunt (1999), the literature available on Ethiopia (in Australia) is all ‘conventional’: it is obstetric, missionary, feminist, public health, epidemiological or development. Hunt’s aim is to dislodge these meanings ‘to relocate this perilous event, packed with meanings about death and reproduction, to a colonial space of confinement and surgery’ (1999:33).
staff at local health centres who provide ANC, normal delivery care and EmOC (Chapter 5).

Yet I found that I was faced with a dilemma in reporting one issue without mentioning the importance of other factors. For example, when reporting women's personal experiences, I met a woman who had planned to give birth at Chiri Health Center (CHC) because she knew she was going to have a breech delivery (Chapter 5). But she returned home after her ANC visit. Her labour started early. By the time her husband decided to organise the neighbours to carry her, made the stretcher, borrowed money, and with the eight hours it took to carry her in the mountainous terrain, at least two days had passed. On the way, they knew the baby had died. The health officer told me that the day before the woman’s labour started, her neighbour’s child had been washed out of his father’s arms trying to cross the river on the way to the health centre. This is why they delayed. The key words could be: ANC, birth, location of birth, decision making, distance, delay, cost of treatment, community involvement and so on. In the end, I felt all of these explanations were inadequate when I met this woman and later travelled to her village.

The purpose in the following chapters is to provide an approach that examines how strategies to reduce maternal mortality and disability move from theory to practice and are linked into the ‘larger context of projects of modernity’ (Pigg and Adams 2005:14). Ultimately I wanted to look at ‘development as a kind of social presence’ (2005:24) in Kafa Zone in south west Ethiopia (Section 2.2 in the next chapter explains how I came to this location). How much ‘development’ is needed if women, especially those in rural areas, are to give birth in a health facility rather than at home?

1.5 Order of presentation

Chapter 2 examines the methodological framework used for this study. It focuses on the research method, the ethics process and issues around interpretation and translation, and the analytic procedures used to make sense of the data.

Chapter 3 is the first chapter of the empirical findings for this study. It focuses on the second part, the “Where” of the questions: ‘Who is giving birth where, and why?’ The chapter describes the fieldwork setting in Kafa Zone with maps, photographs and a
narrative about doing research and travelling to two research locations. The next section, ‘Delays in reaching a health facility,’ has three themes: ‘The referral system,’ ‘Travel distances’ and ‘Transportation’. The chapter includes a table describing a number of the health facilities I visited. These health facilities are part of the government’s response to international strategies and polices for a decentralised health sector. Visiting these facilities makes it possible to observe not only the people who attend them for preventative or curative health treatment but also to consider those who do not. Besides the low number of people utilising health services, there are delays in receiving appropriate treatment in a health facility. This is mainly related to the quality of care, adequacy of the referral system, and shortages of supplies and equipment that may require referral to the next level of facility.

Chapter 4 focuses on the women and asks the “Who” of ‘Who is giving birth where, and why?’ questions. The chapter is organised into four themes: ‘Marriage and pregnancy’; ‘Social interaction and activities women undertake in daily life’ which has four sub-themes: ‘Work inside and around the house,’ ‘The mother/daughter relationship,’ ‘Building good relationships with neighbours and the community,’ and ‘Women and decision making’. The next theme is ‘Marginalisation and Manjo women,’ and the final theme of the chapter is ‘Walking’. The chapter includes a brief profile of each woman interviewed.

Chapter 5 explores the theme of birth: ‘Normal’ birth: giving birth at home,’ which has three sub-themes: ‘Who gives birth?’, ‘Who assisted at birth?’, and ‘Salient aspects of giving birth at home’. The second theme describes what I call ‘(Un)safe’ birth’: if something goes seriously wrong during birth and a woman is carried to a health centre or hospital. The third theme examines the involvement of health workers during birth including TBAs, HEWs and other nurses, doctors and midwives who work in health posts, health centres and the hospital. As there has been no tradition of using TTBA, these health workers only tend to see ‘abnormal’ birth in a health facility. The next theme of this chapter looks examines the ‘Role of health workers as educators,’ ‘ANC at CHC and Deckia Clinic’ followed by the themes ‘Being (un)able to provide adequate and appropriate treatment’ and ‘Conceptualising women and birth’.
Chapter 6 is called ‘Development and Change in Kafa Zone’. This chapter introduces the NGO and local government sector: ‘Development in Kafa Zone’ which describes what the people interviewed thought development meant. The next theme is ‘Decentralisation and sector-based programs’ followed by ‘Development in practice’ which has five sub-themes: ‘The NGOs sector and NGO operations in Kafa Zone’ which examines NGO programs and some of the operational issues they confront. This is followed by ‘Community participation’, ‘Development funding’, and ‘Cost of services and corruption’. The final sub-theme examines ‘Development and women’s education’.

The concluding chapter, Chapter 7, analyses the final “Why” part of the questions: ‘Who is giving birth where, and why?’ It brings together the main themes in the thesis. Beginning with a discussion about the data and findings in Chapters 3 to 6, I outline some of the problems with implementing international reproductive health policy, particularly the goal of reducing maternal mortality and disability, and synthesise the discussion about the difficulties women and other marginalised people position in society have in accessing the health care system.
Chapter 2: Methodology

This research was conducted within the discipline of international development studies. As outlined in Chapter 1, the research is concerned not with what international reproductive health policies have been developed under a mainstream model of development, but how these policies fit into Ethiopia’s national development agenda and the consequences of these policies for women in Kafa Zone. Much of the recent research has concentrated on the proximate determinants of maternal mortality in developing countries: its biomedical causes and the transfer of health service interventions such as the provision of EmOC, safe abortion services and skilled attendants at birth. As around 75 percent of maternal deaths arise from direct obstetric causes, it is argued that the majority of these deaths could be prevented with timely medical treatment (Thaddeus and Maine 1994:1092). As stated in Chapter 1, the Ethiopian National Reproductive Health Strategy 2006 – 2015 (MOH 2006a), is based on the presumption that biomedical health interventions will reduce maternal mortality and disability by devoting resources to modern health care and delivery assistance. There are a number of quantitative studies from Ethiopia that provide data on maternal mortality and disability levels and the low utilisation of modern health services particularly in the rural areas (Table 1). These studies conclude that health care in Ethiopia is ‘woefully inadequate’ (Girma Kebbede 2004:209); that maternal mortality has not decreased in some areas (Asheber Gaym 2000); that the utilisation of health services by women in rural areas is low; and that Ethiopia will not meet the 2015 MDG targets (Mesganaw Fantahun et al. 2000; Fasil Tessema et al. 2002; CSA and ORC Macro 2001; WHO 1999; World Bank and Ministry of Health Ethiopia 2005:200). The small number of qualitative studies include research to determine awareness and planning for MCH Programs focusing on key behaviours around contraception, ANC, and the use of iron tablets for pregnant women (Bhattacharyya et al. 1998). Research titled ‘Women’s health in a rural setting in societal transition in Ethiopia’ (Yemane Berhane et al. 2001) concludes that ‘the factors influencing the health of women are multiple and complex so a holistic approach should be adopted with emphasis on improving access to health care and education, enhancing social status, and mechanisms to alleviate poverty’ (2001:1525). CARE International conducted qualitative and quantitative research on its Safe Motherhood programs in West Haraghe Zone to determine the barriers to prompt and effective treatment of obstetric and neonatal complications and assess the package of
interventions undertaken to increase the availability and quality of EmOC (Alemayehu Mekonnen 2005; Endale Workalemahu 2003; Kayongo et al. 2006). Knutsson (2004) shows how TBAs are part of the health system in Addis Ababa as they refer women when they perceive the birth is beyond their ability.

Because a growing number of studies document the need to take a more comprehensive perspective to understand the problems of maternal mortality and include the macrostructural determinants of health (Gil-González et al. 2006:904), this research aims to report the experiences of a group of women who are pregnant or have recently given birth in rural Ethiopia; to identify the variables that influence their decision making when faced with the alternative options for the location of birth; and, to juxtapose these experiences with staff at local health centres who provide ANC, normal delivery care and EmOC. This means a method of study is required that involves observation of cultural and social interaction with women and health staff over a period of time. For this reason, qualitative research using ethnography to search for ‘patterns of meanings and emotions that make up culture and how these make sense of actions in everyday life’ (Liampittong and Ezzy 2005:17; see also Locke et al. 2000:97) was the best option for data collection.

Ethnography is characteristically defined by the ethnographer’s participation in local daily life for a period of time whereby ‘accounts of the world are produced through selective observation and theoretical interpretation of what is seen, through asking particular questions and interpreting what is said in reply’ (Hammersley and Atkinson 1995:18)27. Ethnography is particularly suited to studying development because it is ‘informed by the theoretical perspective that assumes the interconnectedness of the different facets of

27 Constructing social reality and persuading the reader of ‘the authenticity, plausibility and significance of representations of social scenes or settings’ (Atkinson 1990:57) is not necessarily a straightforward process (Emerson 2001:3; Hammersley and Atkinson 1995:1-10). In particular, as naturalistic methods such as fieldwork became increasingly self-conscious about the problems of representation, explicit accounts of the problems of fieldwork began to appear. Simple realist assumptions were questioned as ethnographic writing was not simply recording what had been observed. It was recognised that ethnography was ‘partial, selective and purposed re-presentation of these ways of life gleaned through the researcher’s efforts to get physically and socially close’ (Emerson 2001:22-3). In time ethnography became more reflexive as it reflects ‘critically the aspects of reality that are considered to be a theoretical and practical problem of… social research’ (Sarantakos 1998:52). Thus the researcher can produce a reflexive account of the social world by invoking and criticising dominant representations of culture (Tsing 1993:33).
life—political, economic, social, and cultural’ (Sobritchea 2002:218). For feminist ethnographers it is an important method to make women’s lives visible, just as interviewing is an important feminist method to make women’s voices audible (Reinharz 1992:48). Ethnography is both a qualitative method and the written account of an ethnographic research project. It commonly uses different data collection techniques by ‘examining data relating to the same concept from participant observation, interviewing, and documents’ (Hammersley and Atkinson 1995:231). This strategy, known as triangulation, ‘is not the combination of different kinds of data per se, but rather an attempt to relate different sorts of data in such a way as to counteract various possible threats to the validity of our analysis’ (1995:232).

Although this thesis is based on ethnographic research, it is not an anthropological account of childbirth in rural Ethiopia but an ethnographic approach to study international development trying to take into account the interconnectedness of everyday life. I used information from other sources including published research from the Ministry of Health in Ethiopia and statistics from Kafa Zone Health Department. I read news reports, relevant reports from the macrolevel on reproductive health policy and strategies, and research from the sociological, political and economic domains to provide a context to changes that have occurred in a woman’s lifetime. It is impossible to ignore the impact these domains have on everyday life; in particular as significant political change has occurred in Ethiopia in the past 40 years. Further, historical and sociocultural change at the macrolevel is something rural women have little or no control over.

2.1 Rationale

Qualitative research is not just the study of words and meaning contrasted to quantitative research which studies numbers or statistics: it is a ‘a systematic, empirical strategy for answering questions about people in a particular social context’ (Locke et al. 2000:96). The theoretical foundations of qualitative methodology are symbolic interactionism, phenomenology and hermeneutics which are based on the beliefs that human actions are based on social meanings which people attribute to and bring to situations, and that behaviour is not ‘caused’ in any mechanical way, but is continually constructed and reconstructed on the basis of people’s interpretations of the situations they are in (Punch 2005:151).
Symbolic interactionist researchers investigate how people create meaning through common symbols: the emphasis is that people develop and find meaning in these symbols through interacting with others (Liamputtong and Ezzy 2005:20). Phenomenological researchers focus on the everyday events in an individual’s life from the viewpoint of the person experiencing it. This means emphasising the taken for granted meanings and routines that constitute their everyday world (2005:20). Hermeneutics is the study of interpretation. It views the process of understanding as bounded by imperfection and uncertainty because human knowledge is socially and culturally constructed. Interpreting human existence is problematic but these assumptions are acknowledged in rigorous research (2005:37). According to a hermeneutic view, reality is ‘socially constructed in the sense that all interpretations and understandings occur within each individual’s mind where they are framed by the person’s earlier experiences’ (Poluha 2007:11). Thus, qualitative researchers ‘place the interpretative process at the centre of their practice. The interpretative process refers to the way that people interpret and give meaning to events and things’ (Liamputtong and Ezzy 2005:4; see also Hammersley and Atkinson 1995:18).

I chose participant observation and semi-structured interviewing to collect data about women’s experiences about giving birth in rural Ethiopia and ‘to capture lived experiences of the social world and the meanings people give these experiences from their own perspectives’ (Corti and Thompson 2004:326). Participant observation involves ethnographers “immersing” themselves as much as possible in the community they are studying to learn how people ‘respond to situations, how they organise their lives; it is about learning what is meaningful in their lives. Through this immersion, the ethnographers themselves experience events in the same way as the local people’ (Liamputtong and Ezzy 2005:169). Semi-structured interviewing differs from structured interviewing where the respondent is asked predetermined questions and unstructured interviewing where there are no predetermined questions. Although I started with list of general questions to begin discussion, the purpose of the semi-structured interview was that these themes would enable it to be more like starting a conversation that aimed to ‘explore the complexity and in-process nature of meanings and interpretations’ (Liamputtong and Ezzy 2005:56). Structured interviews which would seek informants responding to identical questions would limit the responses by not allowing probing for further information on how each woman understands and mediates changes in her life.
particularly around birth. I hoped that semi-structured interviews would enable women to let the conversation go in the direction they wanted them to although I felt it was also important to examine and think about what was not said (Jordan 1993:105). Initially I felt that other methods such as focus groups seemed inappropriate for women who spend their day involved in household activities. Yet a focus group discussion worked well with a group of women who work together at the Women’s Promotion Centre in Wushwush (Chapter 4). These women’s opinions and attitudes were very similar to those of other women and the process did not present an unmanageable body of data which can be a problem with focus group discussions (Knutsson 2004:82-3).

I intended to conduct interviews with women who were pregnant or had recently given birth to gain an understanding of the ‘cultural nuances, complexities and contradictions of pregnancy and childbirth’ (Underhill-Sem 2000:5) within an international development framework. I felt that focusing on childbirth was an entry point into understanding some of the ways Ethiopian women find meaning in their world (see Chapter 4). Sometimes close neighbours and friends would come to the woman’s house to share coffee before the interview started. Each interview lasted about an hour and I did not want to impose on the woman’s time too much after that. The exception to this was Abebech and her mother Almaz, whom I visited on four occasions and Yesharig who became a neighbour and friend after she moved close to my house. I also found that interviewing slightly older women gave me a much fuller description of the range of views around pregnancy and childbirth in the community. I felt that these women were much more confident to speak freely and express their opinions than many of the younger women. Throughout the course of the days and because of the similar responses from women I began to get a feel for the rhythm and routine of daily life. Sessions were organised beforehand to be convenient and usually took place in a woman’s hut often with a number of children present. On four occasions, a woman’s husband was present. I did not feel I could ask a woman to ask her husband to leave and like the women in the focus group discussion, these women’s responses were also similar to those of other women who were interviewed on their own. I used a set of questions about marital history and childbirth to initiate conversation and as a checklist to try to cover all the topics. This type of research approach, where the researcher plans
to ask questions about a specific topic, ‘allows the data-gathering conversation itself to
determine how the information is shared’ (Reinharz 1992:281 note 2).

Qualitative research methods allowed flexibility as the study unfolded because at the
beginning I did not know what information I would find. I used participant observation
to describe the research setting, the activities that take place, the people who participate
in those activities and what meanings can be attributed to what is observed from the
perspective of those observed. As I talked with women I tried to imagine being in each
woman’s social and cultural environment to enhance my understanding of the local
context (Chapter 3). As I walked, rode a mule occasionally, or travelled by bus or four-
wheeled drive to visit women or the health facilities, I wanted to be able to describe the
setting in Kafa Zone to illustrate how travel is possible from the remote kebës to the
woreda or zone centre (Chapter 3).

2.2 Reflexivity

Ethnographic fieldwork is based on two interconnected activities: participating in the
daily activities and getting to know people in a social setting, and secondly, writing down
in a regular systematic way what is observed and learnt. Over time, friction between
these two activities can develop as the fieldworker deals with
detachment and involvement; when to focus on observations of specific actions and
behaviors and when to attend empathetically to differing perceptions and understandings;
when and where to carry out research as a straightforward matter of describing and analyzing
an objectively given, “real” world; and when to direct attention to the ways in which people,
including the fieldworker, represent and construct worlds as meaningful (Emerson 2001:2).

Pausewang (1973) argues that research projects in developing countries such as Ethiopia
need to be worthwhile and relevant to the society in which they are conducted (1973:10).
Doing research in Ethiopia elicited many questions about the nature and purpose of
research and my need to acknowledge and express a lack of objectivity. One way to do
this is to provide ‘a background to the framework within which a piece of research is
conceived and developed’ (Roberts 1981:17).

As a child of missionary parents who spent much of their working life in Ethiopia in the
1960s and 1970s, my childhood was polarised between an authoritarian boarding school
and being home with my parents during holidays, helping my mother in the clinic,
visiting people in their homes, occasionally eating Ethiopian food and going to the
market. My parents were with the Sudan Interior Mission (SIM) which had sought to bring evangelical Christianity into the ‘unoccupied regions’ (Rowland Victor Bingham, founder of the SIM cited in Donham 1999:85) since the 1930s. The missionaries used aspects of modernity, particularly technology and medicine to propagate their Christianity (Donham 1999:82);

the missionaries’ principal appeal to Ethiopians came to rest precisely on their ability to offer an entrance to modernity, as it was locally constructed. Imbued with a progressive sense of time and increasingly impatient with “tradition”, mission converts dreamed of a better day (1999:83).

Like the religious fundamentalist searching for the way to live and knowing how to live so that life has meaning, studying international development has enabled me to understand what is going on in the world, why it is happening, and how I can find a way to live: in this sense, doing research in Ethiopia was inevitable. Like the language of religious fundamentalism set within a framework of polarities of ‘right and wrong, good and evil, light and darkness, mammon and God, flesh and spirit, demons and angels, world temptations and heavenly salvation’ (Wuthnow and Lawson 1994:40), international development also has its own polarities; undeveloped and developed, traditional and modern, unsafe and safe, untrained and trained, illiterate and literate.

History, overall and in all of its stages is irreversibly regressive, precisely because human beings are by nature sinful… modern men and women become historical objects whose behavior requires study and explanation...Dispensational premillennialism is a wilfully “mad rhetoric” and speaking it (being spoken by it) is a political act, a constant dissent, disruption, and critique of modern thought, and specifically of modern historical discourses that constitute hegemonic knowledge about world events, past and present (Harding 1994:63).

International development studies has enabled me to understand why my family was in ‘darkest Africa’ but at times I fear that I have replaced the religious fundamentalism that encircled my childhood with an equally strong critique of international development. Notions of power are central to international development thought (McKay 2004:48) and this is further revealed as a power imbalance between the researcher and those researched. Who is instigating development (or research) and who are the objects of development (or research)? And development expounds its own “mad rhetoric” through economic development, basic needs, PHC, FP or reproductive health policies and so on. Just as the imperative for developing countries has been modernisation as development; reproductive health policies are based on modernisation by means of Western technology and its success with biomedicine. As Donham (1999) points out ‘[m]odernist
conceptions of the future are dramatically different from evangelical ones’ (1999:11) but there is also a sense that the shape of the modernist future is also determined and has to lead to gain and advancement. Thus the past is experienced as “behind” and the future as necessarily “ahead” of the present. Because of the arrow of progress, particularly of technological progress, the future continually arrives ever more quickly. Time speeds up (1999:11).

I returned to Bonga where I had spent childhood holidays (a respite from boarding school in Addis Ababa) to find it now the administrative centre of Kafa Zone, a small town of around 20,000 people that had recently acquired electricity, telephone, slow dial-up internet, and on the day of my arrival, mobile telephone service. Besides talking to women about their experiences when giving birth, and to staff who worked in health centres or the hospital, I wanted to talk to the people who worked for the various NGOs and local government because they are the ones putting government development policy into practice. Donham (1999) describes the Christianity of the SIM that was formed to bring the ‘good news’ to southern Ethiopia in the 1930s as ‘militantly anti-modernist’ (1999:7) and I wondered how much of the future is [still] mapped out in the prophecies of the Bible; today and tomorrow are determined by an epic struggle between Christ and Satan— one that Satan will win again and again until Christ reverses the slide of time by returning to bring world history to an end (1999:10).

Back in the 1960s my mother worked with an interpreter who now worked for one of the NGOs in Bonga. We were reacquainted and my parents were cited for their missionary work and the conversion of this person to Christianity (evidenced by the Bible on the desk and the ‘Jesus is Lord’ screensaver on the computer): I was remembered as a ‘pretty but naughty little girl’. Since I left Bonga at the end of 2007, three NGOs, including the one where this person worked, have closed: changes in government policy at the federal level or corruption and incompetence at the local level being cited as the reasons. I should make it clear that I am not drawing any conclusions here but I was compelled to think critically about the role of NGOs in the development context (Chapter 6).

Given the nature of projects funded by NGOs which are often short term, the Royal Netherlands Embassy (RNE) who funded these projects still remains committed to bilateral funding in Ethiopia and is a partner in the World Bank’s Protection of Basic Services (PBS) funding which directs funding directly to the woredas. RNE emphasises
that the growth of a vibrant private sector is essential for economic growth and poverty reduction and that promoting private sector development is important ‘because the Ethiopian ‘emerging market’ provides good opportunities for Dutch businesses’ (RNE n.d.). Similarly, USAID development assistance directs funding for ‘programs, projects and activities to improve the lives of the citizens of developing countries while furthering U.S. foreign policy interests in expanding democracy and promoting free market economic growth’ (USAID 2006:39). I wondered if the epic struggle between the past and the future was now over. The common thread that still links developed and developing countries to modernisation as defined in the 1950s or 1960s is that of financial assistance. Is international development funding still important to the neoliberal economic agenda when it is equated with opening of new markets for international trade? Are ‘traditional’ people still distinct to ‘modern’ people? Is progress still linear, and viewed through the lens of economic development, literacy and cultural development, technical, social innovation and so on? Chapter 6 examines some of the consequences of the process that brings modernity together with development for people in contemporary society in south-west Ethiopia.

I started out wondering what people in the research setting would think of my role or intentions as a researcher and if my presence would be a positive or negative experience for them. But most of all, I believe that women should not die in childbirth and I felt that the people whom I interviewed shared that belief. Nevertheless, I remain wary of exporting what I perceive as the West’s overmedicalised childbirth28 to Ethiopia (and I relate an experience of this at Bonga Hospital in Chapter 5). Knutsson (2004) describes this conflict as one where the focus in the hospital setting is to deliver, ‘while the birthing woman needs to give birth... [her] need for care and her fear of the unknown are seen as a hindrance in the process of delivery’ (2004:199). A final note: no matter what I did as an individual ferenji (foreigner) trying to fit into everyday life, the efforts I made walking, catching the bus, opening a bank account or going to the market, I was always going to be different. On the one hand, as a researcher I spent a certain amount of time on my own, writing up my research, which meant I did not mix with others as much as I could

28 The 2006 national average for Caesarean rate in Australia was 30.8 percent compared with 20.3 in 1997 (Australian Institute of Health and Welfare 2008). The Caesarean delivery rate in the United States rose 2 percent in 2007, to 31.8 percent, marking the 11th consecutive year of increase (Centers for Disease Control and Prevention (CDC) National Centre for Health Statistics 2009).
have. On the other hand, on the same day I could cross certain cultural barriers: in the morning I could interview a woman in her home about her experiences giving birth at the hospital; and later in the afternoon I could interview the medical director of the hospital. While I wanted to feel that I belonged, in the end I knew I was the ‘other’, the ferenji, the outsider no matter what efforts I made.

2.3 Ethical considerations

Ethical clearance was sought and approved from Deakin University Human Ethics Committee\textsuperscript{29}. I spent time at the outset with each woman explaining my background, the purpose of this research, and how the application of any of the research findings will be confined to the formulation of this thesis (which may also form the basis of a book in the future or be used in the writing of articles for journals). Protecting the rights of the participants and emphasising the voluntary nature of the interviews, confidentiality and the right to withdraw at any time are also the starting points for ethically based research. Informed consent was sought from all participants either orally or in writing in English, Amharic or Kafficho. For those women who were illiterate, informed consent was asked for verbally after it was clear the person had a complete and thorough understanding of the research project. Informed consent also involved when working with an interpreter who was present during discussion with the participants. Another ethical concern is the use of tape recordings. How will women react to my request to record interviews? I explained to the participants that no one else will listen to the recordings except me and that their purpose is to remember what they have said and not lose anything important. Only one participant asked me not to record the interview so I took notes of what was said. The interviewee has prime importance, not the interviewer seeking information so if someone became upset I was prepared to stop that line of questioning and/or suggest we stop, and if appropriate stay until the person regains composure. During one interview I was asked not to repeat personal information about the person’s circumstances which I have respected.

Justifying this research project and its purpose in relation to the women’s situation and needs in an environment characterised by poverty and lack of power is another ethical concern. Following Knutsson (2004) I want to ask how can I use what I have learnt

\textsuperscript{29} For ethics documentation see Appendix One.
from the women and what good is there in it for them? Because the goal of this research
is to understand and represent another culture, as a researcher I need to avoid judging
whether a cultural practice is good or bad, valuable or harmful: ‘The focus needs to be
on the content of practice and knowledge and how it can be explained or interpreted in
the specific context where it occurs’ (2004:71). I tried to adopt a position of ‘empathetic
neutrality’ where empathy ‘describes a stance toward the people one encounters— it
communicates understanding, interest and caring. Neutrality suggests a stance toward
their thoughts, emotions, and behaviours— it means being non-judgemental (Patton

The nature of the research questions requires careful maintenance of participant
anonymity. As much as I tried to protect the participants, everyone in the community
knew exactly who the participants were because they saw me walking from place to
place. Underhill-Sem (2000:70 - 71) discusses the ethical problems of working in a small
community. She used pseudonyms to provide some confidentiality and initially intended
to conceal other details that would reveal personal sensitivities. This proved too difficult
without compromising her arguments so in the end she concealed little. I have given all
the participants pseudonyms to provide some confidentiality. The interview data from
government staff, the staff of NGOs and health workers has been presented in such a
way that would make it difficult to identify individual responses. The government staff
and staff of NGOs were all given copy of report I wrote which presented early findings
of my research (Jackson 2007). A copy of my thesis will also be given to the Population
Studies and Research Centre at Addis Ababa University.

The issue of reciprocity is a delicate issue but one that is important to consider during
and after fieldwork (e.g. Davison 1996:48; Hunt 1999:328). What can I give back to
women who give up their time and provide me with information? There seems to be
agreement in the literature that researchers gain more from their fieldwork than those
who participate in it. After some consideration and discussion with my interpreter I
decided to give each woman interviewed a gift of green coffee or some other food item
such as atmit (ground barley flour used to make a nutritious drink) or shirro (ground chick
pea flour used to make a spicy sauce). I was overwhelmed by the women’s generosity
and welcome into their homes and knew that many women were too poor to offer me
coffee, yet the coffee ceremony is the way that women express hospitality and welcome to visitors. I also knew that coffee was in short supply as it was too early to harvest so it was greatly appreciated by all the women. Most of the women have also been given photos of themselves and their children who were present during interviews.

2.4 Language and interpretation

Ethiopia is a culturally and ethnically diverse state created largely through a process of political subjugation and the exploitation of outlying populations including minorities from its neighbouring states. Although the main racial and linguistic groups speak over 74 languages and twice as many dialects, the conquest and subjugation of non-Amharan cultural groups has resulted in Amharic being associated with the dominant forces of the state ‘and the denial of other communities’ political and economic rights’ (Samatar 2005:468). In the Ethiopian tradition and in Amharic there is no distinction between ‘state’ and ‘government’ both are referred to as mengist (Vaughan and Tronvoll 2003:34). The current Ethiopian government redrew the administrative regions of Ethiopia along ethnic lines after it came to power in the early 1990s by highlighting the positive aspects of ethnic identity and investing in communities who share a common language and culture (2003:50-3). One of the benefits has meant that many languages now have a script and are used as the medium of instruction in primary schools thus enabling children from non-Amhara regions to gain confidence and relish their heritage for the first time in recent history (Samatar 2005:469). In Kafa Zone children are first taught in Kafa or Kafficho (also known as Kafina and Kafinono) before they learn Amharic and English at school.

Pausewang (1973:34-8) describes some of the difficulties planning research in Ethiopia in relation to language and states that ‘a translation into clear, simple, and illustrative language which can be understood by all, and does not give room for ambiguities and misinterpretations, is an aim which will probably never be reached (1973:36). The importance of language is central to the data collection process in this research and there are specific problems to address. Although I tried to learn Amharic before I left Australia and used it in everyday social situations, my language skills were not adequate for research at PhD level. Additionally, many of the women interviewed spoke Kafficho so I decided in the end that I had to make a choice between doing research with an
interpreter, or concentrating on learning the language, but not both. Nevertheless I found by the end of my fieldwork that I could understand most of the responses of people interviewed. For the interviews around Bonga, I worked with a young woman whose first language was Kafficho; her second language was Amharic and her third language English. Azeb was an ideal person for the job: she also set up many of the interviews for me and introduced me to members of her extended family and the local community. She and one of her sisters accompanied me to the market and other local places around town on many occasions, acting as a sort of buffer between me and the unwanted attention I attracted as the only ferenji in town. For interviews at CHC or with the outreach program, I was able to work with one of the two professional interpreters, Tariku and Tadele, who were employed at CHC. Near the end of my fieldwork, I spent time with Tariku checking all the interviews and translations where I was uncertain about interpretation. For example, during my first interview in Deckia, Aden said in Kafficho: *shimmooochen aweeta o billaasheete*

The original translation was:

_Many women have the fistula problem when they give birth in the clinic or the hospital._

Back in Bonga, Azeb translated it to mean: _Many women get breakdown._

When I had Tariku check it he said it was literally: _While delivering some other (women) are spoiled._

When Tariku and I discussed the differences over translation and he told me the Kafficho words for fistula were *sheeyo neeto kayo*. He said it is possible she might not know the word for fistula, so she could mean fistula.

The interviews I did with staff at NGOs or local government offices in Bonga were all conducted in English. The one exception was an interview with the head of the local branch of the main political party. This interview was conducted in Amharic. On this occasion I worked with a young man as an interpreter who had good English as I felt it was inappropriate to take a young woman to this interview.

Interviews were taped and then translated and transcribed at the same time. This process allowed reflection on the choice of wording and gave opportunities to find the
most suitable meaning in English. As the example shows, the process of translating is one that is fraught with difficulty as the ‘values of the culture of the source language may be different from those of the target language and this difference must be dealt with in any kind of translation’ (Rubel and Rosman 2003:6). Katan (1999) describes how the ‘cultural mediator’ is more than a translator or interpreter. The ‘cultural mediator’ needs an understanding of how culture operates and must be able to frame a particular communication with its context of culture before disassociating from that frame when creating a new text in another culture. Translation offers the most obvious way to communicate Ethiopian culture to outsiders; this is similar to the way anthropologists analyse field material to gain understanding of the meanings and behaviours of peoples other than their own;

In addition to the ethnography as the translation of a culture in order to understand it, meaning its translation into some Western language, there is another kind of translation which ethnographers perform... the ethnographer, who sees societies as having similarities as well as differences, will “translate” what has been found on the local level into a series of analytical concepts which will then enable comparison with other societies (Rubel and Rosman 2003:12).

Although I was both participant observer and interviewer, in wanting to achieve a comprehensive understanding of each woman’s situation, I hoped to develop some sense of connection with women during the course of the research. It is difficult to refuse to answer questions or offer feedback as there can be ‘no intimacy without reciprocity’ (Oakley 1981:49). ‘This involves being sensitive not only to those questions that are asked (by either party) but to those that are not asked’ (1981:49). In the end, the representation of women’s voices was ‘translated’ into analytical concepts based on my own understandings and comparison with my own culture.

2.5 Data collection
2.5.1 Sample recruitment

Qualitative research is usually about studying small samples of people because ‘you cannot study everyone everywhere doing everything’ (Miles and Huberman 1994:27). Sampling needs to be purposive so each sample, for example, a person (Liamputtong and Ezzy 2005:44) is selected for a purpose to provide information-rich cases in depth and detail rather than generalisations (Patton 2002:230). The choice of informant, episode or interaction should be driven by a conceptual question and not be concerned with ‘representativeness’ (Miles and Huberman 1994:28). As the research proceeds, we are led
to new informants and new information and we are able to make sampling decisions that lead to new samples of informants and observations, new documents; ‘to clarify the main patterns, see contrasts, identify exceptions or discrepant instances, and uncover negative instances—where the pattern does not hold. Our analytic conclusions depend deeply on the within-case sampling choices we made’ (1994:29). Snowballing is a data collection method for research populations that are considered ‘hidden’ or difficult to locate, however, once key information-rich key informants have been located, they can be asked to recommend other informants whom it could be difficult to approach directly (Spreen and Zwaagstra 1994:475; Patton 2002:237). The sample population is meant to represent a miniature of the population or reflect the ‘population network’ (Spreen and Zwaagstra 1994:477); the term ‘representativeness’ is used because the sample population represents a good cross-section of the target population. Consequently ‘it is possible to make well-founded inferences, despite some bias which is likely to occur in the selection of the respondents, for example, overrepresentation of more socially active persons’ (1994:479 emphasis in original).

I was not so much interested in the network perspective in the use of ‘hidden’ populations described by Spreen and Zwaagstra (1994) but contend that snowballing is a useful sampling method for someone from outside the community to locate individual women who have bonds with other women because they are mothers, and share similar beliefs about pregnancy and childbirth. Yet women are ‘hidden’ because the focus of many studies in developing countries is on their reproductive activities. Women are often only described at the population level, epidemiologically for example, when the MMR measures the risk of death once each woman becomes pregnant. In a sense, this study is no different, because ‘the identity and value of women, at least in part, as life-giving events are firmly within women’s domain’ (Pankhurst 1992:1). I hoped to rethink the way childbirth is understood in Ethiopia from the participating women’s perspective.

2.5.2 Participants

The women in the study live in either Ghimbo or Decha woreda in Kafa Zone (see Map 2, Chapter 3). I chose to study women in semi-urban and rural areas because the majority of Ethiopia’s population live in rural areas and distance to a health facility is cited as a major problem for more than three in five women in Ethiopia (CSA and ORC Macro
The selection of women was based on subjective rather than objective criteria as I was introduced to a number of women in Kebele Three (where we all lived) through Azeb, my interpreter, and her family and then asked these women to introduce me to their sisters, mothers or friends who would consider being part of the research. One woman in Kebele Three requested to be interviewed.

During one of my visits outside Bonga, I asked Azeb and her sister to visit women in Sheyka, particularly Manjo women, to ask if they would be prepared to be interviewed. We visited Sheyka the following week where I also met two women by chance. One woman lived near other women being interviewed and expressed interest in being interviewed. The other woman lived with her extended family near the road and when they came out to meet us passing by I asked if the women would be prepared to talk to me about their experiences of pregnancy and childbirth. Two other Manjo women were referred to me by the head of the Administrative Office of the local branch of Ethiopia’s main political party in Bonga.

In total I interviewed 22 women in their homes and talked with one woman who was an inpatient at CHC. Of these women, five of them had had one pregnancy and eight of the women had had over seven pregnancies. One woman had been pregnant 14 times. I also interviewed 17 women waiting for ANC at CHC. Five of these women were pregnant for the first time and three of these women had been pregnant seven or more times. Chapter 4 describes the social interaction and activities women undertake in daily life. Describing the women is important because it means it is possible to start to identify the variables that influence their decision making during birth. There is a brief biography of each woman interviewed in Table 5 (Chapter 4) including their age at the time of the interview, their ethnic background, the number of children they have had, what activities they do from day to day and their description of the closest health facilities.

In Bonga I initially relied on contact through the Catholic Church to find out some of the people I should interview at various health facilities or NGOs. Over the next couple of months as I visited health facilities and NGOs I always asked people if they could suggest other people I should interview or places I should visit. Most interviews in
Bonga took place during the rainy season (June to August 2007) as walking became extremely difficult with land slides and mud everywhere (Section 2.5.3 describes some of my experiences interviewing people from NGOs).

I interviewed two doctors, one health officer, two midwives, three nurses, another nurse undergoing training to become a health officer, and six HEWs or Primary Health Workers (PHWs). I also interviewed two senior administrative staff from the Zonal and Woreda Health Departments: one from the Zonal Health Department in Bonga and one from Decha Woreda in Chiri. Finally I interviewed three TBAs (one TTBA who had received training from Bonga Hospital, and two untrained TBAs) (see Chapter 5). I have changed all the names of these people so they cannot be identified by their responses. The health workers were employed at Bonga Hospital, CHC, Deckia Clinic, or at one of these health posts: Muti, Sheda, Beha, Kuti, Ufa and Shapa. I also visited Ghimbo Health Centre, and briefly saw Wushwush Clinic and the health posts at Bobagetcha, Ogeya, Dishi, Erimo, and Yoka (Chapter 3).

2.5.3 The context: Doing research in Ethiopia

My research started in Addis Ababa by collecting documents and reports from the macro level on reproductive health policy and services to provide a background to the decentralised health care system in Ethiopia. I was also interested to read unpublished research from Addis Ababa University, Population Studies and Research Centre, the Department of Community Health library and from other sources such as NGOs in Ethiopia. I went to Kafa Zone over the Ethiopian Easter to determine if it was a suitable location to conduct research. Given the difficulties of travel in Ethiopia (and my determination not to go anywhere where there was any possibility of getting malaria which I had had as a child and young adult), I decided to return to Kafa Zone after finalising things in Addis Ababa. In particular, I wanted to obtain formal letters of introduction to the Zonal Health Department, the Bonga Hospital, and at least two of the health centres I wanted to visit. I also wanted to open a bank account with Commercial Bank of Ethiopia, the only bank with a branch in Kafa Zone, and needed a residents’ permit to do this.
On my return to Addis Ababa I soon realised that I needed to learn how to work with the bureaucracy in Ethiopia. Getting letters of introduction took five or six visits to the Ministry of Health, each visit requiring me to negotiate my way around Addis Ababa by minibus taxi and on foot. As a visiting scholar at the Addis Ababa University Population Studies and Research Center I was given a formal letter of introduction to the Ministry of Health requesting formal letters of introduction to health facilities in Kafa Zone such as Bonga Hospital, CHC and Deckia Clinic\textsuperscript{30}. However, the first letter from the university addressed 'To whom it may concern' was unacceptable so I had to have another letter addressed to the correct person. Following a number of phone calls and another visit the letters were written but were addressed to the health facilities in Kafa Zone in Oromia Region rather than Southern Nations, Nationalities, and People's Region (SNNPR). By chance someone from Kafa Zone saw the letters and rewrote them. When I went to pick them up the printer wouldn't work. Finally, on my next visit I received the letters and was introduced to the acting head of the Family Health Department to whom I promised to send an interim report of my research (Jackson 2007).

During my visits to the Ministry of Health I met a number of staff and was given copies of the National Reproductive Health Strategy (Ministry of Health (MOH) 2006a) and Report on Safe Motherhood Community-based survey, Ethiopia (Ministry of Health (MOH) 2006b). One of the senior staff members directed me to CARE International, Ethiopia for further information. At CARE, I met the Sexual Reproductive Health Program Coordinator who gave me copies of research from their projects in West Haraghe Zone (Alemayehu Mekonnen 2005; Endale Workalemahu 2003; Kayongo et al. 2006). On my return to Addis I met with her again and we discussed the ongoing need for training TBAs in Ethiopia despite the international trend to move away from this policy. I also learned that the CARE projects had not continued because of high staff turnover and changes in policies at the hospitals where the projects had been implemented.

Throughout the next month I went through the process of opening a bank account because I wanted to be able to withdraw money in small amounts and I thought it would be the most ‘authentic’ way for me to access my money. But first I needed to get a

\textsuperscript{30} Appendix Two is a copy of the letter of introduction to Bonga Hospital.
residency permit through the Department of Immigration. This required a letter from the President of Addis Ababa University where I was a visiting scholar. To get this letter required another letter from my supervisor at the Population Studies and Research Center to its Director who then wrote to the President requesting the letter. Three weeks later back at Immigration I was taken in to see the Head of Foreigners only to discover that my letter had a typing error. It stated I wanted to ‘renew’ my residency permit rather than ‘apply’ for a residency permit. This required a new letter from the University. I returned a few days later and everything went well until there was another mini-conference with the Head of Foreigners and two staff members. Did I have a student card? If so, they could save me half the application fee! For each step of the process I sat at a desk and conversed with the person who took my form and entered the information on the system; the one who checked it again and took my photograph; the next office where I paid; the office where it was all checked again, and then the next day when I picked it up. Everyone was helpful and friendly once I knew what I had to do.

All these bureaucratic processes held me in good stead as I gained an excellent insight into how Ethiopian bureaucracy works. And sharing ‘bureaucracy’ stories with other people I met made me realise that my experience actually went well when I just ‘went with the flow’. Later I learnt that people working in the decentralised health system learn to be responsible to their superiors and no decision could be made without written permission (Chapter 6). I also learnt that health workers had set routines that could not be altered, including making monthly reports, picking up their pay and collecting medical supplies. For those I visited in remote locations this was problematical given the mountainous terrain and lack of transportation. Perhaps this was why people seemed to take a matter-of-fact approach to timetables and other things as so little was under their control.

The administrative centre, Bonga was also where the single post office and single bank for Kafa Zone was located. The post office was open in the mornings and a couple of hours later in the afternoon after the lunch break. Some mornings I walked to the post office and discovered it was open with a tea break sign on the counter and no staff present. Conveniently, there was a hotel/ cafe across the road where you could wait and drink tea or coffee. Almost next door was the Commercial Bank of Ethiopia. I had
opened an account with the bank in Addis Ababa (thinking it would be easier than in Bonga), only to discover that this meant phoning the Addis branch to approve my withdrawal. Nevertheless, I found the bank a fascinating place and I had plenty of time to observe people’s behaviour. First, you had to go through the gate (trying to avoid as many beggars as possible) and pass the two guards. On the window ledge of the guard house there would be a knife or two and a machete or two that were confiscated before people (only men carried knives and machetes) went into the bank. Inside the bank, I had to fill out two identical withdrawal slips and give them to the young man behind the counter along with my resident’s card and bank book. I was given a numbered token and then another form would be filled out by the bank officer who then placed it on the desk of a senior officer who would check all the withdrawals. This was on a first come, first serve basis. The bank manager’s desk was also behind the counter and on occasions some customers would go behind the counter to greet and talk with the bank manager. The bank was a noisy place always full of people especially full on market days when it was difficult to get change at the market or in the shops. There were constant phone calls and numerous typewriters in use. But most days it took 90 minutes to get a call through to the bank in Addis Ababa so I soon learnt to go shopping, to check my email and to drink tea or coffee while I was waiting. After the phone call was made, three new withdrawal slips were typed up and I was required to sign them before my bank book and paperwork was given to the teller. I should mention that there was a woman whose job was to take the bank books and paperwork from one desk to another. At other times she served coffee to the bank staff. There was generally only one teller although he was assisted by another woman who also ran the noisy machine that counted the notes. Although the teller had a system for handling withdrawals, taking the bank books in order as they came, there were also people who were depositing money who were served although I couldn’t work out the system for this. But there were always people coming into the bank to break 100 birr notes into 10s or ones or to replace torn notes. This system worked by pushing and shoving and trying to push your birr through to the counter before everyone else. The other group of people who were crowded around the counter were those who I presumed ran businesses or shops out of town and who came in with briefcases or bags to withdraw many thousands of birr. They would count every birr at the counter before they left to ensure it was all there, unlike the rest of us who could just put our birr in one pocket. I normally allocated an entire morning to withdraw
money but on a couple of occasions I had to go back the next day because the phones to Addis were out of order. The bank also closed for a couple of hours for lunch, and longer on Fridays so for anyone from outside of Bonga a visit to the bank was easily an all day activity. I knew that the monthly payroll for all the woredas, and even the individual accounts of workers from the coffee or tea plantations meant a long visit to Bonga. Overall, my experience at the bank was time consuming but never dull. The bank officers were always polite and apologetic about the time it took. They conducted their duties in a highly professional way. On many occasions customers would shake hands or kiss the bank staff if they knew them well. Customers would always greet each other and I was surprised to find a number of women had bank accounts and would come in on their own. The biggest surprise was the lack of security. Outside the open back door you could see a huge avocado tree in a well tended garden but on some days the door was jammed shut with a stick in the lock. There were huge stacks of money sitting behind the teller’s counter and the safe door was always wide open so every one could see even all the stacks and stacks of birr. I doubted this bank had ever been robbed and I hoped the day would never come where it was deemed necessary to keep the safe locked during the day. Banking was a safe activity in Bonga.

I was surprised to find so many local and international NGOs in Bonga. Because they were scattered at opposite ends of the town, I found a number of them by ‘accident’ because I walked everywhere or because I was referred to them through other people I interviewed. The people who work for NGOs and for government all work in offices. Most of these offices are less than 10 years old, yet already some are in need of major maintenance because the mud walls have shrunk away from their wooden frames and need to be filled in again. Some of this work was happening in the buildings where I conducted interviews and people had to walk around the maintenance workers. Offices are equipped with basic equipment such as desks and chairs, some have electric lights, others don’t. Most offices have computers although many of them, like the bank, use both computers and typewriters. Only one office had an internet connection (Kafa Development Project [KDP]); although ActionAid had applied for a connection they were still waiting months later for this to happen. There were three internet cafés in downtown Bonga and some days it was necessary to visit all three to find one where the internet was working. All three businesses also offered secretarial services and
photocopying which was used by private individuals, businesses and even by government offices for typing and copying official documents or letters. So all three businesses were very busy which was extraordinary given that (intermittent) 24 hour electricity and internet connections had only come to Bonga in 2006. These shops were also where visiting ferangi researchers met by chance.

My first NGO interview was with KDA. I had been introduced to a staff member who was an elder with the Catholic Church (my contact with the Catholic Church in Bonga came through someone in Australia). The first time I walked up the steep hill to KDA’s offices I began to realise, passing the signs for FARM Africa and a number of government departments, that just getting to work was a real effort. This was before the rainy season and some people were able to get to work by white four-wheel drive Land cruiser or motor bike (although KDA did not have any vehicles). Some of the NGOs had drivers who drove around town picking up staff from their homes, took them home for lunch, picked them up again, took them back to work, and then back home again in the afternoon. The other options for people to get to work were to walk or catch a mini-bus taxi. As the taxi service was unreliable and overcrowded it was not the number one choice of transport but was preferred by many to walking and sliding around in the mud in the rainy season. But there was no taxi service at the southern end of town where KDA was located because the road was too steep. Shortly after my arrival when the rains started, a huge crack appeared across the road at the bottom of the hill which dropped a metre or more making it impossible for any vehicle to negotiate. So there was often a row of Land cruisers parked at the bottom of the hill.

At KDA, I met a number of the staff and was offered the first of many coffees that I had as a visiting researcher to these sorts of offices. Some days I would be taken to the shy or bunna bet with the staff, other days I was offered coffee in the office by the person I was interviewing. In these instances this was always brought on a tray by a young woman. The offices at KDA were staffed by four or five people. There was one functional computer in the manager’s office and a new one which was yet to be unpacked still in its box. Typewriters were also used. The manager’s office had a desk and in front of the desk were four chairs which were set at right angles to the desk, two on either side, facing each other. In this way, it was possible to have a meeting or
interview with the manager sitting at one of these chairs. On one occasion when I arrived, there were three people from the local government meeting with the manager. I was encouraged to take the empty chair as they were almost finished and to introduce myself and have a few minutes to chat about Kafa Zone.

A number of the interviews were fairly informal in this way. The door was open, there were always interruptions from phone calls (if the phone was working) or other staff who had urgent questions or needed to have documents signed. During one interview, the manager had to sign a stack of duplicate contracts that was about 20 cm high (for building a new vet clinic). However, there were a number of interviews that were quite formal and the door would be closed. In these cases the person being interviewed sat behind a large desk and I was required to sit at a table in front of the desk. In one government office there were about 16 chairs around a huge array of tables in front of the desk of the person I interviewed.

All of the government staff and staff from NGOs I interviewed had a female secretary who answered the phone and typed up documents on computers or typewriters. I soon realised that the ‘normal’ way to see one of the people I wanted to interview was to come to their office and queue up outside on one of the benches or chairs. People were then admitted on a first come, first serve basis. Although I was able to see people in this way, I always used the first or second visit to make an appointment with them so I could conduct an interview ‘properly’ rather than just appearing and queuing as others did. I felt it was important to explain why I was there and have their agreement about their participation first. I also felt it might enable them to think about what they would want to say and to choose the best time for the interview. At times, I felt it was impossible to choose a good time for an interview as some of them were always busy and interviews were rescheduled many times. Most of these interviews were interrupted numerous times by telephone calls and staff needing to ask questions or have documents signed.

One of the people I interviewed promised me a copy of a document on numerous occasions but every time I went to ask for it I found this person either out, or in a meeting. So I would sit outside his office on the bench with the others, waiting in the queue to see him. This was not always time wasted as I would have the opportunity to
chat with other staff members or observe the maintenance work going on in the office. One morning as I waited I chatted with a young laboratory technician who impressed me enormously. He had finished his training and had been sent to work at a rural health centre. However, as the health centre did not really exist and there was no laboratory or equipment, he had nothing to do. He was bored and really wanted to work and had made the long journey to Bonga to see what he could do about it.

In the course of the interviews I felt that it was unusual for staff to be asked to do an interview with a ferenji about their work, or to answer questions such as ‘What do you think development means?’ All the staff I interviewed were men although I did meet two women who worked for NGOs in Bonga. When I asked to interview one of these women, because she had also had experience working for government, I was referred to her manager. I also felt it was highly unusual for the male managers to be interviewed by a woman. During a few interviews I felt that I was not always being told the ‘truth’ but the ‘official version’ about government policy and strategy. Nevertheless, no one exaggerated the difficulties about bringing about change in Kafa Zone, especially about the problems with roads, transportation and communication. A number of staff stressed that although change was slow, compared to a few years ago, there had been significant change in the number of roads built, schools and health posts built and so on. At other times I felt some of the staff did not believe me when I told them about some of the financial or other circumstances of some of the women I had interviewed. For example, when I said that a woman with seven children (and no husband) could not send all the children to school because she could not afford the exercise books and pens, I was told the real reason was that the children were being used to help around the house or in the garden. Yet I knew that this woman could barely feed the children once a day, that her tukul was falling down and leaked in the rain, and that the amount of land she had was inadequate to feed the entire family and wouldn’t require the labour of the children.

Older people living in and around Bonga have lived through three major changes in government in Ethiopia from the reign of Haile Selassie; ‘passing from feudal to so-called socialist, and from socialist to so-called democratic rule’ (Poluha 2004:11). Even though there have been many visible changes since the late 1960s, I had the feeling that my experience going from office to office taking weeks to organise and conduct each
interview reflected the difficulties any development project might face. If it took me a month to open a bank account, a week or more to organise an interview, and a morning to withdraw money at the bank, how long would it take to build a health post? If it took me or the staff who work in a rural health post one or two days just to reach the health post, and staff need to report to the woreda centre every month how many days are left to work (Chapter 5)? If there is to be an increase in the number of births attended by skilled health personnel either at home or in a health facility what changes must take place? The purpose of this study is an attempt to answer these questions.

2.5.4 Limitations

At times I felt it was impossible to protect the privacy of people I was interviewing as everyone could see me walking around to visit women in their homes or people in their work place. Nevertheless, the interviews themselves were done as privately as possible. As stated in the previous section, there were a number of occasions where I felt that the answers I was given by people who worked in government or for NGOs were the ‘politically correct’ answer even though it might not be the truth. Some of these examples are cited in Chapter 6. I also felt that people did not give me accurate answers when estimating how long it took to walk from Deckia to Chiri for example but in the end did not feel this was too much of a problem as I was able to estimate these times because I walked to many places myself, albeit not always as quickly as the people accompanying me.

