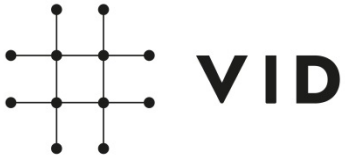

Unseen features of society create hidden health complications.

An exemplification of how socio-cultural environments may impact pregnant women's health. A case-study from Aira Woreda, Ethiopia.

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Abstract

Our understanding of our reality is shaped by our worldviews and the influences from a more intertwined world trough globalization. These forces influence each other as they simultaneously are important invisible dynamics that affect our everyday decisions, priorities and actions. I call these dynamics socio-cultural environments. The goal of this study is to provide a deeper understanding of how social-cultural environments may have an impact on pregnant women's health in Aira Woreda, Ethiopia. A qualitative study consisting of a six-week fieldwork including observations, interviews of 15 pregnant woman, health personal, governmental offices and regular people was conducted in Aira to gather primary data.

Infrastructures such as roads, ambulances and communication technologies are more established today than before. Hospitals, clinics, health centres and health posts, supplied with medical health personnel, are present. Education is given at schools and health facilities. There have been both governmental and non-governmental, and international and national developmental work related to health campaigns, health promotion and/or health education regarding maternal health. However, many initiatives have not been successfully implemented. This is, partly, due to that the prominent aspects of socio-cultural environments many times have been overlooked. This thesis gives examples on how socio-cultural environments and its cognitive, affective and evaluative dimensions may affect pregnant women's health seeking behaviours in Aira Woreda.

A major conclusion of this study is that gender roles, religion and education have proven to be fundamental aspects in understanding how socio-cultural environments leads decisions and actions of pregnant women in Aira Woreda.

Keywords: Socio-cultural environments, pregnant women, maternal health, worldviews, globalization, modernization, gender, religion.

Acknowledgments

I don’t know where to start. Am I really writing the acknowledgments to my master thesis? It’s unbelievable. For over a year, I have thought of the pregnant women’s health almost constantly. I see pregnant women everywhere. My friends and acquaintances who were and are pregnant have gotten many questions and I have discussed my findings with innumerable of people. Sometimes I even felt pregnant myself. It’s true. I have been happy and excited about my topic, other times I’ve been depressed and really fed up. Actually, this thesis has “sort of been *my* baby” that I have been carrying and will now deliver to the rest of the world. It’s exciting and liberating, but a bit scary as well. Hopefully, I have contributed with something valuable.

This shows that I have been engaged and interested in my thesis work. And this is very much because of the amazing people and opportunities I've had around me from the very start.

I want to start thanking Stein Tore Nilsen, who initiated this opportunity for my master thesis. Further my gratitude goes to Øystein Evjen Olsen, who gave me an incredible opportunity on behalf of Stavanger University Hospital to examine issues related to maternal health in Ethiopia. With your support, I got a possibility a master student only can dream about. With a big smile, I am thanking Åshild Berg for accompanying me to Ethiopia and Aira and introducing me to the field of maternal health and Aira. Without you I would not have had such an enjoyable, safe and welcoming start for my fieldwork.

A sincere thank you to my dear supervisor, Marianne Skjortnes, who has always met me with a smile, patience, critical inputs and motivating words. You made me reflect and really make this thesis to my own.

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A thousand thank you´s to you all!

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1 Introduction

1.1 Theme and motivation

Human life is different everywhere in our world. But there is one universal basis for how life is started. This is pregnancy.

There are many things connected to pregnancy, both for women and men. And there are many discourses about family life, reproductive health and gender roles that affects both women and men during the period of a women's pregnancy. I have nevertheless chosen to focus mainly