The main limitation I felt was that my efforts to engage in everyday activities were at times exhausting, especially some of the travel around Kafa Zone. And although I normally never get ill at home, I was quite sick with influenza on three occasions. Most of all I wanted to follow examples of other research that uses ethnographic descriptions of individuals and everyday stories to help to overcome the problems of generalisation (E.g. Boddy 1989; Pankhurst 1992; Abu-Lughod 1993; Davison 1996; Hunt 1999; Poluha 2004). But I was only in Kafa Zone for six months out of the total nine months’ fieldwork so my time was limited. I wanted to be able to talk to women; to people who worked in government and for NGOs; and, to those who worked in health facilities. In the end I had to accept that I am not a student of anthropology but of international development, and that it was impossible to devote more time getting to know more
individual women. In the end, I hope to return to meet some of these women again in
the future\textsuperscript{31}.

2.6 Data analysis and presentation

To overcome the difficulty of reducing data, theory and practice to a single written text
(the thesis) I reduced the data to manageable portions and then organised it around
themes, patterns or similar experiences. Qualitative analysis is a process of data
reduction, data display and conclusion drawing/verification occurring concurrently
(Miles and Huberman 1994:10 - 12). Analysis of data was ongoing as each interview was
transcribed to determine the characteristics of settings, events, and processes... for key
events, interactions in different settings, and episodes embodying the emergent patterns
in the study (1994:33 - 34). In reflecting on the research process, Pankhurst (1992)
writes that this can be a frustrating process because it is difficult to mention one issue in
isolation without mentioning its impact on a series of other factors. Which issues should
be highlighted and which explanations adopted? She cites an example of attending a
christening of a baby which was seen as unimpressive. Was it because the child was a
girl, illegitimate, because of poverty and drought, or because foreigners see events as
more colourful than is actually warranted because they generally have access to people
who are better off than the peasantry (1992:188-189)? Should a description such as this
lead her to develop themes on christening, illegitimacy, social stratification, or traditions
and observations?

I started by organising the data around the themes expressed in the research questions.
This process began with reading the translated and transcribed data to gain a general
picture of what women talked about. Data was coded with an initial label in the margin
alongside questions and ideas that emerged. For example, themes such as
decentralisation and how the top-down planning approach restricts planning and
development to the various pre-existing sector plans, were underlined and coded.

Second, my fieldnotes contained references to how people interacted, the physical places,
people, emotions and events occurring at the same time. Fieldnotes are not just
descriptions of what the ethnographer sees and experiences, but are also her perceptions

\textsuperscript{31} In January 2010 I returned to Kafa Zone for a very brief visit. Unfortunately I only had time to visit
Yehsairg and her family and meet the new baby who had arrived the previous week. I was happy to find
that the other two children (now aged four and six) still remembered me.
and interpretations of the events’ (Liamputtong and Ezzy 2005:171-2). They are an active process of sense-making, of the ethnographer’s feelings and interpretations of what they see and experience during the participant observation. This will guide them to enquire further, hence obtaining more in-depth understanding of the community group (2005:172).

Even as I asked questions about modern health services and sought to understand why women do not use these services during pregnancy and birth, my own ‘pre-existing understandings, experiences and theoretical traditions’ (Liamputtong and Ezzy 2005:17) are integral to what I can analyse and describe. It was at this point that I needed to theorise about how reproductive health, in particular the goal of reducing maternal mortality and disability, fits into Ethiopia’s development agenda. Would the expansion, accessibility and quality of health facilities influence women’s ideas and behaviour about attending health facilities? In my attempt to represent the reality of these women’s lives, some characteristics will be highlighted and others will be regarded as irrelevant. These characteristics could not be determined before the research began but like Pausewang (1973), methods and topics can be forced on a researcher. For example, surveying attitudes towards FP forced him to study land ownership, socio-economic dependencies, and corruption, and other social factors (1973:128). Even so there is no absolute truth to be searched for or found as knowledge is constructed differently for people in other times and spaces. I felt ‘compelled’ to study the time and distance between where women lived and the health facilities because time and distance are built into the referral system in rural areas.

In reality, any conclusions I have drawn only refer to the women whose personal perspectives I describe and analyse at the individual level. However, I hope that I will be able to make well-founded inferences about my conclusions. There is no real solution to avoiding bias in this type of study and all I can do is to concentrate on the themes the women and other participants discussed and to be as representative as possible in acknowledging their voices. In the end I felt it does not matter if the initial study was conducted in one rural area—these findings may be generalised to other rural areas in Ethiopia where maternal mortality is a concern because ‘knowledge is not limited to demographic variables; it is the fit of the topic or the comparability of the problem that is of concern... it is the knowledge that is generalized’ (Morse 2000:6). I found that Kafa Zone is typical of many of the rural characteristics of Ethiopia because of ‘limited access
to health services, high fertility rates, high mortality rates, poor sanitation and water supply conditions, a high rate of illiteracy, women’s subordination and food shortage’ (Yemane Berhane 2000:36). For this reason, ‘for issues that are more influenced by socio-demographic and environmental factors a fair level of generalisability can be assumed’ (Yemane Berhane 2000:36; see also Alemayehu Mekonnen 2005; Endale Workalemahu 2003 for similar conclusions to the barriers to health care).

This chapter examined the methodological issues and the practical aspects of the methods I employed including the ethics process. It discussed the context for doing research in Ethiopia and some of the limitations to the research. In this way, it is an introduction to the location to fieldwork setting which is the focus of the next chapter. Chapter 3 also describes a number of the health facilities that were visited and the referral system linked to these facilities.
Chapter 3: Location, distance and the provision of maternal health services in Kafa Zone

Chapter 3 examines the second part of the questions: 'Who is giving birth where, and why?' Like a map, it sketches, represents or delineates Kafa Zone as a place where over 90 percent of people live and work in rural areas (CSA 2007:78); and like a map it finds its way geographically to the field sites (following Hay 2001:20). Two of the themes explored in this chapter are mobility and accessibility to health facilities. Recognition of the connections between social and economic development and reproductive health means that many nations have made substantial efforts to develop their transport infrastructure, based on the concept that improved connections with centres of innovation and commerce (both domestic and foreign) stimulate economic development and social change in previously isolated rural areas... poor mobility and accessibility of maternal services has a major impact on excluding poor rural women from maternity facilities in low-income countries (Molesworth 2005).

Since interventions to improve health, especially sexual and reproductive health (FP, maternal care, prevention and treatment of Sexually Transmitted Infections (STI) and HIV/AIDS) were found to be cost effective (World Bank 1993), international policy and funding together with the National Reproductive Health Strategy has led Ethiopia to aim for new targets to reduce maternal mortality and disability (Chapter 1). The MDG Five target (To reduce by three quarters, between 1990 and 2015, the maternal mortality ratio) aims to increase the proportion of births attended by skilled health personnel with the target of universal coverage of skilled care at birth by 2015. To meet the maternal health needs of Ethiopia’s rural population, primary emphasis has been placed on the decentralised health system and delivery of basic community-based maternal and neonatal health services, most notably through HEWs and mid-level service providers. Community-based health workers must be able to refer complications to the appropriate facility; and hospitals must be adequately equipped and staffed to provide EmOC services. But is this enough to ensure an increase to 60 percent the proportion of births attended by skilled health personnel either at home or in a facility (a six-fold increase from the current 9.7 percent) (MOH 2006a:18)? Taken as a whole, the distance from international policy to implementation in the kebels is vast and there is a lot of room for misunderstandings along the way. Infrastructure development in Kafa Zone has generally been poor as evidenced by the absence of a good road network, low degree of urbanisation and other services such as power, telecommunications, water supply, education and health services. But infrastructure development is slowly occurring and in
the year before I arrived some towns nominally gained access to 24 hour electricity and telephone services. Road construction and installation of clean water points is ongoing but lack of maintenance often means that roads wash away in the rainy season in many places and may not be repaired, and many clean water points are non-functional.

This chapter describes a number of the health facilities that I visited in Kafa Zone. It begins to explore what it means to ‘go to a rural health facility’ and what shapes decision making in the absence of alternatives for biomedical health services when people are faced with emergencies during childbirth. Other factors that influence decision making such as gender and marginalisation are explored in Chapter 4; the cost of health services is examined in Chapter 5; and, the effect of women’s education on health seeking behaviour in Chapter 6. This chapter first describes Kafa Zone, and then how I found my way to two research locations. These descriptions are intended to evoke a picture of how travel feels (albeit for the outsider) and to make it possible to imagine how travel is possible from the remote kebeles to the woreda or zone centres, in an attempt ‘to connect personal knowledge with cultural knowledge while remaining grounded in the dynamic and contingent processes of everyday life’ (Hay 2001:17).

The second section of the chapter has three themes: the referral system, which is seen as the link between health facilities; travel distances and transportation reflect the themes of accessibility found in Phase II of the Three Delays (Thaddeus and Maine 1994). These themes include the opinions and experiences of staff from health posts, health centres and hospitals who provide ANC, normal delivery care and EmOC. In Chapter 4, I compare these opinions and experiences with those of the women who use the health services. In this graphic representation, it is important to keep one’s feet firmly on the ground because walking is the ‘normal’ way to get from place to place. In the course of my research in Ethiopia, I began to wonder if the normalisation of walking is actually viewed as a problem by the people of Kafa Zone. In the report I prepared for the staff from local government and NGO staff (Jackson 2007), I argued that I was unable to disentangle the disincentive from the obstacle of distance when people decided to walk to a health facility. Nevertheless, I concluded that the Reproductive Health Strategy (MOH 2006a) had structured in delays by default as the most cost effective way to provide health care to the rural population.
3.1 The fieldwork setting

In 2007, health service provision in Kafa Zone consisted of 130 health posts (with the aim of one health post with two HEWs per kebele within the next year); 19 health posts or clinics being upgraded to health centres, eight health centres (including one run by an NGO (Lalmba)—Chiri Health Center (CHC)), five health centres under construction and one rural hospital (Map 1)\(^\text{32}\). The health centres are Type A (catchment area 100,000 people) or Type B (catchment of 25,000 people). According to the Zonal Health Department, there should be 35 health centres with 19 facilities being upgraded to health centres (such as Deckia Clinic), 10 Type A health centres, and two rural hospitals.

I visited Bonga Hospital, four health centres, one clinic and 11 health posts (Map 2 and Table 3). The visits to Bonga Hospital, Deckia Clinic, and to Muti, Gebera and Shapa Health Posts were on foot and the rest were by vehicle. I also walked to all the interviews with women in Kebele Three, Bonga, to Sheyka, Shapa, and to Tigiste’s house in Chiri (Chapter 4), and to all the interviews in Bonga with government staff and staff from NGOs (Chapter 6). The visit to Yoka was first by vehicle and then by foot to the Yoka health post itself and on to Opa 1 and Opa 2 to visit a few families who had recently experienced a measles outbreak. I accompanied staff from CHC on their monthly outreach vaccination clinics to a number of the health posts. My observation was that staff looked forward to the outreach clinics because they were paid an extra per diem allowance. I also had the sense that people enjoyed being away from the work site for the day and they had a chance to talk as they walked and catch up with friends walking along the route as well. The visit to Gebera also gave staff an opportunity to talk to the kebele leader to plan the next visit, to socialise over tella and coffee while waiting for the rain to stop, and to pick up vegetables from a farmer on the way back to Chiri. When required I worked with one of the two professional interpreters from CHC for interviews at health posts or health centres.

\(^{32}\) Note: this is a 2002 map produced by SUPAK which was the only available map of the health facilities.
Map 2: Mud map of the studied area in part of Ghimbo woreda and the north of Decha woreda (I visited all the locations on this map)
Map 3: SNNPR woreda boundaries and Kafa Zone boundaries (SUPAK)
Map 4: Section of the topography of the area between Chiri and Muti
### Table 3: Salient features of health facilities visited

<table>
<thead>
<tr>
<th>Facility</th>
<th>Infrastructure</th>
<th>Location/ referral</th>
<th>ANC/ Deliveries/ Immunisation</th>
</tr>
</thead>
</table>
| **Bonga Hospital**| Funded by SUPAK less than 10 years ago but needs significant maintenance especially plumbing. Approximately 20 inpatient beds (in various states of repair) although never more than a handful of patients. Laboratory, pharmacy, busy outpatients, X-ray (not working), ambulance (not working) and labour ward. Patients first go to the Card Office to get their patient record or register as a new patient. (By comparison, there are no cards at Deckia Clinic or any of the health posts although some of the women at Deckia Clinic have a card recording their TT immunisation). | Referral hospital for entire Kafa Zone. About 15-20 minutes walk from downtown Bonga. Also refers to Jimma Hospital when the surgeon is not around, or unless the O.R. is not functional for some reason like sometimes our generator is not functional and if the light is not around ... the mother [needs] a blood transfusion (Dr Befekadu). | ANC is run on all weekdays. The block where the ANC clinic is held has separate rooms for FP, immunisations and the outpatient clinic for babies and children. Everyone waits on benches outside the rooms or standing along the walls under the veranda that means everyone could see who is waiting for ANC or FP.  
There are a number of lab tests women can have including urine tests and blood tests for anaemia and HIV. Nurse running ANC takes her time with each woman and examines her gently and efficiently. Box 4 describes a number of visits to the hospital including being there during one delivery. |
| **Deckia Clinic** | Being upgraded to a health centre but in 2007 was a five-roomed building with delivery room (with an old delivery bed with a pair of stirrups attached on the end. The only other 'equipment' was a rubbish bin; storage room which only contains a kerosene refrigerator (the smell of kerosene is quite overpowering); main clinic room with desk (covered in a filthy cloth and piles of various record books including ANC, deliveries, FP and general treatment), chair for the nurse and a couple of chairs for patients, examination table in one corner with a privacy screen around it. The next room is the injection room and the room where all the medicines are kept with opened boxes and medicines all over the tables and on the floor. Another storeroom at the right | Visited in June and October 2007 just before and after the rainy season. For a fit person to reach the Deckia clinic from Bonga requires travel for an entire day. Depending on the season and the route it will take around 90 minutes by road and then five to eight hours walking or on a mule. These estimates are based on how muddy it is, the fitness of the person, the route taken and whether or not they are carrying a patient. Map 2 shows Deckia's location in Decha woreda. There are many 'roads' to Deckia (for one example see Photo 5). Being upgraded to be a referring health centre which means distance comes nearer to them [so that people] can reach it easier (Ato Michael—Local government officer). Deckia Clinic currently refers | *More than 20 women a day are coming to ANC... women are coming in increasing numbers to the health centre that means they are accepting so much... There were also increasing numbers of women coming for FP.* |
of the building. Outside are a couple of benches for people to wait. For those who come by mule or horseback there is plenty of grass around the clinic for the animals while they wait. Box 15 in Chapter 6 describes my visit to the ANC in Deckia.

patients to either Bonga Hospital or Chiri Health Center. It serves two kebâs (Agaro Bushi and Daga) and is the referral centre for two other health posts (Gogira and Shitiyo). In Chapter 5 I relate Meseret’s story from Agaro Bushi to Deckia and CHC.

<p>| Chiri Health Centre (CHC) Run by a small US based NGO (Lalmba—A Place of Hope) | Designed according to the government plan for health centres and is the busiest health centre in Kafa Zone often seeing 150 outpatients a day. CHC has around 20 beds for inpatients but there are often two patients to a bed. The majority of these are young children suffering malnutrition. CHC has a laboratory, pharmacy and labour ward. CHC completes monthly, quarterly, and annual reports for the government, Apostolic Prefecture of Jimma and Bonga and to Lalmba in the US. | 23 km by road from Bonga. Road and bridges need significant maintenance. At times cannot use road in rainy season. Referral to Bonga Hospital. | Box 5 is an extract from CHC quarterly reports highlighting the expansion in ANC and FP and delivery services and some of the challenges an NGO faces running a health centre. The outreach program conducts primary and preventative health care programs outside Chiri at 10 locations. CHC organises and implements vaccination visits, disseminates health education and health promotion, conducts epidemiological monitoring and outbreak response in cooperation with government authorities. |
| Wushwush Health Centre Photo 8 | An upgrading health centre serving up to 31,000 people from seven kebâs. There is no delivery bed, no Ergometrine, one delivery kit, no electricity supplied (it is available in Wushwush). There is a refrigerator. I was told there is no budget allocation for improving the service. | About one hour drive to Bonga by road. There is a minibus taxi and bus service that operates between Bonga and Wushwush. As with all taxi and bus services, there is no fixed timetable and the overcrowding in the taxi was the worst I’d ever seen. I managed to get into the front of the taxi and if you turned around there was no view of anything behind the taxi, no trees or skyline, only crowded bodies. | Two male clinical nurses who attend five or six deliveries a month. |
| Ghimbo Health Centre Photo 9 | Comparable to CHC in size and employs one health officer (who has not had any surgical training), senior and junior nurses and health assistants. It has rooms for outpatients, injection rooms, rooms for FP and ANC, laboratory pharmacy, and four beds for deliveries. | About one hour north of Bonga on Bonga to Jimma road. Ghimbo Health Centre sees about 25 to 30 outpatients a day, although some days there might be 40. Mondays are always busier as it is market day. | Around five deliveries are conducted every month with referrals to Bonga (if services are available) or to Jimma Hospital. There is no transport for referrals available. |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muti Health Post</td>
<td>The health post has two rooms, a small storeroom with a cupboard for medications and a large wooden box to store things. It also houses the only satellite solar-powered telephone in the kebele (it is working unlike many of the other phones where I visit). The larger room has a desk covered in paper, medicine boxes, a kidney dish, two wooden chairs and two wooden benches. On the walls are a few old posters and a chart in Amharic (the local language is Kafficho). Muti Health Post offers treatment for worms, headache or pain, disinfectant for sores and wounds. There is no running water, no electricity, and no refrigerator to store.</td>
<td>Muti Health Post is three and a half hours walk from Chiri up and down three significant hills (there is no road) (see Map 2 and 3). Referral to CHC.</td>
</tr>
<tr>
<td>Bobagetcha Clinic</td>
<td>45 minute drive from Chiri (if it hasn’t been raining too much and the road hasn’t washed away). Their telephone is not working but the refrigerator is. Following almost two years with no vaccination clinics there have been high rates of measles and malnutrition in this area. Bobagetcha Clinic was recently reopened by the government and the clinic has two nurses. Referral to CHC.</td>
<td>The nurses are called to attend three to five births a month. The day I went to the immunisation clinic they refused to allow it to happen and said they could run it themselves. There was some discussion about this on the way back and most people thought the issue was who would receive the extra per diem payment for running the clinic.</td>
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</tr>
</tbody>
</table>

**Statistical charts on wall for 1999 Ethiopian calendar (E.C.)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Planned</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>465</td>
<td>692</td>
</tr>
<tr>
<td>Delivery Care</td>
<td>194</td>
<td>88</td>
</tr>
<tr>
<td>Post ANC</td>
<td>463</td>
<td>73</td>
</tr>
</tbody>
</table>

Bobagetcha Clinic was recently reopened by the government and the clinic has two nurses. The nurses are called to attend three to five births a month. The day I went to the immunisation clinic they refused to allow it to happen and said they could run it themselves. There was some discussion about this on the way back and most people thought the issue was who would receive the extra per diem payment for running the clinic.

On the way to Muti we passed five or six very pregnant women who have been turned away from the health post and told to come back next week for their ANC appointment. At Muti it is obvious that it was impossible to run ANC while the immunisation clinic is underway as there were well over 100 women with babies and children plus everyone who has come to see the excitement of a vaccination clinic. There is not enough vaccine for so many babies and toddlers so many are told to come back next month.

Attend 4 – 5 deliveries/month.
<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
<th>Distance from CHC</th>
<th>Referral to CHC</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yoka Health Post</td>
<td>Health post located close to the new school (under construction) and the kebele offices. As the oldest of the buildings, the mud walls are quite washed away from heavy rains. There are three rooms: the treatment room and a couple of small storage rooms. The entire building is in very poor condition with large gaps between the walls and the roof so rats and other things can get in. There is a new stretcher for carrying patients and a new refrigerator in a storage room. The outreach team unpack and try to set up the refrigerator (which is full of rat droppings at the back) but are unable to do so. I suggest reading the manual but they give up after two hours.</td>
<td>About 20 minutes drive from CHC. From the road, the health post is another 20 - 30 minutes walk downhill.</td>
<td>Referral to CHC.</td>
<td>Walked from Yoka to Opa One and Opa Two to review a measles outbreak with one of the nurses from CHC (who was a woreda employee), two of the woreda health officers (health surveillance) and the HEW from Yoka. We met five or six Manjo women with a dozen or so children, all with signs of malnutrition. Some of the children had had measles but were better now. None of the women had ever had ANC but they had received TT during a campaign. HEW at Yoka had never been called to assist with a birth anywhere.</td>
</tr>
<tr>
<td>Ogeya Health Post</td>
<td>Brand new (unoccupied) health post. Still using old health post.</td>
<td>Near road from Chiri to Dishi. Referral to CHC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gebera Photo 3</td>
<td>Although I did not see the health post I observed the outreach clinic see 3.1.4.</td>
<td>Three hour walk from CHC (See Photo 2) Referral to CHC.</td>
<td></td>
<td>CHC outreach: up to 100 vaccinations/ month.</td>
</tr>
<tr>
<td>Sheda Health Post</td>
<td>A couple of rooms at end of building of kebele offices. Clean and tidy. No refrigerator or scissors, only gloves.</td>
<td>Referral to CHC.</td>
<td></td>
<td>Delivery bed. HEW attends four to five deliveries per month.</td>
</tr>
<tr>
<td>Ufa Health Post</td>
<td>Building located near water tank. No refrigerator, but has gloves, scissors.</td>
<td>Near road south of Chiri. Referral to CHC.</td>
<td></td>
<td>Staffed by PHW and a TTBA. Attend four to five deliveries a month. CHC outreach: 50 - 100 vaccinations/ month.</td>
</tr>
<tr>
<td>Health Post</td>
<td>Building Condition</td>
<td>Location</td>
<td>Referral</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------</td>
<td>----------</td>
<td>---------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Erimo Health Post</td>
<td>Building in very poor condition.</td>
<td>Near Bonga - Chiri road. Referral to CHC.</td>
<td>CHC outreach: up to 100 vaccinations/month.</td>
<td></td>
</tr>
<tr>
<td>Kuti Health Post</td>
<td>On day of visit HEW conducting Vitamin A/Albendazole campaign in her home adjacent to the partially completed health post.</td>
<td>Near road from CHC to Bobagetcha. Road conditions poor in rainy season and only used by Isuzu trucks. Referral to CHC.</td>
<td>New health post under construction so HEW had not started ANC or deliveries.</td>
<td></td>
</tr>
<tr>
<td>Beha Health Post</td>
<td>Built by SUPAK. Water tank on roof (empty because there has been no rain), electricity installed (not connected).</td>
<td>Near Bonga - Chiri road. More buses on market days but most buses did not pick up extra passengers on the way as they were too full. Referral to Bonga Hospital.</td>
<td>Delivery bed. PHW and one nurse called to three births a month. Ergometrine expired in 2006. Unable to get new supplies.</td>
<td></td>
</tr>
<tr>
<td>Shapa Health Post</td>
<td>Building in very good condition. Refrigerator not working, examination table, scissors. Gloves 'borrowed' from other health posts or clinics.</td>
<td>Near Bonga - Chiri road. As with Beha, buses unable to pick up extra passengers. About an hour’s walk downhill to Bonga. Referral to Bonga Hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dishi Health Post</td>
<td>No electricity or water on site. Brand new health centre about 500m away. No money for equipment so it remains empty.</td>
<td>Most southern health post in Decha woreda. Near road from CHC. Road washed away in very poor condition. Only used by Isuzu trucks. Referral to CHC or Bonga Hospital.</td>
<td>Delivery bed. Staff attend four to five deliveries per month.</td>
<td></td>
</tr>
</tbody>
</table>
3.1.1 Kafa Zone

Kafa Zone covers an area of 11,114 square kilometres and is one of the 13 zones in Southern Nation, Nationalities and Peoples' Regional State (SNNPR) sharing borders with Oromiya on the north, north-east and north-west, Dawuro on the east, South Omo on the south, Sheka on the west and Bench Maji on the south-west (Map 3). Kafa Zone is divided into 10 woredas, 277 kebeles, and 20 Urban Dwellers Associations (UDA) or urban kebeles. The total population is 880,251 and of this number, 67,864 people (7.7 percent) are urban and 812,387 (92.3 percent) live in rural areas. There are around 180,000 households of which 160,000 are in rural areas. Average population density is 75 persons per square km but in some places such as southern Decha which is inhabited by nomadic people, the population density is less than 10 per square km. The studied area was in and around Bonga, located in Ghimbo woreda (total population 81,211) and the northern part of Decha woreda (Map 2). Bonga is the administrative centre of Kafa Zone and has a population of 20,855. Chiri is the administrative centre of Decha woreda (total population 128,853 of which 5,460 is urban and 123,393 is rural) (CSA 2007).

As well as being mountainous like much of Ethiopia, Kafa Zone's topography is central in its agriculture. A section of the topography of the area between Chiri and Muti shown in Map 4 is characteristic of the fieldwork setting, dominated by steep hills, gorges and streams. Compared to other parts of the country there are still large areas with natural forest. These forests, renowned for their high biodiversity values are the habitat of wild Ethiopian coffee, the origin of the genetic diversity of Arabica coffee (Coffea arabica), found in the shaded understory of montane rainforests in south-western and south-eastern Ethiopia between 1,000 and 2,000 metres above sea level. Coffee is Ethiopia's

33 There are nine regional states in Ethiopia which are subdivided into zones, woredas and kebeles. Each woreda has approximately 100,000 inhabitants although some woredas have 6,000 and others have nearly half a million. Kebeles average around 500 households and each kebele can elect three members to the woreda council.
34 This map was published by the Ethiopian Mapping Authority in 1989. It is still the most in-depth and up-to-date topographic map of the area. This section is included to delineate the terrain between Chiri and Muti where I walked accompanying the CHC staff on an outreach clinic.
35 Historically Ethiopian coffee was produced traditionally which meant picking wild coffee inside the forest or managing the forest by removing competing undergrowth vegetation and some canopy trees (Schmitt 2006:1). There are now four production systems determined by specific ecological, historical, political, and socio-economic factors: forest coffee, semi-forest coffee, garden coffee and plantation coffee (Stellmacher 2006:90). Forest coffee is traditionally managed in forest coffee (FC) and semi-forest coffee (SFC) systems which constitute 14 percent and 54 percent of the total coffee production area in Ethiopia respectively. In FC systems some competing undergrowth is removed. In SFC most undergrowth is removed and some emergent trees are cut. In comparison, in semi-forest plantations (17 percent of total
most important export crop contributing decisively to the country’s foreign currency income (Schmitt 2006:1). As the montane rainforests are located in one of the ‘biodiversity hotspots’ of the world because of the high numbers of endemic species and high floristic diversity (Schmitt 2006:65), an increasing number of research studies have focused on the conservation and use of Coffea arabica in its natural habitat and also in traditional forest coffee systems36. The picture that emerges from this research is that over the past 30 years new settlements and population growth, agricultural activities and timber extraction have modified or destroyed substantial sections of the Ethiopian forest areas which will result in the destruction of the habitat of Coffea arabica and eventually lead to the loss of the wild coffee genetic resources (Hartmann 2004; Schmitt 2006:2; Stellmacher 2006)37. However, as Stellmacher (2006) explains,

the relationship between Ethiopians and ‘their’ coffee is deep-rooted and multifaceted... [and] closely intertwined with Ethiopian history, culture and economy. Coffee has been cultivated, picked, processed, traded and consumed over centuries, and still plays a significant role in the daily life of most Ethiopians and – on the macro level – for the state of Ethiopia as a whole (2006:81).

This means that people’s dependence on coffee is problematic as production fluctuates depending on weather conditions, pests and plants diseases, seasonal change and international terms of trade (2006:86). Moreover, population pressure impacts on resources and local communities will be put under further economic pressure which could result in conflict: ‘Land is the most important agricultural production asset, and questions of access to land are the key for most rural peoples livelihood in Ethiopia’ (2006:138).

Kafa Zone’s ‘mosaic of different land-use types’38 (Schmitt 2006:25) ensures most people are engaged in agriculture with the average land holding per family between 1.25 and 2.0

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36 The focus for much of this research has been the Center for Development Research (ZEF) University of Bonn’s Conservation and use of the wild populations of Coffea arabica in the montane rainforests in Ethiopia (CoCE) project: http://www.coffee.uni-bonn.de/index.html
37 The decline of Ethiopian forests in the past 50 years is from originally 50 percent of the total area to three percent (Hartmann 2004:1).
38 Ethiopian farmers have developed a form of agrobiodiversity based on land fragmentation as crops have been developed and adapted to moisture and temperature regions so each farmer grows cereals, pulses and oil crops. It is also argued that owning two or three plots (in Wollo, north-east of Addis Ababa) ‘serves as
ha. In the Bonga region it varies between 0.8 and 2.5 ha. Of the total land area, only 28 percent of agricultural land is intensively cultivated. Much of Kafa Zone is still classified as forest, wetland or grassland or bamboo forest, around one percent of the total area is tea, coffee or timber plantation, and one percent is classified as urban (Table 4).

### Table 4: Kafa Zone Land Use (2002)

<table>
<thead>
<tr>
<th>Estimated total land: 11,000 km²</th>
<th>Percentage of land use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture land intensively cultivated (&gt;70%)</td>
<td>28</td>
</tr>
<tr>
<td>Agriculture land moderately cultivated (between 40 - 70%)</td>
<td>5</td>
</tr>
<tr>
<td>Closed highland forests (&lt;10% openings)**</td>
<td>26</td>
</tr>
<tr>
<td>Highland forests fragmented and highly disturbed</td>
<td>8</td>
</tr>
<tr>
<td>Lowland forests, woodlands, savannah and shrub lands</td>
<td>21</td>
</tr>
<tr>
<td>Wetlands and grass lands</td>
<td>9</td>
</tr>
<tr>
<td>Bamboo forests</td>
<td>2</td>
</tr>
<tr>
<td>Plantations (tea plantations, coffee schemes, timber trees)</td>
<td>1</td>
</tr>
<tr>
<td>Urban area</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: SUPAK (n.d.). Note: Does not equal 100 percent in the original.

Despite this diversity of land use across the Zone some characteristics may be generalised. The livelihood of the original population, the Kafa and Manjo tribes, was based on dependence on the forest complemented with animal husbandry and typical crops planted around homesteads including enset (*Ensete ventricosum*), coffee trees transplanted from the forest, cereals such as maize (*Zea mays*), and *tef* (*Eragrostis tef*), cocoyam, and vegetables such as *gomen* and *tikur gomen* (cabbage). As continuous population growth and migration from the over-populated highlands resulted in higher population density and gradual changes of the farming systems and accelerated deforestation, settlers cleared the forests to grow more cereals and pulses thus pushing back the forest fringe. Non-timber forest products such as honey, false cardamom (*Aframomum corrorima*) and wild pepper (*Piper capense*) are also important means of income, particularly for the indigenous Kafa population. The forests are an important source for fuelwood, charcoal a risk-averting mechanism in times of drought and possibly even helps reduce the incidence of erosion’ (Dejene 1990:14). In Menz, 300 km north of Addis Ababa, land was subdivided into as many as 13 plots: people prefer their land ‘to remain fragmented, because of the benefits to be derived from micro-ecological variations in soils and climates’ (Pankhurst 1992:81).

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39 The following information in this paragraph is based on a proposal by SUPAK ‘Spatial Planning Framework for Integrated Natural Resources Development in Kafa Zone’ (SUPAK n.d.).
and timber for house construction particularly for the Manjo who make up five to 10 percent of the total population and are the largest minority class still facing prejudice and discrimination (Chapters 4 and 6).

To contextualise Kafa Zone’s contemporary landscape, it is important to locate it, however briefly, in Ethiopian history and culture because the present and the future are linked to the past. One of the main historical themes of southern Ethiopia was the expansion of the northern empires to the south and their incorporation into the Ethiopian empire. Before 1897, Kafa was a large and powerful kingdom with its own monarch exacting tribute from many of the smaller neighbouring kingdoms trading ‘gold, ivory, hides, honey, coffee and slaves’ (Pankhurst and Freeman 2003:70) with the northern Ethiopian empire. But Kafa was defeated during Menelik II’s (1889 - 1913) expansion from the north of Ethiopia to the south, south-west and south-east.

Following years of depopulation, the export of Kafa captives to the north and a ‘general state of anarchy’, the loss of its autonomy meant that Kafa was forced to identify with the Ethiopian empire (Orent 1970:266). McLellan (1980; 1986) describes how coffee emerged as the ‘mainstay’ of the Ethiopian economy motivated by higher prices, improved transportation and low taxation as the export of ivory diminished. Ultimately, as regulation of coffee tightened resulting in more control being put over the land and labour vital to coffee production, there was increased tension between Addis Ababa and its local agents. While this altered the role of Ethiopia’s colonial subjects’, coffee ‘more so than ivory, could better serve the needs of a developing nation since its production could be sustained over an indefinite period of time’ (1980:78) and coffee remains the focal point of the Ethiopian economy to this day.

Historically, the Ethiopian highlands were also the centre for enset agriculture. Ensete ventricosum is a large single-stemmed banana like plant also named ‘false banana’ which has a variety of uses including food and fibre. Enset is drought tolerant resulting in its

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40 The forest is considered de jure as a common good even though de facto the Kafa communities have complex traditional systems of forest use rights (Stellmacher 2006).

41 The centralisation of power continued during the 20th century during the reign of Haile Selassie I (albeit at an uneven pace) (Donham 1986) and has been described as “centralized feudalism” as the semibureaucratized state ‘made claims on resources previously shared by the mass of farming families and a largely nonproducing but dominant minority’ (Gebre Tareke 1991:56).

42 The four agricultural systems in Ethiopia are described as pastoralism, shifting cultivation, grain-based cultivation, and enset based cultivation (Westphal cited in Brandt et al. 1997:4).
association as a safeguard against famine. While each plant takes four to five years to mature, each single root yields up to 40 kilograms of food which is a basic simple starch that is low in protein. If a family of five or six people has 40 to 60 enset plants around the home they will not go hungry. Enset processing is done entirely by women ‘using traditional tools, and the process is laborious, tiresome, and unhygienic’ (Brandt et al. 1997:23). Each house I visited had enset, vegetables and spices growing around it and the women interviewed described it as their most time consuming and tiring task (see Chapter 4).

There are four types of enset agriculture based on environmental, agronomic, cultural criteria and utilisation of the plant as a staple or co-staple crop along with cereals and other tuber crops (Westphal 1975 cited in Brandt et al. 1997:4; Shank and Chernet Ertiro 1996). Some communities are more dependent on grain crops, cattle for fertiliser and oxen for ploughing, than others. In south-west Ethiopia both the hoe and plough are used to grow cereals and enset is grown for security reasons in case cereal crops fail. According to Brandt et al. (1997), the Ethiopian highlands were the centre for enset agriculture but it has virtually disappeared from the north and only remains in the south. It is possible that its demise in the north was caused by disease, drought or socio-political events. Another explanation is that in the 1600s in the Kafa kingdom of southern Ethiopia, the royal court and other elites wanted to eat the ‘prestige’ foods of tef and other cereals as they were better tribute for tax collectors since they could be ‘stored, divided and moved’ (Orent 1969 cited in Brandt et al. 1997)43. Over time Abyssinian emperors consolidated the sub-regions into a single weakly integrated polity, but it was Menelik II (1889 - 1913) who established Shewa as the hegemonic centre of modern Ethiopia. Shewa was ideally located with intersecting trade routes and lines of communication. It was strategically located on the high plateau, adjacent to highland regions in the south that were suitable for colonisation (Donham 1986:23), and Menelik II was able to consolidate the earlier expansion of other emperors, into the south, south-west and south-east. Whatever the cause, the disappearance of enset agriculture from the north left behind a cultural stigma between those who eat injera and those who eat enset that remains today. In addition to this, little research had been done into enset until the late 1990s and Western aid agencies have tended to focus on cereal groups for food aid.

although the current Ethiopian government has elevated enset to the status of a national
crop. During one of the interviews I did with an NGO staff member who was from
Kafa Zone this cultural stigma was expressed strongly: ... the culture they have for
[food] assistance, it is a sort of political injection for all of the country; it is that
everybody should eat injera. If you eat enset with other things, it is a sign that you are
poor. Everyone has to look for... they need to follow that same line, it has the same
effect, and it has been going on for a long time... (Worku, NGO staff member, Bonga).
Thus, eating enset reinforces the cultural stigma that it is a sign of being poor.

The majority of the Ethiopian population are dependent on agricultural activities and
agriculture is the key sector in the government’s development strategy (Chapter 1); a key
issue in the present study is that poverty is concentrated in agricultural and rural areas
(World Bank 2007c:28). Around 40 percent of households in Kafa Zone are categorised
as poor (SUPAK n.d.) and there are seasonal food shortages from April to July. The
nutritional quality of food is insufficient with a lack of vegetables and protein in the diet.
The livelihood of most households is small-scale subsistence farming with around 60
percent of households having access to land. Productivity of these holdings is low. A
large proportion of the population (35 percent) has no access to land (partly explained by
the presence of the Wushwush tea plantation which employs thousands of people).
Livestock rearing and apiary are an integral component of the livelihoods. Livestock is
mostly used for draught power (77 percent of households owning one or more oxen)
and transport (52,000 equines in the Zone), with many households also owning one or
more cows, goats and poultry.

Habtamu Argaw’s community study found that only 8.3 percent of households have
access to functional safe drinking water and 13.3 percent have access to a functional
toilet facility (Habtamu Argaw 2002:xii). The majority of the population (62.3 percent of
households) used water from rivers and unprotected springs and wells. Only 15 percent
of households accessed water from a source less than or equal to 15 minutes walking
distance from home. The main problem with accessing water was its dirty appearance or
bad smell (45.6 percent), muddy and slippery state of the access route to the source (17.2
percent), insufficient amount of yield (11.1 percent), and far distance of the source from
home (6.2 percent). Of the total households who had a safe water source, 22 percent
claimed that the water points were in a deep gorge that had a difficult access (2002:16). Water is carried by plastic jerry can (88.6 percent), clay pot (5.6 percent), and a locally made bamboo vessel called doollo (5.7 percent) (2002:17).

3.1.2 Doing research in Kafa Zone

Kafa Zone is like a collage affixed to the surface of waves of parallel mountains rolling away in the distance. A green collage juxtaposed on the closest wave—tall rainforest green; bamboo stalks deep, dull green; still green sorghum with ripening spikelets; stands of enset or false banana up to 10 metres tall with dark green leaves four or five metres long and a metre wide; and small fields of tef grain grass almost yellow or a yellow almost green. Riding the waves in the distance, the green becomes dark purple, light purple, blue-green, ultramarine blue. Since rain falls much of the year in this Garden of Eden I feel I am in paradise; these mountains made from volcanoes erupting over and over again pushing up the earth higher and higher (from my field notes August 2007).

Even though I am doing research in Kafa Zone, some days I wonder if I am doing research on how to do research in Kafa Zone. It’s not just because it’s the rainy season and it’s so hard to move in the mud. Moving from one place to another takes so much time. In some places roads have collapsed a metre or more. I don’t have a vehicle so I do a lot of travel on foot. And going everywhere on foot means waiting for the rain to stop, waiting for the mud to dry out, sliding around in the mud that hasn’t dried out, and this means trying not to have too many conversations with people on the road. Almost every conversation I have results in a request for money or clothes or something from me and I’m tired of it. It’s just that when I finally get to the office or the clinic or the hospital to organise an interview (I don’t have a telephone) it is most likely the person I need to see isn’t there (here I’m referring to the interviews with government staff or staff from NGOs). I try to find out a good time to come back. And when I come back it’s still likely they won’t be there. Eventually I make contact and explain why I’d like to do an interview with them; I come back at the allocated time only to find that they’re out again. Called away unexpectedly to Mizan Teferi or Addis for a meeting or whatever. This sort of thing goes on for a week or two for every interview. The reason I persist, sometimes ‘wasting’ entire days, is that this is how it is for everyone, not just ferajis doing research. Lots of waiting to get a piece of paper or a signature or a meeting. Or waiting to see a health worker at the hospital or health centre.

44 From May to September although altitude is a crucial factor in determining the spatial variation of weather and climate (Schmitt 2006:23).
3.1.3 Going to Chiri

Before Chiri became the capital of Decha Woreda and the road from Bonga was completed, it took over nine hours to reach by mule. Now the road is finished, it’s only 23 kms by bus, truck, or four wheel drive (except, of course, during the worst of the rainy season when the road gets washed away).

There are two people on the Chiri bus and I am one of them. The bus is parked outside the mosque where two women carry buckets of water from somewhere off-site to the builder for making concrete in the mosque compound. Women often work on building sites around Bonga carrying rocks, dirt, gravel, and there is no hurry with their work; they just continue steadily on. On the other side of the dirt road and the open drain is the hardware store where everything from paint to plastic pipes might be available. Three or four cafes compete in the street opposite the bus but there are only a couple of patrons sitting outside sipping tea and watching passersby.

Huge fat tailed sheep—prized in the rest of the country for their size—are lifted into the back of an Isuzu truck parked in the middle of the road. Further up the main road lined with shops and outdoor vendors selling single spoons, plates, wooden crucifixes, is the marketplace which is crowded on Saturdays with mules, horses, oxen, chickens and people selling mounds of produce. Chaos? Not really. If you go every week the same women in the same location are selling lentils, split peas, spices from open sacks; the same woman selling quality coffee beans, sorry she’s put the price up yet again she tells me in English and Amharic. After a few weeks I stop going to the market because I tire of being the only ‘new’ attraction in town. But buying garlic and potatoes, carrots and cabbage makes me think that all the people in Western supermarkets think they’re shopping and that the last time I was crammed in the doorway of the single ‘supermarket’ in Bonga waiting to buy rice and soap I was given a sini (tiny cup) of coffee along with the staff. A young woman had brought a thermos in a plastic basket and she put a few tender leaves of rue in the sini before she poured in the coffee.

I am sitting in the bus in Bonga thinking about Bruce Chatwin writing about taking to the road. That wandering contributes to a sense of political and mental well-being; of walking being a poetic activity able to cure the world of its ills. Walking. Manjo women
walk past the bus carrying sacks of charcoal or stacks of firewood strapped to their backs (Photo 1). Heavy sacks. They walk bent over with sweat running down their faces. And women go past with hand made baskets filled with dried maize and a live chicken tucked in under one arm. When I’m walking around town or to the villages doing research with my backpack weighing a kilo or two, I make eye contact with them and greet them with A shamasham, the Kafficho greeting for people who are working. This acknowledgment of their labour makes me feel better because they always express surprise, and smile back or even laugh and then talk about it with their walking companions.

Photo 1: Manjo woman carrying firewood
(Photo: d'Arcy Lunn)
Lots of people actually get on the bus but they don’t stay on it because it seems they are just looking to see if they know any of the passengers. Those who do get on with shopping bags leave something on a seat, a coat or an old jantala (umbrella) and then, deciding that there is plenty of time, go off to do more shopping, to drink tea or coffee, or wait elsewhere. I feel that at this rate, if the bus doesn’t leave until it’s full, it will never fill up. Yet every now and then someone sits down and I am encouraged with each potential passenger; that sooner rather than later we will depart.

After a couple of hours, the conductor emerges out of the crowd outside. He turns on the engine of the bus, the radio, and blasts the horn a few times. Then he starts selling tickets to people and I realise I’d lost concentration. The bus is getting full and somehow I didn’t notice; it seemed to have happened by osmosis. At least another hour goes by and finally the driver gets into his seat and blasts the horn again. I have a window seat near the door and next to me is a young woman with her baby. I am given her new jebena (clay coffee pot) to hold. Knowing there is still plenty of time, the woman’s sister takes the woven homemade basket outside to repack. A few handfuls of dried beans have spilled out and she wraps them in the nylon of an old jantala. I see coarse rock salt, a few green coffee beans and berberé the spice mixture based on red peppers.

Suddenly, for no articulated reason, the driver and the conductor decide we are leaving. The horn blasts again and again and all the people milling around get on the bus which was already ‘full’ with standing room only. We speed off around the corner and down the hill, stopping to pick up a couple more passengers after only a kilometre or two. As we pick up more and more people along the way, we pass birr and change to and from the conductor who is wedged in unable to move. By now we are zigzagging up the side of hills, the old bus unable to go any faster than a walking pace. It is impossible to see out the other windows which are firmly shut to prevent birrd (cold air or blowing wind that is dangerous and might cause pleuritic chest pain, shortness of breath, fatigue and localized pain in any area) (Hodes 1997), but two seats in front of me a young man quickly opens the window and sticks his head out. This creates quite a kafuffle as people quickly pull their collars up and cover their head, mouth and nose with their neutalas (cotton woven shawl with embroidered edge women often use to cover their heads), towels or anything
close at hand calling for the window to be closed. A plastic bag is passed from the front of the bus and the smell of vomit overtakes the smell of sweaty bodies. There is only momentary relief when the bus stops and the door is opened to let off or pick up passengers.

Driving on the wrong side of the road leaves me feeling uneasy. The only thing that gives me some sense of ease is the slow speed of travel and knowing that there are so few vehicles on the road there is little chance of something coming around a hill. There are no private cars here, only buses or Isuzu trucks used for carrying everything from corpses to cement or the rare NGO white four-wheeled drive. But occasionally there are buses or trucks that have run off the road: on one hill bank on the wrong side of the road is a truck parked on an ‘interesting’ angle and someone has built a temporary shelter constructed of palm leaves and sticks to keep an eye on things. When we finally reach our destination a couple dozen people push onto the bus before anyone can get off, trying to get the best seat. I feel exhausted and glad to breathe. With all the waiting it has taken over five hours to go 23 kilometres. I feel I could have walked it in that time. The woman sitting next to me now has a three hour walk home to Muti. Saying goodbye I’m not too concerned. There is no vehicular road to her village so everybody walks from one place to another. In fact, with so many people walking it’s virtually impossible to walk alone. And no one would walk without offering to carry the jebena and her shopping.

3.1.4 Going to Gebera with the Chiri Health Center outreach team

The Outreach Coordinator at CHC and I discussed the monthly outreach schedule and agreed on six sites for me to accompany them. The selection was based purely on geography and transport so I could get a feel of diversity in the area and see how an outreach clinic was conducted. I’d walked to Muti a couple of months earlier and it had been tortuous because it had rained in the night, it was grey and foggy, and walking in the mud meant compensating all the time to try and keep balanced. Unpredictability all the way. Up and down. Slipping on the top of the corrugations like on a horizontal ladder in the mud and trying not to slide in between the rungs. Still it wasn’t as bad as the walk to Deckia where the corrugations were twice as deep at one spot and on a 50 degree angle. There even the mules struggled to find their way. But that was two months earlier and I’d done a lot of walking since then. Now the rainy season is over and
the mud has dried out like chocolate fudge. I am finally going to Gebera (Photo 2), another three hour walk, knowing it won’t be quite as up and down as the walk to Muti.

**Photo 2: The road to Gebera**
I am really looking forward to this walk and we start walking past houses on the outskirts of town greeting people as they prepare for the day. It’s flat at first and typical of other places I’ve walked where people’s lives are delineated by agricultural activities. Going down the first long hill, what might look typical or representative of this part of Kafa Zone is only that. Typical.

But this woman on a mule is not typical. First, women don’t ride mules or horses all that often. Second, they almost never go anywhere own their own. The three outreach workers, Elias, Asnagedech, and Tamrat exchange greetings with her and she is given one of the back packs to carry on the mule which she drops off down the track. Soon she is out of view. Walking and talking. People always do both so you might hear someone on the road long before you see them. Greetings. Long involved discussion most of which I don’t understand. When I talk with Elias I discover he’s a father of three and that he’s always lived in Chiri. Asnagedech is dressed in black, still grieving the recent death of her mother. She has two teenage children so we have a lot in common. And Tamrat is from Chocha, the southern part of Decha woreda, where people still live a nomadic way of life and have a reputation for drinking arek’e (a distilled alcoholic drink) and violence. One morning two bodies were brought to CHC from Chocha for a formal cause of death certificate for the police—friends who’d taken to each other with machetes after too much arek’e. Unrelated, a third body was brought in later the same day after another fight.

The bridge on the first river we cross is different from all the other bridges I’ve seen. It’s made of logs but it looks like it could withstand major flooding or an earthquake. Even the road is different here because it’s so well maintained and on our return we pass at least 100 men slashing at the growth on the sides of the road—no one is actually working all that hard and they all stopped to greet us—many still in their jackets with no sweat on their brows. We cross more rivers and streams; walk up hills, down hills. The wide roadway is for people to walk or mules or horses. No cars, buses, or any other vehicle has ever been to Gebera. Elias points out the kebele chairman’s hut as we pass and Tamrat goes to find him to let him know we’ve arrived.
The Gebera vaccination clinic (Photo 3) doesn’t take place at the health post but at a sort of low long house where people normally gather for meetings and to drink tella (local beer, ideally brewed from barley) on market days or other social occasions. When we arrive Elias shouts in various directions, ‘agitating’ its called, to announce our arrival. While we wait we rest and eat the bread rolls we’ve brought. It’s warm and sunny now and good to have the shade. And soon people start arriving, mothers with babies and young children, a few men and one older woman. Elias and Asnagedech start drawing

Photo 3: Record keeping at the Gebera vaccination clinic
up vaccine into disposable syringes and lay them on one of the freezer blocks. There is a cardboard sharps box for the used syringes. Everything is spread out on the grass. Tamrat comes back with the kebele leader and then he talks to each woman and tells Elias and Asnagedech what vaccinations to give the babies. The only other record keeping here is just a count at the end of the day of how many vials of vaccine are used to report back to the health centre. I’m just sitting here delighting in the sight of these mothers and their plump healthy looking babies until a woman shows up with a child of two or three with wasted legs, swollen body and lack of alertness. Back in CHC they have up to 20 children at a time as in patients in this sort of condition. All of a sudden there is the wailing sound that starts when disaster strikes. A woman appears with her child’s arm wrapped in a rag. He’s around three or four and was ‘playing’ was a machete and cut his arm. These wailing sounds are like the world will end. It’s the third time I’ve seen this reaction to crisis. The first was when a man was attacked by an ox and I’d had to shout and shout to get the 20 people surrounding him, wailing and beating their chests, to help me so I could do first aid and get him to the hospital. A few days later a truck had backed down the hill at the market to pick up some sacks of grain and hundreds of people had rushed over wailing and screaming thinking it had run over someone. And now this mother wailing and crying and after awhile Elias calming puts on a pair of gloves and we see the cut. It’s only a couple of centimetres long and could probably use a couple of stitches but it means a six-hour return walk plus waiting at the health centre. There’s no first aid kit but Elias manages to clean and bandage the wound while the woman rocks back and forth in grief, her son never uttering a sound. While all this is happening, babies and small children are being vaccinated and school children are walking past us in both directions. School is run in two shifts; many of the school children, both boys and girls, are persuaded to come over and be vaccinated with Tetanus Toxoid (TT). In fact, a number of men are vaccinated and an old woman receives a booster as well. This is a strategic location to run a vaccination clinic because everyone passing by can be called over by the kebele leader. Gebera is truly different to all the other places I’ve been. This is the only kebele leader I’ve ever seen at an outreach clinic and later I find out he is involved in planning the next month’s outreach clinic. Tamrat, Elias and Asnagedech repeat it is the only place they visit where the kebele leader is as involved and supportive like this.
Finally we are finished for the day but the sky is black with rain. We run to the hut of the old woman who was vaccinated. As it begins to pour we are invited to sit on ox hides on the floor or wooden benches. There’s the four of us from the health centre, the kebele chairman, two other men, a young woman with her baby, a younger girl to help out, and the old woman out the back making coffee. A man passing by in the rain is called in and we all adjust a bit to give him space to fit on the hides. We are brought kocho to eat. Kocho, warm, sour and fibrous. Kocho is made from enset, and is an important root crop important to the diet and economy of south-west Ethiopia. We take pieces and dip them into berberé paste. Delicious. The others drink tella out of old tomato paste tins. The men drink the first tin quickly and then take their time over the second. I’m still not sure about drinking tella— or if it’s safe to drink (it’s made from unboiled water). Sitting here, relaxing, watching the rain pouring outside through the smoky atmosphere, I know its going to be another muddy three to four hour walk back. It doesn’t matter.

The old woman brings out the jebena (clay coffee pot) and the sinis. There’s no little stand for the sinis so the young girl rinses them off and puts them on the dirt floor. The woman with the baby pours the coffee and the girl brings it around one by one as the cups are hot. I am really looking forward to drinking coffee with its ‘intense, almost passionate flavor... as if all the contradictions and tensions of their native earth had gone into forming the character of the bean... ’ (van der Post 1970:32). It looks like coffee but it doesn’t smell or taste like coffee. It’s black, hot salt water. It’s terrible. It’s the worst cup of coffee I’ve ever tasted. Ever. I know some people in Ethiopia like salt in their coffee but this is salt with a touch of coffee. Still, I drink a second cup because I hope there’s enough caffeine in it to help me with the walk back. And despite the coffee being so awful, I’m enjoying being here so much. We decide to leave when the rain stops and the sky is clear and sunny again. The old woman asks us to wait while she goes back inside the house. She comes back with two tiny habesha (Ethiopian) eggs for me. Feeling overwhelmed with her hospitality and generosity, she wants to give me all she has but I don’t want to accept because I feel I have all I need.
3.2 Delays in reaching a health facility

... every book I had ever read about Africa contained long passages and sometimes many pages about enforced delay... it seems as though Africa is a place you go to wait... (Theroux 2004:225, 226).

As the previous two sections show, the benefit of doing participant observation in Kafa Zone meant I could appreciate how long it took people to travel and how much energy it required to get from one place to another. As I tried to spend as much time as possible travelling on foot like the majority of people in the area, I began to have some understanding of how the implementation of the referral system worked in practice. Even where there were roads, vehicles were infrequent and expensive (particularly if you had to charter a bus or truck) so their usage was uncommon. Distance is described as a 'universal barrier' (CHANGE/ The Manoff Group 2005a) that separates potential patients in rural areas from the nearest health facility. Although distance can be an actual obstacle, it can also be a disincentive to even try and seek care, especially when combined with lack of transportation and poor roads. However, it is difficult to disentangle the disincentive and the actual obstacle as the decision making process is also affected by other factors such as the cost of receiving treatment; and, transportation costs which increase with distance (Thaddeus and Maine 1994:1094). The focus in this section is the interview responses of the health providers.

The majority of health personnel do not expect women to come to a health facility for a normal delivery but only if there is a problem during the birth (see Chapter 5). Some of the explanations health personnel gave for why women don’t use existing health facilities were cost and distance or inaccessibility: 'The accessibility of services plays a dual role in the health-care-seeking process. On the one hand it influences people’s decision making ... On the other hand it determines the time spent in reaching a facility after the decision to seek care has been made' (Thaddeus and Maine 1994:1100). In rural areas delays due to distance and the unavailability of transportation are common and in much of the developing world there is a shortage of medical facilities. Those that exist are concentrated in and around urban areas. People may have to travel long or even short distances over difficult terrain illustrated by Photo 4 of a section of the road to Sheyka, only 20 minutes from where I lived in Kebele Three in Bonga and Photo 5 of a section of the road to Deckia.
Photo 4: A section of the road to Sheyka
Photo 5: Section of the road to Deckia
Secondly, even where there are roads, the scarcity of transportation means that rural people often have to walk or improvise transportation to reach a medical facility. During this time the patient's condition can deteriorate making the condition more difficult to treat on arrival. In addition, reaching a health facility does not necessarily mean the end of the journey as the nearest facility may not be equipped to treat the condition or even administer essential first aid so patients are referred to another facility that is better equipped (1994:1102). Section 3.2.1 describes the referral system.

The implementation of the HSDP III (2005/6-2009/10) (MOH 2005:37) for Kafa Zone was outlined for me by a senior government officer: We have a strategic plan for five years, within five years we have to make our health posts in kebeles 100 per cent. This year the HEWs must be equipped 100 per cent, in each kebele two HEWs and by now one HEW must be in all kebeles and rural kebeles around 200. 223 health workers will be training and after two or three months they have completed their training... we have two health workers in each kebele, in all the rural kebeles. Then the next program is town... different from rural health package so I think it will start training this year and this HEWs in rural areas 100 percent this year and next year, town must be equipped. This is our plan according to that, health post must be equipped in kebele and by now we are nearly ready 50 percent for that next two years, this year and the next year must be health post in kebele 100 percent. And health centre is for three years to be equipped. Totally, health centre and health post coverage in five years to be covered in all areas according to the strategy plan: 1 in 25,000; 1 in 100,000 and 1 health post for 5,000. This is five year plan we have... there must be two hospitals according to zonal population.

... to equip the health facility with equipment... this is different, not only from government from UNICEF, from any other donors, I think our main problem is by now we have 130 health posts but most of the health posts there are problems with equipment... there is no refrigerator, no medicine, no midwifery kits and others. So this is a big issue, and this [missing word] from UNICEF, sometimes from any other donors by making projects and we are asking these questions for out of 130, not more than 40 or 50 health posts are equipped, the rest we need some equipment for this and the next program we are asking donors and there are different kinds of donors. The government
The main issue is that 70 or 80 health posts have no equipment and our next plan is to construct additional health posts, so this is the main issue. Our plan is to ask any donors and NG [non-government] types they have to help or they have to support equipment. This is, construction is our duty and to fulfill equipment health facilities this is a wide problem.

3.2.1 The referral system

As stated in Chapter 1, the National Reproductive Health Strategy is based on a system of referrals from the health post at the kebele level providing essential obstetric and newborn care (including ANC, clean and safe delivery, essential newborn care, recognition of complications and early referral) to the health centre at the woreda level providing basic EmOC and newborn care (including the administration of antibiotics, uterotonic agents and anticonvulsants, ability to perform manual removal of placenta and retained products of conceptions and assisted vaginal delivery). Health centres refer to the rural/district hospital which provides comprehensive EmOC including Caesarean Section and safe blood transfusions.

In Kafa Zone, the kebeles can be a long way from the woreda centre where the referral health centre is located and many of the woredas are a long way from Bonga Hospital. All the health workers and government officials knew there were meant to be two trained HEWs at each health post and that HEWs should be equipped to assist at normal birth, and to conduct ANC as one of the 16 packages offered at the health posts. I was told that the strategic plan for Decha Woreda is that there will be 85 percent coverage compared to the current 70 percent coverage in five years time. But while there is funding for programs such as TB surveillance, malaria and so on there is no specific funding for maternal health programs. The health workers interviewed foresee there will still be a problem of accessibility for many people in the rural areas to reach the health facilities. The following response illustrates how the distribution of health facilities will not necessarily overcome many problems in the area: Most of the woredas are inaccessible, especially during the rainy season, and most of the mothers are dying due to inaccessibility, shortage of transport, they are dying of maternal complications, high risk...
pregnancies and the shortage of health professionals in each woreda... I know there are health centres in each woreda, they are far from the kebeles, and the woman should travel on horseback or some other stretcher to reach the health centre, so far from where the farmers are living. I think that is one problem particularly in Kafa... so the mother will not be transported to Bonga. And at the Zonal level, the local government is trying to work to implement the HSDP III, but currently there are no health centres [with the capacity to have an operating room facility] so all cases are being referred to Bonga (Dr Befekadu).

In my interviews some of the health workers describe how the referral system works in practice: Samson: The referring system is, first you know there is a health post, she comes to the health post, and if its difficult to remove the placenta or deliver, they refer to the nearest upgrading health centre, after the health centre there is no health officer, but there is a nurse, the nurse tries to remove the retained placenta or obstructed delivery. When this nurse, it's difficult to take out this retained placenta, or delivery procedure, they refer to the next 100,000 health centre. So this health centre, if there is a health officer, if they can do Caesarean Section or craniotomy, or whatever, they can remove it, unless the health centre refers to Bonga, Bonga refers to Jimma. This is the referring system.

Ruth: And every one is a delay?

Samson: Especially the delay with problem of retained placenta. With no drug like Pitocin and Ergometrine and other things like a glove for example. There are no gloves in a health post, for the last year. For the time being Netherlands is supplying the gloves.

Yonas: ... with uterine rupture we refer immediately to Bonga Hospital and with malpresentation like breech or shoulder presentation or if the BP is very high then she will need a Caesarean Section. Also, if more vaginal bleeding then she is referred to Bonga Hospital. Then if Bonga hasn't got blood she must go immediately to Jimma.

Ruth: What if there is no one here with a vehicle— how can you transfer to Bonga?

Yonas: What we should do is— we go to the woreda administration office and we ask them if they can take a vehicle for us— if they do not have— she has to wait by the bus terminal— so she will go by bus[all the woreda vehicles were out of commission at the
time of writing].

Ruth: *And in the middle of the night?*

Yonas: *We cannot take them in the night [CHC policy].*

Dr Befekadu: *Since last year, because they are being trained on emergency surgery we are not referring much [many] patients to Jimma unless the surgeon is not around, or unless the O.R. is not functional for some reason like sometimes our generator is not functional and if the light is not around we cannot, we refer to Jimma. The other thing is usually if the surgeon is not around we are referring, otherwise we do, unless the mother [needs] a blood transfusion, particularly a patient with a ruptured uterus, they bleed much, they have low hematocrit and we are referring them. There is no obstetrician, there is one GP who has been trained in emergency surgery and he can do Caesarean Section, he can do laparoscopy for some sort of internal obstruction. So they are doing that part, but here, he is the only one and... he can’t work 24 hours a day... and the other thing is if he is available he is doing that, but he can be on vacation or another reason he may be out of Bonga and the only option is to refer the mother to Jimma.*

*We can’t do blood transfusions here— we don’t have the bag itself, the transfusion bag. If we had that I think we can do that, we can do, to do the blood group and to check for HIV, but at least we can transfer to Jimma but we don’t have facility and for other people we refer to Jimma for blood transfusion. Sometimes they are not doing, referred on time. And the other thing, they are being referred, but because of transportation, or because of economic reasons, or any other reason, there is another delay. Actually once they are in the hospital there is no delay because they are being transferred directly to the labour ward.*

I had the impression from talking to health workers and administrative staff at CHC, that there were still ongoing problems referring women for Caesarean Section to Bonga Hospital (see Box 5). Whether or not they were able to refer women seemed unpredictable from one week to the next. For example, one Sunday afternoon, a woman with prolonged labour was brought by stretcher from Chocha. It was likely the baby had died as there was no detectable foetal heartbeat (CHC does not have electronic
monitoring equipment). The health workers kept trying to ring Bonga Hospital to organise a transfer but no one answered the telephone. In the end, we drove the woman and her husband in the car to the hospital and carried her into the labour ward.

Many of the health workers felt that the referral system was not used by other health workers properly. In particular, those with more training felt that lack of education or training contributed to problems such as maternal mortality. One health worker expressed a concern that people did not even know about the danger signs, particularly the vital signs, headache, swelling of the legs, all these vital signs might not be detected (Dr Emabet). Another comment made by a number of health workers was that women needed to be referred early: No one uses the referral system properly I think. We professionals can make sometimes a problem. Even here, I do what I can. What is my level, what I can do. What I can't I should [unclear word] but that system, a proper way. The second thing is that the women they stay at home, they spend a lot of time at home, then they come to us when the time is beyond our capacity, life saving. Even if it should be lifesaving, it should be on time, if it is late, we can't go far, it's too late. I think it is a problem of people who are [unclear word] and sometimes a problem of the profession. They can't handle the problem; they struggle on time and properly. When they get a mother who is in shock, it should do what is emergency, the woman is bleeding. I should secure an IV line, what I should do if I can't do anything, if I have not anything I should refer that woman early on time. So the problem is both (Desta).

Tamrat: The referral system— including the constraints of transporting the woman, the referral system is not correctly linked with the system. There's a gap. The health post is responsible to our system, there is only one health centre that is equipped with EmOC, with surgical and then there is health post or satellite health post that refers to the health centre. But this is not working— the health centre is not functioning like the National Health Plan because there is... they are not performing, they are not examining correctly, and this gap. When we compare these layers, there is primary delay, secondary delay, tertiary delay. In the first delay the person who is the decision maker is the husband. Here I think if women are not empowered, they are not decision makers. Even if she is in labour, the decision maker collects money, they can help the patient or not. So that's a
problem and the delay after the primary is to convey on time. On the secondary delay, after patients come on time to the health institution, the mother who is high risk because they have no skills, for example, who is working at a health centre don’t have any emergency skills. So what they do is to keep the mother for a long time. If they don’t have protection, if there is no transportation, they will keep the mother there...[instead of referring straight away.]

Some of the senior health workers directed criticism at the HEWs who had only had one year’s basic training. Yet during interviews the HEWs explained how difficult it was for them being so far from the health centre or hospital. They were concerned that if people did not have family to help them or if they are poor it makes it doubly hard. Even with these difficulties it takes two or three hours to carry someone to CHC (Abeba). Another HEW explained how they must follow steps to refer someone to the hospital. They must wait until after the baby is born and if the woman is bleeding more than is expected then they refer her. From this health post it takes two hours to carry a woman to Bonga Hospital. There is also a delay because the HEW has no referral papers so she must take time to write a letter to the hospital (Elizabet).

These statements illustrate the health workers understanding and feelings about the referral system. While distance and lack of transportation influences how promptly a woman reaches a medical facility, the process of receiving medical care is also affected by insufficient medical and nursing personnel qualified to assess, diagnose and treat maternal emergencies; lack of equipment and medical supplies including essential drugs such as antibiotics and Ergometrine and blood for transfusions. This problem of limited resources for health facilities common to much of the developing world is often perpetuated by ‘poor management and organization of the available resources’ (Thaddeus and Maine 1994:1104). So when the lack of resources is combined with the long distances women travel using improvised transportation to reach a medical facility, the result can mean the ‘earlier delays leave hospitals with little time to provide lifesaving care’ (Barnes-Josiah et al. 1998:990) when a woman finally reaches the facility: Nothing has changed since 200245, ‘lucky’ mothers are referred from woredas to Bonga, to the

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hospital and if there is an available physician who is trained in EmOC to do the operation. If he is not available, he will again refer to Jimma. Even after a mother came to the clinic in the woreda, she is going to be delayed for a length of time or for a vehicle, and the other delays after arriving at the hospital. The anaesthetist may not be around; the scrub nurse may not be around, all these things happen… so nothing has changed since five years ago (Dr Emabet). Despite these difficulties, the health workers I interviewed who dealt with obstetric emergencies took their work seriously and were deeply affected from losing patients either at the health facility or on the road after referral.

3.2.2 Travel distances

Distance was a recurring theme raised by health workers who cited it as one of the main reasons women did not use existing health facilities for birth. It was also cited as a major problem for those working in remote health facilities. Although distance was seen to influence women’s use of health facilities, health workers distinguished between different ‘categories’ of distance. By this I mean that health workers involved in providing ANC and delivery services to women who were HEWs in health posts, or medical officers or doctors at health centres or the Bonga Hospital, they were all conscious that women may have walked two, three or four hours to reach the facility for ANC or FP or to go to the market. But this did not mean that women would walk to the hospital or clinic for delivery. At all the ANC clinics I observed at Deckia Clinic, CHC and Bonga Hospital, I met women who had walked up to four hours, yet they did not expect to give birth at these facilities unless there was a problem during the labour. I describe how distance influences women’s everyday lives in Chapter 4 and in this section I use observations and interviews with health workers to describe some of the interactions between health workers and women.

Sr Aster from Bonga Hospital acknowledged that women would walk long distances for ANC but not for delivery: You mean the distance? Sometimes they didn’t come. If they come for ANC and the labour has started then, sometimes they didn’t come. If they come from far away, they don’t come for delivery. If she comes on foot, if the labour has started, how can she walk, that’s the problem… There is a cost, but it’s not only the cost, there is no road for the car in the village. If the car, it can go up to the community, they
can try to bring that lady.

One of the health workers at CHC distinguished between those women who lived in Chiri or nearby and those who live far away: The majority of women from Chiri attend ANC— but for those very far away— they don’t come... when I compare the women who live nearby and those who live in the remote areas, then the number of women who are dying is much higher in the remote areas because of lack of consideration how to get here, sometimes of ignorance, they want to deliver at home instead of walking all the way here. So it’s much better for all the women who are living nearby (Yonas).

Tamrat: There is a gap between community and the health service— the government won’t solve this in a short time. In the long run, one is the accessibility of the health station in the nearby area and the other thing is the accessibility of the road and the accessibility of the transport system. This gap may be narrowed. When these conditions are not fulfilled it’s very difficult to narrow this gap— because even if people have awareness, even if we get her to ANC and she was high risk, then to come for Caesarean section or assisted delivery, she has that knowledge and she went, she goes back to her home and when the labour started, there is the road problem, health station is not available, transportation is not available, that’s why the delay [referring to Meseret who was brought to CHC with obstructed labour from Agaro Bushi in Chapter 4]…. What last time KDP/SUPA K did, what the plan is, to have this ambulance in the town, commissioned with the telephone, and if there’s an emergency, they phone to them and they have to wait for the ambulance to go to there and pick up that mother to Bonga Hospital. It’s not working.

The problems related to the location, inaccessibility of health facilities and scarcity of transport also affects nurses and HEWs working in remote locations or even reasonably close in distance to the woreda centre. All government health workers must travel once a month to pick up their pay, hand in paper work to the woreda health desk and put in an order for medical supplies. If their facility has a refrigerator they must maintain a cold chain for vaccinations and other drugs such as Ergometrine. Logistically, it means that health workers can be away from their place of work for a number of days out of every
month. I cited the example of my own travel to Deckia from Bonga but the nurse from Deckia must travel to Chiri every month and in the rainy season parts of the road can be impassable as water comes over bridges. For many of the health workers in Decha Woreda whose health post or health centre is located near a road there is the chance of flagging a passing bus or Isuzu truck. However this ‘chance’ is based on whether or not it is a market day in Chiri and if there is any room in the vehicle. So it is impossible to plan a ‘quick’ trip to Chiri even on market day. For those other health posts or health centres on the road past Chiri (such as Yoka, Ogeya or Dishi), the only option is to catch an Isuzu on market days (as there is no other transportation) or to walk or ride a mule to Chiri.

Thus many health workers viewed inaccessibility, especially in the rainy season as being one of the causes of women dying in childbirth. Transportation is discussed below. Other factors such the shortages of health professionals, medical supplies and equipment are discussed in Chapter 4.

3.3.3 Transportation

As can be seen so far, when explaining some of the difficulties with the health system in Kafa Zone, health workers stressed that there are so many factors due to transport, and the road is not comfortable and geographical conditions are not good to reach health facility, such kind of factors. For example, Chocha is one of the remotest areas that area from Chiri, is a maximum of five to seven days, it’s so far (Ato Yohannes).

Rural people normally walk or use animals such as horses or mules. If they have money, and they reach a road, they can flag a passing vehicle to take the patient to the hospital. For many remote villages where there is a road impassable to buses, Isuzu trucks are the only forms of infrequent transportation available. The ambulance service to the rural areas was not working in 2007 and I had the impression it had not worked for some time.

I witnessed a number of patients being carried by stretcher made from bamboo and other natural products (Photo 6). The patient is tied to the stretcher and covered from head to foot in a white cotton shawl. Usually there are around 20 men to take turns to
carry the stretcher. Other people from the village will also come for support so there could easily be 30 or 40 people accompanying the patient. Only two health workers mentioned that there might be problems getting people to make a stretcher and carry a patient to the closest health facility. One was a senior health worker at Bonga Hospital who felt that *if they make some bed type from the environment, stretcher, if they do that, there is also a problem, the community they are farmers, there is not any cooperation* (Sr. Aster). One of the HEWs also felt it could be a problem if a woman did not have relatives or neighbours who would assist, there would be nobody to carry her to a health facility.

**Photo 6: Showing the stretcher to the researcher at Chiri Health Center**

CHC often transfers patients by four-wheel drive to Bonga Hospital but their policy is not to travel at night for safety reasons. If the patient needs to be transferred to Jimma, staff from CHC will take them to Bonga where there is the option of contracting a bus
or Isuzu at great expense; catching a bus after lunch (on its return trip to Jimma); or waiting somewhere in Bonga for the bus to leave early the next morning. A large part of the CHC budget is spent on maintaining the two four-wheel drives which are in constant use for outreach clinics; trips to Bonga to transport passengers and pick up pharmaceutical supplies and meetings with zonal authorities; and, longer trips to Jimma, Addis Ababa and Awassa for medical supplies and meetings with regional authorities. My observation was that maintaining vehicles and the often unsafe travel on unsealed roads in Ethiopia was not only expensive but extremely time consuming and caused considerable stress to the expatriate staff at CHC. An added stress was the ongoing requests (more often expectation) from woreda officials that CHC vehicles were available for woreda business (e.g. to pick up medical supplies or employees’ pay from the bank in Bonga) as all the woreda vehicles were all out of commission and it was unlikely they would be repaired in the near future given the lack of budget for maintenance.

A former senior health worker from CHC describes the difficulties when there is no transportation: If she is referred to Bonga Hospital it is a great problem. Especially there is no ambulance, this is a huge woreda, in Kafa Zone there are 10 woredas, especially one which is a huge woreda in Decha, there is 61 kebeles, the total population is 124,463 when you calculate the under five, under one, under 45, the great problem is transportation for the community. For example, in Gobachara [a rural location south of Chiri] one teenager came with obstructed delivery which I referred to Bonga, there is no transport. The problem is the baby is transverse, to deliver she needs CS [Caesarean Section]— there is no CS in Bonga, only in Jimma, and so the only option is she is dying. The only problem is not cost; the only problem is transportation (Samson).

Thus the scarcity of transportation often causes delays for women trying to reach a health facility. While waiting for transportation, the patient’s condition deteriorates making it more difficult to treat on arrival (Thaddeus and Maine 1994:1102). Sometimes the patient does not make it and dies on the way as cited by another senior health worker at CHC: We experienced taking a lady with vaginal bleeding to Bonga Hospital… but they are not working, there is no emergency surgeon so again there is a delay. What they did is we refer her to Jimma, and then on the way the car was stuck. And they delayed. She
3.4 Discussion

Since the early 1990s, international strategy and policy has put forward the view that skilled childbirth attendance is the single most critical intervention to reduce maternal death (Chapter 1). The argument in this chapter is that the ‘distance’ from international strategies and policies to its actual implementation in the kebeles in Kafa Zone is vast. A commitment to the MDGs and reducing maternal mortality and disability requires a greater concentration of health services for the rural community; the National Reproductive Health Strategy (MOH 2006a) aims to increase the proportion of births attended by skilled health personnel either at home or in a health facility. Using part of the Three Delays framework, the focus is on the biomedical model of maternal survival that assumes that improved recognition of the danger signs will automatically increase with timely use of skilled care. It implies that the “pathway to maternal survival” is a direct, linear route’ (CHANGE/ The Manoff Group 2005b).

Chapter 5 will address the complex contextual and cultural factors that contribute to maternal care seeking decision making and the frequent “detours” off the pathway that women and families make when seeking skilled care (Moore et al. 2002:63; CHANGE/ The Manoff Group 2005b). While the intention in Kafa Zone is that building new health facilities will bring health programs closer to the community and fulfil the government strategy relating to decentralised health, distance and lack of transportation made it exceedingly difficult if women or their families seek care from the health post, health centre or hospital. These facilities are often forced to refer women to the next level of facility and this delays access to appropriate treatment (Cham et al. 2005:5), adding to the travel costs and other costs associated with travel to a health facility. In Chapter 6 I examine the government’s development strategies and how top-down planning restricts planning and development to pre-existing sector plans. In the health sector, distance is also a key difficulty for health workers in remote locations who must travel to the woreda capital each month to lodge reports and pick up medical supplies. In the rainy season this travel is even more difficult and sometimes impossible. The HEWs have set days (Monday and Tuesday) when they must do outreach activities visiting women in their homes and one HEW travels three hours to visit women far from the
health post. HEWs are regularly involved in one-off campaigns such as Vitamin A, Albendazole (to treat worms), measles and polio which means extra travel around the kebele.

I would argue that it is not only the distance from international policy to its implementation that is the only crucial factor determining maternal survival. It is impossible to delineate how much time it takes to reach a health facility particularly if a woman needs referral to the next level of facility. Time is dependent on so many external factors: weather; the availability of men to make a stretcher and carry a woman; the availability of transport; and, the availability of trained medical staff to treat the woman at the referral centre. Throughout my research, as I waited for the rain to stop or for the bus to leave, while I waited in the queue at the hospital with friends, or outside an office for an interview, I often felt that waiting was so normalised that it seemed opaque. Like waiting for the baby to come and hoping everything would be alright.

In general, it may be useful to think that birth is ‘normal’ if it happens at home and that if a woman is referred to a health facility the birth is seen as ‘abnormal’ because she needs medical care to deliver. In actual fact, this dichotomy is not so clear cut because some ‘abnormal’ things happen during birth at home that are dealt with by traditional practices (Chapter 5). Given that the majority of the population lives in rural areas, walking as the main form of moving from one place to another is taken for granted (Chapter 4). And given the difficulties of inaccessibility and lack of transport described in this chapter, the dichotomy of birth as ‘traditional’ and ‘modern’ is reinforced because ‘traditional’ or ‘normal’ birth takes place at home and ‘abnormal’ or ‘modern’ birth takes place in a health care setting. This also reinforces the view that development only takes place by adopting what is considered ‘modern’ (Knutsson 2004:180). This perception neither encourages women nor health staff to see things with a different perspective or to see past the problems of limited resources for health facilities, especially lack of equipment and medical supplies. These issues are discussed in Chapter 6. But first, Chapter 4 describes the women interviewed who are the targets of reproductive health policies in Kafa Zone.
Box 4: Visiting Bonga Hospital

One of my visits to the hospital was to accompany the young nephew of my interpreter who had developed a massive boil on his eyelid. He had not been taken to the doctor because there was no money so I offered to take him with two of his aunts. First we went to the ‘Card Room’. Because he had not been registered before we bought a new card for eight birr. Then we went to the children’s clinic and after a relatively short wait outside he was examined by the doctor and prescribed antibiotic eye ointment for the next two weeks. We went to the pharmacy with the prescription, to the cashier’s office to pay for it, and then back to the pharmacy to pick up the ointment. On other visits to the hospital I realised how much waiting was involved because if the patient required laboratory tests as well they would have to wait in a queue at the back of the building for that before waiting for the results and then wait to see the doctor again before a prescription was written. Nothing happened over the lunch break. (Back home over the next couple of days it was apparent that no one had treated the young boy and as I had the means to do it with boiled water and disposable gloves, I asked him to come and see me three times a day for the treatment. Thus began the first of three treatments for boils which he developed over the next three months.)

Another patient I accompanied to the hospital was a gardener for the local priests who lived nearby. He had been attacked by an ox and as no one had any first aid knowledge, I ensured he was taken to the hospital as quickly as possible. Because the man was deaf and mute, I explained to the doctors what had happened and then observed one of them begin the examination process before I left the room. I remember feeling appalled at the callous and rough nature of the examination and the sheer terror on the man’s face. He was admitted for surgery the next day and over the next two months I visited him on a number of occasions and wondered to myself why his treatment seemed to take so long.

I also visited the Labour Ward one day and ended up staying with a woman during the birth of her baby because I felt unable to leave when all the staff left for their lunch time break. The baby was delivered five minutes after their return from lunch and I relate my experience below because I felt so distressed by it.

There are four beds in the labour ward. I sit on Bed One, a low bed with four coasters that appear to work, to observe what goes on for awhile. Bed Two is in a corner and totally dysfunctional, rusted out and broken. Bed Three has a very young woman with a baby lying on a mattress with its ripped cover covered with a blood stained sheet; the whole room smells of blood. She was brought in from Chenna and had a Caesarean Section after a number of days in obstructed labour. The young husband takes the baby to wash in a small plastic bowl; the baby screaming and screaming in the cold water while his father’s awkward hands pours more cold water over him. The midwife comes in and tells him to stop and give the baby back to the mother for warmth. But I feel something is wrong because she is lying in a pool of blood and no one checks her vital signs or if she is bleeding. Later I find out that she has an infection and must stay until the end of the week.
Box 4 cont: Visiting Bonga Hospital

One of the legs on Bed Four is sitting on a couple of rocks to keep it level. It has a young woman lying on her left side in labour with her first baby. Her sister is with her, an older woman, a mother of eight. The midwife comes in and inserts a drip and takes the woman into the delivery room for an examination. Through the open door I see the doctor shove his hand into her pushing and probing around for a couple of minutes causing her much pain and distress. She’s brought back into bed and the room is crowded with second year nursing students hanging around doing absolutely nothing except talking to each other and to me. The one exception, a male student, times her contractions and even rubs her back a bit. Something makes me sit here and stay with this woman to support her. The labour is progressing and I am fascinated by this young woman’s fear as she stares at a fixed point in front of her and refuses to make eye contact with anyone. All the nursing students, the midwife and other staff disappear. It is lunch time and I feel it is impossible for me to leave these two women, particularly as the calm older sister has jumped onto the bed offering support by holding her sister from behind.

Over the next hour and a half to two hours the contractions are more frequent and I help the woman go to the labour ward. I send for one of the nurses from another part of the hospital who examines her and decides to increase the flow of the drip. He leaves and five minutes later I realise that very shortly I will be delivering this baby if no one else comes. After I clean her up I can’t find another pair of gloves to catch the baby whose head is now very visible. At this point the midwife arrives from her lunch break and when I show her the baby’s head she quickly gowns up. I take the woman’s hands to help her, and for the first time she looks me in the eye as I try to offer her support. Later I am told that no other woman in this hospital has had anyone support them during labour or birth as it is against all procedures. The midwife pulls back the vagina and telling the woman to push, she cuts her, not once but twice. Screaming as her baby is pulled from her, I am furious that I was unable to deliver the baby and prevent the massive cut which I felt was so unnecessary for this tiny baby girl.

By now I am starting to feel faint and I go back on sit on Bed One. I feel I am a fraud of a support person— for 45 minutes the woman screams in agony while they stitch her back together— three layers of skin and muscle; she is surrounded by laughing second year nursing students and I am not there to support her. When she is finally brought out, her dress is cut off her and a nipple is ‘shoved’ into the baby’s mouth. Once again, the woman is staring into space, still scared what will happen next. I say baka (finished, enough) and use my hands to wave it all away. At least she gives a tiny smile.

The next morning I come back to the hospital to visit but the woman has been taken back to the women’s prison and I never got to say goodbye to either her or her sister. I was told she was there because she was accused of taking a second husband; how many men take second or third wives is of course not comparable.
Box 5: Selections from Chiri Health Center quarterly reports 1998 - 2008


Jan - March 2000 — ANC introduced with 162 women seen
Jan - March 2001 — 244 women seen for ANC
127 women seen for FP (new service)

Apr - June 2001 — 16 admissions including six women for labour and delivery or delivery complications

Jul - Sept 2001 - 279 for ANC, 12 deliveries
Apr - June 2002 - 445 for ANC, 461 for FP

Seven deliveries without complication, 2 vacuum deliveries. Referral hospital (Bonga) without surgeon (women must go to Jimma). No transportation available for women although the hospital’s ambulance is supposed to transfer women.

Apr - June 2003 — 10 deliveries: three normal, four stillborn, three referrals to Bonga. Another woman came to CHC after delivering twins at home— post-partum haemorrhage.

Jul - Sept 2003 — 4 normal deliveries, two stillbirths, 5 referrals to Bonga Hospital
Jan - March 2005 — 22 normal deliveries, 7 abnormal deliveries, 3 still births, 6 referrals to Bonga Hospital for complications during delivery.

Apr - June 2005 — 14 normal deliveries, 2 abnormal, 1 stillbirth, 10 referrals to Bonga, 7 women seen after delivery with complications including infection, post-partum haemorrhage.

Jul - Sept 2005 — 9 normal deliveries, 11 abnormal, 2 stillbirths, 4 referrals to Bonga, 11 women post delivery. No anaesthetist at Bonga Hospital.

Oct - Dec 2005 — 13 normal deliveries, 3 abnormal, 1 stillbirth, 3 referrals. Still no anaesthetist at Bonga Hospital.

Oct - Dec 2006 — 18 normal deliveries, 2 deliveries of twins, 4 referrals to Bonga Hospital, one maternal death soon after arrival at CHC, 2 foetal deaths. Referrals to Bonga Hospital still problematic—limited surgical capacity and no funding to transport patients to Jimma Hospital. Had to bring patients referred to Bonga back to CHC.

Jan - March 2007 — 517 women seen for ANC of which: 174 were for their first visit; 137 second visit; 75 third visit; 131 fourth visit. Of these 65 were classified as high risk; 38 under 18; 15 over 35.

ANC Outreach clinics: 176 women (first, second, third and fourth visits included)

Apr - June 2007 — 6331 outpatients averaging 102 patients a day. 12 normal deliveries, 15 vacuum, 1 abnormal, one set of twins. No referrals. Bonga Hospital not providing Caesarean Section most of this period. Ongoing difficulties getting medications including Erythromycin suspension, Vitamin D, Ferrous Gluconate or Sulphate.

Oct - Dec 2008 — 19 normal deliveries, 4 vacuum assisted deliveries, 6 abnormal (other) delivery, 0 deliveries of twins and 7 referral to Bonga hospital for complications during the course of delivery. There were 25 Manual Vacuum Aspirations (MVA) to treat spontaneous abortions. 1 HIV + mother treated with Nevirapine.

Not included are constant themes about the difficulties of recruiting and training staff and the procurement of medicines and medical supplies.
Photo 7: Deckia Clinic
Photo 8: Wushwush Health Centre

Photo 9: Ghimbo Health Centre—Delivery bed
Photo 10: The brand new (unoccupied) Ogeya Health Post after one rainy season
Photo 11: Erimo Health Post (centre door)

Photo 12: Shapa Health Post
Chapter 4: Women: Who is giving birth, where and why?

The focus of this chapter is the women interviewed, the 'Who' of the first part of the questions: 'Who is giving birth where, and why?' Asking 'Who' is a key question because the Ethiopian National Reproductive Policy aims to reduce maternal mortality and disability by increasing the proportion of births attended by skilled health personnel either at home or in a facility (MOH 2006a:18). 'Who' are the women this policy is intended to impact on? The chapter is organised around five themes emerging from the research which structure the women’s lives as daughters, mothers and members of their local communities. It is based on the interpretations and analysis of secondary sources as points of reference and my own interpretation of interviews and observation. The first theme, 'Marriage and pregnancy' shows that marriage is universal and that women are socially sanctioned to be married to be able to give birth. The second theme, 'Social interaction and activities women undertake in daily life,' has three sub-themes: 'Work inside and around the house'; 'The mother/daughter relationship'; and 'Building good relationships with neighbours and the community'. The third theme, 'Women and decision making' describes how it is husbands who make decisions about health care for their wives. The next theme examines issues around marginalisation for Manjo women in Kafa Zone. While the Manjo only make up a small proportion of the population in Kafa Zone there is complex social interaction between them and the dominant Kafa. The last theme in this chapter considers the action of walking which was a recurrent theme in the fieldwork. Walking is taken for granted as the 'normal' way to move from one place to another. It is the 'walking woman' who creates a link between everyday activities and social interaction in rural and semi-urban Kafa Zona.

Table 5 offers a brief overview of some salient characteristics about the women interviewed. It includes the place where the women lived; their age at the time of the interview (or a near approximation); number of years of education; the number of pregnancies (gravida) and the number of live children (para); whether they attended ANC; and any other preparations for birth including dietary changes. I also noted if women were Manjo. The first section of the table includes women who gave birth at home. The second section of the table includes the women interviewed who gave birth at a health centre or hospital. Table 5 also shows that only two women planned to give birth in a health facility. Makeda gave birth at Bonga Hospital as planned. Meseret gave
birth at CHC but the labour started early at her home in Agaro Bushi and her baby died on the way. Photos 13 and 14 show two of the women interviewed. Verbal permission to publish these photos in the thesis was granted. All women were given pseudonyms.

The women I interviewed lived in Kēbele Three in Bonga (within 10 to 20 minutes walk from my house on the outskirts of Bonga), Sheyka (one to two hours’ walk uphill from my house on the outskirts of Bonga), Shapa (around one hour’s walk uphill from the other side of Bonga or 15 to 20 minutes on the Chiri bus), Wushwush, Chiri, Deckia and Agaro Bushi (see Map 2, Chapter 3). While visiting CHC, I also met women who had come for ANC from surrounding areas including Muti (three to four hours walk), Agaro Bushi (around eight hours walk) and Erimo (around 90 minutes walk). The majority of women interviewed lived in a traditional tukul (Photo 15). Two of the women interviewed who lived in Kēbele Three lived in a ‘modern’ house—a small two roomed rectangular house with mud walls and corrugated iron roofing. One of these houses was rented. Houses in Kēbele Three were on much smaller blocks of land. As can be seen in the photograph, people in rural areas often lived in small groups of two or three houses quite close to each other rather than in defined villages. For all the women interviewed, walking was their main form of transport (see Chapter 3). No one mentioned using a mule or horse.
<table>
<thead>
<tr>
<th>Name</th>
<th>Place of residence</th>
<th>Age</th>
<th>Education</th>
<th>No of pregnancies</th>
<th>ANC</th>
<th>Other preparations for birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yesharig</td>
<td>Kebele Three, Bonga</td>
<td>21</td>
<td>Grade Eight (part)</td>
<td>Gravida 2 Para 2</td>
<td>ANC: Yes—to check the direction of the baby and to take the injection (TT)</td>
<td>None: I eat the same food. At school I was a group leader for exercises (she left school at 16 due to the birth of her first child).</td>
</tr>
<tr>
<td>Abebech</td>
<td>Kebele Three, Bonga</td>
<td>40</td>
<td>Grade Seven</td>
<td>Gravida 9 Para 7</td>
<td>Once during first pregnancy</td>
<td>None: I was very strong and the work is easy for me. I made injera and collect wood and grind maize. Now I get a bit tired.</td>
</tr>
<tr>
<td>Etenash</td>
<td>Kebele Three, Bonga</td>
<td>22</td>
<td>Grade Seven</td>
<td>Gravida 1 Para 1</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Bethlehem (Manjo woman)</td>
<td>Kebele Three, Bonga (formerly of Bitta where her child was born)</td>
<td>25</td>
<td>Grade Four</td>
<td>Gravida 1 Para 1</td>
<td>Yes</td>
<td>None, ate the same food</td>
</tr>
<tr>
<td>Tigiste (Manjo woman)</td>
<td>Chiri</td>
<td>40</td>
<td>For three months during the Dergie</td>
<td>Gravida 14 Para 9</td>
<td>None</td>
<td>None, but ate flat bread made from tef, taro, beans and porridge from cabbage.</td>
</tr>
<tr>
<td>Sara</td>
<td>Sheyka</td>
<td>30</td>
<td>None</td>
<td>Gravida 7 Para 7</td>
<td>None</td>
<td>None: I eat what I have. sorghum, maize, and kocho, nothing extra.</td>
</tr>
<tr>
<td>Fana</td>
<td>Sheyka</td>
<td>30</td>
<td>None</td>
<td>Gravida 7 Para 7</td>
<td>None</td>
<td>None, ate the same food</td>
</tr>
<tr>
<td>Misrak (Manjo woman)</td>
<td>Sheyka (recently moved there with husband and baby, house still under construction)</td>
<td>15</td>
<td>None</td>
<td>Gravida 1 Para 1</td>
<td>Yes, but did not receive TT injection</td>
<td>None, ate the same food</td>
</tr>
<tr>
<td>Name</td>
<td>Village</td>
<td>Age</td>
<td>Grade</td>
<td>Gravida</td>
<td>Para</td>
<td>Extra Information</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
<td>---------</td>
<td>-------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Zena (Manjo woman)</td>
<td>Sheyka</td>
<td>Early 20s</td>
<td>None</td>
<td>Gravida 2</td>
<td>Para 2</td>
<td>None, ate the same food</td>
</tr>
<tr>
<td>Addisalem</td>
<td>Sheyka</td>
<td>35</td>
<td>None</td>
<td>Gravida 7</td>
<td>Para 7</td>
<td>None, ate the same food</td>
</tr>
<tr>
<td>Itaynish</td>
<td>Wushwush</td>
<td>Early 20s</td>
<td>Grade Eight</td>
<td>Gravida 1</td>
<td>Para 1</td>
<td>None</td>
</tr>
<tr>
<td>Hirut</td>
<td>Wushwush</td>
<td>42</td>
<td>Grade Five</td>
<td>Gravida 5</td>
<td>Para 5</td>
<td>None</td>
</tr>
<tr>
<td>Hanna</td>
<td>Wushwush</td>
<td>45</td>
<td>Grade Seven</td>
<td>Gravida 6</td>
<td>Para 6</td>
<td>None</td>
</tr>
<tr>
<td>Tadelech</td>
<td>Wushwush</td>
<td>Late 30s</td>
<td>None</td>
<td>Gravida 4</td>
<td>Para 4</td>
<td>Yes, but only for TT injection</td>
</tr>
<tr>
<td>Aden</td>
<td>Deckia</td>
<td>30</td>
<td>Grade Seven (part)</td>
<td>Gravida 3</td>
<td>Para 3</td>
<td>None. Diet unchanged.</td>
</tr>
<tr>
<td>Wolete</td>
<td>Deckia</td>
<td>Mid to late 30s</td>
<td>None</td>
<td>Gravida 6</td>
<td>Para 2</td>
<td>Only for last child</td>
</tr>
<tr>
<td>Tsehainesh</td>
<td>Deckia</td>
<td>30</td>
<td>None</td>
<td>Gravida 11</td>
<td>Para 9</td>
<td>For last child</td>
</tr>
<tr>
<td>Wubealem</td>
<td>Deckia</td>
<td>25</td>
<td>None</td>
<td>Gravida 4</td>
<td>Para 4</td>
<td>Yes</td>
</tr>
<tr>
<td>Messelech</td>
<td>Agaro Bushi</td>
<td>Early to mid 40s</td>
<td>None</td>
<td>Gravida 2</td>
<td>Para 2 (twins)</td>
<td>None</td>
</tr>
<tr>
<td>Abaynesh (Manjo woman)</td>
<td>Shapa</td>
<td>Early to mid 40s</td>
<td>Grade Two</td>
<td>Gravida 12</td>
<td>Para 10</td>
<td>None</td>
</tr>
</tbody>
</table>
### Women who gave birth at a health centre or hospital

<table>
<thead>
<tr>
<th>Name</th>
<th>Kebel or Hospital</th>
<th>Age</th>
<th>Parity</th>
<th>Gravida</th>
<th>Referral</th>
<th>Labour and Care</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makeda (see Box 12, Chapter 4)</td>
<td>Kebele Three, Bonga</td>
<td>24</td>
<td>None</td>
<td>2</td>
<td>Yes</td>
<td>They said you haven't any blood and they give medicine for it and they said don't carry heavy things. They said when your labour starts come here (to the hospital)</td>
<td>Ate what she had—kocho, cabbage, shiro. Drink made from linseed. Husband collected firewood.</td>
</tr>
<tr>
<td>Birke (see Box 14, Chapter 5)</td>
<td>Sheyka (formerly from Sherada). Last birth from Sherada to Gojeb to Bonga Hospital to Jimma Hospital</td>
<td>Mid 40s</td>
<td>None</td>
<td>11</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Raydet</td>
<td>Wushwush (Birth started at home but transferred to Bonga Hospital after five days in labour for a forceps delivery)</td>
<td>App 22</td>
<td>Grade Eight</td>
<td>1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Meseret (see Box 13, Chapter 5)</td>
<td>Agaro Bushi (Meseret was an inpatient at CHC. We discussed the loss of her baby on the way from Agaro Bushi to Chiri)</td>
<td>App 26</td>
<td>None</td>
<td>5</td>
<td>Yes</td>
<td>Referred from Deckia Clinic to CHC (possibly after referral from Agaro Bushi Health Post) for breech presentation and swollen ankles.</td>
<td>Not known.</td>
</tr>
</tbody>
</table>
Photo 13: Woman from Shapa with family
Photo 14: Woman from Chiri
4.1 Marriage and pregnancy

Marriage is viewed as universal in Ethiopia and is the principal indicator of a woman’s exposure to the risk of pregnancy: less than half a percent of women age 45 - 49 have never married (CSA and ORC Macro 2006:79). Because marriage marks the stage of a woman’s life when childbearing is socially acceptable and the majority of women begin sexual intercourse at the time of first marriage (2006:84), age at first marriage has a major effect on childbearing. Women who marry early have on average a longer period of exposure to pregnancy and a greater number of births (CSA 2006:82). Marriage takes place relatively early in Ethiopia: among women aged 25 - 49, 66 percent were married by age 18 and 79 percent were married by age 20. The median age of first marriage is 16.1 years with little change in the median age at marriage in the five years since the first Demographic and Health Survey in 2000 (CSA and ORC Macro 2006:82). More than twice as many women in the rural areas were married compared to urban dwellers: 17.3 percent of rural women and only 3.3 percent of urban women age 20 – 24 were married (2006:83). In Kafa Zone, around 70 percent of women are married and pregnant before
the age of 18 although marriage at much earlier ages (15 years or less) is much less common compared to other parts of Ethiopia (Habtamu Argaw 2002:59). Because many women are having their first pregnancy earlier than is medically advisable, there is a tendency for these pregnancies to be high-risk because of the 'lack of physiological readiness and experience of the mother as well as the absence of emotional and psychological readiness to care for the child after birth' (2002:58). In addition, high risk pregnancies are more likely to occur when there is a short birth interval. Forty-six percent of pregnancies in Kafa Zone were shown to have a birth interval of less than two years which is much higher than the 20 percent for the rest of Ethiopia.

Pregnancy and childbirth are key stages in a woman’s life in Ethiopia as traditionally this is how women achieve their identity and status (Pankhurst 1992:178). In 2002, giving birth to as many children as possible was high on the criteria of responsibilities for women: the total fertility rate in Kafa Zone was 6.3 children per woman, 20 percent of women have more than seven children, and the value attached to having as many children was high as 51.8 per cent men and 44.3 percent of women desired to have more than seven children (Habtamu Argaw 2002:xi-xii). Generally there is no discussion between a husband and wife about sexual relations or the use of contraceptives (Mirgissa Kaba 2000:39, 50, 54). Children are seen as precious assets to a family (Abiyu Million et al. 2002:29; Mirgissa Kaba 2000:25), and the ‘inability to have children has traditionally been a source of pain, anxiety and shame’ (Hailegebrivel Wolde Gawo et al. 2006:129) reflected in a Kafa saying:

The might of a stream is rain [water] and so the might of a human being lies in how extended his kin is. How extended the kin is, is an important mark of power, strength and respect in Kafa.

All the same, it is God who decides if women will have children, and how many children she will have (Mirgissa Kaba 2000:25).

All the women interviewed were married or had been married. Only two women were not living with their husband. One was Abebech from Kebele Three in Bonga whose husband had left her for another woman. Abebech is now a single mother of seven children. The other woman was Birke (Box 14, Chapter 5) who had been forced to leave her husband after the birth of her last child left her with chronic health problems. A number of women were not sure of their age at marriage and/ or their present age. In
actual fact, I wondered about those who confidently told me they were married at 18 because it is now illegal to be married at an earlier age. For example, Tigiste told me she was married at 18 yet she has no education and 14 pregnancies so I doubted she was married as late as 18. It can be seen that a number of women married very young: Sara at age 12 and Misrak and Fana both at age 14. The oldest reported age at marriage was Wolete at 21 or 23 and Bethlehem, Birke, Itanish and Tadelech married at age 20.

The data confirms that marriage was the principal indicator of a woman’s exposure to the risk of pregnancy. However, given the small sample, the evidence is not strong enough to say if age at marriage has a major effect on the number of lifetime births as there are other factors that could affect this such as access to contraception and education both of which were not available in the past. For example, Sara who is 30 and Fana who is 35 have both had seven children, yet Bethlehem who is 25 and Itanish is around 29 have only had one child. Sara who had no education was married at the age of 12 and has had seven children; while Hanna who completed Grade 7 was married at 15 has had six children. A number of women who completed Grade 7 were married at ages 17 or 18 while others who had no education were married at age 20 (see Section 6.3.5, Chapter 6 on education).

Ethiopia’s population policy aims to harmonise the rate of population growth with socioeconomic development to achieve a high level of welfare (CSA and ORC Macro 2006:4). Three targets are to reduce the total fertility rate from 7.7 children per woman in 1990 to 4.0 children per woman in 2015; to increase the prevalence of contraceptive use from 4 percent in 1990 to 44 percent in 2015; and, to significantly increase female participation at all levels of the educational system. Given the universal nature of childbearing in Ethiopia and the perception of fertility equated with social status for women, more and more women appear motivated to have smaller families and use contraception (MOH 2006b:16). I did not ask women about their use of contraceptives but this information was offered to me during a number of interviews possibly because I asked women if they were ‘happy’ to be pregnant. Many of them expressed dissatisfaction with the number of children they had had and that they didn’t want to have anymore. I had asked this question because I had read that it was important to be ‘happy’ during pregnancy in Ethiopia for the overall balance of health and well-being of
the mother. This may have prompted a misinterpretation about 'happiness' and pregnancy during some of the interviews because ‘happiness’ is associated with a positive outcome of the pregnancy. Conversely, unhappiness is linked to miscarriage which has [i]mplications for unplanned or unwanted pregnancies (MOH 2006b:23).

Many of the women interviewed and others I observed went to Bonga Hospital for Depo-Provera injections. In fact, there were always far more women waiting outside the FP outpatients room than those waiting for ANC. For instance, Yesharig did not want to have any more children (she was Catholic) as she was struggling to manage financially. Sara from Sheyka was most unhappy about having so many children. Addisalem from Sheyka walked the two hours to the hospital for Depo-Provera and Abaynesh (Shapa) also walked at least 90 minutes to the hospital even though she could have gone to the much closer health post. The reason she cited for going to the hospital was that she had to pay for the needle and syringe at the health post and only for the medicine at the hospital. Fana from Sheyka wanted to have fewer children because of the evil spirits associated with jealousy and having too many children: *When somebody puts magic on pregnant women and then for instance she delivers a small child, the people back-bite. They say she delivered something (a deformed child) or the woman might have been seen by an evil-eyed person. We are frightened; for this reason I want to stop having children.* And Tigiste strongly talked about the difference between then and now, being pregnant while carrying a child on your back, being pregnant one after the other (Box 6).

**Box 6: Tigiste: Comparing then and now**

Tigiste compared the past to the present and explained how women just had one baby after another even carrying one child on her back while she is pregnant with the next. She felt sure that none of her children would have died if she had delivered now: *When I compare that time, today with previous time, when I see women have been taking care of their child and pregnancy, I wish I had been pregnant now (instead of then)...if I was educated on how to give birth I would be safe, I was bleeding a lot and no one educated me and I lost a lot of blood. Actually, I would be still young, if I was told how to be pregnant, just how often, then I would not know what is happening, I did not recognise, actually when I was pregnant, I just delivered a child one on top of another. You know they are all small and today I can see children, the eldest child taking care of the youngest child...I remember that we carry one child on our back while we are pregnant. Now women are cheerful. None would be dead if I delivered today.*
4.2 Social interaction and activities women undertake in daily life
4.2.1 Work inside and around the house

As described in Chapter 3, the world in which the rural Ethiopian woman lives and works is one set in a loose collection of scattered family households embedded in domestic agriculture and industry. Production, reproduction and consumption are oriented to the household unit of husband, wife and their children. Work takes place in and around the household with appropriate tasks allocated by age and gender (Pankhurst 1992:75; Poluha 2002b:70). Poluha’s ethnographies of daily life for women and men describe how the work around the rural household is so gender-specific that ‘there is a strong interdependence between members of the household. Husband and wife in particular are so dependent on each other that it was almost impossible for an adult to live without a spouse’ (Poluha 1988:150). Women’s responsibilities extend to caring for and disciplining their children and teaching them good manners and social behaviour. Poluha (2002a; 2002b) describes how children ‘are thought to be the most beautiful gift from God’ but much value is attached to teaching children to respect their elders. Until the age of four or five, children stay at home and help their mother. Sons have higher status than daughters (2002a:68). Generally, male children from an early age assist by herding flocks of sheep and goats, collecting hay and running errands. Between the ages of 12 and 14 they learn to plough with plenty of time to roam around without much responsibility. They are taught to experience space and to be forward (2002a:70). On the other hand, girls are encouraged to ‘stay in’ to help their mother close to the fire and cook. They are expected to stay inside the house, be obedient, work and take responsibility when their mothers are away:

Girls thus get little exposure to space from home, but learn to fear public places as areas where they do not know how to act. While boys are encouraged to be outspoken, forward, even a little aggressive, girls are expected to be taciturn and withdrawn (Poluha 2002a:68).

The differences between responsibilities for boys and girls became evident one afternoon while I was visiting in Deckia. I had asked to see some of the places where people collect water. First, I was taken to a beautiful stream with large smooth rocks on the edge, perfect for accessing water or washing clothes before it ran over the rocks creating a waterfall. Next, I was taken to an ‘improved’ water point that no one could use because the water just trickled out of blocked pipe creating an inaccessible muddy bog. Then I was taken down a steep hill to a place where water flows out of the ground and runs over the rocks creating a stream between the hills. A shy young girl was collecting
water with two plastic jerry cans and then a woman came to wash some barley for arek’e or tella preparation in a homemade sieve. On the grassy side of the hill, a group of boys were playing a ‘hunting’ game. We sat and watched as they threw a hoop made of a piece of bamboo tied together with string either up or down the hill. Then they threw their spears (sharpened sticks like small javelins), aiming for the hoop. After each boy had thrown his spear, they would run and collect the spears and throw the hoop again. Clearly, this was a favourite pastime for boys and an opportunity to learn the skills of throwing and aiming at a target, while girls had to work.

In Kafa Zone peasants use traditional farming techniques and simple tools to grow cereals, coffee and enset, and to raise cattle, sheep, goats and bees for subsistence and festivities, the local economy and the payment of taxes. The women I interviewed live a similarly gendered existence as described in the preceding paragraph. Ploughing the fields, sowing the seed, harvesting and house construction are men’s work. Men are more involved than women in harvesting, processing, storage and marketing of coffee, cereal and legumes production because these are the crops that are more likely to generate cash income— an important role for men (Abiyu Million et al. 2002:14). They are also involved with cattle, sheep and goat husbandry and beekeeping for the same reason (2002:18). Men are not supposed to be involved in household activity with the exception of occasionally collecting firewood and there are cultural beliefs that a man busying himself with household activities will be seen as ‘becoming a female’ and not capable of running his household properly (2002:12).

The Economic Contribution of Women, Decision-making Processes in the Family and Gender Related Behavior in the Kafa Zone (Abiyu Million et al. 2002) reports that on average 79 percent of all household tasks are performed by women. Only two household tasks are contributed to by others: collecting firewood (sons and husbands) and collecting water (mainly daughters) (2002:10). Other common activities women are involved in are enset preparation, food and coffee preparation, pounding, grinding, plastering, washing clothes and going to the mill, planting and weeding vegetables, root crops and spices around the home, threshing and assisting with animal production tasks especially cleaning the shed, herding and feeding, and milking, butter and cheese making. Feeding chickens and collection of eggs is mostly a woman’s concern (2002:11-19). As mentioned earlier, one of the women I interviewed had to leave her husband because she was no longer able to
do the heavy work required of a wife. In the next chapter I relate how she lost her baby and suffered complications from the Caesarean Section. Birke now lives with her mother and her brother’s family in Sheyka.

In many of the homes I visited there appeared to be little or no food and I was left wondering what women and their families ate. Many of the women interviewed were very short and thin and I did not think they had had a nutritious diet rich in iron and folate which is necessary to assist a developing baby and to keep the mother healthy. Short stature is commonly used as a signal that a woman may have been undernourished and may have difficulty delivering due to cephalopelvic disproportion\textsuperscript{46}. And Tew (1998) shows that high mortality in developing countries often results from undernourishment over many generations, the young age of birthing mothers before skeletal developed is complete combined with manual hard work and frequent pregnancies and breastfeeding (1998:304-7). The women interviewed said they ate what they had. They ate injera or kocho\textsuperscript{47} or maize for example, and did not change their diet because they were pregnant. The only exception was Wubealem who said that when she is pregnant she eats fresh food or food that has been freshly prepared, not from the night before.

Each house I visited had enset and vegetables or spices growing around it. Not everyone grew the same things but generally the women grew gomen\textsuperscript{48}, green pepper, onion, garlic, taro, red beet, and beans. Spices such as false cardamom (\textit{Aframomum corimima}) commonly grew in large patches or were collected in the forests along with wild or Kafa black pepper (\textit{Piper capense}). After collection, spices and coffee are laid out to dry in the sun each morning. Some of these vegetables, spices and coffee were grown for domestic consumption and the rest were for sale at the market so that salt and other essentials could be purchased. The women I interviewed were also expected to assist with the preparation of agricultural fields for seeding, weeding (along with other members of the family) and helping keep wild pests out of the fields. While their husbands would do the ploughing and sowing of the grain, the wives were expected to prepare food and coffee

\textsuperscript{46} Disproportion between the size of the foetus and the size of the pelvis which could mean the pelvis is not large enough to accommodate the foetus for vaginal birth. Commonly associated with obstetric fistula which occurs disproportionately in impoverished girls and women, especially those far from medical services (Creanga and Genadry 2007).

\textsuperscript{47} See page 146.

\textsuperscript{48} \textit{Brassica carinata} A. Braun (\textit{Brassicaceae}) commonly known as Ethiopian mustard or kale used as a leafy green vegetable and as a seed oil on the earthenware mitad to cook injera and in folk medicine to cure stomach ache.
and bring it to the fields for them. Poor female-headed households rented out their land through sharecropping (Box 7).

**Box 7: Abebech: Female-headed households and sharecropping**

> After her husband left her, Abebech became a single mother of seven children aged two (twins) to 16. She lives on a small piece of land adjacent to her elderly mother. Both Abebech and Almaz live close to a fast flowing river so sometimes it is impossible to send the children to collect water or firewood because it is deemed too dangerous. Abebech’s small tukul is in a state of disrepair and leaks when it rains although it is only a few years old. She has no money to build a new tukul. One day when I arrived to visit, there were two young people picking maize in the field and I was told these were the share farmer’s children. Because Abebech does not own an oxen (and women do not plough with oxen), she must contract her neighbour to plough her field. He is then entitled to 50 percent of the maize crop. Abebech has a few gomen plants and a few enset plants near the house. There appears to be nothing else to eat.

> Only two of Abebech’s children go to school. She does not have enough money to buy the uniforms, the exercise books, pens and pencils for the other children.

Some women interviewed have older children and send them to collect firewood or water but many of them still had to do these tasks during pregnancy. Only one woman (Makeda) said she was assisted by her husband with firewood collection during her pregnancy. This was because she had been told not to do heavy work during an ANC visit. But with water collection, there were always dozens of children on the road carrying plastic jerry cans to water points to collect water wherever I walked in Bonga. Fana was able to send the children to collect water if they were not at school (later she said only two or three of her children regularly attended school). The large clay earthenware pots that I remembered from my childhood were no longer used in Bonga to carry water: *Now they have the plastic gallon, they don’t have the big heavy pot* (Tigiste, Chiri) (Box 8). In fact I only saw a couple of these pots in people’s kitchens and I was told they were only used for making tella now.
Box 8: Tigiste: From clay pots to plastic containers

While we waited for Tigiste to come back from collecting firewood (she went an hour or so ago to the forest and came back with a bundle on her back shortly after we arrived), her husband (who suffered from severe arthritis and walked with a noticeable limp) was plaiting a beautiful rope made from enset fibres. During the interview Tigiste said women still chopped firewood and collected water on their backs even when they are pregnant. She said the big change in her lifetime has been the introduction of plastic containers and women don’t have to carry the big heavy clay pot.

For women who only had young children, activities such as collecting water or firewood were always problematical because it meant either taking the children with them or leaving them with a neighbour. For Makeda, this was an ongoing problem because her husband was not around and she had no close relatives nearby. Others such as Etenash and Yesharig could leave their child(ren) with a neighbour so they could collect water. The other activity that required negotiation about childcare was when a woman walked to the market. For some women who lived close by this was not such a problem but most women could not carry a child and their produce to or from the market. For Manjo women this was especially a problem as they had to carry huge bags of charcoal or stacks of firewood (see Section 4.4). I had noticed there were few small children or babies at the market although there were plenty of older children who were capable of walking. For the women from Sheyka, carrying loads to the market was also a considerable problem because it was a one to three hour walk part of which meant going down a slippery steep hill (Chapter 3) and crossing a small river to reach Kebele Three on the outskirts of Bonga before the walk to the centre of town to the market. I did see two of the women I interviewed from Sheyka on the road on market days because they walked past my house. Sara did not have any children with her and Addisalem was walking with two of her daughters. For the women in Deckia, the market was very close by, only five to 15 minutes to walk. Abaynesh walked from the far outskirts of Shapa to Bonga to the market which was an hour to 90 minutes walk downhill. She went once or twice a week and also went to Bonga Hospital for her Depo-Provera injection every three months.
Of all the reported tasks, enset processing is one of the heaviest performed by women as it is the most time consuming and tiring. Enset is processed around 45 times a year (by married women) and 28 times a year (by single female household heads) (Abiyu Million et al. 2002:12). Enset is a staple food in Kafa Zone especially in the form of kocho. Harvesting enset by uprooting the plant is the role of men. Women then begin processing the plant by removing the leaves and older leaf sheaths from the internal leaf sheaths (commonly up to two meters in length). The internal leaf sheaths are separated from the pseudostem down to the true stem, which is separated or stumped from the underground corm. The concave side of the leaf sheath is peeled and cut into pieces of about one meter length and split lengthwise in order to shorten the leaf sheath to a workable size. Then the leaf sheath is decorticated using a locally made bamboo or metal scraper while the leaf sheath is held on an incline (at 45 to 80 degrees from the ground) against a wooden plank. Sometimes decortication takes place with the woman sitting on enset leaves on the ground and using one leg to hold the leaf sheaths in place. After decortication and grating is completed, the leaf sheath pulp is spread on fresh enset leaves covering the ground and the grated corm is spread on the processed pulp. Some ethnic groups use a starter of already fermented kocho with various spices and herbs to aid fermentation. During the next 15 to 20 days the mixture is turned, mixed, rinsed and chopped until it begins to ferment. Now the mixture is called kocho. It is stored in pits of various sizes and depth lined with enset leaves for at least a month and even several years. Finally, the fermented pulp is taken from the pit, squeezed to remove excess water, chopped to shorten the fibres, kneaded into elastic dough, before being baked for about 15 minutes.

Six of the women interviewed worked at a Women's Promotion Centre organised by the Catholic Church. Yesharig worked at the Women’s Promotion Centre in Bonga a few minutes walk from her home. She made cards and calendars using dried banana and enset leaves and bark (see Box 9). Other activities for women in Bonga included sewing, mixing and packaging food products such as berberé and shiro. There is no regular income for the women as products are sold on an ad hoc basis to various charities and the cost of paper and other materials is deducted before payment.

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49 Description following Brandt et al (1997).
Box 9: Getting to know Yesharig

One of my first interviews was in Yesharig’s two roomed rented house, where she lived with her husband and two children. Azeb (my interpreter) and I walked there and I asked about all these houses so close to each other. There were five houses and three or four of them were rented out by the owner. Yesharig began by making roasting and pounding coffee and then calling over neighbouring women and children when it was ready. While she was making the coffee her young daughter pulled out a breast to suckle although her mother tried to discourage her. Later, during the interview little Meskerem would lay and breastfeed upside down across her mother’s lap with her legs on the wall, quite the little acrobat. Yesharig’s beautifully brown and creamy coloured chickens, quite different to anything I’d ever seen with fluffy cream crowns on their heads, came in to steal crumbs or bits of roasted corn from the floor. The sound of chickens clucking and roosters crowing provided a constant backdrop to all my recorded interviews with women. One hen went into the corner, sat down and laid an egg as we did the interview. Meskerem would shoo the hens away one minute and feed them the next. Around the corner there was another hen sitting on eight or nine eggs in an ingenious nest on top of a wooden pole a meter from the ground. She was the most magnificent of all the hens.

Over the coming months I became quite close to Yesharig and her family, particularly after they moved to another rented house just up the hill from me. I was visited by her son twice a day because I insisted on cleaning his boils with boiled water and disinfectant and then rewarding him with a banana or some bread or something else to eat. Before Yesharig moved I bought two chickens from her so I could have fresh eggs and to help her out financially. One of the hens was far too young but I wanted to fatten it up before it was ready to lay (and to help her out financially). A few days after our interview, Yesharig was washing clothes in a large bowl just outside the back door near her favourite hen’s nest. The hen flew down to have a drink and drowned when Yesharig was called away to one of the children. She was absolutely heartbroken but worse was to come as all the other chickens died mysteriously over the next few weeks. When I left Bonga I gave all my chickens back to their original owners with the exception of the rooster who had moved into another neighbour’s hen house. The rooster was given to Abebech’s family so they could celebrate the Ethiopian Millennium. I was grateful for the Millennium celebrations because it ‘took care’ of two huge visiting roosters who competed in crowing competitions and competed for the attention of my hens outside my back door (from my field notes June 2007).

Imabet, Itaynish, Hirut, Misraknesh and Tadelech all worked at the Women’s Promotion Centre in Wushwush where they make woollen products such as jumpers and baby layettes on knitting machines. The women travel to markets to sell their work and have some orders through the Catholic Church. All costs, including trips to Addis Ababa to buy wool, are factored into their business. The final products are of an extremely high
standard but the women had trouble selling them at a price high enough to make a profit. Although these women worked long hours at the Women’s Promotion Centres they were still required to perform all the other household tasks including meal preparation and making coffee at lunch time for their husbands.

4.2.2 The mother-daughter relationship

To be a good wife entails a lot of hard work. Although it is important for women to bear children, especially sons, to carry on their father’s name, the importance of having a daughter is also an important theme in the women’s lives because it is daughters who can buy a dress, plait their mother’s hair with butter or hair food (Vaseline), make coffee, clean the house for her mother and so on, all little things that show that they care and worry about you.

All the women interviewed had children with them during the day. For those women who had babies or toddlers, the child was breastfed on demand. Apart from the daily chores collecting water and firewood and helping out in the garden or the fields, older children helped make coffee, or were sent on errands to borrow a sini or buy one birr of shimberra (chick peas for roasting as a snack with coffee) at the local shop. Typically, girls spent a lot of time with their mothers and many of the women interviewed had been assisted in their last delivery by older daughters who still lived at home. Families with many children could only afford to send one or two children to school and even then, they did not expect their children to walk one or two hours each way in the rain to school so the children still helped their parents at home.

Abebech’s mother, Almaz, from Kebele Three told me she has lived through eight governments (I think she meant eight provincial governments in Kafa Zone). As a young girl she remembers when Ras Getachew came to Bonga by aeroplane and her father instructed them not to be frightened or go near the plane (possibly in the early 1950s). Almaz worked for the family making coffee and grinding maize, collecting firewood, cutting enset, grinding tef, and cleaning the house. Almaz never attended school but she has clear memories about the past. She said that back then everything was cheap and the farms were much bigger. Everyone had enough land. Now everything is expensive and the land is too small for one person. Some of the positive changes are that now there are
grinding mills so grinding doesn’t have to be done by hand. There is also electricity and telephones now: Thank God it is a good change but for me there is no change. I don’t have electricity but for other people I am happy. Another big change is that girls were not allowed to leave the house and go to the market and now they can.

Almaz lives in her son’s house, uses his furniture, looks after his cow and has no cash income. She had 12 pregnancies but only three of her children are alive. Her daughters are too poor to assist her and her son who is a teacher a long way away occasionally sends her 50 birr. I asked her how many children she thought Azeb (my interpreter and her granddaughter) should have. Laughing, she held up two fingers on her right hand and said one girl and one boy. Almaz still grieved for her daughter who died the previous year and commented that there was no one to help her out as her clothes were falling to pieces: Since Azeb’s mother has died who will give me a new dress? Almaz’s life is bound up with that of her two surviving daughters and numerous grandchildren who depend on her for guidance and stability because the future looks bleak for all of them with no regular income. A few weeks later I came to interview Abebech a second time. It was still the rainy season but a beautiful sunny day and we all sat outside drinking coffee. Half way through the interview, Almaz quickly urged the children into the maize growing behind the tukul. She had heard monkeys attacking the crop over the voices of the rest of us. No one else had noticed.

Amina was my next door neighbour in Kebele Three in Bonga. I knew she had significant health problems and she spent a lot of time just standing or sitting in the gateway watching the world go by, or sitting under a tree at the mini market across the field. Amina lived with her three grandsons, only one who had a regular income as he worked for a tailor in town. The second grandson was no longer going to school and spent time doing weight lifting in the front yard and early morning or late afternoon martial arts on the grassed open space between the houses, a primary school, the Catholic Church compound and the creek before Sheyka road started. Her youngest grandson was still in school.

I invited Amina over for coffee on a few occasions and I was quite sure she did not normally have coffee (she never spent any money at the mini market). She was always
keen to come and I was glad to be hospitable although we could not communicate well unless there was someone to interpret. One day, after I chased a wandering cow out of her front yard and invited her over for coffee, a couple of us related how well the middle grandson had played the role of someone who was ‘down and out’ in a graduation play at the Women’s Promotion Centre. But relating this story had an unexpected effect. She held back the tears and then gave in and wept as she told us how worried she was about her grandsons’ future. Since her daughter died she has become even more concerned for them because there is no one else to care for them. And this meant there was no one to care for her. From this conversation with Amina and the conversations I had with Almaz I felt that although women must bear sons to do the heavy work on the farm, it is daughters women grieved for the most. And daughters grieve for their mothers as Sara (in the next chapter) expresses how she had to give birth ‘alone’, without family support with her mother far away and no close friends or neighbours to call on.

4.2.3 Building good relationships with neighbours and the community

Building good relationships with neighbours and the community is a critical role for women (Abiyu Million et al. 2002:29). Although they are not expected to go to meetings at the church or kebele but are normally represented by their husband, women are expected to provide food and drink. Religion is taken for granted as an important aspect of everyday life for Ethiopians and the women interviewed were Ethiopian Orthodox, Roman Catholic or Protestant. In Kafa Zone, around 73 percent of people are Ethiopian Orthodox, 15 percent other Christian, 9 percent Muslim and three percent have other religions (traditional) (Habtamu Argaw 2002:39). Religion did not appear to influence the women’s behaviour around childbirth or health seeking behaviour but formed a backdrop to everyday life. In fact, a number of the women I interviewed and others I knew through observation who were Roman Catholic went to Bonga Hospital for Depo-Provera. Nevertheless, many women maintained close relationships with their neighbours who were of the same religion.

There is an expectation that women’s ability to work and perform all the tasks expected of a woman is synonymous with a broad understanding of women’s health: on the one hand, Ethiopian women define their health as a disease free state, and on the other, they emphasise that being healthy is a social obligation. It is not just that the unhealthy
woman is regarded as a failure; she is unable to perform the tasks expected of women (Yemane Berhane et al. 2001:1530). This definition relates to the cultural construction of health in Ethiopia which is defined in terms of an equilibrium: physiological, personal acts, harmony with fellow human beings and ritual propitiation of and magical control over supernatural forces (Vecchiato 1997:186). For married women, the prerequisites for good health relate to wealth and a harmonious relationship with her husband: “We say a woman is healthy when her house is full with everything. She is also said to be healthy when she is having peace with her husband.” (Yemane Berhane et al. 2001:1530)50. A common way to build relationships is by sharing in the coffee ceremony. Preparing coffee is an activity frequently performed by women, one that is central to Ethiopian culture and one that enables the building of good relationships with neighbours and the community. Many women referred to coffee preparation as ‘work’ because they were required to do it for their husband while he was at work in the field. But the coffee ceremony also gives women a time to sit, relax and gossip especially if the men are not around; it is impossible to separate the daily socialising from consumption (Pankhurst 1992:56). Unless you are well off, the coffee beans, having dried outside in the sun, must first be cracked from their black shell in the mortar. After the husk is separated, the green beans are washed and then roasted on the fire on a flat steel plate or on the clay mitad (griddle). The roasted coffee beans will be taken around the room so each person can wave the aroma towards themselves and so the smell of freshly roasting coffee can fill the air. The beans are then pounded in a wooden mortar and pestle, and the powder put into the jebena (clay coffee pot) with water for brewing. Fresh grass is often spread on the floor to bring the freshness and fragrance of nature and a few coals are put into an incense burner with a few pinches of etan (incense granules) to fill the air with heavily perfumed smoke. The sinis (tiny cups) are rinsed and put onto the wooden stand. Sometimes butter or salt is added (or sugar for fersiis), and over the next hour or so each person is served three cups of coffee. Each serving has a name, the first abol, the second huletegna, and the third bereka (blessing). Bread, popcorn, roasted barley or chickpeas, or boiled or roasted maize in season are served with the coffee.

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50 In a quantitative study of 675 women and qualitative study of 20 women from the Butajira Rural Health Program in rural south central Ethiopia in 1988 (Yemane Berhane et al. 2001:1528), 23.4 percent of women reported heavy workloads (2001:1532) and 32.0 percent of them felt that their heavy workload had adversely affected their health (2001:1533). Women they dealt with heavy workloads by working in social groups (74.5 percent) or by hiring assistance during intensive work times (25.5 percent) (2001:1533).
Many of my interviews began with coffee. Often neighbouring women would be called over or I would be invited to a neighbour’s house where the woman was drinking coffee before we started (Box 10). It was a good way to start chatting about everyday life and to find out a little about the women and her responsibilities. Yet despite living and working in Kafa Zone, the birthplace of coffee, many women were unable to offer me coffee because it was out of season and they were too poor to buy any. This was a cause of embarrassment for many of the women. For this reason, I would bring coffee to the interviews as a gift which was greatly appreciated. A typical response was, ‘How did she know how much I like coffee?’

**Box 10: Almaz: Coffee and interviews**

It began to rain heavily when I arrived to visit Almaz this morning. She was so embarrassed that she could not offer me coffee but I had some in my bag and gave it to her. We ran to the dilapidated small kitchen out the back which was shared with a new calf. There was no firewood either but Almaz pulled a few sticks out of the walls so we could boil the water. Azeb roasted and pounded the coffee and eventually, after the coffee had brewed and the rain had stopped, we went to the house where I was also offered freshly made cheese. Abebech and five of her seven children came over to share coffee but none of the grandchildren were given any cheese. I had been to the bakery before I left home and gave all the children bread rolls. Even the twins (aged two) were given a few sips of coffee and then one of them threw a tantrum until he was given his own sini of coffee. Of the twins, this one regularly threw terrible tantrums and sulked every time I visited and he still demanded to be breastfed regularly. I noted he was considerably fatter than his sibling (from my field notes August 2007).

**4.3 Women and decision making**

The land tenure system in southern Ethiopia is characterised by patrilineal inheritance and virilocal residence. This means that at marriage young girls generally move to the home of their new husband and do not inherit land from their parents (Holden and Tewodros Tefera 2008:12). Although marriage is now supposed to be voluntary by law, traditionally, the family and the clan generally decide whom a girl will marry and, in locations where it is important, the value of bride prices and dowry. On marriage, the husband is considered the head of the household. He is in charge of most farming activities and makes most of the decisions. Females are only the head of households if
they have no husband. Federal and regional land reform has strengthened inheritance rights within families giving equal rights to inheritance for sons and daughters. The new laws imply that husbands and wives should share land equally on divorce and ‘the wife and children should take over the land if the husband/ father dies’ (2008:11). Holden and Tewodros Tefera argue that while recent land reform allowing joint titles to husbands and wives is an important step in the right direction, strengthening women’s rights is clearly in conflict with the traditional role of women and ‘is likely to meet resistance’ (Holden and Tewodros Tefera 2008:13). The land reform has increased perceptions of tenure security for women and men, especially women’s perceptions that they would keep land after the divorce or death of their husband. However, the proclamation in 2007 that land held before marriage was not lost because of the marriage, may cause some married women of the next generation to become landless in the case of divorce or death of the husband. Women may be able to stay with their inlaws or return to their blood relatives but not be able to keep any land if they do not have their name on the land certificate of their husband. Thus, the recent changes in land reform are likely to favour men given the current marriage and residence system. However, the study emphasised that since the land reform, some women have become involved in decision making with their husbands regarding land investment and expenditure but changes in women’s independent decision making over their own income and involvement in non-farm activities was not significant.

In many countries including Ethiopia, women do not decide to seek biomedical health care on their own, nor would they have money to pay for their treatment. This decision is made by their husband or other senior members of their family including the mother and mother-in-law, often after traditional means in the village have been tried first (Thaddeus and Maine 1994; Kloos et al. 1987; Endale Workalemahu 2003; Mirgissa Kaba 2000; Yemane Berhane et al. 2001; MOH 2006b:29). The influence of a husband’s disapproval for prenatal care has been shown to be a strong barrier to women’s health seeking behaviour in south-west Ethiopia (Belay T. Biratu and Lindstrom 2006). The decision making process for the husband is dependent on a number of factors including availability of money or assets that can be sold, rented or used for getting a loan and the
willingness of people to lend money. Sometimes, the community or the iddir is mobilised to help with financial costs and human power to carry the woman to the health facility (Endale Workalemahu 2003:20). If there is no iddir, the husband relies on relatives and neighbours.

Abiyu Million et al. (2002) reported that decision making in Kafa Zone about income generating activities, use of crops, livestock and livestock products, schooling of children and FP was claimed to be a joint venture although women never make a decision on their own (2002:23). The consequences of taking some grain from the store without permission, for example, was reason enough for punishment, or even divorce or abandonment. Women’s decision making is limited to the sale or exchange of kocho, livestock products such as butter and cheese, poultry and partly in vegetables and root crops (2002:24). Control over more valuable resources such as land, cattle, oxen, freight animals, cereals, legumes and coffee belongs to men (Abiyu Million et al. 2002:34-5; Holden and Tewodros Tefera 2008:6, 55). The exclusion from important decision making extends to public life in many communities where men represent women (Mirgissa Kaba 2000:24, 39, 50). Women can advise, suggest and argue with their husbands at a household level about how to make life easier but they are not part of decision making in public. Women find out about public decision making through their husbands; if they are present at public events they do not participate in the presence of men. Women’s contribution at public events is to contribute to collaborative agricultural tasks, marriage and funeral events by preparing food and drink (2000:54).

A number of other studies in Ethiopia determined that women were often not involved in decisions about their own health (CSA and ORC Macro 2006:239; Holden and Tewodros Tefera 2008:56). Yemane Berhane et al. (2001) reported that the overwhelming majority (89.3 percent) of women from Butajira required permission from their husband to visit a health facility. This decision was generally made after traditional methods had been tried (2001:1534). In my interviews all the women and health practitioners confirmed that the husband was the decision maker about whether a woman would be taken to biomedical health care. The point here is that this universal view included untrained and TTBA’s, HEWs, nurses, midwives, health officers, doctors

51 The traditional association where people get together to support each other in case of funerals and other emergency situations is mobilised to help carry the woman to a health facility.
and senior administrative staff. Although a number of the women interviewed reported
that their husband attended them during birth, some health practitioners told me the
husband would only be called if there was a problem that the mother, mother-in-law or
neighbour could not deal with. So during the earlier stages of birth there would usually
only be one, two or possibly three people assisting. But if there was a problem there
would be a discussion with the husband about what to do. Sometimes the husband
would go to community leaders or to the elders or ‘magic’ people (witchdoctors) for
advice. Other times, it was clear that when there was deemed to be a problem and a
health practitioner was called there, the house could be full of people trying to work out
what to do. Kloos et al. (1987) reported that patterns of normative health behaviour in
Ethiopia are characterised by a

wait-and-see attitude in the case of most mild and transitory illnesses’ and ‘the tendency of
many people to delay the trip to modern health services until all other health resources
(traditional and transitional) have been explored and disease is exacerbated or has reached a

In the next chapter, I suggest that this wait-and-see attitude includes prolonged labour
which is somewhat ‘normalised’ and results in considerable delays to seeking biomedical
assistance.

Several of the health personnel elaborated on the decision making process and how it
could affect women during ANC or birth. In this excerpt, Dr Befekadu who works at
Bonga Hospital said: I think that is a social, when I say social, I mean that the decisive
person for the woman is her husband, particularly for the person who is pregnant. The
husband should agree with the female so that she will be having ANC and whatever care,
whether in the hospital or the nearby health centre. So if they go to the health centre and
they have delivered, even the husband should have to find some sort of money, so that
the mother should be transported to the nearby hospital. What I have seen from the
community is because of economical, social factors as well as a lack of knowledge or
awareness of the cause of the delivery may cause, they don’t have such knowledge.

We don’t have much maternal death in our hospital, probably three or four in the last
year during labour. These are mothers referred to Jimma. I know one mother referred to
Jimma and the husband said he has no money. It was at midnight and I tried to contact
all possible with transportation. At that time, we have no form of transportation; even this ambulance is not working. At that time the husband said he hasn’t any money at all. Then the mother stayed in the hospital for a day and she expired. Actually, she was referred from the woredas and she had obstructed labour. But after the death of the mother we found that the husband has more than 700 birr in his pocket ... many people, they have money in their pocket but they don’t want to pay for their wives. This is another challenge in our hospital. That’s what I told you, who decides, it’s the husband. So if the woman is referred from the health centre and the husband was not willing, then, this is another [delay].

Two other examples serve to show how women have little power to make decisions around fertility and pregnancy. During one interview with a health practitioner (Sr Aster), I was told how women come on market days to the hospital for Depo-Provera injections. They carry their foodstuffs to sell and tell their husbands they are going to the market. But on the way to the market they seek urgent attention at the hospital so their husband won’t find out. I wondered if this ploy worked given that everyone could see everyone else going to the card room and waiting outside on the benches for treatment. Off the covered verandah there were specific rooms for FP, ANC, outpatients—everyone knew which room was which.

Sr. Aster: For them, that [five pregnancies] is a small number, but for us it is many, they don’t accept this. Also, her husband does not accept, he doesn’t understand his wife’s problem simply without her need she can’t give birth, that’s a big problem. They bring some ideas on marketing, I have to go to market, and they bring something and they don’t tell their husband. Some clever ladies, they do some type of thing and during the market they bring their material and they put here and say, ‘I have to get help at this moment please, I can’t come tomorrow, if I have some problem because my husband can send me she said’.

Sr. Aster would tell the women: We can help at any time.

A further example of how the husband being the decision maker affects his wife occurred when I was observing an ANC one morning at Deckia Clinic. A pregnant
woman came in accompanied by her husband. It is most likely she had a urinary tract infection and she was in extreme discomfort and could hardly walk. Her husband was extremely argumentative and did all the talking. He refused to pay the eight birr for treatment but he demanded that the nurse massage his wife’s stomach ‘to take away the pain’. The nurse refused and they left without treatment.

4.4 Marginalisation and Manjo women

The common experience of all the women interviewed is that they live in Kafa Zone and have given birth. While there appears to be no real differentiation based on social characteristics such as religion, education or employment, some of the women belong to minority groups of craftworkers and hunters who are excluded from mainstream society throughout Ethiopia. The largest minority group and the most marginalised in Kafa Zone and surrounding areas are the Manjo who account for five to 10 percent of the population. The Manjo were formerly hunters with their subsistence derived from wild animals such as Colobus monkeys, baboons, antelopes, porcupine and wild pig. In addition to hunting, they traded firewood for enset and cereal crops. The Manjo were also expert bee keepers and tree climbers, first making the hives from clay, straw, bamboo, enset leaves, bark, dung and wood, and then hanging them up to 40 metres from the ground in trees in the forest (Hartmann 2004:1): Some Manjo women make pots but their main source of income is supplying most of the firewood and charcoal for town use. In Shapa, a hilltop one hour south of Bonga, most Manjo make money from carrying firewood and charcoal to town (Gezahegn Petros 2003:91). Peripheral People: the Excluded Minorities of Ethiopia illustrates how minority groups are spatially segregated, economically disadvantaged, politically disempowered, socially excluded and culturally subordinated (Pankhurst 2003:2): interaction between the dominant Ethiopian society and its minorities has resulted in a necessary but ‘complex reality of simultaneous integration within the very fabric of society’ (2003:23). The segregation and non-reciprocal relations (2003:6) that characterises the social dimension in Kafa Zone is still evident in people’s minds as a number of people I interviewed told me that until recently people would never enter the house or eat with the Manjo. The Manjo are not welcome at social events and if they attend they must sit on the ground or attend as musicians, grave-diggers or as specialists in purification rituals. They may be served inferior food

52 Other minorities are smiths who are now only partly marginalised, and the Mana who work as tanner potters in Kafa and Shekacho, and as potters in Dawro (Freeman and Pankhurst 2003:70).
on leaves, broken pottery or even on their hands. While they might eat the food of their hosts, farmers would never eat food prepared by the marginalised. In bars where farmers drink, if the marginalised are permitted entry they must use different glasses. The marginalised are also buried separately and cannot marry members of the dominant society. The cultural dimension is conveyed through the negative stereotyping, polluting work and mythological justification of the low status of minorities (2003:7). Common themes of stereotyping are that people are portrayed as lazy, cowards, anti-social, lacking in morality and so on. They are considered wasteful and thoughtless about their future; they have a reputation for drunkenness, singing and dancing in the marketplace; and to have temporary small and shabby houses. The submissiveness and oppression of the Manjo is so strong that one informant told a researcher that they greet the Kafficho with a phrase, ‘Showock Mopock qebbon!’ which literally means, ‘Let me lie flat on the ground for you!’ (Gezahegn Petros 2003:94). Prior to the 1974 revolution, Manjo were landless and moved from one area to another. Since then, the Manjo have been given land often on the edges of villages close to forests or on poor land on slopes or in ravines. They have been able to grow a few enset plants around their homes and cultivate cereal crops on a small scale (Gezahegn Petros 2003:80-91). Places where the Manjo live are often characterised as poor land with steep slopes or in ravines, providing a ‘buffer zone’ between the forest and cultivated areas prone to attack from wild animals. In symbolic terms the Manjo are said to mediate between nature and culture’ (Pankhurst 1999:497).

For these reasons I deliberately sought out Manjo women to interview because of the important roles they play in society providing products essential for rural livelihood and the need to continue economic, social and cultural exchanges which generates structured interaction between social groups. I interviewed five Manjo women in the course of my research (out of the total of 24 women): Bethlehem (Kebele Three, Bonga), Tigiste (Chiri), Misrak (Sheyka), Zena (Sheyka) and Abaynesh (Shapa) (see Table 5). The Manjo were also the target population of two projects run by NGOs in Kafa Zone which is described (Chapter 6). Four of the women I interviewed lived on land on the edges of villages close to forests. The one exception was Bethlehem who lived in Kebele Three with her husband who was also Manjo and had an administrative job in Bonga. I did not interview her at home but at work (she was employed by an NGO) so I did not see where she lived. Tigiste lived in a rather rundown tukul with her husband on the
outskirts of Chiri. Both Misrak and Zena lived very close to the forest in Sheyka. However I noted that many of their closest neighbours were not Manjo as they lived quite close to Addisalem. Misrak and her husband had only recently moved to Sheyka and their house was in the very early stages of construction. They were sleeping in a nearby tukul and had a temporary shelter to use during the day. As a very young mother, Misrak did not carry charcoal to Bonga but her husband was making charcoal on the day of the interview. Zena lived close by with her husband and two young children. She told me she used to carry charcoal to Bonga and had even done it while she was pregnant but she said she had stopped carrying charcoal now. They had very little land under cultivation, no enset growing, certainly not enough land to provide enough food and I wondered how they survived as there appeared to be no food in the house. They also had no bed but slept on mats on the floor. I had the feeling that the Manjo women and their families (with the exception of Bethlehem) were struggling financially even more than the other women I interviewed.

Throughout my stay in Bonga I regularly observed men and women, some even with their young daughters, carrying heavy loads of charcoal and firewood past my house. Because I lived on the main route to Sheyka I knew that everyone coming from there had to come down one of the various routes down a very steep hill, cross a river and later a stream before the 30 minute walk into town. There was no firewood or charcoal for sale at the market as Manjo people are not allowed to sell charcoal and firewood as their goods are seen as polluting (Hartmann 2004:10). For this reason people walked door to door. I cooked with charcoal or firewood like the people around me and the new bags of charcoal were so heavy I could not even lift them off the ground. Of course, many of my neighbours could not afford a full bag of charcoal and only bought small amounts in a plastic shopping bag.

In September 2007 shortly after the Ethiopian Millennium, I interviewed the head of the Administrative Office of the local branch of the Ethiopian political party. I was referred to this person by a person who worked for one of the NGOs in Bonga because I mentioned I was interested in interviewing some people who are Manjo. Pankhurst (2003) points out that minorities were excluded from political organisation in the past but more recently they have been allowed to participate but not to obtain leadership.
positions (2003:5) so this person was an exception to this. During the interview we spoke about the interaction of Manjo women at health centres because I had been told that historically the Manjo are served last. I was told that this was a problem with the previous governments, during the time of Haile Selassie and the Dergue. Back in those times, Manjo could not use transport or get any health services, go to school or live in towns: they could not use any services at all. I was told that now it is not like this, there is freedom with the current government and everyone is entitled to go to school. He went on to say that if the government continues in this way, the problems for the Manjo will be solved. I asked if things were different in the rural areas compared to Bonga town and was told that there were still problems in the rural areas.

Many people including Manjo were able to tell me about the government and NGOs efforts to tackle the effects of marginalisation in recent times. Nevertheless, I wondered how much stigmatisation of the Manjo continues to be taken for granted and considered ‘natural’ despite reassurances that the Manjo are being treated differently now. Until recently, the Manjo could not own land and were excluded from agriculture which forced them into non-sustainable practices of hunting and fuelwood gathering for cash. These practices perpetuated their marginalisation. They were also segregated at social events so it can be inferred it was ‘natural’ to exclude them from attending health services at least at the same time as the majority population. People stated that now things are different in Bonga than in the rural areas, but in reality I felt that there was still a great deal of inconsistency in what people told me and how people were treated. The most obvious example of this was the sale of firewood and charcoal which could not be sold at the marketplace. One NGO in Bonga employed a Manjo woman to serve tea and coffee. I was told this would serve as a good example to the rest of the community, to be able to work in close proximity with someone who is Manjo. I was able to interview this woman and when I asked about the differences between past and the present she said: In different woredas they are isolated of course, they [the Manjo] are made to delay, and they do not give medicine on time. Now I am in Bonga, there is no problem, when I was in the rural area there is a problem. Indeed, when we go to the hospital they did not treat us immediately (they call our name but hold us up for a long time). Box 11 describes my interview with another Manjo woman I called Abaynesh.
Box 11: Interviewing Abaynesh

My final interview in Ethiopia was with a Manjo woman called Abaynesh and her family on the outskirts of Shapa. They lived about 50 metres from the 'main' road, and their tukul was surrounded by enset and numerous edible plants and spices, so much so that we had to duck and weave through it all to find them. Tariku, my interpreter that day, and I arrived mid-afternoon and made our way down a pathway to a small tukul. Spread out and drying in the sun were piles of coffee beans, *corrororima* (false cardamom, *Aframomum corrorima*) and *timiz* (wild pepper, *Piper capense*). Children appeared from everywhere, the boys from their play with a pile of newborn puppies and the girls from behind the hut where they were plaiting each other's hair. After Tariku explained why we were there and Abaynesh agreed to be interviewed, her husband went and brought a wooden bench from the house for us to sit on. He then returned with a small padlocked bag which he struggled and fumbled nervously to open. Inside he found a small card which had the date for his wife's next appointment at Bonga Hospital. After 12 pregnancies they had decided not to have any more children. Abaynesh walks to Bonga Hospital every three months for the Depo-Provera injection rather than go to the much closer Shapa Health Post because she did not have to pay for the syringe at the hospital, only for the Depo-Provera. But because everyone in the family was illiterate, they did not know how many days were left before the appointment (there were 15 days left).

We sat outside in the sun; Abaynesh was sitting next to me practically on top of the *timiz*. The lime pepper smell was overpowering making her sneeze and cough but I loved the zesty smell. The combination of the sun and the pepper made Abaynesh's face run with sweat and her husband went inside and found her an old umbrella. Behind us was the eldest son's honeymoon hut; he was recently married to one of the girls who was also having her hair done. She was so young I had presumed she was one of the family. None of Abaynesh's 10 children attend school now although some of them have gone in the past.

When I asked how Manjo people are treated at the hospital or health centre I was told they were not isolated or treated differently now. Abaynesh's husband said: There has been debate about this issue at the kebele level (about the Manjo being treated differently) but now, since the current party, we have been equally treated.

At the end of the interview when we were getting ready to leave, we talked a little about the four year old girl's condition (scabies) and also suggested to Abaynesh that she should buy some *chow duket* (iodised or 'powdered' salt) to add to her coffee as both Tariku and I had noticed she had a goitre. When I gave Abaynesh and her husband some coffee as a small gift, they were genuinely surprised and overwhelmed that I would want to give them something. When I asked if I could take their photograph, their happiness was palpable. A final note: just a couple of minutes before we had finished the interview, my voice recorder ran out of recording time because it was full. It seemed a fitting ending to my interviewing in Ethiopia, meeting this lovely family. It felt like I was leaving friends even though we had only met.
4.5 Walking

Whether caring for their children, tending the garden or preparing food, collecting water or firewood or going to the market to sell or buy food; all activities are oriented to the household unit. The link between all these activities is the woman. And the action linking women to these activities is walking. Whether it is a few minutes to collect and carry water or further to the forest for fuelwood, to visit neighbours or relatives nearby, to attend church close by or the far-off market, women must walk. Another reason for women to walk is to go to a health post, health centre or hospital for ANC or for Depo-Provera injections.

Based on my observations with women in their homes and while walking with or passing women on the road and visiting health facilities, it was common to see women walking together on the road, whether they were Manjo women carrying charcoal or firewood, older women walking together on their Saints’ day to the Orthodox Church on the hilltop with their crosses, or women carrying baskets of food to a neighbour who had had a baby or lost a relative through death, or going to the market on Tuesday or Saturday. Wherever women walked, they mostly walked together. And wherever women walked they talked. Almaz, Abebech’s mother, told me that in the past, girls were not allowed to leave the house and go to the market, boys went but not girls. Now everyone can go out. In recent research in two woredas in Oromyia and SNNPR\textsuperscript{53}, a household survey of 600 households, found that on average, 41.9 percent of women are permitted to go to the market place alone (Holden and Tewodros Tefera 2008:55). My observation in Kafa Zone was that it was common to see women walking but still uncommon to see them walking on their own (Box 12).

Women walk to take produce from the farm to home, from home to the market and the mill, and from the market and the mill back home. For transportation to the market, one study on the economic contribution of women in Kafa Zone (Abiyu Million et al. 2002) found that 74 percent of men use freight animals and 61 percent of women carry products by head or back. Only 18.5 percent of women shared in the use of animals (2002:23). Going to the market is now an almost universal activity as 100 percent of

\textsuperscript{53} From Shashemane Arsi, Negele, Wondo Emabet and Wolla’ita.
wives, 98 percent of men and 92 percent of single female heads of households go on average once a week. Of those single female heads of households who did not go, the reason given was that they were too poor and had nothing to sell (2002:22). I regularly saw women walk long distances carrying heavy loads of charcoal, firewood, large bundles of gomen and maize on the head or back ‘in order to obtain some cash money, even when the profit in fact is minimal’ (2002:23). Many of the women I interviewed walked a minimum of one to two hours each way in mountainous terrain to go to the local market once or twice a week. But going to the market is not just about obtaining cash money. Women welcome the opportunity to get out of the house and socialise with other women; to talk on the way and at the market. Stopping at a favourite tej (wine made from honey and the local gesho plant) or tella (mild alcohlic drink made from maize or barley) bet on the way home is a social occasion as women gather together to gossip and catch up with all the news with friends and neighbours before the long walk home.

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54 Tēj, tella and arēk’e making is mostly handled by women with some minor assistance from other household members for collecting firewood and chopping gesho (a green plant essential for the preparation of tej and tella). For example, tella is prepared regularly for household consumption and social occasions by many wives (36 percent) and single females (32 percent) (Abiyu Million et al. 2002:12). Habtamu Argaw’s (2002) community based study found that the occupation for 1.4 percent of household heads was as tella sellers (2002:13). Bet means house. Tēj or tella bets are generally in the front room of the house. Outside the house on the edge of the roadway will be a pole with a bunch of a trumpet like flowers attached on the top to indicate a tella bet. A broken piece of an old metad (earthenware oven used for cooking injera (flat pancake like bread) on the fire) indicates where food is served. Bet is also used to indicate bunna (coffee) bet, tanhert (school) bet, shint (toilet) bet and so on.
Scores of people walked past my house to town on market days. Occasionally there were men with horses or mules carrying loads, but mostly women walked past carrying home made baskets full of maize and perhaps a knob or two of butter wrapped in enset leaves and tucked in the top of the basket, large bundles of gomen or kocho, and often a rooster tucked in under one arm. They had walked long distances from way past Sheyka, crossed the stream near my house, and come up the hill to rest under the shade of a huge tree. A ‘mini satellite’ market operated here because the women were keen to sell their produce so they did not have to carry it all into town. And it meant we did not have to walk all the way to town. If you were not in a hurry, you could sit in the shade and wait for an hour or two for what you wanted; fresh maize for the afternoon coffee, a few avocados or bananas. I enjoyed this ‘mini’ market much more than the main market because I could sit with my neighbours and watch the world go by without being harassed.

I noticed on market days or at the corner store near my house that most people would only buy one birr of shirro or meser (small lentils used to make a sauce with onions and berberé). Many people would carry empty bottles, often beer bottles with natural fibre tied around the neck, to the shop to buy one birr of palm oil (about two tablespoons). They simply did not spend more than a birr or two at a time. At the shop there would also be long discussions over the quality, smell and price of various bars of soap. At the market people bargained and bartered over everything from carrots to chickens to coffee. I realised that poverty meant you expended more energy to walk to the market or the shop more often so you could purchase something that cost one or two birr because that was all you could afford.

### 4.6 Discussion

In this chapter I singled out and described some of the visibly similar characteristics in the daily lives of the interviewed women. Despite differences in location in Kafa Zone (semi-urban or rural) and aspects of life that are multifaceted and distinctive for each woman, common characteristics stand out and structured how women could live their lives. It is taken for granted that the work women do in and around the house is ‘women’s work’ and differs from ‘men’s work’. Another way to think about this gender-specificity is to consider female-headed households. Abebech had to negotiate with a
male neighbour about sharecropping as women cannot plough the fields and sow grain. Over the course of my fieldwork I met two women who sold tej or tella in the front rooms of their homes. This was a common way for female-headed households to earn money, especially on market days when many passers by would drop in on the way home. While some tasks such as weeding the fields and going to the market are not done every day, other chores such as collecting water, preparing food and making coffee are done daily. At times women can send older children to collect water. For Abebech, this was when there had not been recent rain and the river was not flowing too fast. Fana sent the children when they were not at school. Makeda often had to take her children with her to collect water, but Etenash and Yesharig could leave the children with a neighbour while they collected water. It is obvious that women have to spend time negotiating about work as well as doing the work itself. Some of this negotiating would be done at home with family members or with neighbours most likely during the coffee ceremony. The women who worked at the Women’s Promotion Centre in Bonga or Wushwush did not work in the fields but they were still expected to perform all the household tasks including meal preparation and making coffee for their husbands at lunch time.

When the women say they eat what they have (see each woman’s profile in Table 5), it is taken for granted that they are responsible for everything related to cooking, household processing of food for consumption, fetching water and firewood, grinding and pounding grain in the house, household sanitation, looking after children and the elderly and taking care of the livestock around the house while they are pregnant (Mirgissa Kaba 2000:21; see also Pankhurst 1992: ch 5; Poluha 1988, 2002b). From my observation, the enset based diet in Kafa Zone may provide calories but women rarely eat protein and do not have access to a wide range of fruit and vegetables. Many of the women like Meseret from Agaro Bushi were very short and had preexisting conditions. Abaynesh (Shapa) had developed a medium-sized goitre. Prior to and during pregnancy, a woman’s nutritional status and the existence of infections and parasitic disease or other chronic conditions may influence her chances of developing and surviving a complication during the birth (McCarthy and Maine 1992:26; Gill et al. 2007:1350).

55 Goitre is caused by iodine deficiency although it can also be caused by a high consumption of certain foods that neutralise iodine, such as cabbage. In Ethiopia people eat large volumes of gomen (Brassica carinata A. Braun (Brassicaceae)) and tikur gomen cabbage.
Much of the work performed by women is heavy, with enset processing being the most time consuming and tiring. Some Manjo women have the additional task of carrying huge bags of charcoal or stacks of firewood to the closest village or town for sale while other women carry large bags or bundles of grain or vegetables to or from the market. A woman's multiple responsibilities in and around the house extends to caring for the elderly, the sick in her own household and her neighbour's household. When a woman is menstruating or towards the end of a pregnancy she should not do heavy tasks for a period of one week to a month after the birth. During this time she is assisted by a neighbour and/or daughter. In reality, many of the women interviewed stated they were still responsible for household tasks and had little assistance from others throughout their pregnancies.

Building good relationships is defined as a critical role for women as interactions with their mother or mother-in-law, neighbours and the local community is essential. The focus of these relationships is the coffee ceremony which is also a time for women to relax a little and enjoy each others' company. The importance of good relationships becomes evident in the next chapter as most women give birth at home (Chapter 5). If something goes wrong during birth, then relatives and neighbours will be asked to lend money, to help make a stretcher and to carry a woman to the nearest health facility.

The next section of this chapter considered the action of walking as it is the walking woman who links all the activities between the home, the field, water and firewood collection, visiting neighbours, going to church and going to the market. It should be emphasised that until quite recently women did not venture out; some women still require their husband's permission to do so and it is still rare to see a woman walking on her own. Yet women often initiate changes in their daily routine. Makeda was forced to walk on her own to take food to her husband. The women who walked to work at the Women's Promotion Centres had initiated changes in their daily routine as they entered the world of (sporadic) paid employment. Most women welcome the opportunity to go to the market as it gives them an opportunity to get out of the house and socialise with other women. And some women also walk to a health facility for ANC or Depo-Provera injections, even without their husband’s permission (Section 4.3).
The traditional position of women in southern Ethiopia is lower than men both within the household and in society (Holden and Tewodros Tefera 2008). As stated earlier, the role of women has generally been confined to childcare, food preparation household chores and assistance with some farming activities. As men are the head of the household, they make most major decisions concerning agricultural production, the sale of crops, livestock, and livestock products and schooling of the children. They are involved with decision making about whether or not a woman can access family planning. In this study, the women and health practitioners confirmed that the husband was the decision maker about whether a woman would be taken to biomedical health care. This decision is dependent on other factors including the availability of money or assets that can be sold, rented or used for getting a loan and the willingness of people to lend money. Sometimes, the community or the iddir is mobilised to help with financial costs and the wider community is always involved if a decision is made to carry the woman to the health facility.

As stated in Chapter 1, feminist critiques of WID emphasised that women in developing countries were portrayed as being ‘ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized’ (Mohanty 1997 [1991]:80). While it is impossible to ignore the key ways in which the women and each woman’s experiences have been constituted in their rural environment, much of the research around maternal health in developing countries still aligns women within categories of rural and uneducated. In Chapter 3 I used the metaphor of the map as a way to represent finding the field sites where people live and work. A simple cultural ‘map56 of the people of Kafa Zone would need to describe the language, knowledge of the past and the present, social activities and personal experiences that help orient people in everyday life. This chapter provided an introduction to the women who took part in this study and provides a description of some of the daily activities of people in Kafa Zone. Each woman I interviewed was a mother who had had to contend with everyday life in a rural or semi-urban setting; to deal with the difficulties in life: the death of a child; abandonment by a husband; unalleviated poverty; marginalisation. There are the daily interactions with their children, husband, extended family members and neighbours. There is constant change

56 I do not want to get bogged down here with the various interpretations of culture in anthropology: ‘anthropologists are trying to capture what is shared, the code of shared “rules” and common meanings’ (Keesing and Strathern 1998:20) or ‘shared experiences and interpretations’ (Poluha 2004:18).
throughout their lives as women leave home to be married and start having children. Each year more girls go to school and more women utilise health services such as ANC and FP (Chapter 6). Nowadays, most women are aware of the possibility of biomedical health care at the health posts, health centres and hospital. This implies that there is likely to be increasing tension in the future between the traditional role of women as mothers and their desire to access these services.

The importance of women as mothers is emphasised ‘because maternal health most directly affects a woman’s health and survival and that of her newborn child’ (Gill et al. 2007:1347). Gill et al. (2007) argue that women not only have the potential to deliver children but also to deliver ‘broader development’. For this reason, childbearing plays a key part in the lives of women in developing countries and ‘maternal health probably has an important effect on their ability to fulfil this potential’ (2007:1347). In the following chapter, Chapter 5, I focus on birth and the contrasting definitions between ‘normal’ and ‘abnormal’ birth and the involvement of health workers including TBAs, HEWs and other nurses, doctors and midwives during birth who work in health posts, health centres and the hospital. As there has been no tradition of using professionally trained birth attendants, these health workers only tend to see ‘abnormal’ birth in a health facility.
Chapter 5: Birth

Childbirth is a process personal, collective, physical, symbolic, significant in countless ways. It is also a sometimes precarious deliverer of life and death (Lukere 2002:201).

This chapter explores taken for granted assumptions in the literature about the ‘overwhelming trend of community-based childbirth [that] reflects the perceived naturalness and normality of the process’ (MOH 2006b:26 emphasis added). What is a natural birth? What is a normal birth? At first these rhetorical questions are easily answered with the reply that natural and normal childbirth is what medicalised childbirth is not. The tendency to dichotomise birth is explored by Jolly (1998; 2002a; 2002b), Rice (2000:83), Lukere (2002), Afsana and Rashid (2009:124) and others who draw attention to the binary oppositions of ‘traditional’ and ‘modern’ birth in relation to birthing postures and practices, the site of birth, birth attendants, ‘safe’ and ‘unsafe’ motherhood. First, when ‘traditional’ and ‘modern’ are reinscribed in relation to birthing postures and practices (Jolly 2002a:8), distinctions are commonly made about the posture of the birthing mother who gives birth in ‘active’ or ‘passive’ positions: women giving birth at home or in traditional settings use a range of positions such as squatting, kneeling forward, or gripping a pole or rope behind or above. In comparison, hospital births use the supine position where the woman lies with her legs in stirrups as the ‘most convenient posture for obstetric surveillance and intervention’ (2002a:9).

The second difference between ‘natural’ and ‘traditional,’ and ‘medical’ and ‘modern’ birthing is imagined in the location where the birth takes place. Most births in the village are home births as they happen in the home of the birthing mother compared to medical or modern births that take place in the hospital (2002a:12). Third, distinctions are made on the basis of who attends the mother. In the village, women are mostly assisted by other women such as close relatives or women who are either specialist midwives or healers compared to those who have had some medical training (2002a:15). Finally, motherhood is depicted as ‘unsafe’ or ‘safe’ in the discursive frames of FP or other risk factors such as HIV/AIDS, especially for women who are perceived to have high risk factors if they conceive too young, have unsafe abortion or too many children thus contributing to overpopulation (Lukere 2002:189-90). Some practices such as traditional massage are said to cause intracranial haemorrhage in the unborn child and are viewed as unsafe. Yet other traditional practices such as providing social and cultural comfort
before, during and after birth are valued: from the biomedical point of view, some traditions are now discouraged while others are positively encouraged (2002:200).

The tendency to dichotomise birth is deeply problematic for scholars analysing transformation in birthing in comparative cross-cultural contexts because ‘modern’ birthing highlights the differences of ‘then and now’ (Jolly 1998:17) or ‘before’ and ‘after’ and is entangled with differences between the indigenous and the foreign (2002a:2). This difference in contrastive language puts emphasis on natural or ‘organic’ and interventionist or ‘technocratic’ models of birth particularly where ‘modern’ birthing was promoted during colonisation or during later projects of development when ‘programs address practical questions of infant and maternal survival in developing countries’ (2002a:2). Likewise, there is a tension between the ‘dark’ pictures of mothering that emerges from the epidemiological languages of demography and development, and a ‘lighter’ picture of ethnography that values ‘tradition’. Jolly (2002b:148-177) describes the accounts in missionary and medical journals where mothering is seen as dark and forbidding with descriptions of barbaric or horrific customs as the birthing mother is accompanied by ‘some old hag’ who strips her, shaves her and uses a wooden probe to clear a passage for the child. The mother is kept in an upright position and after the birth ‘plunges headforemost into the sea’ to remove the dangerous sanctity of birth. This practice and feeding the newborn boiled coconut cream and sugarcane juice were viewed as unclean practices by the missionaries. In this way, indigenous childbirth was portrayed as ‘a terrible ordeal’ (2002b:149). In contrast to these ‘dark’ pictures of childbirth, a ‘lighter’ picture emerges through ethnographic writing. For example, there are numerous mythic narratives that link the fertility of crops to that of the human body (2002b:164-8) and the revaluation and revival of the art of mat making that has been ‘central to the broader project of revaluing women’s creative culture role in Vanuatu’ (2002b:168-74). Nevertheless, Jolly concludes by asking if she is in danger of reinscribing

the very Manichean language of darkness and light, the standard tropes of both Christian and developmentalist language, which imagine a passage to enlightenment—through the word of God or by that process called development (2002b:174).

Deciding to do qualitative research to examine how reproductive health fits into Ethiopia’s development agenda means that the data, collected over a period of time provides complex, vivid, descriptions of ‘naturally occurring, ordinary events in natural settings
so that we have a strong handle on what ‘real life’ is like’ (Miles and Huberman 1994:10 emphasis in original). During my fieldwork in Kafa Zone I sought to learn how a group of women go about their everyday lives and their ‘daily trials and tribulations... in the context of the ‘seemingly insurmountable economic, political and social problems of Ethiopia’ (Poluha 2004:13). In Chapter 4, I focused on the relationships women form and the work they do in and around their households. I also wanted to contextualise how childbirth fits into their world. The antithesis of birth as a life-giving process, maternal mortality\(^{57}\) can also reveal the complexity of the issues and the diverse social, cultural, economic and environmental settings for changes in maternal health to take place (Boddy 1998). Thus the intention is that women and their pattern of living can ‘methodologically, be used as a window onto the society of which they are a part’ (Poluha 2004:16). This chapter explores birth through four themes: ‘Normal’ birth: giving birth at home’, which has two sub-themes: ‘Who assisted at birth?’; and ‘Salient aspects of giving birth at home’. The second theme describes what I call ‘(Un)safe’ birth: carrying a woman to a health centre or hospital’ if something goes seriously wrong during birth. The third theme examines the involvement of health workers including TBAs, HEWs and other nurses, doctors and midwives during birth who work in health posts, health centres and Bonga Hospital. As there has been no tradition of using trained birth attendants, these health workers only tend to see ‘abnormal’ birth in a health facility. The fourth theme of this chapter looks at ‘The role of health workers’ which has four sub-themes: ‘The role as educator’; ‘ANC at CHC and Deckia Clinic’; ‘Being (un)able to provide adequate treatment’; and ‘Conceptualising women and birth’. But first it is important to listen to the women and set aside one’s taken for granted assumptions about them.

5.1 ‘Normal’ birth: giving birth at home
5.1.1 Who assisted at birth at home

As stated in Chapter 1, the overwhelming majority of women in Ethiopia (94 percent) (CSA 2006:116) and in Kafa Zone (96.5 percent) (Habtamu Argaw 2002) give birth at home. Table 6 shows the percentage of births attended by skilled and unskilled birth attendants. It is evident that the majority of births in Ethiopia and in Kafa Zone are not

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\(^{57}\) Although this study focuses on maternal mortality, not infant mortality, which affects many women who suffer miscarriage or whose baby dies during childbirth due to obstructed labour or other problems during childbirth, I interviewed two women whose baby had died during childbirth. Moreover, many of the women had lost young babies and young children (see the women’s profiles at the end of Chapter Three).
attended by a health professional. Only six percent of births are delivered with the assistance of a trained health professional, that is, a doctor, nurse, or midwife, and 28.5 percent are delivered by a TBA\(^{58}\). The majority of births are attended by a relative or some other person (62.9 percent). Over five percent of all rural births are delivered without any type of assistance at all (CSA and ORC Macro 2006:118).

### Table 6: Percentage of births attended by skilled and unskilled birth attendants

<table>
<thead>
<tr>
<th>Health professional</th>
<th>TBA</th>
<th>Relative/other</th>
<th>No one</th>
<th>Don't know (DK)/missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Ethiopia*</td>
<td>2.6</td>
<td>28.5</td>
<td>62.9</td>
<td>5.8</td>
</tr>
<tr>
<td>SN NPR*</td>
<td>4.2</td>
<td>14.8</td>
<td>68.6</td>
<td>12.4</td>
</tr>
<tr>
<td>Kafa Zone, SN NPR*</td>
<td>23.0</td>
<td>DK</td>
<td>DK</td>
<td>DK</td>
</tr>
<tr>
<td>Kafa Zonal Health Department*</td>
<td>28.0</td>
<td>DK</td>
<td>DK</td>
<td>DK</td>
</tr>
<tr>
<td>Kafa Zone°</td>
<td>4.2</td>
<td>2.0</td>
<td>89.4</td>
<td>DK</td>
</tr>
</tbody>
</table>

* Ethiopia Demographic and Health survey 2005 (CSA and ORC Macro 2006:118)

^ SN NPR 1999 E.C. (unpublished document from SN NPR Regional Health Bureau)

\(\text{n} \) Zonal Health Department 1999 E.C. (printout from reproductive health officer)

\(\text{o} \) Community-based baseline study 2002 (Habtamu Argaw 2002)

Mirgissa Kaba’s (2000) qualitative study on health seeking behaviour in Kafa-Sheka\(^{59}\) Zone confirms that the husband, women members of the kin living with them or living in the neighbourhood and any women in the neighbourhood are the main people to provide assistance during labour and delivery (2000:24). Most of the women interviewed in this study gave birth at home with the assistance of their neighbour, mother, mother-in-law, husband or sister (Table 7). Only two of the four women who gave birth in a hospital or health centre (Makeda from Kebele Three and Meseret from Agaro Bushi, see Table 5, Chapter 4) had planned to do so. Of the other women who gave birth in a hospital or health centre, Raydet was assisted by her aunt and husband at home for five days before being transferred to Bonga Hospital. Meseret was assisted by her mother in law and husband before being taken to CHC. Birke did not indicate who assisted her at home before she was taken to the health facility.

\(^{58}\) Note that the large difference in the number of births attended by health professionals reflects the inclusion of TTBAs as health professionals by the Regional and Zonal Health Departments.

\(^{59}\) Kafa Zone became a separate zone in 2000.
Table 7: Who assisted births at home

<table>
<thead>
<tr>
<th>Neighbour</th>
<th>Mother</th>
<th>Mother-in-law</th>
<th>Husband</th>
<th>Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etenash (Bonga)</td>
<td>Yeshang (Bonga)</td>
<td>Misrak (Sheyka)</td>
<td>Sara (Sheyka)</td>
<td>Tadelech (Wushwush)</td>
</tr>
<tr>
<td>Hirut (Wushwush)</td>
<td>Abebech (Bonga)</td>
<td>Zena (Sheyka)</td>
<td>Fana (Sheyka)</td>
<td></td>
</tr>
<tr>
<td>Aden (Deckia)</td>
<td>Bethlehem (Bitta)</td>
<td>Addisalem (Sheyka)</td>
<td>Hanna (Wushwush)</td>
<td></td>
</tr>
<tr>
<td>Wolet (Deckia)</td>
<td>Itaynish (Wushwush)</td>
<td>Meseret (Agaro Bushi) (before transfer to CHC)</td>
<td>Meseret (Agaro Bushi)</td>
<td>Raydet (Wushwush) (also assisted by aunt before transfer to Bonga Hospital)</td>
</tr>
<tr>
<td>Tsehainesh (Deckia)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wubelelem (Deckia)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Messelech (Agaro Bushi)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abaynesh (Shapa)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Giving birth marks a milestone in the mother-daughter relationship and some Ethiopian women will return to their mother’s home or village to give birth to be surrounded by other women to help take care of her (Mendlinger and Cwikel 2006:62, 76). However, as most women move near their patrilineal kin at marriage, for those women who have moved far from their mother’s home, the importance of a good relationship with ones neighbours and the community becomes evident during birth. This relationship is also reflected in the Ethiopian proverb: ‘A close neighbour is much better than a far away relative’ (Knutsson 2004:103). The depth of this feeling of closeness was expressed by Sara who had not been able to call on a neighbour or close relative.

Sara was one of the women I interviewed from Sheyka. The location of her house was not close to any other houses and Sara expressed how isolated she felt at birth. She was not only far from her own family, but she felt she had no close friends or neighbours to call on to support her, only her husband who assisted by massaging her abdomen and holding her shoulders during the labour. Sara said nobody came to help and expressed

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60 I found it unusual for a house to be so far from other houses and I was later told that the vacant house site next door had deliberately been destroyed because a curse had been put on a woman living there and she became paralysed. The reason for this appeared to be jealousy as her husband ran a successful tej bet in the home.
her sorrow about being ‘alone’ during birth by saying that no one was there to watch over her, even when she was at death’s door: The labour was very heavy. In this place I haven’t got any family, my mother is far away—no one is watching my back even when I am at death’s door. She repeated this again and said:

Halla ogyiiniyee maxxo taanni mabee too woggeenne zlloyiichiiyee keexoochii ciikkaa taa shiiyaabeetto woggeenne allochiiyee halla wuxxittommoniyee taa woddabeettoo.

The labour is very heavy. If my family is behind me (with me) I would not give birth at home (in Sheyka). I’m alone, for this reason I give birth here at home.

Apart from asking who attended the birth, I was interested to find out if others in the community knew when it happened. I asked women if it was common for birth to be kept a secret or if others in the community knew when it was taking place. On the one hand this seemed important because the ‘level of skill and knowledge of the birth attendant is the key variable in the perceived severity of the complication, and in the timeliness or delay of referral’ (MOH 2006b:28). On the other hand, health-seeking behaviour involves not only the person in attendance but also the husband of the birthing woman and relatives or neighbours who lend money and assist with transporting a woman to a health facility.

Some women said birth should be kept secret, while for others it was just better not to have too many people around. I asked this question knowing how common it was for women to be invited to visit each other, to drink coffee and to enjoy sitting around, talking and gossiping. Hirut from Wushwush said: This one time—it is different. What happens is she is having labour pains and if they [other family members] are asked “Where is your mother?” and they want to say she has a headache or even she is not around. That time they make a secret, anything that is not a labour pain connection…Too many people are not good for the baby. They pray for Our Lady and they are waiting and Mary helps them. They do not tell to anyone else.

Some women observed that God had assisted them and many of the women called on Maryam (Mary) during the labour to help them deal with the pain. For example, Tigiste (Chiri) said that no one assisted her except God. Later during the interview she said her eldest children helped her by providing her with a razor blade and giving her a drink to
replace lost blood after haemorrhage. Because Tigiste referred to various family members assisting in some way at the time of birth, I wondered if she meant that no one outside the family, except God, assisted her during birth. Abaynesh said: Everyone should not know a woman is in labour except the intimate friend. We don’t want others around until she delivers the child, that’s why we keep it a secret but nothing bad happens.

Wolete from Deckia also said: They keep it silent until they give birth, they don’t tell anyone. For some women such as Wubealem, the thought of having others around would bring bad luck: When a woman is giving birth the husband must leave the house and wait outside. He should be invited in [afterwards] to visit his wife if she delivered normally. But if the pain continues he is told to take her to the health centre. Everyone knows when she is in labour—passers by can bring bad luck.

None of the women interviewed gave birth totally ‘alone.’ In some instances, women were transferred to a health facility but everyone had the assistance of someone: their neighbour, mother, mother-in-law, husband or sister. Several women wanted to keep pregnancy secret as long as possible (see also Pankhurst 1992:129) and they expressed how they did not want others, with the exception of the close neighbour or friend, to know that they were in labour. Yet other women stated that birth is an event that involves social interaction with close family members and neighbours, and religious interaction with God and Maryam through prayer. Whatever happens, the role of female relatives and neighbours is to support the birthing woman. For those women with no family or neighbours close by there is a sense of being ‘alone’.

5.1.2 Salient aspects of giving birth at home

Childbirth generally takes place in the privacy of the home although in some parts of Kafa Zone such as Gebera and Agaro Bushi a separate hut is built in the compound for menstruating and birthing women. Generally local communities in Ethiopia ‘perceive that the resources and knowledge necessary for a healthy pregnancy’ are ‘generally available within the community’: this includes advising women not travel long distances

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61 After menstruation, a woman must purify herself by washing her clothes and body with local leaves before rejoining the household (Mirgissa Kaba 2000:24).
or to expose themselves to the sun during pregnancy (MOH 2006b:22-3). A study of health seeking behaviour found that in one kebele in Gicha in Kafa Zone, home delivery is preferred because women do not want ‘to be exposed to cold while going to or staying in the health facility, [or] to expose ones body to others as they believe to get desired assistance while at home’ (Mirgissa Kaba 2000:24).

During the labour the main role for the birth assistant is to hold the woman tightly on the shoulders from behind so she feels supported and to massage the abdomen with kibbi (butter) or hair food (Vaseline). Almost all the women reported that someone had massaged their abdomen during labour which is a common practice to deal with pain and speed up the delivery. When I demonstrated with my fingers and asked if the massage was gentle or with pressure, all the women said the massage had been gentle. By contrast, health practitioners asked about abdominal massage said that abdominal massage is one of the main causes for stillbirth, uterine rupture, bleeding and even death (Section 5.4.1). A couple of the women said that if the baby is displaced the TBA knows how to put it into the right position.

Two nurses told me that another traditional practice was to shake the woman to make the baby come out. One of the untrained TBAs I interviewed said she did this. I am unsure how often it happens but Doyle (2008) reports that untrained TBAs in the Somali region in Eastern Ethiopia often use two assistants to hold a woman by the arms and thrust her up and down to help the baby come out faster. This forces the baby out and can cause severe complications for the mother and baby rather than allowing the woman to push the baby out with her muscles.

Like women in other cultures such as the Bariba of Benin where the ideal of courage and stoicism at delivery is important (Sargent 1990:189), women said they needed to be strong during childbirth. Aden expressed it as suffering but we just take it. Abebech’s mother told her: Don’t worry, be strong, God will help you. Itanish and Hirut were two of the many women who mentioned that people prayed and pleaded to Maryam (Mary) to help them because she is associated with childbirth. Etenash’s neighbour also said to her: I will help you and Maryam will help you. Yesharig also talked about needing to be strong and associated this with the delivery time: If I am strong it takes one hour….
legs and my back are shaking and they say don’t be afraid and they hold my legs and back. Abaynesh expressed stoicism as well and said: I just delivered by God’s help. I bled a lot— it just stopped by itself. And Fana from Sheyka said: All seven births normal— only a lot of pain.

Prolonged labour was described by some women who had been or knew women who had been in labour for many days hoping the baby would come. Other women said that labour was too long when it took more than one day. Messelech from Agaro Bushi said that birth takes places in a special hut and is kept a secret or hidden. If other people know it might bring bad luck and make the labour take too long. Tigiste who lives in Chiri gave birth to her children in the house but she said that in the past there were beliefs about prolonged labour which required a separate shelter to be built: Sometimes they say the place belongs to the guardian spirit and because this is his place— the house should be moved. After the house is moved she will deliver. If it is a permanent house we make a temporary shelter— if you get back into your home your child will die. On account of this we move somewhere else. Actually, we have a belief, if a person steps out of what he has been told is true, if he comes back he will die. We did believe in idols and the guardian spirit, today we don’t believe in this, just in God.

In another example, Wubealem expressed how sometimes it could take up to four days for the baby to come. And Meseret (see Box 13, Section 5.2) had been in labour at least two days (and probably two nights) before she arrived at CHC (the Health Officer at Chiri told me this): her baby died on the way. Finally, Tigiste provided an evocative example of prolonged labour. She had already told me that if a labour goes too long, the husband must go to his neighbours and ask for their help to make a stretcher and carry his wife to the health centre so she can have an assisted delivery. So, I asked, how long is it, from when a woman starts labour, before you think you need to go to the health centre?

Maato maato yiichi tumi shabaa tooch gaata woyee yoochi araa ikkooch woyee araa guttooch gaata maabeesaabee keyi hariye woyee baakkoo kukkaha shiijeemmo, kafoo qaadaha shiijeemmo iiibeta decho waacci hariye uree mararehan, bunee gufooch bediye womiye illa baka aakumooch dambone geteehe.
We decide, for example, if labour starts at dusk, at 6 pm and it stayed overnight, and the daybreak is over and in the morning it is time to prepare coffee and the woman is still screaming, and no one has prepared coffee, it is time to think about the health centre.

Most women I interviewed knew that things could go wrong during birth. The only exceptions were the young women who had only had one pregnancy. A number of women told me that the techniques to deal with both prolonged labour and retained placenta included shaking the woman, shouting, massaging her abdomen with butter or binding it with cloth. Yesharig said that some women, when the baby doesn't come they shout and hit them, and the baby is born normally or they will die. Aden stated that some women felt unable to bear the long labour and the pain: Some women hang themselves, curse their mother, father, ancestors, the day they were born.

For retained placenta Abaynesh had a plate pressed onto her abdomen. She said she had the normal amount of bleeding. Zena, from Sheyka, also had retained placenta with one of her pregnancies. She said someone was called who knew how to take it out (the TBA). Her abdomen was massaged and she was given atmit to drink. At her last birth Abebech delivered twins: It was difficult to keep them warm because they are twins and I cut one placenta put the baby on the bed and I cut the other placenta. After the birth she haemorrhaged and her mother gave her a drink made from coffee leaves and told her to sleep on her back. Tigiste was given a drink made from crushed garlic and mustard seeds to replace the lost blood (the seeds are crushed and sieved and the separated liquid is given as a drink to replace the lost blood). She said: Before, we just kept bleeding after we delivered a child. If the bleeding stops by itself—if it doesn't stop somebody dies from bleeding.

Aden also spoke about some women dying after two to three days in labour. But for other women she said they get 'breakdown' which could mean a fistula: other women at the time of birth they get breakdown or while delivering some other women are spoiled.

Women who experienced problems such as retained placenta, haemorrhage or obstructed labour also talked about being taken to the hospital, health centre or clinic or having someone brought to the house to assist. Other women, who had not experienced
problems themselves, still said that if there was a problem, women should be taken to the hospital. They were certainly familiar with women who had been taken to the hospital or health centre. For example, Wubealem was bleeding after the birth of her first child and someone from Deckia Clinic was called to give her an injection which stopped the bleeding.

As a young woman of 16, Yesharig's first birth felt so traumatic she was scared to give birth the second time: *In [first child’s name] time, the big placenta is out with the baby and the small placenta is not out. My mother and my sisters ran fast and called the doctor from town. He put gloves on and put his hands in and took out the small placenta [membrane].* In the morning I went to the hospital [she was taken by car by an expatriate woman who was nearby at the time]. *They sewed me up and gave me tablets and a check like ANC.* She went on to say that a few years later, she married and was pregnant with her second child. When she went into labour: *I'm thinking, it's like [name of first baby], and I cry and my mother told to my husband and he says no problem.*

Ruth: *Why did he say no problem?*

Yesharig: *At that time there is no money for him.*

Yesharig knew that if she needed to call the doctor or be taken to the hospital this time, her husband had no money to pay for the medicines or the call out fee. The cost of medical treatment during birth is a serious problem for most women who have little or no income. Yesharig went on to say: *If there is a problem—if someone is rich they bring a car from town [it takes 40 minutes to walk to the hospital if you are fit and strong]. If that pregnant person is poor—they shout and if the baby comes it is good for the mother, if it is not, they will die.* Other women discussed the problem of money and being unable to pay for treatment. Abebech said: *Sometimes I go to look after them sometimes they are sick and someone when the birth starts they shout for someone if the baby doesn’t come out she walks on four legs [crawling]. If the pain is for three days she gets tired and if she can’t go to the hospital (because she has no money) she will die.* The effect of cost on medical treatment is discussed in Chapter 6.
If birth is at night and there is an additional problem as it means waiting until the morning. Addisalem from Sheyka said: *For one girl the placenta is stuck. We couldn’t go to the hospital because it was night. God helped me.* No one I interviewed travelled at night and even CHC which had the resources and vehicles, has a policy that they will not drive anyone to Bonga for emergency Caesarean because it is deemed too dangerous to be on the road then.

Finally, I asked women if there were any proverbs about childbirth. After my interview with the witchdoctor in Agaro Bushi and one of his wives (and by this time it seemed like half the village was there and there was much discussion (in Kafficho) and laughter about this question). I was told ‘Kechee kechiti qaqqoo keellee kexoa michiye’ when translated means ‘The fire from his own oven (or house) damaged his own granary by his door step’. It could also be translated to mean ‘If the husband is a troublemaker—the wife is pregnant’ or ‘Don’t force something—just accept it if it happens’. Tariku and I discussed the difficulties in translating this proverb (and me in trying to understand it). In the end we came up with the meaning that ‘A problem during birth is probably caused by the man himself on his own property’. There is another Ethiopian proverb relating to childbirth: ‘If a labour of a pregnant woman becomes painful and long, it means her husband is internally a very cruel person’ (Wondwosen Terefe 2006:99)\(^\text{62}\). Because this proverb is similar to the Kafficho proverb it is possible it means a cruel husband could cause the problems during birth too. Tariku also pointed out to me that a man’s wife is also considered his property. Another explanation for problems during birth was Tigiste’s explanation: *A long time ago, we had a belief that if labour is prolonged for more than two days, family members discuss this and if her husband owed money to someone else and did not pay it back, the owed person cursed them.* Accusations of sorcery or witchcraft causing illness still seems quite common between kinsfolk and neighbours, especially if there is an atmosphere of mistrust when a wife comes from outside the community (Haile Gabre Hiwot cited in Wondwosen Terefe 2006:204).

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The next section continues the theme of social interaction with close family and neighbours from Section 5.1.1 and examines what happens when a woman is having problems during birth and needs to be carried to a health centre or hospital.

5.2 (Un)safe birth: carrying a woman to a health centre or hospital

...the husband begins accumulating money since he knows his wife is pregnant...and if something goes wrong he goes to his neighbouring friends and asks for their help to provide a stretcher and she will be carried to the health centre (Tigiste, Chiri).

To anyone who works or visits a hospital or health centre in the West, it is taken for granted that a person needing medical attention is usually dependent on others to provide transportation. Generally this transportation is a car, ambulance, or even a helicopter or other form of air ambulance. In 2007 in Kafa Zone, there were virtually no private cars, the single ambulance did not appear to be working, and the only other vehicles were a few NGO owned four wheel drives, commercial buses and Isuzu trucks. There were also no roads to many places where people lived. While out walking at various times through my stay in Kafa Zone, I frequently observed people being transported either to CHC or to Bonga Hospital. I also met some inpatients who had been brought from remote places in the Zone. During the journey most patients were covered in a white cloth from head to toe to protect them from the sun. They were carried on a stretcher made from bamboo, usually with 20 men to take turns to carry the stretcher and many others who came to offer support (see Section 3.3.3). One woman I observed was carried in a heavy looking wooden chair. She was clearly in labour and suffering a lot of pain. On another occasion I was on my way to the hospital and caught up to a large group of around 40 people. They were taking a woman on a stretcher and when I talked to a couple of the people accompanying her I found out that they had walked for four days and that the woman on the stretcher had had an abortion and now needed medical attention.

Another example of carrying a woman to Bonga Hospital came from Abaynesh’s husband. He related how concerned everyone had been about his friend’s wife during labour as they watched and waited for two days as the baby’s head was stuck and unable to move. He had been one of the men who helped carry the woman to the hospital.
from Shapa: *We were watching while she was in labour and we could see the head of the child and it was stuck... she was in labour for two days and we began carrying her to Bonga at 4 pm. When we got there they did a Caesarean section but she was urinary incontinent when she came back home. She was told to go to Jimma because she couldn’t control her urine but finally she died* (before she could go to Jimma).

All the women I interviewed in Deckia were familiar with the problem of maternal mortality and mentioned it during the interviews.63 Aden said: *Many women have died on the way to Bonga.* She did not feel there was any point in going to the Deckia Clinic less than five minutes from her home: *If I go to the clinic there is nothing there. God helped me at home.* Wubealem said: *Other women, when they carry them to Bonga or Chiri on the stretcher she gets tired and passed away on the way. Many mothers died from childbirth related problems. Other lucky women are survived by God’s help.* During another interview in Deckia, Wolete said: *The man who came before to greet us [he passed by during the interview]— his wife, when she gave birth, she died in a chair on the way to Bonga six years ago. She was in labour for three days.*

Several of the women interviewed spoke about the process of taking a woman to a health facility when she was experiencing difficulties during birth. Messelech from Agaro Bushi said: *After much suffering, when it’s serious the husband will decide, then the neighbours would come... To gather people to carry takes around two to three hours at least... To walk to Chiri takes nine to 10 hours.* Meseret’s personal experience (Box 13) shows that it can take quite some time to borrow money, to organise people, to make a stretcher and then to carry a woman from a remote location. This story also shows that sometimes seemingly unrelated incidents can bring other dimensions into play that make people feel more vulnerable.

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63 During my first visit to Deckia I met a group of teachers and the school principal one evening who were interested in discussing why I was there. They promised to write out a list of the women who had died in childbirth on the way to Bonga. A couple of months later I was given a document that listed the names of 154 women who have died, many on route, from 1974 - 1999 (E.C.). On my return visit to Deckia I met the (now former) principal of the high school who had prepared the list and he said he knew of other names that were not included.
Box 13: Meseret’s story: From Agaro Bushi to Chiri in the rainy season

Meseret’s baby died on the way from Agaro Bushi to Chiri Health Center. Meseret is around 25 to 27 years old, this was her fifth pregnancy; she has three children, one stillborn. All her other babies were born at home with the help of her husband and mother-in-law. She had walked to Chiri two weeks earlier for ANC after referral for swollen ankles and breech presentation at Deckia Clinic. She said she planned to give birth at Chiri this time but she went home to wait until the baby was due.

The labour started in the night, nine days early. After sometime had passed, her husband started to organise the neighbours to carry her. This took about three hours. Making a stretcher took around 30 minutes. He then had to borrow money from her cousins. This took about 30 minutes. Then the journey from Agaro Bushi to Chiri took about eight hours over mountainous terrain. Around 20 men helped to carry her. Along the way, Meseret was in terrible, agonising pain, tied to the stretcher. She told me she cried the whole way. Half way to Chiri, they knew the baby had died. She was delivered at Chiri Health Center and later the health officer told me that she had been in labour at least two days. Though the baby’s body had been born, the head was stuck.

What Meseret didn’t tell me was that only the day before her labour started, her neighbour’s child had been washed out of his father’s arms trying to cross the river on the way to Chiri for medical care. She was afraid of crossing the river. This is why they delayed. This happened in the middle of the rainy season.

Birke was one of the women I interviewed who had personal experience of being taken to Bonga Hospital. Box 14 highlights her story and how she lost her baby. It also shows how the referral system often works (and fails) in practice. In Chapter 4 I examined the theme of the referral system but at this point, for those women who live in rural communities and have an ‘(un)safe’ birth, referral to a health facility follows a circuitous route that does not guarantee a safe delivery.
Box 14: Birke’s story: From Sherada to Jimma

There was an elderly mother who had had 11 children, her daughter Birke who had had 10, and the elderly mother’s daughter-in-law with her first baby. We were taken into the new hut that was still in the final stages of completion and the old woman apologised that they had just finished coffee. With chickens running in and out and continually squawking and the baby crying I strained to hear as Birke spoke slowly and made no effort to speak over the noise. She told me how she had been in labour for three or four days in Sherada in a rural part of Kafa Zone. They kept hoping the baby would be born but the labour continued. There was no nurse so she was carried by stretcher for five hours to the road at Gojeb. There she was taken by bus to Bonga. In Bonga Hospital she was in labour for another two days. The baby died but they didn’t remove it as she needed a blood transfusion which could not be done in Bonga Hospital. Her husband went home, sold the cow and borrowed extra money for her treatment and the cost of transportation. Finally, Birke was taken to Jimma Hospital (three hours drive away) where the dead baby was removed by Caesarean.

Birke left her husband because of ongoing ill health and now lives with her elderly mother and other relatives in Sheyka.

What differentiates the birthing experience of the women who give birth in a health centre or hospital from the ordinary experience of those who give birth at home invokes the sociological imagination: the ‘personal troubles’ of a woman in labour becomes a public issue ‘of social structure’ (Mills 1978:8). A woman experiencing difficulties in labour is dependent on her ‘kinfolk and neighbours who may consider an illness a crisis for the whole group’ (Wondwosen Terefe 2006:204), as they are the ones who will have to lend money, make the stretcher and carry her. Women must contend with the pain during labour and the knowledge that women they have known have died on the way to the health centre or hospital. In the case of the women who experienced being carried on a stretcher while they were in labour, both women had to deal with the death of a baby. What this says is that in the 10 years since Bonga Hospital and CHC were built, people have developed the ability to come together and deal with the difficult situation of obstructed labour or the complications of abortion or other obstetric complications by carrying a woman to a health facility. They can also articulate the experience of when this goes wrong: *Many women have died on the way.* From the biomedical perspective, a woman dying on the way is most likely to occur when the decision to take a woman to the health facility is not taken early enough. It also appears that some factors place
women in greater danger than others. Distance was a factor for Birke but when she finally arrived at Bonga Hospital there was no one able to perform a Caesarean Section so she was referred to Jimma. Cost was also a significant factor as Birke could not be transferred to have her dead baby removed until her husband returned with enough money to pay for transportation and treatment.

In the next section I use observations and interviews with the health workers to show their role in education and the provision of ANC, normal delivery care and EmOC in Kafa Zone. This will enable a comparison with the women’s experiences and inform whether the opinions of the health workers correspond with that of women about the benefits of biomedical health care around birth. Some of the health professionals had had first hand experience being called to attend a woman experiencing problems in birth in her home. On being called, they generally found many people in the hut conferring about what to do. That neighbours and other community members will assist with making a stretcher, providing money for the treatment and carrying a woman to a health facility was taken for granted. Of course, for many of the health workers themselves, walking was the only way to move from one place to another. However, one PHW interviewed said if people do not have family or neighbours there will be no one to carry them to get to the health centre. She also said that poor people would not be able to pay others to assist with transport (interview at Ufa Health Post, October 2007). This implies that if you are not near your family or do not have good relationships with your neighbours and others in the community, you may be unable to call on others to assist you.

5.3 The health workers

The major objective of the human resource development component of HSDP is to train and supply relevant and qualified health workers of different categories governed by professional ethics. The specific objectives are to i) supply skilled manpower in adequate numbers to new health facilities ii) improve the capacity of the existing health manpower working at various levels iii) initiate and strengthen continuing education and in-service training iv) review and improve the curricula of some categories of health workers and v) rationalize the categories of personnel (MOH 2005:22).

In 2007, Kafa Zone had three doctors, five health officers, 150 nurses with certificates or diplomas including 11 midwives, one laboratory technologist and nine laboratory technicians (for a total population of 880,251 of which 92.3 percent are rural) (CSA
2007). There were 360 HEWs in the Zone with another 223 currently in training. I interviewed two doctors, one health officer, two midwives, three nurses, another nurse undergoing training to become a health officer, and six individuals who were either a HEW or a PHW. I also interviewed two senior administrative staff from Zonal and Woreda Health Departments: one from the Zonal Health Department in Bonga and one from Decha Woreda in Chiri. Finally, I interviewed three TBAs: one who had received training from Bonga Hospital, and two untrained TBAs. I have changed all the names of these people so they cannot be identified by their responses. The health personnel worked at Bonga Hospital, CHC, Deckia Clinic, or at one of these health posts: Muti, Sheda, Beha, Kuti, Ufa and Shapa. I also visited Ghimbo Health Centre, and briefly saw Wushwush Clinic and the health posts at Bobagetcha, Ogeya, Dishi, Erimo, and Yoka (see Map 2 Chapter 3).

5.3.1 The TBAs

The term TBA was coined by the WHO in the 1970s to encompass the various terms used to describe those women who had had little or no formal training but had learnt from relatives or other TBAs and were traditional, local or lay midwives who assisted other woman at birth (Knutsson 2004:25). In 1982, the Ethiopian MOH started a training program for midwives or awalaj’s or TBAs as part of the PHC program. A walaj’s were to be taught basic modern health principles, to abandon harmful traditions such as massaging the abdomen of a woman in labour, basic precautions that should take place during delivery; and the danger signs during labour so they can refer immediately if there is a problem (Wondwosen Terefe 2006:91). Research by Wondwosen Terefe (2006) describes the traditional role of the awalaj or TBA in Addis Ababa whereupon the awalaj palpates the parturient woman and checks the shape and size of the abdomen and then massages it lightly and manipulates the vagina if she feels she needs to improve the position of the baby. During the labour she tries to make the labour swift and simple by massaging the abdomen lightly and exerting pressure by squeezing to facilitate the birth. It is her job to cut the cord and shape the infant’s skull, nose and mouth (2006:90-98). Knutsson (2004) studied a group of TBAs in Addis Ababa and shows that their main role is to attend the birthing woman at home during the actual time of birth. Using their

64 Original citation: Misrak Agonafir, 1986, The Role of the Ministry of Health for the Promotion of Traditional Medicine, unpublished BA Thesis, Addis Ababa University
operational, procedural and caring skills, they interact socially with the family and neighbours, religiously with God and Maryam through prayer, and culturally through traditional norms and customs.

The TBAs base their understanding and explanations of phenomena and the course of events in childbirth from their own experience, their practical knowledge, and physiological concepts that emanate from the cultural and religious beliefs that are part of the Amhara concepts of health, as well as on modern medicine (Knutsson 2004:146).

Changes in PHC policy mean that the TBAs can now turn to the biomedical health system for assistance with cases perceived to be above their ability; however, changes in Ethiopian society mean that the TBAs must deal with the devaluation of traditional customs and the possibility of contracting HIV/AIDS through their job.

Despite the move in international strategy away from training TBAs as a way to reduce maternal and infant mortality (Chapter 1), training had still taken place in Ethiopia in 2006. CARE International’s SMI in West Hararghe was based on a strategy of meeting the community half-way, feeling it is counter-intuitive to educate and motivate the community to seek EmOC until services and accessibility are adequate. TBAs were trained resulting in significant improvements in infection prevention and referral for high risk mothers and management of different stages of labour. The TTBAs were also able to provide other services such as the provision of iron and vitamin A to pregnant women, and health education to mothers relating to FP. Importantly, the TTBAs are considered a reliable and credible source of information by their local communities which could increase the community based service utilisation in rural areas (Alemayehu Mekonnen 2005:45). A report assessing the project concluded that TBAs are the most available and accessible health resource in most rural settings so it was imperative that they continue their training along side linkages with an effective referral system that links them to well equipped EmOC facilities (2005:19). A second phase of the SMI was to strengthen the referral system from the TTBAs to the hospitals. Major renovations were done in two hospitals’ maternity units with repair to water supply systems, provision of small generators, repair of waste management systems and replenishment of equipment and supplies with a special focus on operating rooms. A new system for record keeping and data collection was introduced (Kayongo et al. 2006:312). This project brought

65 On two occasions I met with the Sexual & Reproductive Health Program Coordinator at CARE Ethiopia and on both occasions she stressed the importance of retaining the position of TTBa at the time being for rural Ethiopia given the current lack of other health services in many communities.
about a significant change to the UN processes indicators: doubling the Caesarean section rate overall by 50 percent; increasing the met need for EmOC from 2.0 percent in 2001 to 4.5 percent in 2004: the result was a decline in the case fatality rate by 35 percent (Kayongo et al. 2006:315; Alemayehu Mekonnen 2005:vii).

A further example of training TBA's came from FARM Africa who organised for 12 Manjo TBAs to be trained at Bonga Hospital in 2006: *Last year we trained I think 12 Manjo and I was fascinated with them because they are capable of doing that, we trained them for a month, the TBA ... Most of our mothers are delivering in the community. This is one challenge. What I am saying is I think both approaches are important because certain mothers, because society is not, they are not being educated, they prefer the TBA. It's good not to deliver alone, to deliver with the TBA and to deliver in the health post. So I think we can use both to prevent maternal mortality and also neonatal mortality. Actually we trained those TBA as the HEWs to know the danger signs of labour, to refer that type of mothers to the nearby health centre or the nearby health post and to have a link between the TBA and also the HEW. If we can do that approach, then we can prevent maternal and neonatal mortality. Otherwise, if the TBA is not trained on the danger signs and so on, the woman can be in danger to deliver in the community. If we train the TBA in the hospital when we refer mothers then particularly we can reduce mortality... and if the hospital, if she's not capable of coming to hospital during labour, then she can have a represented delivery at home, especially at midnight, they can't come to the hospital. So such mothers, there must not be a risk during the fetal lie, the transverse lie, breech presentation. Such type of mothers should come to the hospital* (Dr Befekadu).

I was able to interview one of these TTBA's who lived in the community some way off the Wushwush road. Segenet described herself as an awalaj (midwife). She has had 10 children of her own and no education. After her training she now advises women to sleep on a comfortable bed, not to clean the house or to carry heavy things and to eat what they have (not to avoid certain foods): *I advise them not to carry firewood and some take my advice and some of them don't*. During the birth if there are no problems Segenet is able to help women. If it is difficult or dangerous she sends them to the hospital: *I only help them by my hands, nothing else. I give them good things to drink.*
The people attending the birth are the woman, her husband, her mother and some of her family: *we hold the woman on the back. If there is bleeding and it doesn't stop I say to sleep on your back and if it doesn't stop I take them to the hospital. If it's by car it takes one hour. If it's by foot it takes one and half hours. If the pain starts in the morning we take in the afternoon.* Segenet said that if the women have not got money they borrow it from someone but if they are poor she does not take any payment from them. Segenet told me her biggest problem is that during the training she was given protective clothes and gloves to wear while she was attending births. Because she does not take payment from people she has no way to replace them.

I also interviewed two untrained TBAs, Aberash and Dawit, who had both attended a handful of births. I met Aberash and Dawit because I had asked my interpreter and another woman I knew if they knew anyone who helped out at births from the local community where we all lived (Kebele Three). In a sense Aberash and Dawit could be described as ad hoc TBAs because they were not called very often, but I felt it was important to include information about them because they had been identified in the role of TBA by others. Aberash was a woman probably in her late 40s who had delivered 10 babies and had five herself (2 living, 3 dead). She has had no education. She gives pregnant women advice about food and said they should eat “hot” foot, that is, not warm or cold food. Pregnant women should not carry heavy loads and they also needed to be checked by the doctor at ANC. The pregnant woman’s husband would call her when the birth had started and other people present would be the neighbour and daughters. She prayed to Maryam during the birth and after the birth she washed the baby. Aberash said the doctor would be called if there was excessive bleeding and one of the babies she delivered was a breech delivery. Aberash was not paid to attend births but was given kibbi, atmit, injera, cheese or vegetables.

Dawit was an elderly man who had had two years of schooling. Dawit’s slow and careful speech matched his hand gestures which were compelling as I watched; it was like his hands were massaging my own abdomen when he described how he massaged the pregnant woman’s abdomen during birth. He had delivered eight babies. Dawit advises the pregnant woman to eat eggs, milk, vegetables and meat. He would tell her not to carry heavy loads or to sit near the fire because she could get sick and hot. He also
advises them to go and be checked by the doctor at ANC but said that none of the women he attended had needed to go to the hospital. At the births he had attended the husband and the husband’s mother were also in attendance. Dawit does not receive cash payments to attend births but receives coffee or food. However he is paid 10 birr or some clothing for doing uvulectomy, milk teeth extraction or circumcision (we did not discuss these traditional practices as Dawit needed to return to his work). Dawit had converted from Catholicism to Protestantism and he prayed to God during the birth:

_We pray to God please help us with this baby—you must help us._

He demonstrated how the placenta was cut:

_Shuuyee ma cci halle xaaqqo beete hiiriichi indde doashoochi guullechi kuxxiyeetee_

In the placenta there is a natural stone, we measure it by hand, tying it on the mother’s leg and cut it.

The goal of the TBAs was to assist women giving birth at home. Although the two TBAs from Kebele Three had only assisted a few women they also advised the pregnant woman to go to the hospital for ANC. Neither of them had had experience of referring a woman to the hospital during birth because they had to date attended ‘normal’ births although one birth was a breech delivery. Segenet, the TTBA, spoke confidently about her role as an experienced awalaj who had attended many births. A number of times during the interview she said she would refer women to the hospital if the birth was beyond her ability. Most of the time she performed this role unpaid which left her unable to replenish her supplies of protective clothing and gloves. The comments by Dr Befekadu from Bonga Hospital alongside the conclusions from research conducted by CARE Ethiopia show that TBAs are still an available and accessible health resource in many rural settings. The reality for most birthing women in Ethiopia, who cannot come to the hospital or other health facility during labour, is that in the short term at least, it is probably better to have a TTBA at the birth to refer her if something goes wrong. This contradicts the evidence cited in Chapter 1.
5.3.2 Health Extension Workers (HEWs) and Primary Health Workers (PHWs)

HEWs are all young women who have completed Grade 10. They are selected from their communities to undergo a one year training program (generally in Bonga) before going back to their communities to become one of two HEWs for each kebele. HEWs are expected to collect and document basic data on the kebele. They spend 75 percent of their time in outreach activities going from house to house teaching mothers to care for newborns, cook nutritious meals and how to construct latrines and disposal pits. The HEW identifies and trains model families to become role models to help diffuse health messages and adopt desired practices and behaviour. They are also expected to communicate health messages by involving the community, provide ANC, delivery care, immunisation, growth monitoring, nutritional advice, FP and referral services at the health post. HEWs report to woreda health offices.

Although there are many HEWs undergoing training, most of the HEWs I interviewed were working on their own at the health post. One HEW worked from her home adjacent to the health post because it was not completed. (In this case, only a brief interview was conducted with the interviewer and interpreter sitting on her bed. The room was packed with women, babies and young children who were there for the latest health campaign—Albendazole\(^{66}\) and Vitamin A— they were all happy to chat and tell me about their birth experiences and they were excited about their having photos taken.).

In my interviews I asked health workers and the staff from NGOs to elaborate about the government policy of training HEWs to provide essential health care and the health posts being the first point of contact for people within the health system. A number of the HEWs and PHWs reported that they were called to attend births four or five times a month. If they are called to the house during birth there are usually many people there visiting and giving advice about what to do. As the HEWs are young unmarried women, and decision making is primarily done by the husband, close relatives and neighbours, I was unclear at what point the HEWs were called and if they were able to refer women early to reach a health facility if required.

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\(^{66}\) Used to treat intestinal worms.
Two of the staff from NGOs in Bonga felt that there were problems with the HEWs because they were required to work in remote places: *the extension workers from school they take them and train them from technical school and hospital. They are afraid and they send them to the remotest parts, even they don’t like to go to work there because of the forest, the mud* (Temesgen). Another NGO worker felt that HEWs are much more inclined to be curative, sitting in the clinic or the health post and giving curative... they have too much purpose, roles. One is to give minor treatment of the kind to go house to house, the latter are some difficulty especially with women, to move from place to place, to cross rivers and forest, these are not much interested and they don’t have backing up from others and they prefer to sit in the clinic and distribute some drugs without moving from house to house (Worku).

On the other hand, one of the senior health workers I interviewed was quite positive about the role of HEWs but felt that the government was not following through with its plan to train local women to go back to their own area where she knows the community: *I think the government plan is very good because they train these women, HEWs, to have vaccination, ANC, health education, but in our system especially in our Zone, the problem is they are not from that local area. What the government plan is to select women from the local areas and to train her and she has to come back to that area and she will help that community. But this system is not working. What people did is they take from other places and they are sent, for example, someone from Chiri town has to go down to Chocha or somewhere, and she refuses because that is not, if you compare, it is very different. She doesn’t know the culture of the community; she doesn’t know what they need... I think they are not committed, I think commitment is very important. If I am committed I can do whatever, so they are not committed. And they don’t know what they are going to do. They teach and then they... and they are not working to help the community, they are involved only for the money. That’s the problem* (Tamrat).

Because the National Reproductive Health Strategy (MOH 2006a) aims to reduce maternal mortality based on a referral system: from HEWs providing essential obstetric care at health posts, to mid-level service providers being able to provide basic EmOC and to refer complications to appropriate facilities that are equipped and staffed to provide
comprehensive EmOC services, it is argued that this “flagship” or referral system is the key to reducing the delays that currently contribute to maternal mortality and disability in Ethiopia. Yet none of the women I interviewed used the health post for normal delivery or referral during delivery. Many health practitioners said that staff at some health posts do not refer on time, do not examine patients properly and that their training and experience is inadequate at this stage. But the HEWs I met described their heavy workload and expectations on them. I observed that they are often called to organise campaigns in their areas for polio, measles or Vitamin A and Albendazole which takes them away from other duties. Many of them are doing their best with no supplies, no delivery kits, no gloves or Ergometrine\textsuperscript{67}, no functional refrigerator, examination table and so on. These shortages of supplies and equipment must in part be attributable to insufficient budgets and weak management skills at the woreda level.

5.3.3 Nurses, doctors, midwives

While it is still uncommon for students to complete Grade 10 in Kafa Zone (Chapter 6), two options for those who do so is to go on to teaching or nursing training. Teacher training is available in Bonga, but there is no nursing or medical training available locally so a family must be able to support someone to live outside of the Zone to undergo training either through the government offered courses or one of the many private colleges that are being built in Addis Ababa or in major regional areas such as Jimma, Nazaret or Awassa. The training required for health officers and doctors means that they are clearly ‘unique’ individuals because they have achieved a certain level of education and have financial backing to support the longer training required.

Two of the three doctors in Kafa Zone are male. Of the nurses and midwives I interviewed, three were female and three were male. Unlike in the West where doctors traditionally wear white coats, all the medical staff including doctors and nurses at the hospital and the health centres wear white coats so it is impossible to determine a person’s status from their clothing. Doctors and nurses at the health facilities appeared to be held in high esteem. During my observation at ANC clinics, while waiting as an observer before interviews, and accompanying friends who went for medical treatment, most people were prepared to wait many hours to be seen and did not question the

\textsuperscript{67} Used in obstetrics to facilitate delivery of the placenta and to prevent bleeding after childbirth.
judgment of the health professionals. The exception to this was when I accompanied friends to the hospital and observed one friend who did not question the doctors' authority but refused to wait around in a queue to be seen. On two separate occasions I watched her go and find the doctor in the office and demand that he come and see the person she was accompanying immediately. I remember feeling quite amazed by her behaviour as it was not something I felt I could do in Ethiopia or Australia.

5.4 The role of health workers
5.4.1 The role as educator

The goals of the HSDP III are to improve maternal health, reduce child mortality, combat HIV/AIDS, malaria, TB and other diseases to improve the health status of Ethiopians and achieve the MDGs (MOH2005:xii). There are specific targets which aim to improve health service delivery; expand, construct and equip health facilities; and, provide training for health workers. One of the key roles for these health workers in policy documents is that of educating the community. All the health workers I interviewed, (with the exception of the TBAs) discussed the importance of their role in educating women or the local community. Information, Education and Communication (IEC) is a key component of the Health Extension Package (HEP) which aims to promote political and community support for preventive and promotive health services through educating and influencing planners, policy makers, managers, women's groups and potential end users' and improve the Knowledge, Attitude and Practice (KAP) about personal and environmental hygiene and common illnesses and their causes (2005:xv). As stated in the plan, HEWs are the main target for the provision of appropriate health communication materials and equipment (2005:xvi). It is intended that the health post in each kebele will be the focus of the preventive and promotive aspects of health care and that HEWs are to provide this information and to educate the local community. For example, one target of the National Reproductive Health Strategy is:

By 2010, ensure that 80 percent of all households/families recognize at least three danger signs associated with pregnancy-related complications in areas where HEP is fully implemented (MOH 2006a:17).

The HEWs and PHWs I interviewed all follow the government program whereby they go house to house visiting women on Mondays and Tuesdays each week. Sometimes they also give education at the church and other meeting places. Apart from education about the prevention and control of communicable diseases they discuss matters to do
with family health, hygiene and environmental health, gender based violence and harmful traditional practices (MOH 2005:72). They also advise women to come to them on time, when the labour starts. *Education is about coming on time* (Emabet). In another example Rahel said: *Our situation to avoid this problem (referral, transportation problem) we educate them in advance like from Muti, Deckia, Gebera there is no infrastructure; when they are here [at CHC], we tell them to avoid some of the cultural, instead of holding the woman at home, they should come in advance if they are scared, if she can walk instead of being carried by stretcher. That does not mean they all come here. Because it's far, because if they are pregnant, few come and listen to our education, they just tell each other, it just spreads out.*

In fact, the role of education was seen as crucial because the lack of it resulted in many harmful consequences for pregnant and birthing women. According to the Ministry of Health’s, Report on Safe Motherhood Community-based Survey (MOH 2006b), there are a number of traditional or cultural practices that are thought to be harmful to women. These include the normalisation of giving birth in the community and not in a health facility; Female Genital Cutting (FGC) (performed on approximately 73 percent of Ethiopia’s female population); high fertility and cultural preferences for large families; and restrictions on the mobility of women (MOH 2006b:6-7). These beliefs or practices have programmatic implications within maternal and newborn health programmes as they aim to raise awareness about them while at the same time increasing utilisation of modern health services. Only one person I interviewed raised the practice of FGC and uvula cutting as traditional practices that needed to be phased out through education. A number of people discussed other traditional practices which are described as problems: delivering in the community and not at the health service, high fertility and the restrictions on the mobility of women. Statements about the mobility of women tended to focus more on practical issues such as distance and lack of transportation rather than it being a cultural restriction.

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68 The 2002 community-based baseline study on health status, health services and health related knowledge, attitude and practices (KAP) in Kafa Zone ranked common traditional practices. Most common was uvula cutting (77.2 percent), newborn swallowing butter (74.5 percent), and milk tooth extraction (67.1 percent). Female circumcision was only practiced by 20.2 percent in Kafa Zone (Habtamu Argaw 2002:25) compared to the national figure of 80 percent (World Bank and Ministry of Health Ethiopia 2005:53).
During the course of interviews with health workers a number of other harmful traditional or cultural practices were highlighted. The first of these is uterine massage which is associated with stillbirth and the second was shaking the woman to remove retained placenta. Most of the women interviewed had experienced abdominal massage. The two TBAs and the TTBA that I interviewed all performed some sort of abdominal massage. Aberash said she would rub the stomach with butter if they are sick and *I hold the woman from behind and shake her to help the baby out.* Dawit also said he rubbed the woman’s abdomen to help fix the direction of the baby. He described how he would squat and hold the woman from behind and massage her slowly and softly with butter. And Segenet, said: *If it comes by the feet I push out the baby— I rub them with water or with hair food (Vaseline).* I asked if she rubbed softly or with pressure: *I don’t push the baby when it starts to come, I rub with hair food and God helps me.*

Clearly these practices are viewed as negative by trained health workers. These comments are representative of how health workers viewed these practices. Surafel (a senior nurse) said: *Heavy massage is one of the causes for stillbirth... the TBAs... they put too much [pressure], they don’t understand, if the baby have, you know meconium stain, they don’t understand such words, then they push it, after that the child would be dead, this is one of the causes of stillbirth.*

Sr Zewditu (midwife): *During pregnancy they massage the woman’s stomach with butter, also during labour, the TBA massages to shorten delivery— this is a cause of stillbirth. And for retained placenta, they ‘hang’ the woman up by her hands and two people pull and shake the woman to try and get the placenta to come out.*

Another senior nurse, Sr Aster said: *If the placenta doesn’t come, they put something like this*[she takes the blood pressure cuff and puts it across her stomach like a bandage], *they put it on the abdomen and they move it in such a way to expel the placenta.* Ruth: *Do they shake the woman?* Sr Aster: *They get her on the back and shake her, such type of thing... we are teaching them not to do this. And rubbing the stomach with butter, it is a bad traditional practice,*
we are also, we teach that on different problems, TBAs in some areas, not all kebeles, we can also tell them it's a bad traditional practice.

Yet another senior nurse who is upgrading her training to become a health officer (Desta) also said that traditional massage can cause bleeding and even death: When I was in Bonga Hospital there was a lot of women who are dying with uterine rupture, even a lot of women a lot of mothers when they come to us its too late. They have their own massage, this massage which makes the uterus relax, but that is a uterus prone to rupture, for that reason a lot of women, even... a lot of bleeding and they die.

Finally, Rahel who works at CHC said: They use a plastic bowl and they put it on the belly of the woman when it is delayed a long time, and they shake her up and down.

During ANC, health workers have the opportunity to educate women and their families about the danger signs and symptoms associated with pregnancy and childbirth and the benefits of seeking skilled care. Women can also be made aware of the consequences of harmful traditional practices, the importance of preventing disease, managing existing medical conditions and ensuring proper nutrition. In Chapter 6 I discuss ANC in relation to women’s education.

The following statements illustrate how health workers teach pregnant women during ANC about the danger signs during pregnancy. Surafel takes the opportunity to tell women not to work too hard: Generally I say to them not to work so hard, they do so many work, they carry so heavy loads, this is one of the problems for them I advise them not to carry the dry goods and some necessary food, this is my advice. After this, I don’t know if they take this advice— I don’t look at their home but I look at their kilo [to see they are putting on weight] when they come here for the ANC, for the blood pressure, their physical change... People don’t know about things like obstructed labour, other problems...

Sr Aster said women were told about the danger signs and any sign of bleeding or show or watery discharge or high fever, headache, you just have to come. It could be early
rupture of membrane and suddenly if there is bleeding, if there is high fever, headache,
you have to come... We tell women if they have any problems, like the danger signs, any
of these things, they have to come immediately and we will see them. They can come
without appointment, don't keep or stay for appointment; just you have to come... its
education, also nutritional advice as they come, to get extra protein. She also referred to
the way women get together over coffee, discuss things, and reinforce common
practices. For example, the practice of women eating less during pregnancy in the belief
they would have a smaller baby and an easier delivery was something women might
discuss amongst themselves. Women needed to be told to have a balanced diet to have a
normal baby and not to try and eat less.

Another senior nurse, Desta, felt that no one in the community knew about pregnancy
complications or FP and must be taught: Nobody knows about pregnancy
complications—[but] everybody has a chance to be pregnant... so everyone gets pregnant
annually. Even for family planning, we teach them such problems, when we are giving
health education, then we see, why you are making me stop being pregnant, this is a
natural gift. Nobody has knowledge about pregnancy, about family planning,
complications of labour and delivery.

Tamrat (a health officer) also said it was important to teach people about the danger
signs of pregnancy: When I was in Bonga Hospital we did these things, whether the
community knows about the dangers of pregnancy for this matter IEC is very important,
teaching people about the danger signs, even at ANC, or at vaccination time, then that is
they don't have. They don't know when they should bring during delivery or during
ANC or during pregnancy, they don't know the danger signs, they don't have any
information about that.

These statements show how important all the health and administrative staff feel it is for
women to come to ANC. At the same time, there was awareness and concern about
women who do not attend ANC because these women are missing out on important
information about the danger signs of pregnancy, nutritional advice and other advice
such as not working so hard. All the health personnel I interviewed noted that the
number of women attending ANC is definitely increasing over time. At Deckia Clinic I was told: *More than 20 women a day are coming to ANC... women are coming in increasing numbers to the health centre that means they are accepting so much... ’*. And at Bonga Hospital, there has been a huge increase in the number of women coming for ANC and FP. One senior nurse who has worked in Bonga for 15 years commented about the many changes in that time. Now they are able to do Caesarean Section at the hospital and attend to up to 20 births a month, but one of the biggest changes is the large number of women coming for ANC and for FP: *Especially in family planning now more than 300 - 350 a month. According to their problem we advise them to prevent frequent pregnancy. According to economical problem, poverty, they can’t afford all things, to educate, to dress, to feed; they have many problems* (Sr Aster).

Dr Emabet: *When a pregnant mother comes to ANC, the nurse or health care worker is expected to give her information about the danger signs like headache, bleeding etc— to go to a nearby health institution.*

Ruth: *But if she doesn’t go to ANC?*

Dr Emabet: *Then she cannot know.*

The role of education was reinforced by people who worked at the most senior levels of government in Kafa Zone and Decha Woreda. One senior government official stated that there are two gaps in the health care system. The first is the shortage of skilled human power in the health centres. He went on to say that the second gap is that women in the reproductive age group are not fully aware to come to the health centre. *That is the gap. To minimise this gap, solving problems one is giving education in every community about the dangers of maternity which is to minimise that she must come to a health centre or a health post for taking care. And taking immunisation...[if women] don’t get any education (if they don’t come to ANC)— the main problem here is if there is community radio program everybody, some people's they have radio, they can teach the danger signs, if they translate into their community language. The other thing is the leader. For example, they go to the community leaders or to magic [witchdoctors] or to elders and they make the decision— to go to the health institution or to stay home. So if*
we are teaching these community figures like magic people they can take this information to the community so that is the gap.

Ato Yohannes: There are so many programs especially in health program, then during ANC follow up with mothers. When she's pregnant she has to know minor and major signs, minor complications and major complications during pregnancy...when she has seen any sign or symptoms, immediately she has to go to health facility and she has to get advice from health person. Such kind of education mostly given by now each kebele, I think you have seen there are HEWs in each kebele and those HEWs they have to teach the community and they have to make the community to be more aware especially such education is given. So most of them take, they have to go to health facilities and they get advice especially most of the time remote areas are I think too difficult because there are no access health facilities or health centre and...transport such kinds of problems.

While the role of education was seen as a crucial role for health workers, the provision of education was linked to ANC which meant that women who did not attend ANC missed out. The next section continues the theme of health care provision beyond ANC by examining the ability of health workers to provide adequate and appropriate treatment.

5.4.2 ANC at CHC and Deckia Clinic

I briefly interviewed women while they were waiting for ANC at CHC, asking where they lived, if they had ever been to school, how many pregnancies they had had, their age, where they had had their last child, and if there had been any problems. I also asked where they intended to have the next baby. A number of the women had had complications with previous deliveries. One woman from Chiri town who was seven months pregnant had had 10 pregnancies with seven surviving children. Her last two deliveries were at CHC. She said her neighbour and her husband would assist her but she would come to CHC for delivery if the birth was complicated: her definition of complicated was if the labour was over 12 hours. Another woman from Kuti (approximately 90 minutes walk in the dry season), had come to ANC because she had a headache. After the birth of her last child she had retained placenta. A woman in her early to mid twenties from Gone Woja (about three hours walk in hilly terrain) had had four previous pregnancies with two children surviving. During her last labour she also
had retained placenta and was carried on a stretcher for six hours to CHC. For her next delivery she planned to give birth at home but will come to CHC if the labour is long (over four hours). Finally, a young woman of 18 had come to ANC for a check-up and possibly had a urinary tract infection.

Before the ANC clinic started, I asked if the women wanted to sit somewhere private to be asked these questions but they were all happy to sit on the bench together. They were quite relaxed and there was a lot of laughing as they answered the questions. I also sat in the examination room and found the women were quite relaxed about having their blood pressure taken or having their abdomen examined. The CHC staff were efficient and when the woman from Erimo, who had never had an examination before, didn’t know where to sit, or how to get on to the examination table or to pull up her top to expose her abdomen, the staff quietly explained what she had to do. Nobody was asked to expose any part of their body except their abdomen. Women were also sent to the laboratory for a urine sample and a blood test.

I was also able to sit in for a few ANC examinations at Bonga Hospital and twice at Deckia Clinic. At both places I was impressed with the gentleness and rapport the staff had with the women which was in stark contrast with other examinations I observed. Privacy was maintained with the exception of my presence. Although I didn’t understand everything that was said, I knew the women were given advice about trying to look after themselves. Then they would have their blood pressure taken and their height and weight measured before being asked to lie on the examination table. I only saw four or five women being examined in Bonga Hospital and felt they were reasonably comfortable with the process. I felt that ANC at Deckia Clinic was quite different as women only came because they had specific problems (Box 15). I had the sense that none of these women had ‘normal’ pregnancies because they had all come to the clinic for a specific reason (see Table 8). They had physical symptoms such as low blood pressure, possible pre-eclampsia, baby lying in a transverse position or weak foetal heartbeat. I had a sense that those women who had never attended ANC before were very frightened as the nurse tried to examine them they would tense up and lie so stiffly the nurse would be unable to palpate their abdomen to determine the position of the baby or how many weeks pregnant they were. It was difficult to know if the problem
was that the nurse was male, or if the women thought the baby could be harmed. I wondered how much my presence at the other side of the room affected their uneasiness but was told it was common for the women to react like this (and the nurses’ body blocked much of the view). The nurse also said that some women believe his touch will take away any pain. This was confirmed when the husband of third woman who came into the clinic asked the nurse to massage his wife’s abdomen to take away the pain. One woman was unsure if she was pregnant and the nurse could not detect any sign of pregnancy but suggested she go to CHC to have a pregnancy test because she had previously had a tumour.
Box 15: ANC at Deckia Clinic

I was invited to attend the ANC clinic which is normally very busy but only seven women came this morning. The nurse invites each woman into the main room of the clinic and makes a point of shutting the door which is often not done for other patients. The woman sits on the opposite side of the desk. Most of them appear very nervous and shy. After explaining why I’m there and asking if I can be present, the woman is asked her name and if she has been before. There is a separate record book for the ANC visits with columns for name; village (some of the women have walked from other kebeles up to two hours away); age (the majority of women are in their 20s or 30s); gravida (the total number of times a woman has been pregnant, including this pregnancy, regardless of whether these pregnancies were carried to term); parity (the number of viable births over 20 weeks); no of dead children; EDD (estimated date of delivery); BP (blood pressure); Wt (Weight); Ht (Height), Foetal Heart Beat, Presentation, Week, Bleeding, Visit No, and Remarks. There are also columns for TT 1, 2, 3, and 4 (number of TT immunisations).

The nurse makes a few comments to me about the record keeping. First, TT has only been administered in the past few weeks as previously it was either unavailable or not requested by the previous health worker. Second, as the weight of the women is recorded the nurse notes that earlier weights could have only been ‘guesses’ because a number of the women have ‘lost’ six or eight kilos since they were previously seen. Third, all the women need their husbands’ permission to come for delivery. In the book I note that of all the births over the past four years, only 99 deliveries were performed at the clinic and the majority of these women were classified as ‘normal’. There were seven recorded stillbirths. I also note that the women we see in their early 30s are in their third, fifth or seventh pregnancy.

With each woman the process is the same. After some discussion about her health, the nurse takes the woman’s blood pressure, asks her to stand on the scales to be weighed and then has her height measured. All this is recorded and the woman is asked to lie on the examination table. Some of the women have clearly never been examined before and need to be told how to get on the examination table and to lie on their back. They find this extremely difficult to do, probably out of modesty. The nurse rubs his hands together to warm them and then examines the woman’s eyes for obvious signs of anaemia and then lymph glands for signs of swelling which could indicate anything from bacterial or viral infection, rubella, syphilis or toxoplasmosis. I note how quietly he talks to the woman, asking how she is feeling, trying to help her relax. He asks her to pull up her dress so he can examine her belly. Nothing else is exposed, only the belly, trying to preserve the modesty of the woman. He says to me that he never examines their breasts. I can see each woman tense up curling the toes of her bare feet and lying stiffly trying to protect herself. The nurse palpates the abdomen to feel the size and position of the baby. He is so gentle compared to the women’s fear. Yet while the women are frightened about being touched, they also believe it will help the pain. As the nurse continually talks to them, he tries to help them relax as he measures from the top of the groin to the belly button to determine how many weeks pregnant they are. When he is finished, he helps the woman to sit up and come back to the chair where he administers a TT injection.
Table 8: Women attending ANC at Deckia Clinic
(Note: First visit to Deckia: women 1-7; second visit: women 8-10)

<table>
<thead>
<tr>
<th>Location (home)</th>
<th>Age</th>
<th>Gravida/ Parity</th>
<th>No of weeks pregnant</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Two hours walk</td>
<td>30</td>
<td>Gravida 5</td>
<td>28</td>
<td>First ANC visit. Low BP 90/50 Shows signs of pain when examined.</td>
</tr>
<tr>
<td>2 40 minutes walk</td>
<td>Approx 18</td>
<td>Gravida 1</td>
<td>30</td>
<td>High BP 160/100; lower after 30 minutes rest. Possible pre-eclampsia has had frontal headaches and dizziness. Came with mother—very frightened.</td>
</tr>
<tr>
<td>3 Deckia</td>
<td>Approx 30</td>
<td>Gravida 1</td>
<td></td>
<td>Patient well known to nurse. Has possible urinary infection. Husband refused to pay 8 birr for treatment but wanted his wife's stomach massaged to take away the pain. Woman is in extreme pain, even to walk.</td>
</tr>
<tr>
<td>4 Shityio</td>
<td>32</td>
<td>Gravida 7</td>
<td>39</td>
<td>Weak foetal heartbeat. High risk. Nurse commented to me that it is an unwanted pregnancy.</td>
</tr>
<tr>
<td>5 Shityio</td>
<td>30</td>
<td>Gravida 6</td>
<td>24</td>
<td>Baby transverse. Advised to sleep on left side.</td>
</tr>
<tr>
<td>6 Daga</td>
<td>28</td>
<td>Gravida 4</td>
<td>25</td>
<td>First ANC visit with this pregnancy or ? first ANC. Very tense and uncomfortable about being examined.</td>
</tr>
<tr>
<td>7 Mid 30s</td>
<td></td>
<td></td>
<td></td>
<td>Woman unsure if she is pregnant. No pregnancy detected but referred to CHC because she has had a tumour. Last child 18 months old.</td>
</tr>
<tr>
<td>8</td>
<td>30</td>
<td>Gravida 3</td>
<td></td>
<td>First ANC visit. Very frightened and unable to relax during examination. Said husband's father will help with delivery.</td>
</tr>
<tr>
<td>9</td>
<td>22</td>
<td>Gravida 3</td>
<td></td>
<td>Has come for FP not ANC. Doesn't want any more children as she was abducted at age 13. Sad and despondent.</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Gravida 7</td>
<td></td>
<td>Although pregnant has come with her husband to enquire about FP. So exhausted she looks traumatised.</td>
</tr>
</tbody>
</table>

On my second visit to Deckia, two women attending the ANC clinic came to enquire about FP. The first was a woman who had three children. She volunteered the information about her abduction at age 13 (which is one form of marriage in Ethiopia (see Pankhurst 1992:105-6)) and asked about preventing further pregnancies. The last woman I saw at Deckia Clinic was a woman who looked so worn-out with her seventh pregnancy that I thought her husband who accompanied her must now agree that this would be her last pregnancy. They were assured that after the baby was born, she would be able to have the Depo-Provera shortly afterwards.
5.4.3 Being (un)able to provide adequate and appropriate treatment

The health workers expressed many issues and problems regarding their ability to provide adequate and appropriate treatment for their patients. Many of them described how the lack of equipment and supplies meant they had to ‘make do’ with what they have (Photo 16). My observation at the health facilities I visited was that the supply of drugs and equipment was patchy and that the Revolving Medicine Fund was not functioning as most health facilities were unable to purchase drugs to replenish those that had been dispensed. Starting with the health posts, one HEW said: *There is no refrigerator or scissors, only gloves. We don’t have the equipment to do delivery here; we do not have a stretcher made from metal— they make from wood— what if the wood is broken?* (Emabet). Another HEW also had no refrigerator and no scissors but she had gloves (Abeba). Yet another HEW had a stethoscope and sphygmomanometer to measure blood pressure, one pair of scissors, gloves (which she had borrowed from...
other health post), and a refrigerator which is not working (Elizabet). One health post which was built by SUPAK (now KDP) had a sink and a tap but no water because there had been no rain to fill the tank, electric lights but no connection to the electricity grid, and a working refrigerator. I asked if they had Ergometrine (which requires refrigeration) and was shown the expired packets (by two years) sitting on the window ledge and was told they had been unable to get new supplies.

In this interview excerpt from one of the remote health posts, the PHW69 describes the supplies and equipment.

Ruth: Can you do examination for ANC? [There is no examination table, refrigerator or any other equipment in the health post, only a desk and a couple of chairs and two benches].
Amanuel: We use two benches.
Ruth: Can you give antibiotics here?
Amanuel: Just vitamins and iron for the pregnant woman. We are trained how to give antibiotics, we just don’t have any.
Ruth: How many births would you attend?
Amanuel: About four or five a month.
Ruth: So if there is a problem during delivery do you have any equipment or any drugs to help?
Amanuel: We have anti-pain medicine, paracetamol.
Ruth: And after the birth, if she is bleeding?
Amanuel: Nothing—no Ergometrine.
Ruth: If she’s bleeding what do you do?
Amanuel: She has to go on a stretcher [to Chiri Health Center].
Ruth: Is there a stretcher?
Amanuel: They make it by themselves.
Ruth: How long will it take to carry her?
Amanuel: Three hours because many people will help carry her.

For the HEWs and PHWs who are expected to spend 80 percent of their time in the community rather than at the health post, it can be difficult to balance all their work commitments. They are all called about once a week to attend to a birth. One HEW said she covers seven villages which means she is responsible for about 400 houses and 2,400 people. She said that when she goes to do outreach from house to house, there are many people waiting for her return to the health post for FP or other services (Elizabet).

In 2007 there were many HEWs in training with the plan that each health post will have

69 Although PHWs have received more training and are able to provide more complex care than HEWs, their positions are being phased out in favour of HEWs.
two HEWs, but most of the HEWs I interviewed were still working alone. This meant that if they were called out to attend to someone in their home, they had no option but to leave the health post unattended. Another person I interviewed, an experienced nurse midwife, described how difficult it was to balance the workload and manage with insufficient and qualified staff. He cited this example: it’s so difficult to take care, when you are coming to our staff and I am doing assessment, and other things, an emergency is coming with human bite, I will leave you to suture, then I am suturing, there is a delivery coming, it is frustrating, so I leave this fracture or whatever, I go to this EmOC so that is the problem (Yonas).

That adequate and appropriate treatment was not viable much of the time was taken for granted by the health workers who talked about difficulties moving around the Zone, the lack of funding and the difficulties people had in paying for treatment. When I presented a hypothetical question about the birth location (depending on the age or gender of the person) if they or their wife or daughter was to have a baby now; I was sometimes told it would be OK for the woman to give birth at the health facility where the interview took place as long as the woman did not have any diagnosed problems during ANC. However a number of people thought it was unacceptable and said that they or the birthing woman should go to Jimma or Addis Ababa. One of the health workers at Bonga Hospital was hesitant to give me an opinion and it was only when I asked the question more directly... are you happy with things at Bonga Hospital? At this moment? The person asked.

Yes I replied.

There is no confidence, no manpower, no anymore for staff, everything is not good, shortage of room, shortage of class, shortage of materials, everything is not available, contamination, according to the economical problem, just the same, if there is any treatment they can come, they fear the many payments, the women they haven’t any money at village area for that purpose simply she sit in that gojib besu [hut] which is made of grass and she collect her baby and she simply lie down and she get the problem. The problem is created if everything is difficult, if they enter to the community that birth attendant she doesn’t understand... Not everything is available, it is not good management, there is some problem, no, it is not convenient, it is not comfortable, this is
the problem for a woman. If it is available to go to the higher referral hospital, it is a different problem, to curb their life; if they come here we have to help them, to say that’s not good for her confidence.

5.4.4 Conceptualising women and birth

International research has shown that identification of high-risk pregnancies during ANC has had limited successes in reducing maternal mortality as many complications cannot be predicted prior to birth (WHO and UNICEF 2004). ANC is now intended to focus on promoting health and health-seeking behaviours including birth preparedness (Campbell and Graham 2006:1294). From my interviews I concluded that some health workers rely on ANC to predict abnormal births especially to determine the position of the baby and refer for malpresentation. Health workers stated that women would only come to a modern health facility for ANC if there is a problem, if they are in pain or want to determine the position of the baby. *If everything is normal she will give birth at home* (Sr Zewditu). Surafel, a senior nurse, said that: *For delivery, almost 90 percent of them are normal delivery, they don’t need to come here, they deliver at their home and some are, around five percent after delivery they have obstructed placenta, then we go to their home to deliver the placenta, and some are, stillbirths. Stillbirths are common here; around two percent is stillbirth here.* Nevertheless, women who came with other problems such as swelling, pain or high blood pressure were not necessarily expected to give birth at the health facility. I concluded that many of the health workers also considered birth to be a ‘normal’ event at home unless a problem developed during the labour itself. It is likely that there is a certain amount of fatalism because maternal death is seen as an outcome of complications.

Other health workers such as Emabet (HEW) said that even if people recognise there is a problem, they don’t perceive how serious it is but instead they just hope things will get better: *The people expect that the woman will have a baby very soon that’s why they did not call.* There is also a cultural taboo about staying in the dark (Sr Zewditu) or not telling others if there is a problem because it might bring bad luck (Surafel and Rahel). Sr Aster reported that people say: *She can deliver now, don’t worry, don’t hurry. But if they do that she can pass, there is some problem and lastly she become weak and the baby*
becomes in distress, they bring on that situation, on the stretcher, not any good result, she can pass away, the baby will pass and she can develop infection, she can get fistula, that type of things, early, if they didn’t bring early.

Surafel explained that one of the main problems was that women don’t come on time for treatment. Because there is not enough equipment he had to refer women to Chiri or Bonga so we tell them, not to kill time, they should have to go on time, and otherwise it is forbidden.

Ruth: If it is forbidden, is it because she shouldn’t go outside, why is it forbidden?

Surafel: They don’t care about one thing, they look at everything so easily so to frighten them, so they think maybe she will die, they think that, they think she will be managed at home if they don’t they think that we are not OK to do that.

Ruth: How long do you think a woman will be in labour before calling health worker?

Rahel: I don’t have information, but when the woman is in labour family members don’t want to let the other neighbours know about her, this is a kind of confidence because of a belief she will die. Then if the woman is suffering from pain they will let her stay in secret….one day, when we ask them, after the woman has been brought here, the family members say it started yesterday.

Of the two untrained TBAs I interviewed one felt that the length of labour, if it was strong, should only be four hours. (Dawit) said from now (mid afternoon) until tomorrow is too long. However, Aberash, the other TBA gave this reply: Busho hayillona angigata kejjee qeemmon maxo maanee.

If the baby is fat, it takes three days.

Each health worker (including the TBAs) has had different experiences with birthing women yet their comments illustrate the tendency to dichotomise birth as ‘natural’ or ‘normal’ or else ‘abnormal’. And ‘normal’ or ‘traditional’ birth appears to be redefined as ‘medical’ or ‘modern’ when there are problems during birth. This is imagined in the location of birth and who attends. Whether the health workers are in Bonga Hospital, or
in a remote health facility such as Deckia Clinic, they share similar frustration that when something does go wrong they are not called earlier or that the woman is not brought early enough to be treated. These comments are made despite the inadequate equipment and supplies available to them. Furthermore, the health workers share a common understanding about Kafa Zone's topography as it impacts on the women and their own ability to move around freely especially in the rainy season.

5.5 Discussion

This chapter began asking rhetorical questions about natural and normal childbirth because the literature abounds with examples of birth being conceptualised in terms of binary oppositions. Is natural, normal birth just part of everyday life that takes place at home in conjunction with traditional birthing postures and practices? Does medicalised childbirth takes place in a health facility using 'modern' birthing practices? Boddy (2003) points out that 'self-evident statements are seldom transparent; they are clues to the presence of naturalized cultural assumptions that demand to be explored' (2003:60-61). As an example, Knutsson (2004) observes that TBAs and other women in Addis Ababa do not speak of birth in terms of 'normal' or 'abnormal': 'Childbirth is in itself a 'normal' event. Women get pregnant and give birth; that is the natural way of things... the fact that women and children die in childbirth is also seen as part of life. It is in that sense part of normality' (2004:145). Using ethnographic data and not just epidemiologic data or statistics means that maternal mortality and disability can be seen from the perspectives of the women, spouses, neighbours and health care providers in a way that shows how 'case-unique constellations of risks, in the context of individual and family decision-making' (Janes and Chuluundorj 2004:249), can be brought together to enable better understanding of the contextual factors that contribute to maternal mortality or disability (e.g. Hay 1999). For Obermeyer (2000), risk strategies related to childbirth can be expressed as:

a continuum of possibilities: the archetypal modern birth at one end, with its multiple alternatives and its panoply of interventions, all construed as increasing safety, and the traditional birth at the other end, with its diffuse risks, limited management options, and its focus on a woman's capacity for endurance (2000:193).

The argument in this chapter is that there appear to be two ways of knowing about birth: at home and in the hospital [and I would add health centre] (Knutsson 2004:176). In most cases, from the women’s point of view, home is the first ‘choice’ for the location
for birth—the biomedical option is only ‘chosen’ when the something goes wrong or the situation is deemed to be ‘abnormal’ because of haemorrhage, obstructed labour or retained placenta. From a biomedical point of view, around 15 percent of all deliveries are expected to develop serious complications. Most of these could be prevented by timely medical treatment. However, a decision to seek care, whether self care, traditional, modern or a combination of them, depends on the cause to which an illness such as prolonged labour is attributed. In the first instance, traditional remedies may be tried because that is what is available and accessible (see also Thaddeus and Maine 1994:1098). What if a woman’s husband owes money? Will passersby bring bad luck and prolong labour? For Sara, passing birds bring good or back luck: There is a bird with white on the chest and black on the back and it says ‘shah tai, shah tai’. It is saying, don’t be frightened. We are happy when we hear this bird sound. The bird says, fight against. If we hear another bird say ‘koi, koi, koi’ it’s not good for her, something might happen to her, she might die.

When birth is at home, the data shows that suffering, pain, bleeding, or birth at night are managed by shouting, holding the woman tightly from behind, hot drinks, massage, pressing a plate on the abdomen, urging the woman to be stoic or just to wait for the baby to come. A number of women also mentioned prayer as a ‘palliative strategy’. Most of the women were able to describe what happened during labour and a number of the problems that could occur during birth. For some women this was from personal experience, while for other women it was something that had happened to women they knew. Nevertheless, in the community it appears that there can be considerable delays to seeking assistance as prolonged labour or waiting-to-see if the baby will come is also somewhat ‘normalised’. Abaynesh’s husband said they watched and waited for the baby to come for two days. Birke kept hoping the baby would come. It is difficult to estimate exactly how long women should wait but it seems they should be stoic and strong during the labour. For some women, having others around brings bad luck and having a husband owing money brings bad luck. Perhaps the most rational interpretation of waiting-and-seeing (Kloos et al. 1987:1016) is the possibility of dying on the way. I would suggest that the reason people delay relates to all these factors as the alternative involves considerable negotiation with the larger community to carry a woman to a health facility. On the other hand, from a biomedical point of view, there has tended to
be an assumption in policy and other documents that there is a ‘low awareness of danger signs and symptoms during pregnancy, labor, delivery, and post-partum’ (MOH 2006a:16). It is also understood that a number of these actions people take at home and those of the TBAs may contribute to delays and taking more proactive steps (MOH 2006b:29). It would seem that there is still much potential for TBAs as they are already supporting birthing women in most rural settings. From my observations and the comments by Dr Befekadu, a TTBA such as Segenet is more likely to know when to refer a woman experiencing difficulty than untrained TBAs such as Aberash and Dawit.

If a decision to seek biomedical care is taken, the importance of good relationships with relatives and neighbours becomes paramount as these people will be asked to lend money, to help make a stretcher and to carry a woman to the nearest health facility. In these instances the mountainous terrain, the long distances to travel and lack of transportation also contribute to the delay in reaching a health facility. Many women die on the way. Yet distance to a health facility or attendance at ANC appeared to have no bearing on the planned location of birth with two exceptions: Makeda’s first baby was born in Bonga Hospital following the advice of medical staff during ANC. And Meseret planned to give birth at CHC but the labour started ‘nine days early’ (five days after her return to Agaro Bushi). In the end she was taken to Chiri by stretcher but lost the baby on the way.

Even though women did not speak about birth using terms like ‘natural’ or ‘normal’, or ‘safe’ or ‘unsafe,’ I would suggest that they feel that giving birth at home is ‘normal’. It is likely it is ‘normal’ because almost all women give birth at home and they are supported by close relatives and neighbours. For Sara, it was ‘abnormal’ because she felt she was alone. And it is ‘normal’ to give birth at home even if there are problems because there are traditional practices to deal with the problems. However, it is always ‘abnormal’ or even ‘unsafe’ to go to a health facility—when things are can not be not dealt with at home. Decisions about transfer to a health facility if something goes wrong are not made by the birthing woman (see Chapter 4), those who make the decision, the woman’s husband and other close relatives and neighbours who have had no training about when to refer a woman to skilled health personnel, will be those who make and carry the woman on a stretcher. There is no doubt that by the time a woman reaches a health
facility it is likely there is little time to provide the lifesaving care she needs. It is also clear that there are considerable delays in receiving adequate or appropriate treatment once a health facility has been reached (Thaddeus and Maine 1994; Jackson 2007). And if birth is at night, it means waiting until the morning as no one will travel at night. Because the biomedical health system is only used when a birth is seen as ‘abnormal,’ a picture emerges of ‘unsafe’ childbirth denoting those births that are transferred to a health facility such as Bonga Hospital or CHC. Thus it is likely women feel it is ‘unsafe’ to go to a health facility because of the very real possibility they will die on the way. On the other hand, for health workers, ‘unsafe’ birth takes place in the home and a ‘safe’ birth is one that they are in control of in a health facility.

As stated in Chapter 1, the basis of introducing maternal health services in developing countries means that the location of birth is relocated from home delivery to health facility based delivery. In Ethiopia new health facilities are intended to bring health programs closer to the community and fulfil the government strategy pertaining to decentralised health. Concurrent to these changes is the medicalisation of maternity care (Koblinsky et al. 1999:404). The Ethiopian National Reproductive Health Strategy (MOH 2006a) aims to increase the percentage of births attended by skilled health personnel either at home or in a health facility from 9.7 percent to 60 percent by 2015. Using the basic framework developed by Koblinsky et al. (1999:400-1), Table 9 shows the features of maternal health service organisation (including where women give birth and who performs deliveries) applied to Kafa Zone using community based data (Habtamu Argaw 2002). Most rural women (95.8 percent) deliver at home attended by their neighbours, mother, mother-in-law, husband or sister beyond the reach of modern health facilities. To reduce maternal mortality or disability, family members or sometimes a TBA must recognise there is a problem and organise access to essential obstetric care with the HEW at a local health post if it is available. Under Model 1, birth still takes place at home or at the health post but with the HEW in attendance (currently 3.3 percent). If there are problems, the HEW should be able to provide basic care and refer the woman to the nearest health centre or hospital. Under Model 2, birth takes place at Chiri, Ghimbo or Wushwush Health Centres (0.9 percent) where trained professionals can recognise complications and provide either basic essential obstetric care or early referral to Bonga Hospital. Bonga Hospital is the only facility in Kafa Zone that can provide
EmOC (Model 3) although there are still instances, if the surgeon or anaesthetist is not around or there is a need for a blood transfusion, that a woman is still transferred to Jimma Hospital.

Table 9 shows that Ethiopia is aiming to provide Model 1 type of maternal health care which will potentially reduce the MMR from 720 to 115 (as in rural China) or 120 (as in Fontaleza, Brazil). The actual aim of the Reproductive Health Strategy is to reduce the MMR 350 (MOH 2006a:18). However, the main actors in this strategy are the HEWs who are trained in clean and safe delivery and recognition of complications to enable early referral to the appropriate health facilities that is equipped and staffed to provide comprehensive EmOC services. The HEWs and PHWs interviewed attended only four or five deliveries a month and were expected to deliver 16 health packages including ANC, first aid, growth monitoring and immunisation which meant that they had a huge workload. Koblinsky et al. (1999) argue that it is difficult to achieve success with this model when maternal mortality is high: nevertheless, ‘it is clearly desirable to make this model work, since nearly half the women in developing countries give birth at home in the presence of unskilled attendants’ (1999:400).

The HSDP is also using medium to long term planning to manage a ‘transition to predominantly professional providers of care’ in Models 2 and 3 and it is also argued that this transition requires ‘strong political support and long-term planning as a foundation for progress’ as well as ‘infrastructural investment’ (1999:404). As the data from this chapter shows, only a small number of births are referred to health centres and Bonga Hospital. This includes early identification of its location and the means to get to a skilled provider (Mihret Hiluf and Mesganaw Fantahun 2008:16-17). Although education was identified as one of the main roles of the HEWs and other health workers interviewed, most stated that women who did not attend ANC generally missed out on this information. The only divergence from this was from HEWs who visited and provided this information to women at home. Other significant barriers to referral for birthing women and their families include distance, lack of transportation, cost and quality of care. These factors are magnified if assistance is sought at a health post, health centre or hospital and these facilities are forced to refer women to the next level of facility.
### Table 9: Current utilisation of maternal health services in Kafa Zone

<table>
<thead>
<tr>
<th>Who delivers</th>
<th>Where birth takes place</th>
<th>Referral Capacity</th>
<th>Examples from other countries: with MMR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home</td>
<td>Basic EmOC facility</td>
<td></td>
</tr>
<tr>
<td><strong>Non-professional</strong></td>
<td>At home (95.8 percent of women). TBA, husband or neighbour recognises complications and contacts HEW.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Professional</strong> (provides clean and safe delivery)</td>
<td><strong>Model 1:</strong> At home or health post (currently 3.3 percent). TTBA or HEW recognises complications and provides basic essential obstetric care.</td>
<td>Referral and transport needed for serious complicated cases. Many barriers and may involve long distances.</td>
<td>Rural China (1994):115 Fontaleza, Brazil (1984): 120</td>
</tr>
<tr>
<td><strong>Professional</strong> (skilled in antibiotics, uterotonic agents, assisted vaginal delivery, anti-convulsants, manual removal of placenta, removal of retained products)</td>
<td><strong>Model 2:</strong> At health centres such as Chiri, Ghimbo or Wushwush (currently 0.9 percent). Professional recognises complications; provides essential obstetric care and basic EmOC.</td>
<td>Assumes functioning essential obstetric care available in selected health centres. Referral and transport needed for serious complicated cases. Many barriers and may involve long distances.</td>
<td>Malaysia (mid 1980s – 90s): 43 Sri Lanka (1996): 30</td>
</tr>
<tr>
<td><strong>Professional</strong> (skilled in all EmOC services plus Caesarean Section and safe blood transfusions)</td>
<td><strong>Model 3:</strong> Bonga Hospital (included in Model 3). Professional recognises complications; professional provides basic and comprehensive EmOC or refers to Jimma Hospital.</td>
<td>Referral and transport for complicated cases if the doctor is not around, if there is no blood transfusion, no power etc. Barriers such as cost and difficulty organising transport to Jimma.</td>
<td>UK: 9 US: 12 Urban China: 20 Mexico City: 114</td>
</tr>
</tbody>
</table>
There is an implicit expectation that community members will assist with making the stretcher, providing transportation and money for the cost of treatment. Moreover, while distance delays access to appropriate treatment (Cham et al. 2005:5), it is also a key difficulty for health workers in remote locations who must travel to the woreda capital each month to lodge reports and pick up medical supplies. In the rainy season this travel is even more difficult and sometimes impossible. Yet I observed that the Decha Woreda Health Desk for example, organised numerous campaigns for polio, measles, and Vitamin and Albendazole, that required significant logistical efforts and resources. For these reasons, during my fieldwork I concluded that MCH Programs have not been prioritised by the region, the Zonal Health Department or NGOs due to lack of funding and political will. As stated in Chapter 1, in the short to medium term, as health coverage increases more and more sick women will initially seek care, but over time as more women who are less at risk seek care, the average mortality in those seeking care will decrease (Ronsmans et al. 2010:292). Following Afsana and Rashid (2009), I would suggest that as the Ethiopian government cannot afford to provide adequate obstetric services to six percent of births, there might be ‘a dreadful situation if the number of births at public hospitals increases’ (Afsana and Rashid 2009:132).

Thus far, women base their understanding and interpretation of childbirth on their own experience and that of the other women they know. And despite the fact that each woman has her own story, childbirth appears to be a part of everyday life unless something goes wrong. It is not so much that the goals of the Reproductive Health Strategy involve atypical behaviour because women are well aware that problems that arise during birth may well involve travel to CHC or Bonga Hospital. Chapter 7 extends this theme beyond the women and explores other reasons why women give birth where they do: Who is giving birth—where and why? But first, Chapter 6 describes the theme of development and change in Kafa Zone which is seen as an essential component to reducing maternal mortality and disability.
Chapter 6: Development and change in Kafa Zone

Development and change is a theme that is directive, pervasive, and elides ‘in a single concept notions of increased output and improved welfare’ (Cooper and Packard 1997:4). Development interventions have included policies and strategies for improving health, including maternal health, and Ethiopia’s Reproductive Health Strategy aims to mainstream reproductive health and ensure its place in the national development agenda (MOH 2006a:7). This chapter introduces the government staff and staff of NGOs in Kafa Zone who could be called the development agents or agents of change. It describes the perceptions they have about government development policies, strategies, and implementation. Decentralisation now connects the experiences of government and NGOs in Ethiopia with development theories in health care provision. Decentralisation also encompasses how the top-down planning approach restricts planning and development to the various pre-existing sector plans. It was also a condition for IMF/World Bank sponsored structural adjustment programs which have dominated development policy since the 1980s. The next aim of the chapter is to describe how development works in practice. In doing so, I draw attention to the NGO sector and its operations in Kafa Zone by examining NGO programs and some of the operational issues they confront. I then look at ‘Community participation’, ‘Development funding’, ‘Cost of services and corruption’ and finally ‘Development and women’s education’ which looks at the links between women’s status, maternal health and development.

Before I describe the local government and NGO sector and how development and change takes place in Kafa Zone, it is important to restate that while development is highly adaptable and its interpretation varies from place to place, the initial mandate for international development appears to originate with international organisations and agencies such as the United Nations, the World Bank and the IMF. Chapter 1 summarised the way development theory and reproductive health policy have influenced developing countries. In particular, an extensive range ‘of actors with different interests and influence’ (Lush and Campbell 2001:180) have been involved with international reproductive health policy actions over the past 50 or 60 years: these actions have been increasingly defined, explained and controlled through biomedical knowledge and practice (Obermeyer 2001). While the mandate for international development in Kafa Zone is external, it also derives from the Ethiopian Federal Government and its regional
counterparts which ‘still rely heavily on traditional hierarchical approaches to development’ (World Bank 2001: Section 7). As stated in Chapter 1, the Ministry of Health is responsible for ‘policy formulation, standard-setting, issuance of licenses and qualification of professionals, establishment of standards for research and training, coordination of external loans and grants’ (World Bank and MOH 2005:84). The federal government provides budget support to national health programs by devolving spending authority and a share of the national budget to regional health departments (which run autonomously) thus maintaining their dependence on the federal state. In turn, the regions delegate broad powers over local development to the woreda councils, who have responsibility for planning and implementation of all woreda development programs including the construction of schools, health and veterinary facilities, water points, tracks, agricultural development programs and the protection of natural resources (World Bank 2001: Section 7.40). While the Bamako Initiative and subsequent health sector reforms mandated user fees for basic health care funding (James et al. 2006), most maternal and child health services in Kafa Zone do not appear to have a fee for service but patients may be expected to pay for medicines and medical supplies such as gloves, needles and syringes. The interview data are consistent with the view that decentralisation in Ethiopia is characterised by ‘deconcentration’ or administrative decentralisation which shifts the central authority to regional authorities: it does not devolve power but takes advantage of established bureaucratic disciplines and a tradition of popular compliance with authority (Manor 1999:9; World Bank 2001: Section 7). This is very much the situation in health in Kafa Zone.

6.1 Development in Kafa Zone

The Ethiopian government’s core development objective is to reduce poverty through economic growth based on a free market economic system. One of the main aims is to use ADLI to enable Ethiopia’s economy to develop rapidly to reduce its dependence on food aid. The main beneficiaries of economic growth should be Ethiopia’s poor (Federal Democratic Republic of Ethiopia [FDRE] Ministry of Finance and Economic Development [MOFED] et al. 2002:36). The World Bank’s Country Assistance Strategy also aims to foster economic growth, improve access to and the quality of basic services, reduce Ethiopia’s vulnerability and to foster improved governance (World Bank 2008a). Local woreda development programs focus on rural water supply, rural roads and
agricultural extension, primary education and PHC. The health policy aims ‘to give comprehensive and integrated primary health care services in a decentralized and equitable fashion’ (MOH 2006a:5) by focusing on maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases with the ultimate aim of improving people’s health status and thus achieving the MDGs (MOH 2005:xii). HSDP III promotes ‘meaningful participation in local development activities’ with administration of public health occurring at the regional level and planning and political administration being done at the woreda level (2005:3). During HSDP III 2005/06 - 2009/10, Ethiopia aims to increase the potential access to health posts from 20 percent to 100 percent, and health centres from 18 percent to 100 percent (MOH 2006a:67).

During interviews I asked government staff and staff from NGOs what they thought development meant. They referred to development as: economic development, the construction of roads and bridges, clean water supplies, electricity and telephones, schools, health centres, hospitals and so on— the more visible or tangible signs of change. For some of the NGOs, development means that they provide services on behalf of the outside donor. But other staff reflected on the exclusion of some members of the community such as women or the Manjo people and how these groups of people should be included in development.

One NGO manager said that development was related to modernisation: We don’t philosophise about the meaning of development. We have many problems. We see development from the point of education, food security, valuing ourselves. NGOs work in collaboration to change the picture of the country, also construction of buildings, roads— to educate the people to help themselves and care for the environment, care for their health/ build the philosophy of the west side by side. Technical things like mobile phones will help us; globalisation, we cannot separate ourselves from the world. People are illiterate, food insecure; we have to work to reduce these with the government, to change the picture of the country. Development is change: modernisation, education and so on (Alemayhu, NGO manager).

Temesgen, who worked at the same NGO, linked development with the freedom to work and bring about changes and its benefits to the community by building health
centres, roads and clean drinking water. Similarly, Haile who is an NGO manager defined development primarily in terms of physical infrastructure: *It means transportation, electricity, roads, schools, telephone. Before 50 years ago there was only one high school, now there is in woredas, in Chena, Wushwush, Tello. This is development. Before we didn’t know what the meaning of telephone, communication was; now my father’s house is from here, four hours, but I can communicate with him by telephone, before we couldn’t do this. This is a kind of development. There were no health centres, now there is in Chiri, Decha and so on.*

Tesfaye was the manager of another NGO in Bonga. He described its activities in economic terms that should benefit everyone in Kafa in general although there was a focus on people from discriminated groups who need to be fully engaged in local development. This NGO was involved in many projects: they negotiated with Omo Microfinance to support women’s groups; they worked to reduce the social exclusion of minority groups; and they built farmers’ organisations to enter into new businesses specialising in spices, coffee and honey. An important part of the Community Initiated Projects (CIPs) focused on enhancing the social and economic status of women. Forty women had been assisted to start businesses in enset processing. The coffee cooperative that had been set up had not paid a dividend to its members but the honey cooperative had paid 300 birr to each member for the first time in 2007: *There is huge potential with the forest in Kafa, huge potential for honey production.* Tesfaye also commented that the aim in Kafa Zone was to bring tangible things in organising the honey cooperative or the women’s income generating groups. *All our income generating activities we do in partnership with the government.*

People speak about change in a positive way when they describe economic growth or the visible signs of development such as road building, telecommunications, health centres and so on: *I hope change will come, gradual change in town... now there is radio in every kebele, telephone, but change is slow, not radical change, gradually, the change will come* (Temesgen, NGO staff member). An extensive explanation of development came from Michael, a senior government staff member in Kafa Zone. First he said: *We are an undeveloped country; we consider more rapid economic development: linked to bring*
that productive development we have different policies. The first policy is rural
development, the biggest goal because more than 80 percent of the population are
farmers related with agriculture development so that first of all we have to grow or to
develop rurally, then after that we can extend to industry and development. He talked
about other policies related to development that included reproductive health and the
population policy, urbanisation, and also micro institutions for development in urban
and rural areas. And lastly there is a cultural policy because there are a lot of harmful
traditional practices and we are working to improve that especially with the harmful
traditional practice of early marriage, polygamy marriage, we have to exclude all these
harmful practices. That's all related to our economic growth by now; we are practicing all
these policies, integrated, not separate. The biggest objective is rural development, but all
these belong to development, yes they are all integrated. So when we see sector
development programs, we have education sector development programs, health sector
development programs, and other programs related just to poverty and to reach our
MDGs that we are expecting what you have mentioned, to reduce maternal mortality,
infant deaths we are practising all these are integrated, they can assist, they can help us
with economic growth. We are working on all these policies together and during our
annual plan we are trying to test which goals can reach with different sectors. All these are
related with our economic development.

This explanation reveals the complexity of development by means of modernisation:
rural development, demographic change, economic development, urbanisation and
cultural change which help reduce harmful traditional practices. However, for Ethiopia,
the primary objective is rural development because the majority of people still live in
rural areas. Another explanation is that these visible signs of change or development
such as roads or health centres are how Ethiopia defines development through the
government's sector development plans. These things are measurable by the number of
kilometres of road construction or the number of health facilities built—critical issues
for the local government staff and staff of NGOs—without them, none of these people
would have employment. The emphasis on the numbers attached to physical
infrastructure such as roads and health facilities could also be interpreted as the way to
satisfy funding bodies who expect positive outcomes.
Interviews with many of the government staff and staff from NGOs revealed a mixture of optimism for the future along with some insights about the difficulties along the way. Several people compared the past and the present. Getachew, an NGO board member, stated that there was no health facility in Bonga 15 or 10 years ago but now we are building health centres in the woredas and health posts in the kebeles. Even if change is slow people can look to the past and see that there has been significant improvement in roads as it is now possible to reach other parts of the Zone in a couple of hours whereas in the past it took many days by mule. Michael also described how much change there has been in the past 10 years: Kafa will get better—in 1993 our budget was 16 million birr but by now from government treasury, it’s 115 million. That shows that government investment is getting more and more. After September we start construction of the asphalt road from Jimma to Mizan, the main road. Before there was only one road to Ghimbo woreda and Chena woreda that connected zone with road. Eight woredas can communicate, even Chiri, you can go by mule before 10 years we are riding mule for more than eight or seven hours to go from Bonga to Chiri... or [to leave Bonga at 6 am] and reach Gesha at 8 am. Before it takes three and a half days. That makes me an optimist because otherwise you can’t see or get development.

Michael also explained that local communities must be involved in development. The government policy about road building means that community roads must be constructed by the community in the dry season and are not the responsibility of the woredas. Rural roads have to be constructed by the regional/federal government but we are backward from this, we are not developed, and even in Bonga we have this muddy road. The construction of rural bridges, we have to construct local bridges to carry out on mules, they can be brought, but to construct new bridges or rural roads that is not feasible for government. That might be constructed by community.

In relation to travel, I related my experiences waiting for buses to leave and how a bus that is licensed to carry 25 or 30 people will not leave until it is overcrowded. Was there a shortage of buses? Michael stated that these businessmen are not well trained or well disciplined or not obeying government regulation. They are just trying to be wealthy at once and they take 50 or 60 persons in one Isuzu or one mini-bus. That’s our problem,
not a shortage of buses. If you see in the bus station there are empty buses sitting there. That’s an artificial problem because the driver needs to get more, to put a lot in his pocket, for his assistance, to traffic policeman. We have to fight all this with government regulation. We are trying to improve day-to-day because there is no shortage of bus here. Yet I still felt there was a shortage of buses because whenever I was in a bus we always passed people wanting a ride, enough people to easily fill another bus, especially on market days. And on non-market days many buses would not travel at all so there was no possibility of getting a ride. This could mean a long wait on the road to reach Chiri or Bonga. No buses travelled past Chiri which meant the only vehicle transportation was the occasional Isuzu which were usually restricted to market days. Given the key role of transport in bringing people and goods to markets or to health facilities in Bonga, I felt the lack of transportation was not emphasised enough in development planning.

Worku was an NGO staff member who has worked for two NGOs and been in Kafa Zone for many years. He defines development quite differently to other NGO staff by saying that development is much more than visible signs such as buildings and technology: development must be more holistic and address human issues such as freedom and security as well as the environment. He cited education, building trust, preparing people for change; all these are facets of development and they take time to develop: It is sometimes dynamic in understanding; all the different parameters come into picture to define development. In the past, most of the people especially in the developing countries, consider development when you get technology, construction, but now, most people, especially officials at the local level, when you go down to the village, woreda, they see construction of buildings, cars, these are all signs of development, computers, but they give less attention to those human mentality, psychological satisfaction, freedom, security, all issues which are important, the environment, these all come in a mentality. During the interview Worku expressed how systematic development and change can become possible because people who might never have met in the past now make new connections by meeting at the marketplace on Saturdays: This sort of connection will give them a vision to think themselves, with all the system, they start thinking as a system, the wider system, the community... they bring change on
its own... in fact, the driving force was structure, systematic result comes from very little action, and change can multiply this way. And that is the best change, I dream. Worku went on to explain how important formal and information education is to create trust in the community and that it is not enough to lecture people about culture, gender, development, nutrition, and so on. He cited another example whereby reproductive health officers from another NGO (where he previously worked) were concerned with distributing as many contraceptives as possible to women without providing any education or information about side effects.

Worku also referred to new problems in Kafa Zone because economic development takes priority over the natural environment resulting in large tracts of deforestation. Part of this problem was caused by donors and the central government because they prioritise road construction and the road follows investment without considering the environment. Unlike the rest of Ethiopia where there is virtually no forest, Kafa Zone is expected to finish all the forest to reach its share of the impact....the investment desk is interested in splitting all the wetlands for investors so they have been giving to investors without any consideration on the ground—environmental, endemic birds which we need to conserve to maintain the ecosystem. They said [the government planners], does it bring money?—[and I said] it's very important for the whole ecosystem and that has a benefit more than money and they said investment is one of the big issues which development is reliant on, so it can't be our priority (Worku). One of the most obvious results of deforestation was when both roads and houses were washed away with heavy rain in the rainy season.

Hailegebriel, who was the manager of another NGO, was very pessimistic about development in Ethiopia in general and Bonga in particular. His outlook for the future for the local community is quite bleak: The main issue is that we don't know what to do. The only model we have is the West, which we do know is not the right one—what else can we follow, what else can we bring—if we know it is not the right model, why should we bring them anything. Addis Ababa— with buildings, wide roads— we want it modernised and that's it finished. And then you come to Bonga, in Kafa, and Kafa is much better off than other parts of Ethiopia. In five, ten years—we will see big
improvements in big infrastructure like we are seeing now, roads, technology, mobile phones, but no real change for the community. We'll keep the health post like it is now, we'll keep education at the quality it is now, my really big worry is not five or ten years time what about 100 years. I don’t know.

All the government staff and staff from NGOs that I interviewed recognised that development meant potentially beneficial change but they also recognised that sometimes change brings its own problems and that everyone may not benefit. Many of those interviewed articulated that there was a gap between the government’s policies and strategies and the implementation of those policies and strategies. For Hailegebriel, this gap resulted in a feeling of cynicism about development and he wondered if he was just wasting his time. He cited government employees who sat down to discuss protecting the forest one day and on the following day would meet with investors to give them permission to cut down the same forest. He also expressed frustration because the federal government is seen to follow international policy such as building health posts, one health post per kebele and so on, and then in a year or two, you have a very nice statistical data about health posts but no budget for equipment or supplies.

Overall, what the interviews with government staff and staff from NGOs in Kafa Zone show is that the essential characteristic of development is derived from modernisation, economic growth and the more visible signs of change. This may have resulted from me asking ‘What do you think development means?’ However, some of those interviewed were concerned that any definition of development needed to consider people such as the Manjo who were often excluded from mainstream development.

Habtamu explained it like this: We are working on social development, but most people tell you about the physical aspects, which means better roads, availability of health centres, schools, college etc. But from our perspective, this alone is not development. Because even if you have all this physical infrastructure, some people, some sections of the society, are not allowed to use it equally with others. We don’t think that is development. We are trying to develop the minds of people in terms of internationally accepted standards of human rights. Unless the human rights are respected, when the equality of people is
realised, there are some sections of the society who are discriminated because of they cannot be equal—from social, the schools, health centres, and others, even employment opportunities. In the past the Manjo were discriminated against and had very little participation in social, political, and cultural life and were not represented in any government institution. They have not been able to use transport, health services, go to school or live in town. The new government strategy is that all people, including the Manjo, are to be treated equally. One of the new opportunities for NGOs in Bonga is that they can try to assist people who are marginalised in society: Development is not a financial issue; development is psychological, structural, capacity building, many dimensions. To look for development, even gender issues—focus on the marginaly [sic] in society. Development is not only some building of schools or building the health office but working with some capacity building and recreation for the children all these matters are concerned with development (Getachew, NGO board member).

One NGO employee (who is Manjo) told me that now we can use everything because of the change in government policy. However, in my interviews with government staff and staff from NGOs a number of people said that there is still a problem in the rural area as marginalisation and social exclusion of the Manjo continues and is difficult to change (Temesgen, NGO staff member). One NGO staff member said that even if the trend is for integrated development, discrimination of the Manjo continues: They will say every time, people will not give attention for us, they undermine us, even government employees, public servants are part of this. They are a product of this society—the educated ones, required to give equal attention to all sections of the society but the reality is different. When you go to a health centre and priority is given to the dominant ones they are served next, locally they are called second, second people (Habtamu, NGO staff member). In this interview I was also told that women are also discriminated against: because of the tradition that women will not bring any fundamental change whether they are educated or not, they have to be married and serve their husbands. This is the traditional perspective, so if you go to school you will not find an equal balance of girls, especially as you go higher up the education levels. Habtamu illustrated how the Manjo are excluded from high schools because high schools are located in the capitals of the woredas or the Zone. As the Manjo have not been allowed to own a house in towns,
their children cannot come to towns to attend schools. Despite the government rhetoric about integrated development, in practice, there are few Manjo children in school: You may find at the lower levels equal numbers, in Grade 1 no problem, in Grade 2 no problem, 3, 4, it is getting lower, smaller. We have conducted a survey in Chena and Ghimbo woredas, we didn’t find any boy or girl in secondary school, only in Grade 7 and 8, we found two people. If you go to school you will not find an equal balance of girls, especially as you go higher up the educational levels, from secondary levels onwards.

I expected that roads and health centres would be built according to the various sector development programs. No one questioned whether these were good things. What I did not expect however, were the unquestioning attitudes about how some of these things operated in practice by most of the people I interviewed. I felt much of this might be due to the hierarchical nature of Ethiopian society and people's reluctance to criticise the government but I did not expect a total lack of criticism of the visible signs of development. For example, all the roads in Kafa Zone needed ongoing maintenance but there did not appear to be any maintenance program for any of the roads and many were in a constant state of disrepair with some sections impassable in the rainy season. Many people I interviewed have become dependent on these roads to move around the Zone and yet every rainy season the roads deteriorate and in some places become impassable. Moreover, there is now an expectation that buses and Isuzu trucks will be available to provide transport on these roads but the number of buses and trucks that did run could have been filled three or four times with people waiting on the side of the road. Beyond Chiri, the many health posts, health centres and schools I visited employed people who needed to travel to the woreda centre every month. Government staff and the staff from NGOs are also expected to travel to various parts of the Zone. At times I felt I agreed with Hailegebriel and that some of the projects were just done to 'tick the box'. However, the comments by Worku really surprised me as he described how change becomes possible when people meet in the marketplace. Change is possible because people who would never meet in the past are now making new connections and starting to think differently about their future. Perhaps what he was trying to say is that development does not only come from government or from NGOs but that it can begin when ordinary people make new connections. And because the government staff and staff of NGOs live side by side with ordinary people in the same community it means they make new connections everyday. While no one yet appears to question the
government’s policies and strategies, new connections made in the marketplace or in the work place raise the possibility that dialogue has the potential to influence development.

6.2 Decentralisation and sector-based programs

Most government staff and staff from NGOs whom I interviewed single out the government’s decentralisation policy as the main guiding principle of their work. In practice, decentralisation is ‘still evolving because woredas still depend on regional and central levels for a number of health system related services such as the recruitment and allocation of health personnel and the procurement and distribution of supplies’ (World Bank and Ministry of Health Ethiopia 2005:84). The regional government is responsible for implementing economic and social development policies developed by the federal government. In 2001 decentralisation moved to sector departments, from zonal to woreda level (Muir 2004:13). Michael, the most senior government staff member I interviewed put it like this: From region to zone to woreda, we are sharing all this budget we are allocating … we are practicing decentralisation for the last five years… already woredas are experiencing planning. They give their priority for each sector and for each project or activity in which kebele they have to establish or they have to construct that is priority from woredas … The priority comes from the community. Government bodies are checking the relation of that activity or that project with the policy of government because when we establish or construct health posts that should be related with health sector development policy. Because we have planned already to have one health post at least in one kebele. By now we are already 50 percent constructed, 50 percent are remaining. The woreda administrator are checking that, just there have to be a fair distribution in all kebeles, education, and cultural and health sector planning. But priority comes from the community to be easier for participation of all communities the implementation of that. We are trying to plan with communities. So the government is the driving force, the woredas are prioritising the projects or activities for each different sector (for example the health sector), while at the same time the priority comes from the community.

Since all intervention activities are in line with the zonal, woreda and kebele government policies, the government is described as the driving force behind current and future
development activities by NGO staff: Long-term plans are made by the government, the government sets policies: national policy, regional policy, zonal policy, woredas and kebeles also plan, so both plans, for example, the health plan have targets which could be achievable in 5 - 10 years (Alemayhu).

Another NGO staff member said they worked in partnership with the government: All our intervention activities are in line with the zonal, woreda and kebele governments— we are supporting the community— to create a link with partners so the project can run properly whether we are here or not (Tesfaye, NGO staff member).

Given that government and NGO activities are in line with sector-based government policies and priorities, there is a distinction between those who view decentralisation positively and those who are skeptical. Worku, an NGO staff member, explained that the groundwork for introducing the decentralised system to the community was not done so perceptions of it at the local level are different to reality. He said no monitoring or assessment is made to see how decentralisation is working in practice. Sometimes I feel hopeless, the last thing is worsened by the decentralised system is very important because you didn’t choose it, there was not firm ground to put a foundation and now it is perceived by people, especially at local level, differently than the reality. The provision is, to reverse this you need to have a very huge investment, not in terms of money, but time, to let the system develop. One of the big problems, is the monitoring system by something, checking, correcting we should have a better thing. The monitoring that is today, the system, regulation, you don't go back and check and see how it’s working. You don’t have time to correct because you become used to the system and it becomes the normal way of thinking.

There were a number of other explanations for skepticism about decentralisation. One reason was that the NGO staff felt nothing was really changing for community groups who are marginalised from others in society. Second, part of the problem of decentralisation was that although powers were given to woreda administrators this power was not accompanied by the resources needed to implement policies: The idea is that the woredas administration of Kafa Zone gets funds straight from the embassy of the Dutch
government and the technical advisory team was supposed to support the woredas in planning, budgeting and reporting. Now they just want to give money to the federal level and they can do whatever they want. 12 billion dollars was given to the federal government. Not one, not one, report was submitted because no... just get the money and do whatever you want. What is the point of giving 12 billion dollars per year to the central government which shows no result?... if we could work in the right way, if we worked properly, with the right budget report... woredas to kebeles... The money goes to the central government, half goes to the region, 25 percent of it comes to the zone, and then 10 percent probably reaches the woreda. And what's left for the kebele? Each kebele is meant to have a health post (Hailegebriel).

Habtamu, an NGO staff member stated that: These days everything is said, things are getting decent, decentralisation of the power is decent, and this is the way people are getting empowered. This is what is said by the government, but in fact it's different. What we feel, there are some truths, but most of the things are nominal because of the power, there are powers that are given to the woreda administrators but that power is not accompanied by resources.

Third, decentralisation was also described as being authoritarian. For example, Habtamu argued that decentralisation uses a top-down approach as most decisions are made at higher levels and ordinary people at the bottom are just expected to accept those decisions without asking any questions. Authoritarianism also meant that lower level government workers were expected to implement government policies without question as the power base was at the top and did not filter down.

Fourth, the top-down planning approach which is restricted to sector-based planning also means that zonal and regional staff are the dominant actors with little community involvement (World Bank 2001: Section 7.06). It is evident that there is some disconnect between what communities feel they need and what is communicated to the woreda. Many communities have very low expectations of the official planning process because in many cases kebeles received little or nothing of what they requested through the planning exercise (2001: Section 7.09-7.10). While I did not attend any NGO
community planning meetings, the data corresponds with the Woreda Studies and shows that the role of communities is to discuss suggestions for a capital menu ‘the scale of which is severely limited and the final design of which will be referenced to pre-existing sector plans’ (2001: Section 7.15). In fact, I would suggest that the principal role of communities appears to be in-kind contributions, particularly unremunerated labour and materials for construction projects such as health posts or roads which also corresponds with data from the Woreda Studies (2001: Section 7.57) (see Section 6.3.2 of the thesis).

The current Ethiopian government’s decentralisation policy was motivated by a desire to devolve power from the centre where it had been identified with impoverishment, oppression and exploitation and the root cause of Ethiopia’s modern political history of war, famine and underdevelopment (Vaughan and Tronvoll 2003:26). In practice, the federal government requires that policy-making should develop in line with federal norms. The financial balance of power is tipped in favour of the centre which controls the flow of federal subsidies which provides the major budget flow to the regions (2003:12). Most of the government staff and staff from NGOs interviewed stated that the decentralisation policy was the guiding principle of their work. This meant that their views were consistent with government policy which was restricted to sector-based planning. This also means that these people are the dominant actors in planning and implementation of government policy in line with zonal, woreda and kebele policies and that the role of the community is limited.

6.3 Development in practice
6.3.1 The NGO sector and NGO operations in Kafa Zone

Many of the health posts and health centres in Kafa Zone have been built and paid for by NGOs, others by local government. The data shows that some of the NGOs provided financial resources for projects that were not able to be met by the local government capital works budget (Box 16 gives a brief overview of the NGOs in Kafa Zone in 2007).
Box 16: NGOs in Kafa Zone in 2007

ActionAid— is a branch of ActionAid International, which is a partnership of people, organisations and social movements committed to fight poverty and injustice. It has offices in Bonga and Chiri. In 2007 a new project commenced in Bonga to educate people on the principle of fundamental human rights and to work on the problems of marginalisation and social exclusion with Manjo people who are one of the 200 clans in Kafa Zone. Assessments of Manjo participation in political, cultural and social life in the woredas revealed that there were no Manjo working in government institutions or in any decision making positions although there are four male Manjo policemen and one male Manjo employed at an agricultural and rural development office. There are no Manjo females employed in any government insitution. A study of the total number of students attending school in Ghimbo woreda shows that 3.92 percent of students were Manjo in Grade 1 and 4.18 percent in Grade 2. The percentage declined with each grade so by Grade 6 it was 0.68, Grade 7 was 0.51, Grade 8 0.01 percent. There were no Manjo students in Grade 9 or 10.

Chiri Health Center (CHC)— see Table 3 and Box 5 Chapter 3.

FARM Africa— FARM Africa’s goal is ‘to reduce poverty by enabling African farmers and herdsmen to make sustainable improvements to their well-being through more effective management of their renewable natural resources’ (FARM Africa 2004:4). One component was the Reproductive Health outreach program which funds immunisation and contraceptives. FARM Africa organised TBA training at Bonga Hospital in 2006 for 10 days but the program had no follow up. Funding for FARM Africa (and SOS Sahel) was through the European Union, UK Department for International Development and Comic Relief. Note: FARM Africa’s operation in Bonga closed in late 2007.

Kafa Development Association (KDA)— KDA is a local NGO that started in Jimma in 1958 to support local development in the region (Muir 2004:23) as Kafa had virtually no communication with the Ethiopian central government. One of KDA’s first activities was local road construction as it could take one to two months to reach Addis Ababa on foot or horseback. Nowadays, KDA has a locally appointed board and 11 offices in 10 woredas. KDA differs from other NGOs because it is also funded through its membership fees which are based on a person’s ability to pay. Fees range from five to 25 cents for students to others who paid 50 or 100 birr a month. KDA’s projects now include school and health post construction and installation of safe drinking water points. KDA also works with women and children through sponsorship of students from poor communities and loans money to the poor through Omo Micro Finance. KDA receives funding from organisations such as USAID and A Glimmer of Hope (a US and UK based NGO that supports programs in water and sanitation, education, health care, micro credit agriculture and irrigation).

/ cont.
Box 16 cont: NGOs in Kafa Zone in 2007

Kafa Development Program (KDP) formerly Sustainable Poverty Alleviation for Kafa Zone (SUPAK)— focuses on the rural, health, and education sectors. As SUPAK it funded the construction of roads and bridges, schools and agricultural projects, upgraded the Bonga Health Centre into Bonga Hospital, and funded the construction of Ghimbo Health Centre and numerous health posts. SUPAK also commissioned a number of studies such as The Economic Contribution of Women, Decision-making Processes in the Family and Gender Related Behavior in the Kafa Zone (Abiyu Million et al. 2002), Health status, health services and health related knowledge, attitude & practices (KAP) in Kafa Zone The results of a community-based baseline study (Habtamu Argaw 2002) and Reproductive Health especially Safe Motherhood & Family Planning: Situation Analysis and Action Plan (Wiebenga 2002).

KDP aims to strengthen the capacity of government and non-government institutions and to guide and support people-led development in Kafa Zone. After a shift in policy in 2007, KDP’s focus changed to government delivery capacity with programs designed to help planning and financial management at the woreda offices. In effect, KDP supported the Zone to implement national policies in education, health, agriculture and financial management. Special emphasis was placed on strengthening woreda capacity in planning and programme implementation essential for achieving the decentralisation policy of the country, and on the stimulation of economic development through the support to farmers’ organisations and marketing. Note: KDP was closed in June 2008.

SOS Sahel—SOS is a Community Initiated Promotion project of KDP. It piloted and developed alternative development models on how best to work in partnership with multiple actors (NGO, community institutions and the private sector and the government) (SOS Sahel 2008:8). SOS Sahel was funded (along with FARM Africa) by the European Union, UK Department for International Development and Comic Relief. I was also told some funding came through GTZ (a German international cooperation enterprise for sustainable development) along with community funding. SOS supports the community in building capacity by bringing people together from 75 kebeles to come together and discuss, agree and create awareness about community development. These groups elected representatives who met to plan priorities in water, health or other projects. SOS contributed 85 percent of funding for projects with the community contributing the rest. Projects included financing enset processing with women, honey and coffee cooperatives. SOS also supported the woreda governments in building capacity and implementation of their annual plan but previously had on occasion funded health post construction in addition to their economic development activities. Note: SOS Sahel closed in late 2007.

There are also church based NGOs operating in Kafa Zone such as the Apostolic Prefecture of Jimma Bonga which runs an agricultural development project and a kindergarten for children. Chonjo Bonga runs an HIV/AIDS orphanage and centre for people living with the disease.

Food and Agriculture Organization (FAO) UN—FAO leads international efforts to defeat hunger. It also helps developing countries and countries in transition modernise and improve agriculture, forestry and fisheries practices and ensure good nutrition for all (FAO n.d.). (Note: FAO is not an NGO but included here as its office apperared similar to those of NGOs and it operated under similar restrictions).
During interviews I asked how development projects take place in Kafa Zone. Note that all NGO development projects are undertaken in consultation with, and the approval of the related government bodies 'before and during their program operations' (Dessalegn Rahmato et al. 2008:27). For Kafa Zone, the SNNPR regional constitution has delegated broad powers of local development to the Kafa Zonal authority. Kafa Development Association (KDA) provides a good example. A new project starts when staff from KDA seek funding from external sources such as USAID or Glimmer of Hope for the construction of health posts, schools or veterinary posts. Along the way the staff work closely with the Zonal Health Bureau or Education Bureau to get technical advice and to have their projects approved before sites were selected. At the kebele level, KDA set up a series of meetings to consult with local communities about their development priorities and ensure both its members and the local communities are involved in providing volunteer assistance during construction. Finally, at completion, projects are handed over to the government who assigns workers and takes over its management. This process takes about one year and was described as slow and frustrating by one KDA staff member. According to Alemayhu, KDA is separate from government but works in collaboration with government in line with decentralisation policies: We are not there to duplicate services but to go to the more remote parts of the Zone where the government had not been able to provide services... KDA is like a bridge bringing money from the donors and passing it on to the communities. To construct schools we bring the budget, money... the Zonal Education Bureau who go and select the site. We go to the kebele level and have discussions with our association at the kebele levels, they discuss with community what the share of the community should be, and also by selecting the site. We hand the proposal to zonal construction department. Local contractors do construction and we pay the money, then hand the site to the government. We give it with full equipment and the government assigns workers and pays them.

Alemayhu also explained that KDA is organised by members who are interested to participate in development activities—willingly to help the government and themselves... have a part/share of the community implementation. However, as KDA’s focus is around constructing schools, safe drinking water points and health posts for local communities, KDA does not restrict its development projects to members (Muir 2004:28). KDA members participate in their local area by collecting materials and
helping with labour and so on. KDA also works with women and children by sponsoring children to go to school. *We are trying to change development policies through education, education of the farmer, women, targeting those groups. We bring new technologies to women—flour mills, safe drinking water, teaching them to send their children to school, empowering the women* (Alemayhu).

A number of staff from NGOs described the difficulties they had trying to get their projects approved. Part of this was due to shortages in manpower at the zonal level. As Muir (2004) points out, the job vacancy rate in Ghimbo woreda was reported to be 54 percent which is comparable to some of the vacancy rates of 41 percent (administration), finance and 39 percent (finance and agriculture) found in the Woreda Studies (World Bank 2001:7.43). In 2004, the job vacancy rate in Ghimbo for professionals in rural development was 76 percent; information (professional and support service workers—88 percent) and health (professional and support services—57 percent) (Muir 2004:36). Clearly there is a large gap between the number of positions for both professional and support services and what can be achieved. This reinforces the difficulties NGOs face in their day-to-day operations.

One NGO manager said that part of the problem was the lack of a work culture as people don’t really understand what it is to work: *We don’t have a work culture—getting work is being hired in the government offices—no innovation activities, no cultivation, horticulture* (Alemayhu). Does the concept of work have a different meaning in Ethiopia? Do people expect that once they are employed by the government their employment problems are over and they won’t have to work hard? The offices where I conducted interviews are quite representative of how strictly hierarchical social interaction is in Ethiopia. Women are generally secretaries or serve coffee and tea to managers. Staff wait quietly outside to be seen by their managers so all decisions can be approved and signed off on. If people are not encouraged to show initiative ‘for which they will be held responsible, it implies that state officials order people about and demand that they do what the bureaucrats consider good for them’ (Poluha 2004:114). Inadequate budgets and staffing are an indication that this is what occurs in the work place as the top-down planning approach to development projects is restricted to sector-based planning.
Another problem that emerged was the time it took to get projects approved. Hailegebriel, one of the NGO managers commented about the planning approval process at all levels from the donors down to the kebele leaders: *It took four months, four months to get the approval for the new strategy. Four months stuck doing nothing... because nobody cares... when the approval comes, they ask for more documents, so everything is always a final starting point... if we keep on the starting point, when are we going to work? And then people do not care. That is from donors up to the kebele leaders.*

Temesgen’s explanation about the process of building a health post provides another example of how difficult he found it to work with government: *There are problems with zonal construction as we need surveyors with engineering to give us permission, to certify us. It takes a long time to do construction. We only facilitate the construction, materials only. We have zonal problems. I can write down the project, ask any donor, bring the money, the construction—they have to certify it. If we had an engineer it would be easy for us. Going to the zonal government took six months, seven months like fighting, telephone fighting, and personal fighting. The problem is not the money, not [the NGO]—it is the construction engineers, the government bureaucracy, and also they do for themselves like this, the kebele... they are afraid... even if we had engineers it would be difficult because they have to know. We are only seeking permission.*

The other NGO that had considerable difficulty dealing with the local and regional government was CHC. During numerous conversations the manager cited the lengthy periods of time and huge amounts of energy being devoted to tasks such as renewing the pharmacy and project agreement renewal licenses, placing and picking up pharmacy orders (a full day’s exercise in Jimma), and writing numerous evaluations and reports. The Quarterly Reports from the past 10 years show that this problem was ongoing as managers explain that on the one hand they struggle to find out what they were required to do while at the same time they were constantly being told that they should be running new health programs (described to me as ‘blackmail demands’ to start treatment for HIV/AIDS) or to construct new buildings which was impossible given their limited resources. To add to this, with the only functional vehicles in the area, CHC was
subjected to constant requests or demands for transport by the woreda government officials. For example, in a 2004 report CHC had been asked to drive to Pharmid in Jimma to pick up medical supplies and deliver them to all the health posts in Decha Woreda because the Woreda Council maintained all their vehicles were needed during the election period to ‘stir up the public’. During my visits in 2007, the Woreda Health Office requested transportation for at least three vaccination campaigns that required trips to Bonga to pick up the vaccines and then deliver them around the woreda (while maintaining a cold chain). CHC was expected to provide vehicles for this on the day of the campaign with no prior notification. Some of these requests were refused, others agreed to if they did not inconvenience staff at CHC or could be accommodated with other previously arranged visits to Bonga.

As shown above, the NGOs operating in Kafa Zone vary between those who are mainly involved with the construction of facilities such as KDA, those concerned with civil society and governance issues such as ActionAid and KDP, and those involved in service delivery such as CHC. While all NGO activities are in line with and support government sector based priorities, the relationship between NGOs and local government is often strained as NGOs must respect hierarchical authority when submitting projects for approval.

6.3.2 Community participation

Pankhurst (1992:68-9), Keeley and Scoones (2000), Muir (2004:31), Poluha (2004) and others point out that authoritarianism, hierarchical, centralised rule and a lack of transparency are long standing characteristics of the Ethiopian state which means challenging authority figures is unacceptable. Social interaction in Ethiopia is also strictly hierarchical, with a ‘largely invisible but rigid system of collective sanctions, to obey the ‘orders from above’ (yebalal akal)’ (Vaughan and Tronvoll 2003:33). Whether a fatherly command to help with household chores, or to join a political meeting at the kebele, the socio-political arena of interaction is defined by male gatekeepers who control access to this arena. The male is the head of the household. Males represent women in the public arena as women do not attend public meetings. If women do attend, they are

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70 I do not discuss the ‘overt and visible’ religious beliefs of Ethiopian Orthodox Christianity here which imposes work taboos, purification ceremonies and rules about fasting, and the ceremonies of birth and death (Pankhurst 1992:171).
not permitted to speak. At the kebele level, the gatekeepers are the local kebele administrators (2003:33-4). Thus the long history of ‘extremely coercive government’ in Ethiopia and ‘its continuing ubiquity and importance in the lives of the population is important for comprehending the construction of, and response to, policies of participation’ (Harrison 2002:599). These are not characteristics synonymous with new methods of learning including bottom-up or decentralised government.

A further feature of decentralisation and power is that it can be difficult to separate representative and civil service aspects of government. The current Ethiopian leadership plays a strong role in development and exercises ‘considerable leadership and control throughout local government’ (World Bank 2001:8.04). Muir (2004:35) found that people tend to see both aspects ‘as one amorphous whole’ which seemed unavoidable given that the woreda cabinet contained both councilors and co-opted civil servants. Furthermore, it was difficult to differentiate the role of the EPRDF as the party is strongly represented in both council and civil service. During my interviews I did not ask questions about the local branch of the EPRDF or if government staff or the staff of NGOs were members although in two interviews there were comments made about particular individuals who had decided not to become involved in politics. This was expressed as a positive attribute. However, I was well aware that there must have been strong links between the party and some government staff and staff from NGOs because the local branch of the party had a large compound where the government funded Coffee Museum was to be built. I walked past the compound daily and often saw ‘familiar’ vehicles parked inside and I was referred to the local manager of the party headquarters for an interview by an NGO staff member who seemed on very good terms with him.

Community participation in development is communicated hierarchically as kebele cabinets communicated information through meetings. Participation generally means accepting the decisions of kebele leaders or other figures of authority without question. As Harrison (2002) points out, ‘ideas about participation are not solely the province of international development organisations’ (2002:600) but need to be understood in the context between the different understandings of participatory policy. Moreover, representatives of the Ethiopian government would argue that participation has been a
central pillar of policy independent of donor influence and ideas. The central ideas of participation are tesatfo (mass mobilisation) and limat (development). For example, under tesatfo, people in rural areas have been expected to work on community projects for a specified number of days (around 20) in a year. In this way, tesatfo is described as ‘participation’ because people were ‘working together to help their community’ (2002:600). Nowadays more effort is made to consult with farmers about the timing of this participation compared to its compulsory nature in the past along with penalties, fines or even threats of the loss of land for non-participation.

My interviews explored the government’s development strategies and how the top-down planning approach restricts planning and development to the various pre-existing sector plans. I did not examine the kebele administration, the lowest government hierarchy and the network of mengastawi buden (development teams) which operates below it with less formally recognised groupings of 50 households or less who interpret and implement government policy (Harrison 2002:600). Nor did I examine local definitions of development such as limat, tesatfo, iddir (the burial association), or iqquub (rotating savings and credit groups). Instead I focused my interviews on government staff and the staff of NGOs. In hindsight, this exclusion is unfortunate because ‘kebele cabinets commonly communicate information and make requests for community assistance (e.g. labour), particularly through agricultural work groups and iddir’ (Muir 2004:7), and people respond better to calls from the iddir than the kebele cabinet (2004:30). I was unaware that in Ghimbo woreda, where I conducted many interviews there is almost 100 percent iddir membership (2004:6)71.

Community labour and in-kind support for work such as road building, maintaining school buildings and soil and water conservation structures in Ethiopia is described as ‘notable’ but ‘the degree of voluntarism can be questioned’ (World Bank 2001:7.53 (iii)) and much of the work is decided by government rather than chosen by the communities.

71 In Ghimbo, there are two types of iddir: the burial association and multi-purpose iddir which has broader functions including financial supports for medical and other emergencies. Contributions can be made to a member if an ox dies or for if there is a serious financial need (Muir 2004:25). Iqquub is a rotating savings and credit groups, and both iddir and iqquub ‘provide access to lump sums of money for sudden necessary expenditure (funerals) and for larger expenditures (such as house construction) respectively’ (2004:23). According to Muir (2004), 95 percent of households in Ghimbo are also involved in agricultural work groups and 30 percent of households are involved in NGO projects (2004:24).
themselves (2001:7.56). Muir (2004) describes a ‘wariness’ about the possible nature of government support which is sometimes perceived as ‘interference’ rather than, for example, technical and financial management support (2004:31). This comment by Worku is representative of how NGO staff view community participation: *When the electricity line was moving [being built] from Bonga to Chiri, the rural communities—every kebele was forced to come and give support— boring the holes, getting the poles, clearing. Then after the electricity jumped from Bonga to Chiri, in between the people didn’t get it, especially in Baha [a village about half way]— even I heard they are dismantling the poles to show their anger. They participate, they contribute their participation, they give what they have, and they don’t get back what they need. This is the sort of thing which also affects the benefits of a few people who are concentrating on a better, relatively better area and those pay for it.*

I observed a couple examples of community participation during my fieldwork. First, two members of my interpreter’s family in Bonga were expected to attend kebele meetings on Saturday mornings. They were also required to do a few hours work; for example, on the ‘road’ outside their property, just around the corner from my house. The road had to be cleared of any encroaching bushes and trees. Although not on public land, the entrance way to their house was always swept clean and most people tried to make an effort to have attractive shrubs or flowering plants outside the house. Another close neighbour built a small bridge so people could cross a muddy point on the road where a water pipe overflowed. Second, I saw a community working group when I accompanied the Outreach Team from CHC to Gebera (Chapter 3). Of all the hikes I did to various health posts this was on the widest and the best maintained road I walked on. It looked good enough to drive a vehicle in places and the wooden log bridge to cross the river had been so well built I remember thinking it seemed indestructible compared to other bridges I’d walked over. On our return later the same afternoon after a heavy downpour, we came across a large group of 40 or 50 men working on the road. They were all there with their machetes cutting the bushes on the roadside. The majority of them were still in their jackets and they didn’t appear to be too hot and sweaty as they all stopped work to greet us and chat as we passed. This was the same area where the kebele leader attended the vaccination clinic personally and planned future activities with staff.
from CHC. I remember thinking there must be a link between this enlightened leader and the quality of his bridge and his cheerful road maintenance team.

I was told the NGOs organised community meetings to ensure there was discussion about each community’s priorities for a school, clean water supply or health post. Tesfaye, an NGO manager, and Getachew, an NGO board member explained that the community needs to initiate what project they want because there needs to be some contribution of the community on that base for that project (Getachew). Tesfaye stated that now that the government is in the position to provide these services, the NGO gives training to community representatives to write project proposals, based on the community consensus, which are then present to the Community Development Fund Board to be scrutinised and approved for funding: The community will decide what they want, and with government expertise we go to the field, because unless we involve the government body, things will not be going smooth—they provide the expertise—give technical support to the woredas.

A further means of community participation occurs when government staff and staff from NGOs identify various members of the community who should be targeted by their development activities. For example, SOS Sahel through its Community Initiated Projects developed ‘alternative development models’ to work in partnership with multiple actors including the NGO, community institutions, the private sector and government (SOS Sahel 2008:8). SOS Sahel tries to target groups because they see huge potential for honey production, coffee, spices and sheep fattening projects. There are two priorities: to support the community to build capacity and to support the government in building capacity and implementing their annual plans. The benefits of this approach is that once the community is empowered and has the capacity to demand services from the government, the government will then have the capacity to provide services to the community. Although committed to economic development and improving access to fair and sustainable agricultural markets, SOS Sahel is also concerned about raising the consciousness of the poor and works to offer development interventions that empower the poor ‘to exercise their environmental, social, civil, cultural and economic rights’ (SOS Sahel 2008:2). Thus the role of the NGO is to
transform power relations at the grassroots level by giving a voice to the poor, to women, to the marginalised.

Many government staff and the staff of NGOs have attended gender workshops, they are now expected to ‘fill a quota’ for the representation of women at meetings or in development projects. In my interviews, a number of staff from NGOs made comments such as this: *In any development work we always check the participation of women, even in elections we expect 80 percent men and 20 percent women to participate. Now we are working/planning informal education for the women and men—after education, we expect development, when they start seeing the broader place, even the world they can change their families and themselves* (Alemayhu). However, another NGO manager thought that *people come to meetings in the woreda because of the per diem; they get money for coming, for the bed and so on so they come once, three times* (Temesgen, NGO staff member). While I did not attend any kebele meetings, I did observe a number of gatherings at the Catholic Church after Mass. On one occasion in Deckia I was surprised when a young woman spoke quite passionately after a meeting but it did not appear that her opinions were taken seriously. In the end, I wondered if the ‘participation’ of women means little more than attendance at meetings as there is no real opportunity for women to express their views or put forward ideas around issues that affect them. As discussed in Chapter 4, women do not decide to seek biomedical health care without their husbands’ approval, they are not expected to deal with management issues at the community level and if they were present at meetings at the church or kebele gatherings they were restricted from saying anything but were represented by their husband: women can contribute to decision making in the home but public decision making is a male responsibility (Abiyu Million et al. 2002:22).

On the one hand, statements about community participation during interviews confirm that NGOs and local government emphasise the importance of involving local communities, but on the other hand, the interview data shows that community participation is generally limited to sector development through planning infrastructure works such as health posts or water projects. This means there is little opportunity for the community to be involved in service delivery at the health post or how a water project is implemented or maintained. Moreover, the community is hampered because
the recurrent budget is allocated at the regional and zonal level and there is no opportunity for their input. Hence the community is relied on ‘less for ideas than for their ability to mobilize labor-power’ (World Bank 2001:7.57).

6.3.3 Development funding

Ethiopia’s international donors provided more than US$5 million per year on average to Ethiopia from 2000 to 2006 (World Bank 2008a). The World Bank’s Woreda Studies (2001) depicts a number of challenges Ethiopia faces in development planning, budget management and project implementation. It states that limited local revenue generation is not sufficient to cover woreda development requirements thus necessitating transfers from above. This implies a diminution of control over total revenue available to a woreda— the revenues, which are generated locally, are applied to the recurrent component of the woreda budget over which the woreda has no effective control at all. The capital component of the budget which ostensibly falls under the woreda’s jurisdiction is transferred from outside. The report concludes that severing the link between revenue and budget expenditure further diminishes the woreda’s influence over its own development process (2001: Section 7.39).

Even though planning and implementation of development projects is always subject to constraints, severe limitations on budgets makes it necessary for the government to choose between the quantity and quality of service. These constraints mean that community attention is focused on capital projects while service delivery is through recurrent budgets (World Bank 2001: Section 7.16). It also means that the representative structures at the woreda level and below only deal with a small portion of the total budget. For example, in one woreda only 15 percent of the capital budget was made available for development through formal channels; if bilateral/ NGO and other similar resources were added, this figure diminished to six to seven percent in two other woredas (2001: Section 7.39). In the studied nine woredas, the transfer of funds varies between zones but it was always discretionary and followed no objective formula. Determining the amount was based on: ongoing expenditure commitments, the woreda’s record of project implementation, and how much extra budgetary financing was available from other sources (2001: Section 7.23). Moreover, a
high proportion of development resources [is] devoted to maintaining regional and zonal bureaucratic superstructures and in the strong budgetary preference shown for salary expenditure over either capital projects or operating costs, despite what community preferences appear to indicate (World Bank 2001: Section 16).

In this study, respondents identified funding capital works in Kafa Zone with the available budget as difficult to achieve, particularly when there were shortages of building materials and severe difficulties in transporting them to remote places. They also referred to the inadequate operating budget. It should be noted that many of the projects had in kind support from local communities. For example, the projects organised by KDA had the members’ participation in their respective areas: They collect materials, they help with labour, it’s their property, they pay attention for these projects, not for the government, they don’t care about government projects; they are members (Alemayhu).

The government was responsible for recurrent costs of salaries and capital items for the expansion of health facilities. Nevertheless, a number of new health facilities had been started but were incomplete because of insufficient funds, and other new facilities were vacant because there was no budget to buy equipment and supplies. None of the health facilities I saw had adequate equipment or medicines. Equipment was always breaking down and often there was no one who could repair it in the short term, or at all. For CHC and Bonga Hospital this problem meant a significant financial outlay if equipment such as an X-ray machine or an oxygen concentrator broke down as these items were too expensive to repair or replace. In theory, local management bodies of health centres or health posts could purchase whatever they wanted such as refrigerators or motorbikes. But during my fieldwork none of the Decha woreda vehicles were operational. I saw a new refrigerator and stretcher at one health post but the only medical supplies were the three bottles on the single table (Photo 16, Chapter 5). The only furniture was one bench and two chairs.

While it is clear from the above comments that there was not enough funding for all the development projects in Kafa Zone, the government staff and staff from NGOs did not

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Focus groups in the Woreda Study also cited inadequate operating budgets with shortages of material and their availability at the right time. This included drugs in health posts, spare parts for water pumps, furniture, books, seeds, fertiliser etc. (World Bank 2001).
expect all the goals to be reached at the same time. My observations were that the zonal government was choosing quantity over quality of service because that was what required with the sector development plans. This meant there were numerous building projects underway—brand new health centres and health posts—yet none of them were functional because they appeared to have no budget for medicines and equipment. Clearly user fees which were intended to improve drug availability through the Revolving Medicine Fund are either insufficient or the monies are being used elsewhere. In many instances it was not clear how the fees people paid for a record card or medicines were used.

### 6.3.4 Cost of services and corruption

They usually transport these type of mothers on Isuzu, you know, they are not made for such purpose, they are made for other communities but they are taking that car, its expensive it costs 600, 500 birr to transport a woman from somewhere like Chena to the hospital (Dr Befekadu, Bonga Hospital).

Regarding the cost— the majority are living in the countryside, very far away. Because the transportation, so when they arrive they don't have any money, even for eating. So that is a problem (Tamrat, CHC).

Dr Emabet (Bonga Hospital): We know if a mother comes in with obstructed labour, the physician immediately puts all other jobs aside to concentrate on her. But even with that hurry, it is delayed; even she is expected to have money for gloves, for antibiotics, for everything. The negotiation even to have these materials will take some time, these contribute for the delay.

Ruth: How long will the negotiation about money take?

Dr Emabet: About 20-25 minutes.

Ruth: What if she doesn't have any money?

Dr Emabet: It will not be done for them because the physician cannot do without IV fluids, without antibiotics, without gloves, and if the patient doesn't have any paper for free, he is not going to do that.

Ruth: (after a pause to let this sink in): So she might die for lack of money?

Dr Emabet: (after another very long pause): Actually, he does the work, and they make the family to promise to pay after the operation, but the physician does not allow the mother to die or the child to die if they don't have—they do that patient and they ask for it after.

According to Thaddeus and Maine (1994), 'the literature simply does not provide systematic evidence that cost of services is a major barrier to seeking care in the developing world [but] [t]hese findings seem to contradict anecdotal reports from developing countries' (1994:1095). They also state that while cost and distance are linked
because longer distances lead to higher transportation costs, improvements to roads and transportation on their own do not necessarily increase the utilisation of health facilities because the financial cost of treatment is a major barrier for many women seeking treatment (1994:1094; see also Yisa et al. 2004; Tadele Bogale et al. 2005; James et al. 2006). Kloos et al. (1987:1013) report that the cost of health services in Ethiopia is seen as less important than the quality of services and perceived efficacy of treatment. But since the introduction of the new governance system of democratisation and decentralisation coupled with a free-market economy in Ethiopia, it is a difficult challenge to provide adequate health services for the rural population (Yemane Berhane et al. 2001:1538). CARE’s community based assessment of health seeking behaviour in West Haraghe, particularly around childbirth and ANC also determined that lack of money was the main reason given for not taking a woman to a health facility (Endale Workalemahu 2003:13). With only one exception, all the women and health workers I interviewed talked about the difficulties for women around the financial cost of treatment. The comments at the beginning of this section are representative of how health workers view the difficulties their patients have in paying for medical treatment. When I asked them to elaborate about the financial cost of treatment a number of health workers told me about the ‘free’ letter which exempted women from paying some fees. However, obtaining the letter sometimes delayed medical treatment and a number of people interviewed talked about the need to bribe kebele leaders to obtain it.

Cost is closely linked to quality of care, corruption, and how people are treated in the health facility or even treated at all. Many people I interviewed talked about the negotiation about payment in the hospital which creates further delay because people must pay for the card, gloves antibiotics, IV fluid and so on. During a number of interviews such as the excerpt cited above, I wondered if the hesitation in some responses when I asked if a woman would die for lack of money indicated that it was a possibility. In this instance, after I asked the question directly, I was told that someone would have to go back to the village or elsewhere to borrow money to pay for the medical treatment. In theory, poor people are able to get a ‘free’ letter from their kebele chairperson to cover the cost of medical treatment. However, a number of people told me that those receiving the ‘free’ letter were not the ones who needed it. Although a new system has been put in place to bypass this problem, none of the kebêles or woredas
(with the exception of Bonga town and Wushwush tea plantation) had signed agreements with the hospital allowing people with a particular ID card to receive free treatment.

There are no morals in the government regarding the free letter; most of the people who get it don’t deserve that. The deserving ones, they don’t get that because they are shy, they are weak, they are marginalised... people have their own connection, their own network, they give priority for the people they are working for and so on, the system and they don’t understand these things and this networking has much influence on their post. You see corruption and this is magnified in the rural areas and that still is a problem (Worku, NGO staff member).

I report the next interview at length because this was the first person to tell me about the bribes needed for the ‘free’ letter. It was very difficult for him to tell me this. There were long pauses and delays as he struggled to admit the problem even existed and was extremely uncomfortable revealing this information. I too, took my time, and let the pauses lengthen with each answer; each response, revealing that people had to bribe kebele leaders to get the letter. Once I knew about the need to bribe some kebele leaders, other people easily admitted it during interviews when I asked them if it was a problem.

Ruth: The free letter, how do you get the free letter?
Samson: First, when she has no full money, she must hand in this free letter and she must hand in a minimum of 15 or 20 birr and then the person in charge says, you must pay 200 birr. ‘No I’m sorry, I don’t have 200 birr, but I have a free letter’ she says. The person in charge can decide she must be...
Ruth: But how does she get the free letter, where does she get it from?
Samson: From the kebele.
Ruth: So her husband must go to ask the kebele?
Samson: Yes.
Ruth: How long would it take?
Samson: Especially, if there is a kind person, some many kind person, and some cruel person and some unnecessary person in charge it takes three or two days to get the letter. But in some kebeles it takes only two hours. Two hours.
Ruth: Do you have to bribe anyone to get the letter? Or can you just get it....I’m interested in how difficult this is...all the delays I’m interested in exploring...
Samson: ...especially in some areas, the person in charge, the chairman, he wants...he needs...something...
Ruth: ...some incentive...
Samson: ...some incentive...
Ruth: ...more than a cup of coffee?
Samson: Yes. *In some kebeles the chairman does not do this because he is a kind person, maybe he believes in God to write promptly the letter.*

As Manor (1999) points out, democratic decentralisation coincides with an increase in the number of people involved in corruption because it inevitably increases ‘the number of people with at least minimal access to political power’ (Manor 1999:74). Transparency International’s Corruption Perception Index ranks Ethiopia near the middle of sub-Saharan countries on perceptions of corruption (Transparency International 2008) but the topic of corruption raised high emotion with some staff working for NGOs such as Hailegebriel: *Corruption characterises human society everywhere... every single body is looking after money, themselves, power. You mentioned the kebele leader; the kebele leader is the lowest of the lowest of the government. So the only way he can show power is when a poor guy needs a letter to go to the Bonga Hospital. The only way to show his power. Now why show his power? To get money, he gets respect.* A similar view was expressed about working with the local government officials: *The only way you can work with the government officials is paying per diem. The first thing, the first thing they ask you, is ‘how much is the per diem?’ ‘How much you pay?’ Then we can talk about what to do.*

Ruth: *Do you pay it?*

Hailegebriel: *Of course [we pay it]....we must work with the government. You don’t work if you don’t pay it, so no way out. Unfortunately.*

Molesworth (2005), Gil-González et al. (2006) and Endale Workalemahu (2003) argue that the cost deters poor women from accessing delivery in health facilities. In Chapter 5, both Abebech and Yesharig stated that women who were poor and could not afford medicine or to go to the hospital might die. For Birke, not having money for treatment at the hospital meant waiting for her husband to go home, sell the ox, borrow extra money and pay for transportation to Jimma Hospital. There was also an implicit expectation that people would lend money to relatives or neighbours to assist with the cost of medical treatment. However, this may not always be the case as Dr Befekadu relates in Chapter 4 where a husband refused to pay for the transportation of his wife who needed urgent medical attention. Because the cost has been identified as being linked to quality of care and corruption, cost and corruption are linked in this section.
Sometimes corruption took the form of needing to bribe officials to get a ‘free’ letter, and other times it appeared that local government officials refused to work with NGOs (on development projects) without being paid a per diem. Hailegebriel interpreted this practice as bribery or corruption. The end result of these practices was that people who really needed ‘free’ letters were missing out because they could not afford to bribe community leaders. Or that money spent on per diem payments to government officials was not being spent on development projects. The next section examines the issues around who is gaining from development.

6.3.5 Development and women’s education

Numerous studies have shown that investments in education, particularly for women, lead to better child health, lower fertility and reduced maternal mortality. For that reason, the success of RH initiatives in this strategy relies heavily on ensuring high levels of awareness and education among the population at large (MOH 2006a:3).

As stated in Chapter 1, evidence suggests that investment in health centre-based intrapartum care focusing on skilled attendance at birth, health facility improvement and EmOC will reduce maternal mortality. However, a woman’s ability to access and utilise these health services is affected by her status and empowerment ‘measured by education, employment, intimate partner violence, and reproductive health’ (Gill et al. 2007:1350). Gill et al. also argues that women’s involvement in decision making is associated with an increased use of maternal health services (2007:1351). In Chapter 4 I described how it is usually the husband in who makes decisions about utilising maternal health services. To open up the possibility for change through development, this section now shifts the focus to women’s education which is cited as the best example of the link between women’s status, maternal health and development (2007:1350-1).

In 1994 Thaddeus and Maine argued that the link between formal education and the utilisation of health services was not straightforward and that the mechanisms through which education plays a role is poorly understood. Nevertheless, they concluded that there is positive association between a mother’s education and the use of maternal child health services and some significant positive association between the use of prenatal services and women’s education (1994:1099). Shiffman (2000) has also shown that female education and trained delivery assistance indicators are strong predictors of national maternal mortality levels; ‘the interventions that appear to be most critical are
educating women, devoting priority to health care and ensuring that pregnant women have access to appropriate medical services’ (2000:286). The governments of Malaysia and Sri Lanka, for example, identified equitable access to basic health services and education as priority issues to their country’s development (see Pathmanathan et al. 2003:38).

McCarthy and Maine (1992:29) identified three factors that determine how women’s education affects maternal mortality or disability. First, education is associated with later marriage or the increased use of contraceptives after marriage is generally associated with lower fertility in women. In Chapter 4, I described how marriage itself was the principal indicator of a woman’s risk to pregnancy in rural Ethiopia. Given the small sample in this study, there was not enough evidence to conclude that formal education has been associated with later marriage. It is possible that as more schools are built, further research in five or 10 years might reveal a change in the age of marriage in Kafa Zone. However, many of the women interviewed expressed a desire to stop having children. As Tigiste commented in Chapter 4, in the past women delivered children one on top of another. When she looks back and compares the past to the present, Tigiste makes the point that she would now be able to have fewer children which means it is less likely that any of them would have died. Moreover, the increased demand for contraceptives was evident at all the health facilities and it is likely that this demand will only increase in time.

The second factor identified by McCarthy and Maine (1992) was that women who are better educated may develop fewer complications before and during pregnancy as they are likely to have better general health than other women. Again, in this study, it is impossible to conclude from the interview data that the women who were better educated developed fewer complications. I interviewed four women who developed serious complications or planned to give birth at a health facility (Table 5): Makeda, Birke, Raydet and Meseret who was an inpatient at Chiri Health Centre. Makeda was supported by her husband who was in the military at the time and presumably had gained some education. Birke had received no education. Raydet had completed Grade 8 but she was not taken to Bonga Hospital until she was in her fifth day of labour. Meseret had received no education but was referred from Deckia Clinic to CHC. Other women I
interviewed who had complications at home said that bleeding stopped spontaneously or with traditional remedies. Those with retained placenta were either assisted by a TBA or by a doctor but generally biomedical health care was only sought for serious complications. There is not enough evidence to determine if better educated women developed fewer complications.

Third, there is a likelihood that better educated women will receive appropriate treatment for complications that may arise. In this instance, educated women may be better informed about complications and make a decision to seek care; they may be more likely to live in urban areas where there are more health facilities; they may have better access to transportation to reach health facilities; and finally, ‘they are more likely to receive appropriate and timely care when they do reach a health facility, either because they are better able to pay for that care, or because by virtue of their status, they are more likely to be well-treated’ (McCarthy and Maine 1992:29). Similarly, Shiffman (2000) concludes that women who are better educated are more likely to have control over their lives, more likely to take action that benefits their health, more likely engage in healthy behaviour when they are pregnant and more likely to use medical care during pregnancy (2000:284). The review by Gill et al. (2007) contends that women’s education is a strong predictor of maternal mortality as it increases the use of maternal health services including ANC, safe delivery and postnatal care and results in improvements in women’s health (2007:1350).

Box 17 shows that education levels vary between urban and rural areas in Ethiopia. Despite some improvements in education, the female primary school attendance rate in rural areas is 38.5 percent. Many of the women interviewed had children of school age and I observed many of my neighbours who were school children, at either primary or high school, coming and going to either the morning or afternoon shift of school.
Box 17: Education in Ethiopia

Over 80 percent of males and 69 percent of females in urban areas in Ethiopia have some education, compared with only 42 percent of males and 27 percent of females in rural areas (CSA and ORC Macro 2006:17). Forty-two percent of Ethiopian children who should be attending primary school are doing so. Of these, the rural primary school attendance rate is male 39.1 percent and female 38.5 percent (2006:20). The proportion of women in Ethiopia with no education has declined significantly from 99 percent among women age 65 and over to 41 percent among women age 10-14 (2006:18). Despite these improvements in education, 52 percent of males and 67 percent of females have never attended school and 32 percent of males and 25 percent of females have only some primary education (2006:17).

In my interviews with the staff from government, the NGO staff and also with women in rural areas, I asked about children’s attendance at school. The main reasons children did not attend school were poverty and distance. For example, Abebech was only able to send two of her children to school as she could not afford the uniforms and stationary to send the other children (Box 7, Chapter 4). Fana, who lived in Sheyka, was unable to send her older children to high school in the rainy season as it was not feasible for them to walk in the dark to be in time for the 7 am shift in Bonga, or to reach home before dark during the week of the afternoon shift (the shifts changed each week). So for those students who progressed to high school, fewer and fewer of them were able to continue their education, not only because of poverty but because it often meant walking to school a minimum of two hours each way (see Box 18).

Box 18: Travelling to school in Kafa Zone in the rainy season

When I was working from CHC I used two interpreters who were originally from Shapa, a 90 minute walk downhill to Bonga High School. Although they traveled from Shapa to Bonga during some of their education, at some stage both of them were offered accommodation by the Catholic Church who had built rooms for promising secondary students from outlying areas of Kafa Zone. These rooms were adjacent to my house in Bonga and I got to know a few of the students and their colleagues. It was still at least 45 minutes to walk to the high school. I woke up early one morning in the rainy season— to rain so heavy it was unthinkable that one could go out— knowing that students had to be at the high school that morning at 7 am for Year 10 exams.
As mentioned, a handful of students from remote parts of the Zone had been sponsored to stay in Bonga so they could attend Bonga High School. None of these students were Manjo. From the comments by Habtamu earlier in this chapter it can be concluded that Manjo students were unable to attend high school because their parents were unable to build houses in towns for them to live in. It would be difficult not to conclude that poverty and distance were also contributing factors to the ongoing exclusion of students especially Manjo students.

In conversations with my interpreter and a number of the high school students who lived next door, many of whom were preparing for the Year 10 exams, I was given the impression that education was about ‘rote learning, subservience and discouragement of initiatives in class’ (Poluha 2004:100). As outlined in Section 6.3.2, the Ethiopian state has been described as authoritarian, hierarchical, centralised and lacking in transparency which means challenging authority figures is unacceptable. Poluha (2004) defines the educational system in Ethiopia as bounded and unchangeable, and that the way in which it was communicated was hierarchical. These two aspects of the learning–teaching process in turn promoted continuity with two important Ethiopian traditions, on the one hand, an acceptance of hierarchy as a legitimate social order, and on the other, an understanding that taught knowledge should not be questioned nor a search for new information encouraged (Poluha 2004:99).

To date, I would suggest that formal school education has had limited influence on whether women will receive appropriate treatment for complications during childbirth in Kafa Zone.

If better educated women are more likely to take actions that benefit their health and use medical care during pregnancy, attendance at ANC is one possible way to measure healthy behaviour. ANC is seen as an opportunity to educate women and their families about the danger signs and symptoms associated with pregnancy and childbirth, and the benefits of seeking skilled care73. Women can also be made aware of the consequences of harmful traditional practices, the importance of preventing disease, managing existing

73 At CHC there were two large blue and white posters (in English) on the wall sponsored by IntraHealth International, University of North Carolina, Ethiopian Ministry of Health and USAID. Both posters focused on birth preparedness such as using ANC as an opportunity to detect and treat existing problems, planning the appropriate location for the delivery, choosing a skilled provider; knowing the location of the nearest health facility where EmOC is available; having a means of travelling to this facility; and, setting aside funds for medical care in advance so the woman can reach appropriate medical facilities as quickly as possible.
medical conditions and ensuring proper nutrition. The Ethiopian target is to increase the national ANC coverage levels to from 42 percent in 2003/04 to 70 percent by 2015 (MOH 2006a:18). In Kafa Zone, ANC is offered at all clinics, health centres and health posts and Bonga Hospital. In 1999 E.C., the Kafa Zone Health Department reported 85 percent coverage for ANC and 71 percent coverage for FP, however, the DHS reported that 30.3 percent of women in SNNPR actually received ANC in the five years prior to the survey (CSA and ORC Macro 2006:112).74

The profiles of the women interviewed (Table 5, Chapter 3) show that both educated and non-educated women used ANC. Table 5 shows that most older women did not attend ANC. Only one woman over 30 (with five years education) had ANC: Hirut (age 42). Fasika (29) who attended school for eight years did not have ANC. Two older women only used ANC for their last child: Wolete (approx 35 - 40) and Tsehainesh (approx 30). Of the younger women, only two women under 23 did not have ANC: Zena (early 20s) and Imabet (22). Table 5 also shows that younger women tended to use ANC: Yesharig (21), Etenash (22), Misrak (app 15), Aden (30), Bethlehem (25), Tadelech (app 27), Tsehainesh (last child) (30) and Wubealem (25). For the women who had complications, Imabet (Grade Eight) was eventually transferred to Bonga Hospital for forceps delivery after four or five days in labour. Birke (no education) was transferred by stretcher to Gojeb, then to Bonga Hospital, then to Jimma Hospital for Caesarean (Box 14). Meseret whom I met at CHC was most unlikely to have had any education given the remote location of her home at Agaro Bushi (two hours walk from Deckia) (Box 13).

My observations of interactions between women and health workers during ANC, delivery and at other times were that the health workers tended to treat women gently and speak to them quietly during ANC. I noticed this in contrast to how other patients were treated, which I often felt was rough and disrespectful. Given that all the health workers emphasised the overall importance of education, the provision of education was linked to ANC which meant that women who did not attend ANC missed out. In practice, what the health workers actually meant by education was that they would talk to the woman imparting important information to her while she sat there quietly and listened. Women would answer direct questions but they did not ask questions. Perhaps

74 I do not have actual attendance records for Kafa Zone.
their presence at ANC was testament that they were in need of education as they wanted to check the position of the baby, to receive TT, or felt there was a problem with the pregnancy. Generally, age tended to be a more likely indicator of ANC than education but this could simply be because ANC is more available now. Distance to a health facility did not appear to have any bearing on attendance at ANC as women were prepared to walk up to eight hours for ANC. The stated reasons given to attend ANC were to check the direction of the baby, to take the TT injection, or if women thought they had a problem with the pregnancy. In this study it was impossible to draw any firm conclusions about education and health seeking behaviour such as ANC because education has only been available for a few years in Kafa Zone and the sample of women is very small.

6.4 Concluding Remarks

The argument in this chapter is that both the Ethiopian government and NGO sector are concerned with development by providing basic service delivery in agriculture, education, health, water supply and sanitation, and rural roads. Health and education are defined as

important ends in themselves. Health is central to well-being, and education is essential for a satisfying and rewarding life; both are fundamental to the broader notion of expanded human capabilities that lie at the heart of the meaning of development (Todaro and Smith 2009:369).

The MOH is responsible for the policy formulation especially the HSDP which aims ‘to give comprehensive and integrated primary health care services in a decentralized and equitable fashion’ (MOH 2006a:5). The objectives of decentralisation are to devolve decision making power to lower levels of government and enable regional and woreda governments to provide planning and implementation for standard health services. However, in my interviews the NGO staff showed how decision making is limited because their projects must be in line with government sector planning. Funding is currently focused on infrastructure and staffing and is inadequate for equipment, supplies, and on-going maintenance.

When the long-established tendency for top-down planning in Ethiopia is combined with the restriction of planning and development to the various pre-existing sector plans, the result is that development is conceptualised and defined by sector planning with 'little
consideration given for other priorities’ (World Bank 2001:7.16). So in spite of decentralisation and sector planning, it appears to be taken for granted that the people in power in Ethiopia today behave in much the same way as the centralised governments of the past (Poluha 2004:11). Decentralisation can therefore, through its system of structuring rules be a further means to maintain subordination. In a hierarchical society it is not easy to see how ‘meaningful participation in local development activities’ (MOH 2005:3) occurs under Ethiopia’s HSDP III as the health strategy excludes community participation except for building construction, and there is little opportunity for feedback outside monthly reporting from the health posts and health centres to the Zonal Health Desk. Most of the government staff and staff from NGOs, whom I described as the development agents for Kafa Zone focus on development as a modernising process. Development means change, albeit slowly, through building new health and education facilities, new roads and so on. As the administration of public health occurs at the regional level, and planning and political administration is done at the woreda and then kebele level, community decision making appears restricted to capital projects, especially in-kind support for construction of projects such as health posts which might not offer immediate benefits for the community. All the same, even if health, education or other facilities are built, it is clear that the ‘presence of a service is of little value unless an individual can make use of it’ (World Bank 2001:7.47).

Bringing health facilities closer to the people were visible signs of change that seemed to be welcomed by many people especially during immunisation clinics and in demand for contraceptives. But with poverty just below the surface and underpinning people’s lives, many could not afford to pay for health services. This problem includes many people in the rural community who would have to borrow money from relatives and neighbours to access medical services. Recall in Chapter 5, Abaynesh walked past the Shapa Health Post to Bonga Hospital so she did not have to pay for the needle and syringe for her Depo-Provera injection. Both Yesharig and Abebech stated that a woman might die if she could not afford to pay for EmOC. And during the interview with Dr Emabet I had the strong feeling that admitting a woman might die because she had no money for gloves or other medical supplies was not an ‘acceptable’ response—this was corrected and I was told that the family was made to promise to pay after treatment. Many NGO staff and health workers indicated that the ‘free’ letter for health treatment at the hospital
sometimes went to those who didn’t need it while others were expected to bribe kebele leaders for the ‘free’ letter.

In earlier sections in this chapter, government staff and the staff of NGOs pointed out that as the Manjo and women were traditionally excluded from development they have been singled out through community consultation processes. There appears to be some positive changes for the Manjo as they are now able to use health services and some Manjo children attend school. However, during interviews with Manjo women who lived close to the forest or on the edges of villages, I had the impression that their households were poorer and that their struggle to provide for subsistence was still associated with being Manjo. Some Manjo still walk significant distances to supply firewood and charcoal for people in villages and in Bonga itself. It is likely there has been little change for the Manjo in remote parts of Kafa Zone.

International and local NGOs have incorporated gender empowerment terminology to integrate gender considerations into development programs that target women. Women are the target of a number of health interventions but it would seem that they are still excluded from making key decisions either in the home or at the community level. The picture that emerges from Chapter 4 is that women are socially constructed as mothers and that ‘their reproductive role [is] central to the definition of their identity and status (Pankhurst 1992:178). They are expected to send their children to school but, in many instances families cannot afford the exercise books and pens for all the children or the location of the school is too far from home. Women’s education and household decision making are identified as important enabling factors to increasing the use of maternal health services in developing countries. Because the sample was small, I could not conclude that education had had any affect on the number of pregnancies each woman had but the data confirms that marriage is the principal exposure to pregnancy in Ethiopia. However, the take up of contraceptives by the women is consistent with evidence from the health workers and through observation and the DHS Survey (CSA and ORC Macro 2006:64). There appears to be high demand from women to limit the number of children they have and many women were prepared to walk long distances for Depo-Provera injections every three months.
My observation at ANC and in interviews was that many women only sought health care if they thought they had a problem with the pregnancy, to check the direction of the baby or to receive a TT injection. Age tended to be a more likely indicator of ANC than education. Distance to a health facility did not appear to have any bearing on attendance at ANC as women were prepared to walk up to eight hours for ANC. A number of women attending ANC at CHC were referred from outlying health posts by HEWs or PHWs who had been instructed to refer women to CHC for blood and urine tests once during their pregnancy. This suggests that women will attend ANC for a ‘normal’ pregnancy. Yet on the two occasions I attended ANC at Deckia Clinic I had the sense that none of the women had ‘normal’ pregnancies because they had all come to the clinic for a specific problem. Given that the senior nurse had only arrived three months prior to my first visit, and that numbers had increased significantly during that three month period, I would suggest that there will be many more women attending ANC over time.

Given that the National Reproductive Health Strategy 2006 – 2015 supports the nation’s commitment to achieving the MDGs by 2015 and aims to mainstream reproductive health and ensure its place in the national development agenda (MOH 2006a:7), there are still significant barriers to access to health services including poverty, education, gender and membership in minority group such as the Manjo in Kafa Zone. The barriers to health care are even greater for those who must travel long distances to the nearest health service. So for women in rural areas who are exposed to hard work... the problem is people are too far from them [health services], the day is not clear for them because they are busy with food preparation and care of their children and all these things, and the same time the gender problem, giving service for the females less than the men (Getachew, NGO board member). The main characteristic of development as modernisation in Kafa Zone is that there is still a long way to go. Progress towards MDG Five has faltered in many developing countries given the scarcity of resources and ‘the perceived failure of conventional health education and primary health care to deliver substantial health benefits’ (Manandhar et al. 2004:977). In the next chapter I conclude that there is a need to find an alternative that is ‘potentially acceptable, scalable, sustainable, and cost effective as a public-health intervention’ (2004:977), one that is more woman-centred, one that contributes to reducing maternal mortality and disability in rural Ethiopia.
Chapter 7: Conclusion

Pregnancy and childbirth are two of the primary risks to women’s health in developing countries. As international policies and strategies to reduce maternal mortality and disability continue to highlight the inequality between developing and developed countries, the overarching question which initiated this research was ‘How does reproductive health, especially the goal of reducing maternal mortality and disability, fit into Ethiopia’s development agenda?’ The thesis examined the experience of women in Kafa Zone giving birth at home or being transferred to a health facility such as CHC, Bonga Hospital or Jimma Hospital. I researched some of the variables that influenced decision making about the location of birth which included distance, cost, education and the ability of women to make decisions themselves. To compare the women’s experiences with those of staff at local health facilities, I examined the way the decentralised health strategy imagines skilled birth attendants being able to recognise and refer complicated deliveries from the health post at the kebele level that provides essential obstetric and newborn care, to the health centre at the woreda level providing basic EmOC and newborn care, and finally the rural/ district hospital providing comprehensive EmOC including Caesarean section and safe blood transfusions. Many of the health workers felt they often had to ‘make do’ with limited equipment and supplies. As around 15 percent of women develop direct obstetric complications, the National Reproductive Health Strategy 2006-2015 (MOH 2006a) aims to increase to 60 percent the proportion of births attended by skilled health personnel either at home or in a facility. It would appear that this goal is a long way off. After reviewing the salient factors from earlier chapters, I then discuss the why part of the questions ‘Who is giving birth where, and why?’ because the why suggests how: how can maternal mortality and disability be reduced in rural Kafa Zone?

Chapter 1 provided a brief analysis of international development which was initially characterised by means of modernisation and economic growth: international development emphasises the need for modern health services and much of the existing literature about reducing maternal mortality and disability remains focused on ‘health system factors’ (Bullough et al. 2005) and ‘the performance of health systems in terms of access to health care and the quality of care provided’ (Gülmezoglu et al. 2004; see also WHO et al. 2004:14). Moreover, the indicators to measure progress towards MDG Five
are the MMR and the proportion of births attended by skilled health personnel (United Nations Millennium Project 2002 - 2006)— where MMR is high, one must conclude that the health care system is dysfunctional either in adequate access to care or the quality of care provided (Gill et al. 2007:1353-4).

If maternal health has been identified as a key development outcome, then ‘assessment of improving maternal health as a development goal is essential’ (Gill et al. 2007:1347): the health centre-based intrapartum care strategies described in Chapter 1, implies that ‘certain levels of development and availability of infrastructure— roads, cars, telephones, literacy, skilled manpower and clinics/ hospitals— are necessary for implementing this approach’ (Bang 2003:320). To this list I would add power supplies and repair capacities for vehicles and equipment. For this reason, other studies document the need to take a more comprehensive perspective as health service availability alone is not enough to increase utilisation and reduce maternal mortality (Barker et al. 2007:85; Bale et al. 2003:297). In particular, medical anthropologists argue that if policies are to be applied in diverse locations, health outcomes are likely to be influenced by the socio-cultural and political context of each setting.

Chapter 2 orientated the research towards a methodological approach that facilitated engagement with the reality of everyday life of rural women, health workers, government staff and staff from NGOs in the study area. Semi-structured interviews and participant observation enabled me to begin to understand the meaning people assign to experiences themselves. At the beginning of Chapter 3, the concept of location was used to represent or delineate Kafa Zone as a place where people live and work and as a map to find my way geographically to the field sites. In addition to visiting women in their homes, I visited Bonga Hospital and the health centres and health posts to observe the decentralised system of health care that aims to increase access to the rural population in Ethiopia. The benefit of doing participant observation meant I could observe how long it takes and how much energy is required to travel to the closest health facility and from there to the next level of facility for referral, reflecting the theme of accessibility found in Delay Two of the Three Delays. The recurring theme of distance suggests that it is taken for granted that in a rural society most people’s lives are to some extent slowed to a walking pace as that is the only way to travel both short and long distances. The theme
of distance was raised by also health workers who cited it as the main reason women did not utilise existing health facilities for birth. Using the referral system was especially problematical at night when no one would transfer a woman needing EmOC. However, other problems affected the referral system. Lack of training meant that some health workers did not know when to refer a woman with direct obstetric complications; yet most health workers had no choice except to refer women because of limited or no medical supplies or equipment. There did not appear to be any expectation that health staff were expected to travel to assist women during delivery despite some new roads and transportation such as an ambulance at Bonga Hospital. Distance also affected many health workers personally as they had to travel to woreda centres to lodge monthly reports and to pick up their pay and medical supplies.

Reporting the personal experiences of women during pregnancy and birth was the first objective of the thesis and Chapter 4 offered insights into the everyday life of women. Marriage is universal in Ethiopia and is the principal indicator of a woman’s exposure to the risk of pregnancy. After marriage it is taken for granted that women are responsible for everything related to the processing of food for consumption including grinding and pounding grain in the house and fetching water and firewood, household sanitation, looking after children and the elderly and taking care of the livestock around the house. The theme of the ‘walking woman’ emerged in this chapter as the action of walking links the daily activities between these activities in the home, and those with neighbours, the church and the market. People’s lives are also embedded in the cultivation, picking and processing of coffee, and the daily coffee ceremony brings people together and gives them the opportunity to relax and talk. Building good relations with their mother or mother-in-law, neighbours and the local community is defined as a crucial role for women especially as these people may be asked to assist at the birth, to lend money, help make a stretcher and to carry a woman to the nearest health facility in the case of an emergency. The importance of these relationships was evident from comments by the women. Sara expressed how alone she felt during the birth of her children as she was far from her own mother and close family. For those women who did not have a husband to support them, bringing up the children on their own was difficult: Abebech had to contract her neighbour to plough the field for her; Birke had been forced to leave her husband because she was unable to work; and Almaz relied on her family and only
received irregular support. Makeda faced many years bringing up her two sons alone as her husband was in jail. My close neighbour Amina still grieved for her daughter and as she was responsible for her three grandsons she could only imagine a bleak future for them.

When faced with decision making about the alternative options for the location of birth, the second objective of the thesis, the argument in Chapter 5 was that ‘normal’ birth happens at home and ‘abnormal’ birth happens when something goes wrong and a woman is transferred to a health care facility such as Bonga Hospital or CHC. Most women deliver at home attended by their neighbour, mother, mother-in-law, husband or sister beyond the reach of modern health facilities. When there is pain or birth is at night, traditional remedies are generally tried first which means there can be considerable delay if a decision is made to take a woman to a health facility. A number of women also mentioned prayer as a ‘palliative strategy’. The data confirms that women themselves are not necessarily part of the decision making process to seek biomedical care because decisions are made primarily by a woman’s husband, close relatives and neighbours, and sometimes even village elders or witchdoctors. In doing so the decision making process generally involves people who have no training about when to refer women to skilled health personnel. Thus the influence of husbands is not ‘trivial’ as women who are married to men who approve of health care are more likely to use it (Belay T. Biratu and Lindstrom 2006:91). Clearly messages targeting both men and women will potentially have a positive effect on health care utilisation and the National Reproductive Health Strategy aims to ensure that women, men, families and communities recognise pregnancy related risks and develop and implement appropriate responses (MOH 2006a:17).

Comparing the women's experiences with the experiences of staff at local health centres who provide ANC, normal delivery care and EmOC was the third objective of the thesis. It is likely that women giving birth at home feel ‘safe’ because that is where birth ‘normally’ takes place and they are supported by close relatives and neighbours. Because the biomedical health system is only used when a birth is seen as ‘abnormal’ or when something goes wrong, a picture emerges of ‘unsafe’ childbirth denoting those births that are transferred to a health facility. Thus it is likely women feel it is always ‘unsafe’ to go to a health facility because of the very real possibility they will die on the way. Yet this
sharp dichotomy is starting to be broken down over time as more and more women are accessing modern health care for ANC and FP even if they are non-users for ‘normal’ delivery. The view that birth at home is ‘safe’ contradicts the public health view that obstetric risks are ‘easily preventable with current medical knowledge’ (Obermeyer 2000:186) and the view of the health workers who argue that ‘unsafe’ birth takes place in the home because there are a number of traditional practices that endanger the life of the mother and her baby. The health workers also felt there was a problem for many people to access rural health services especially in the rainy season. As stated earlier, part of the problem was due to distance and lack of transportation but other problems arose because without medical supplies or drugs, they were unable to treat women with complications and had to refer them to another facility. Dr Emabet described the women who are referred from the woredas to Bonga Hospital as ‘lucky’ because there was so much going against a woman receiving emergency treatment if required. And Wubealem from Deckia said: Other women, when they carry them to Bonga or Chiri on the stretcher she gets tired and passed away on the way. Many mothers died from childbirth related problems. Other lucky women are survived by God’s help. Thus far, these two features of birth neither encourages women, supporting relatives and neighbours, or health workers, to move beyond the taken for granted assumptions about childbirth as a natural, normal process that takes place at home unless there is a serious problem.

Why do women give birth at home? Is it just because it is taken for granted to do so? The short answer is probably yes because the alternative is restricted to ‘abnormal’ births, and that means it involves a woman’s husband, her relatives and neighbours and the wider community making the decision to take a woman to a health facility. But the alternative also involves imagining the worst outcome for the woman. A birthing woman is expected to be stoic, and when stoicism is combined with the normalisation of prolonged labour it means people just ‘hope the baby will come’. This is how Birke referred to her experience in Chapter 5. Abaynesh’s husband described watching and waiting for two days before they carried his friend’s wife to the hospital. I concur that people are willing to use biomedical health services despite significant shortfalls in equipment and supplies for existing health facilities, but it seems to be a last resort as ‘normative health behavior’ is characterised by a ‘wait-and-see’ attitude to see if things
improve on their own (Kloos et al. 1987:1016). If development expectations are oriented towards a future where the majority of women give birth with skilled attendance as the way to reduce maternal mortality and disability, then I envisage that future being a long way off in Kafa Zone and in much of rural Ethiopia where most maternal death takes place: ‘current safer motherhood and newborn care programmes emphasise interventions that do not reach the poorest households’ (Costello et al. 2004:1166). The international and national view of birth at the local level replicates the dichotomy between traditional and modern. From a distance it appears straightforward to employ a skilled attendant at birth and to refer a woman to another health facility if there are problems. But the road is on mountainous terrain. In the rainy season it is slippery and muddy and sometimes there are rivers that are impossible to cross. Unfortunately for women being carried to a health facility, the topography and lack of transportation also contribute to the delay in reaching a health facility and many women die on the way. So how is it possible to separate the social and cultural dimension of birth from the physiological? Where is the space for the emotional and social significance of birth? How can the dangers and problems that women along with their husbands, mothers, mother-in-law and neighbours envisage, compare to those that biomedicine creates which suggest that without development interventions pregnant women and children will be neglected?

To examine maternal health within the broader development agenda was the fourth objective of the thesis. Two ‘enabling factors’: household decision making, and women’s status and empowerment measured by education were discussed in the thesis as they are likely to affect a woman’s capacity to access and utilise health services (Gill et al. 2007:1349-52). I noted that land reform has increased the perception of land tenure for both women and men but it has had a limited impact on women’s ability to influence farm management given the male dominance in household decision making. This tradition is being challenged as some women have involved themselves in decision making in land investment, production and common resource utilisation decision making with their husbands (Holden and Tewodros Tefera 2008). Yet all the women and health practitioners confirmed that the husband was the decision maker about whether a woman would be taken to biomedical health care (Chapter 4). Decision making is

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75 These questions follow Pigg (1995:58).
dependent on other factors including the availability of money or assets that can be sold, rented or used for getting a loan, the willingness of people to lend money, and concern about repaying loans. Sometimes, the community or the iddir is mobilised to help with financial costs and the wider community is always involved if a decision is made to carry the woman to the health facility. In Chapter 6, education has been prioritised within development as women who are educated are more likely to bear fewer and healthier children and to seek professional ANC and skilled delivery assistance. The data shows that education is necessary but not sufficient to bring about change in Kafa Zone. It appears that a woman’s age appeared to indicate attendance at ANC and the demand for smaller families and contraception is gaining popularity. However, this self-selection meant that most women in rural Kafa Zone do not attend ANC indicating that the majority of women do not receive information about the danger signs and symptoms associated with pregnancy and childbirth and the benefits associated with skilled care at birth. Of the women interviewed or observed who were receiving Depo-Provera some were limiting or spacing the number of children they had while the higher parity older women clearly did not want to have any more children. I was told that some women secretly saved money and attended FP on market days without their husbands’ approval. There is no doubt that the prevention of unwanted pregnancies through the improvement of reproductive health services will save lives from pregnancy related complications (Winikoff and Sullivan 1987:141; McCarthy and Maine 1992; Costello et al. 2004; Bang 2003). On the other hand, another reason for maternal mortality is women’s undernourishment (Tew 1998:304) and I felt that many women had poor health due to poor nutrition and their heavy workloads which seemed unlikely to change in the near future. Clearly there is scope for improving ANC visits to focus more on treatment of maternal anaemia caused by malaria, hookworm infection and nutritional deficiencies. I suggested that formal school education has had limited influence on whether women will receive appropriate treatment for complications during childbirth in Kafa Zone as most women attended ANC to check the direction of the baby, to take the TT injection, or if women thought they had a problem with the pregnancy. For Manjo women who walked to a health facility, the situation is slowly changing in urban settings but appears to be unchanged in the more remote parts of the Zone where they would have to wait until everyone else was treated. As ANC coverage improves with more HEWs and other health staff being employed and more facilities being built, it is likely
that attendance at ANC will improve in the future. In time, the capacity of HEWs to communicate with women about the benefits of ANC and FP will improve and should help influence the number of women attending receiving these services.

It is one thing to observe that many women travelled long distances to the market, to collect firewood and water, to visit friends and relatives or to go to a health facility for ANC to check the position of the baby, to receive the TT, or if they thought there was a problem with the pregnancy. It is another thing to observe that the same women would not travel short or long distances for delivery at a health facility. With only one exception, the women interviewed who lived in Kebele Three, less than one hour’s walk away, did not attend Bonga Hospital for the birth of their babies. And the women who lived five minutes walk from Deckia Clinic were not prepared to go there for delivery because there was nothing there to help them, nor were the women who attended ANC at CHC. For this reason the argument in Chapter 3 is that there is a significant ‘distance’ from international strategies and policies to its actual implementation in the kebeles in Kafa Zone and that the ‘pathway to maternal survival’ (CHANGE/ The Manoff Group 2005b) is not a direct, linear route.

The notion of a linear view of progress has been common to the idea of ‘development as modernisation’ as development has often been portrayed as either a continuum from traditional to modern or by creating dichotomies such as traditional/ modern, rural/ urban or then/ now. As I outlined in Chapter 6, this position was taken by a number of the government staff and staff of NGOs who view development as modernisation that needs to take place by means of visible changes such as the construction of roads and bridges, clean water supplies, electricity and telephones, schools, health facilities and so on. And although Ethiopia’s long history of top-down planning has been replaced by a policy of decentralisation, development planning seems restricted to sector-based planning which means that regional and Zonal government staff are the dominant actors. In effect, the ‘deconcentration’ of power has resulted in minimal involvement for local communities and the data shows that community participation is generally limited to in-kind support for infrastructure works such as health posts, roads or water projects. I would also suggest that as the referral system expects rural people themselves to travel to woreda or zonal centres this reinforces the
view that power and resources are decentralised and never bottom up. One outcome is that the health posts receive the least amount of funding for staff, equipment and supplies. Furthermore as most communication is decentralised from the centre to the regions, zones, woredas and kebeles, there appears to be little opportunity for communication from the kebeles except for monthly reporting. There does not appear to be any feedback from the hospitals to the health posts or health centres and I was told that it would be inappropriate for a doctor to report to a nurse, for example, as reporting only went one way.

The figures in Table 9 (Chapter 5) show the utilisation of maternal health services in Kafa Zone in 2007. As most women give birth at home there is still a long way to go to increase skilled birth attendance with the expected reduction in maternal mortality and disability. Ethiopia’s focus is on HEWs at the kebele level and the aim is to reduce maternal mortality to 350 deaths per 100,000 live births by 2015. This appears to be similar to Model 1 where China and Brazil reduce the MMR to 115 and 120 respectively.

It is important to point out again that in sub-Saharan African developing countries the most common causes of direct maternal death are haemorrhage, sepsis, prolonged and obstructed labour, pregnancy induced hypertensive disorders, and complications of unsafe abortion (Khan et al. 2006). But in places where there is a low level of skilled birth attendance, women tend to seek care when they are in a critical state which may result in an increased risk of death ‘suggesting that the decision to seek skilled care is often made too late’ (Ronsmans et al. 2010:293). Managing life-threatening complications needs intensive rather than obstetric care except for uterine evacuation or Caesarean Section (Costello et al. 2006:1478). I would suggest that this was certainly the case with the women I interviewed who had lost babies on the way or in health centres or hospitals. Yet there were considerable constraints to the planning and implementation of new development projects in health as the available budget meant it was necessary to choose between the quantity and quality of services. In particular, a number of new health facilities had been started or even completed but there were insufficient funds to buy equipment and medical supplies. For example, sulphonamide drugs are needed for the management of sepsis and injectable oxytocics are needed to treat haemorrhage within the median time from onset to death (no more than six hours) but these were generally not available with the exception of Bonga Hospital and CHC.
For these reasons, it would appear that in the short term this strategy is not achievable with ‘current resources and infrastructure’ (2006:1477) and if these drugs had been purchased they had not been replenished when stocks ran out.

As stated above, most mortality and disability takes place in poor rural households beyond the reach of health facilities. Costello et al. argue (2004; 2006) for context-specific service and community-based strategies in addition to health centre-based intrapartum. As most women prefer to give birth at home supported by their close relatives and neighbours, strategies to deal with socio-cultural constraints should involve the active partnership of the community (Diallo 1991). In particular, reproductive health strategies need to identify and implement innovative solutions and support networks for effective communication and transportation to EmOC services to shorten delays to health facilities. Manandhar and associates (2004) show that involving local communities in activities that link them with PHC services resulted in more women likely to have ANC, institutional delivery, trained birth attendance, clean delivery kit use and hand washing by birth attendants resulting in reduced neonatal and maternal mortality rates. And harnessing ‘the creativity, self-interest, and self-organising activities of poor women… seems to have had results unpredicted by linear biological models’ (Costello et al. 2004:1167). The women I met in Kafa Zone were capable of that. During the coffee ceremony and at the market place they meet and talk and discuss the benefits of biomedical health services. If they are concerned about their pregnancy they will walk long distances to attend ANC. They come up with innovative ways to ensure they get FP. They find ways to cope with the loss of mothers or daughters. Their local communities were capable of innovative solutions and support networks for effective communication and transportation to EmOC health services. Kebele health committees could be formed to work with HEWs to work through birth preparedness plans especially in rural areas where distance and lack of transportation is a major barrier to reaching a health facility without delay. Financial assistance to cover the costs of EmOC could be included in multi-purpose iddirs as these organisations pool resources, are based on trust and shared identity, have a high degree of participation, and provide social, moral and emotional support to members (Muir 2004:22). There is also evidence that actions at the community level need to be supported by changes at high levels in the
health system especially in providing women and their husbands with the information they need to make informed choices about family planning, pregnancy and delivery.

The Three Delays model is a medical model of maternal survival based on the understanding that most maternal deaths caused by direct causes are preventable with prompt medical intervention. Delays in receiving care are a prominent factor in maternal death: delays in deciding to seek care; delays in reaching appropriate medical facilities; and, delays in receiving quality care at the medical facility. Thaddeus and Maine (1994), Barnes-Josiah et al. (1998) and Wiebenga (2002) argue that the third delay is the most important because all factors feed into each other and are key stages in the decision making process. Focusing on hospitals first (improving the availability of drugs and supplies, improving hospital management and quality of care), then on secondary health facilities (expanding and decentralising provision of EmOC, improving staffing and skills), and finally on communities (improving emergency transportation, availability of blood, first aid and encouraging the early treatment of complications), is more likely to be successful as it means meeting the community half-way. They point out that it is counter-intuitive to educate and motivate the community about seeking EmOC until services and accessibility are adequate. Murray et al. (2001:353) sets out the requirements of effective referral system including communications, designated transport, teamwork between referral levels, unified record system and mechanisms to ensure patients do not bypass referral levels. I would suggest that the Zonal Health Desk and the Administrative, Finance and Economic Departments should play a strong leadership role followed by the woreda and kebele leadership to ensure that the National Reproductive Health Strategy is prioritised and implemented. They should start at the top with Bonga Hospital to ensure all the elements of comprehensive EmOC are available at all times. To be an effective referral point the hospital needs access to blood transfusion and 24 hour electricity, the generator needs to be made functional and the ambulance should be available to refer patients to Jimma Hospital.

76 This approach was taken by CARE International’s SMI in West Haraghe. Major renovations were done in two hospital maternity units with repair to water supply systems, provision of small generators, repair of waste management systems and replenishment of equipment and supplies with a special focus on operating rooms. A new system for record keeping and data collection was introduced. TBAs were training and the referral system was strengthened (Kayongo et al. 2006:312). This project brought about a significant change to the UN process indicators by doubling the Caesarean rate; increasing the met need for EmOC from 2.0 percent in 2001 to 4.5 percent in 2004; and reducing the case fatality rate by 35 percent (Kayongo et al. 2006:315; Alemayehu Mekonnen 2005:vii).
Chapter 6 found that some NGOs provide direct services or are involved in implementing government policy, and others are more concerned with the nature of development: both the local government and NGOs are concerned with the development and modernisation of Ethiopia. If development in Kafa Zone is taken for granted by some government staff and staff of NGOs to be synonymous with modernisation, the main characteristic of development is that there is still a long way to go. Some NGO staff reflected on other meanings of development because they felt that women and the Manjo had historically been excluded from development projects. Historically, the Manjo were excluded from participation in everyday life and were not permitted to use transport, health services, go to school or live in town. While the current government strategy is that all people are to be treated equally, excerpts of interviews and observation with Manjo women and their families reveal that there is still some concern about social discrimination, and a number of NGOs were funding projects to deal with problems associated with marginalisation and social exclusion. This suggests there is still a long way to go especially in the rural areas. The following proverb draws attention to this expression of development:

**ወንንፋ ህንቋ ያሆን ያስል ከ:**

*When two elephants fight, it is the grass that is affected.*

The implication in this proverb is that people at the bottom are trampled when ‘elephants’ or ‘big’ people fight over resources. Embedded in the conversation with Worku (an NGO staff member) was his concern about women and the Manjo and other marginalised groups in Kafa: I am optimistic by nature but sometimes when I sit here there should be something done. The thing to be done is not just a big change, but to follow the system that takes interrupting corruption, stopping, beginning, turning very sharply. These systems should be upgraded. What I learn now is there is development, there is change, but sharp turns are too much. All these cracks you see, for example for education, you can huge development, huge movement, I also see confusion, there is short change. These changes have their own positive things and also they affect the central structure, they affect politics, but I see that there will be some progress, with too many people falling under poverty. So who is gaining from development? It is important to ask this question to determine if the investment in the health centre-based intrapartum care that aims to increase skilled attendance at birth by improving health facilities and
providing EmOC will reduce maternal mortality in Kafa Zone. As already mentioned, development is reaching those ‘weak in the public arena’ (Poluha 2004:185) in rather ad hoc ways so I too wondered if ‘change becomes an exception rather than a rule’ (2004:202). If progress towards MDG Five has faltered in many developing countries given the scarcity of resources and ‘the perceived failure of conventional health education and primary health care to deliver substantial health benefits’ (Manandhar et al. 2004:977), is there a ‘potentially acceptable, scalable, sustainable, and cost effective... public-health intervention’ (2004:977), one that is more woman centred, one that contributes to reducing maternal mortality and disability in rural Ethiopia? If there is, then the purpose of this study has been to identify some of the social and cultural issues that should be considered alongside biomedical health interventions.

To conclude on a personal note: perhaps the point all along has been to learn more about what development is and to better understand its complexities in our own culture. Even though the word development conveys the idea of progress or growth, international development ‘embodies an urge to protect and better others less fortunate than ourselves’ (Duffield 2007:227). And health development discourse assumes that ‘only the medical solutions offered by development saves lives... [and] the agendas of major development donor institutions are made to seem like the only possible way to deal with problems of poverty and social inequality’ (Pigg 1995:49 emphasis in original). Even when there is development and even if there is a system so that birthing women can be referred on time for direct obstetric complications, we can begin to describe the difficulties for rural women and their families in Kafa Zone to access health facilities, and the difficulties health workers face trying to assist them. Embedded in this analytical space it was almost inevitable that the discourse of development which I tried to distance myself from, did not allow me to find any real alternative for those women whose lives could be saved by a Caesarean Section or assisted delivery. But what I did find was that if development is anything at all, perhaps it should be described more as a fertile exchange of ideas, stimulating and absorbing friendship and other positive values, well-being, harmony, capacity for reproduction and sustainable growth... and none of these have an end stage (Dahl and Gemetchu Megerssa 1992; Vecchiato 1997).
Appendix One: Ethics documentation

Research Services
Office of the Deputy Vice-Chancellor (Research) (Melbourne Campus)

MEMORANDUM

TO: Ms Ruth Jackson
International and Political Studies
Geelong

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 11 August 2006

SUBJECT: PROJECT: EC 143-2006
(Please quote this project number in future communication.)
RISK, UNCERTAINTY AND AGENCY: SAFE MOTHERHOOD AND CULTURE IN RURAL ETHIOPIA

This application was considered by Deakin University HREC on 26 June 2006.

APPROVAL HAS BEEN GIVEN FOR MS RUTH JACKSON, UNDER THE SUPERVISION OF DR MAX KELLY, SCHOOL OF INTERNATIONAL AND POLITICAL STUDIES, TO UNDERTAKE THIS PROJECT FOR A PERIOD OF THREE YEARS FROM 18 AUGUST 2006.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

• Serious or unexpected adverse effects on the participants
• Any proposed changes in the protocol, including extensions of time.
• Any events which might affect the continuing ethical acceptability of the project.
• The project is discontinued before the expected date of completion.
• Modifications are requested by other HREC's.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Vicki Xafis
Secretary, DU-HREC
(03) 9251 7123

Signature Redacted by Library
My name is Ruth Jackson and I am studying for a doctorate in International Development Studies at Deakin University in Australia. My research project is an important component of the course and I am undertaking this under the supervision of Dr Max Kelly. The information obtained from this project will be used for writing a thesis to obtain the academic qualifications for my Doctorate of Philosophy (PhD), and may also be used to write articles for development journals.

The aim of this project is to explore the cultural factors surrounding childbirth in Ethiopia. It is titled Risk, Uncertainty and Agency: Safe Motherhood and Culture in Rural Ethiopia. I invite you to consider participating in this project.

I want to talk to women who are pregnant or have had a recent pregnancy. I want to talk about women’s lives before their pregnancy, the time during their pregnancy and then the process of labour and delivery. To do this I would like to spend some time getting to know you and perhaps learning some skills such as preparing injera or making berberé from you over a period of two or three weeks so we can talk about these things. We could make a time for me to come and meet with you each day. I could sit with you at home while you are preparing food, cleaning the hut, collecting water or other activities. I would not always need to be asking you questions. If you agree our conversations will be tape recorded and I will take some notes of what you say as well. I will need some help with language so someone will help me talk with you. Afterwards you can look at the transcripts of the tapes or listen to what you have said. Some of the questions I will ask you are on the attached sheet.

You do not have to be involved if you don’t want to. But if you choose to talk to me and it causes distress, you can change your mind at any time by asking me to stop talking to you or you can say at any time that you have said enough to explain. You can also ask me to stop recording or taking notes at any time too. If you wish, you can talk with one of the staff members at [insert name of health centre] and I can arrange to take you there.
If you agree, our conversations will be tape-recorded and I will take some notes of what you say as well. I will need some help with language so someone will help me talk with you. Afterwards you can look at the transcripts of the tapes or listen to what you have said. If you agree I could take some photographs of you and when they are processed I would be able to give you copies for you to keep as well.

The information we talk about will be confidential. I can change your names and the place where you are from. The information that I write down will only be seen by my supervisor and me although coded dated is stored for six years at my University in Australia.

If you have any queries or want to know about the research please let me know.

Thank you for agreeing to talk to me.

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services Division, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125 AUSTRALIA  Tel (03) 9251 7123 (International +61 3 9251 7123)
Consent for Individuals (English)

Deakin University Human Research Ethics Committee Consent Form for Individuals:

I, ………………………… ………………………………………………………………………

… ………………………………………………………………………………………………..

Hereby Consent to be a subject of a human research study to be undertaken
By Ruth Jackson
and I understand that the purpose of the research is to contrast women’s ideas about
risk during pregnancy and childbirth with their behaviour regarding the use of
modern health services

I acknowledge
1. That the aims, methods, and anticipated benefits, and possible risks/ hazards of the
research study have been explained to me.
2. That I voluntarily and freely give my consent to my participation in such a research
study.
3. I understand that aggregated results will be used for research purposes and may be
reported in scientific and academic journals.
4. Individual results will not be released to any person except at my request and on
my authorization.
5. That I am free to withdraw my consent at any time during the study, in which
event my participation in the research study will immediately cease and any
information obtained form me will not be used.

Signature: ………………………………………… Date: ………………………………..
Plain Language Statement (Amharic)
Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services Division, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125 AUSTRALIA. Tel (03) 9251 7125 (International +61 3 9251 7125).
 Consent Form for Individuals (Amharic)
Appendix Two: Letter of Introduction to Bonga Hospital, Chiri Health Center and Deckia Health Center

Bonga Hospital
Chiri Health Center
Decida Health Center
SNNPR

Subject: Request for support in research on PhD dissertation

Mr. Ruth Jackson is a visiting research scholar at the Population Studies and Research Center, Institute of Development Research, Addis Ababa University. The purpose of her visit is to conduct research for her PhD dissertation on "Risk, Uncertainty and Agency: Safe Motherhood and culture in Rural Ethiopia."

As Reproductive Health is one of the components of demography, Mr. Jackson will be working at your hospital reviewing documents, interviewing patients and staff as part of the research starting form May 2007, for a period of one year.

Hence, we kindly request your full cooperation and support in her research by providing supportive links with the community leaders and the concerned ones at grass root institutional levels.

Let us work together for our health

Ayele Debebe (Dr.)
Family Health Department A/Head

CC:
- Kefa Zonal Health Department
- SNNPR
- SNNPR Health Bureau
- Awassa
- Office of the State Minister
- Family Health Department
- Moll

Signature Redacted by Library
References

Note: All Ethiopian names are entered, as is traditional practice, in alphabetical order of the author's first name followed by the father's name.


Amanuel Gessessew and Mengiste Mesfin, 2003, Obstetric Labour in Adigrat Zonal Hospital, Tigray Region, Ethiopia, The Ethiopian Journal of Health Development, 17 (3) pp 175 - 180


AusAID, 2002, Gender and Development: GAD lessons and challenges for the Australian aid program, Canberra,


Economist Intelligence Unit (EIU), 1998, Ethiopia: Country Profile, Economist Intelligence Unit, London


Fasil Tessema, Makonnen Asefa and Fekadu Ayele, 2002, Mothers’ Health Services Utilization and Health Care Seeking Behavior During Infant Rearing: A Longitudinal Community Based Study, South West Ethiopia, Ethiopian Journal of Health Development, 16 (special issue) pp 77 - 87


Girma Kebbede, 2004, Living with Urban Environmental Health Risks: The Case of Ethiopia, Ashgate, Aldershot and Burlington


Habtamu Argaw, 2002, Health status, health services and health related knowledge, attitude & practices (KAP) in Kafa Zone: The results of a community-based baseline study, (Unpublished report), SUPAK/DHV, Bonga, Ethiopia


Hay, M.C., 1999, Dying Mothers: Maternal Mortality in Rural Indonesia, Medical Anthropology, (18) pp 243 - 279

— — —, 2001, Remembering to Live: Illness at the Intersection of Anxiety and Knowledge in Rural Indonesia, University of Michigan Press, Ann Arbor

Hemmings, J., Tseday Wubshet, Seblewengel Lemma, Tenanesh Antoni and Tesfaye Chernet, 2008, Ethiopian Women's Perspectives on Reproductive Health Results from a PEER Study in the Gurage Zone, Centre for Development Studies, University of Wales, Swansea and Marie Stopes International, Ethiopia, Addis Ababa

Hodes, R.M., 1997, Cross-cultural medicine and diverse health beliefs: Ethiopians abroad, Western Journal of Medicine, 166 (1) pp 29 - 38


Hulme, D. and M. Edwards, 1997, NGOs, States and Donors: An Overview, in NGOs, States and Donors: Too Close for Comfort?, edited by D. Hulme, M. Edwards and in association with Save the Children, St. Martin's Press, New York, pp 3 - 22


James, C., K. Hanson, B. McPake, D. Balabanova, D. Gwatkin, I. Hopwood, C. Kirunga, R. Knippenberg, B. Meessen, S.S. Morris, A. Preker, A. Soucat, Y. Souteyrand, A. Tibouti, P. Villeneuve and K. Xuh, 2006, To Retain or Remove User Fees? Reflections on the current debate,

Jarrett, S.W. and S. Ofosu-Amaah, 1992, Strengthening health services for MCH in Africa: the first four years of the 'Bamako Initiative', *Health Policy and Planning*, 7 (2) 164 - 176


Katan, D., 1999, Translating Cultures: An Introduction for Translators, Interpreters and Mediators, St Jerome, Manchester


--- , 1995, Writing at the Margin: Discourse between Anthropology and Medicine, University of California Press, Berkley, Los Angeles and London
Lane, S.D., 1994, From Population Control to Reproductive Health: An Emerging Policy Agenda, Social Science and Medicine, 39 (9) pp 1303 - 1314
Lukere, V. and M. Jolly, 2002, Birthing in the Pacific Beyond Tradition and Modernity?, University of Hawai`i Press, Honolulu
———, 1999, Risk as moral danger: The social and political functions of risk discourse in public health, International Journal of Health Services, 23 (3) pp 425 - 435


Makonnen Bishaw, 1991, Promoting Traditional Medicine in Ethiopia: A Brief Historical Review of Government Policy, Social Science and Medicine, 33 (2) pp 193 - 200


Ministry of Health (MOH), Federal Democratic Republic of Ethiopia, 2005, Health Sector Strategic Plan (H SD P-III) 2005/ 6-2009/ 10, Planning and Programming Department, Addis Ababa


———, 2006b, Report on Safe Motherhood Community-based survey, Ethiopia, Addis Ababa

Mirgissa Kaba, 2000, A Qualitative Study on Health Seeking Behavior and Community Based Health Care Potentials in Kafa-Sheka Zone, SNNPR, (Unpublished Report), Jimma University, Jimma


Morse, J., 2000, Qualitative generalisability, Qualitative Health Research, 9 pp 5 - 6


———, 2000, Risk, Uncertainty, and Agency: Culture and Safe Motherhood in Morocco, Medical Anthropology, 19 pp 173 - 201
Pigg, S.L., 1995, Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development, Social Science and Medicine, 41 (1) pp 47 - 68
Poluha, E., 1988, The Producers Cooperative as an Option for Women: A case study from Ethiopia, in Cooperatives revisited, edited by H. G. B. Hedlund, Nordiska Afrikanstutet, Nordic Africa Institute, Uppsala, pp 139 - 152
Ross, E., 1995, New Thoughts on "the Oldest Vocation": Mothers and Motherhood in Recent Feminist Scholarship, SIGNS, 20 (2) pp 397 - 413
Ross, J.A. and J.E. Begala, 2005, Measures of Strength for Maternal Health Programs in 55 Developing Countries: The MNPI Study, Maternal and Child Health Journal, 9 (1) 59 - 70
Rugendyke, B., 2007, Lilliputians or leviathans?: NGOs as advocates, in NGOs as Advocates for Development in a Globalising World, edited by B. Rugendyke, Routledge, Hoboken, pp 1 - 14
— — —, 2003, Generating political will for safe motherhood in Indonesia, Social Science and Medicine, 56 pp 1197 - 1207


Stellmacher, T., 2006, Governing the Ethiopian Coffee Forests: A Local Level Institutional Analysis in Kaffa and Bale mountains, PhD, Institut für Lebensmittel- und Ressourcenökonomik (ILR), University of Bonn, Bonn


Tadesse Kitilla, 2003, Reasons for referrals and time spent from referring sites to arrival at Tikur Anbessa Hospital in emergency obstetric: A prospective study, The Ethiopian Journal of Health Development, 15 (1) pp 17 - 23


Theroux, P., 2004, Dark Star Safari: Overland from Cairo to Cape Town, Houghton Mifflin, Boston


Turshen, M., 1999, Privatizing health services in Africa, Rutgers University Press, New Brunswick


Van Hollen, C., 1994, Perspectives on the Anthropology of Birth, Culture, Medicine and Psychiatry, 18 pp 501 - 512


Vecchiato, H.L., 1993, Illness, Therapy, and Change in Ethiopian Possession Cults, Africa, 63 (2) pp 176 - 195

———, 1997, Sociocultural Aspects of Tuberculosis Control in Ethiopia, Medical Anthropology, 11 (2) pp 183 - 201


———, 2004, Antenatal care in Developing Countries: Promises, achievements and missed opportunities: An analysis of trends, levels and differentials, 1990 - 2001,


Wondwosen Terefe, 2006, Medical Pluralism in Ethiopia, Shaker Verlag, Aachen


Yemane Berhane, 2000, Women's health and reproductive outcomes in rural Ethiopia, Umeå University Medical Dissertations, New Series No 67A, Epidemiology, Department of Public Health & Clinical Medicine, Umeå University, Sweden, Department of Community Health, Medical Faculty, Addis Ababa University, Addis Ababa

Yemane Berhane, Y. Gossaye, M. Emmelin and U. Högberg, 2001, Women's health in a rural setting in societal transition in Ethiopia, Social Science and Medicine, 53 pp 1525 - 1539
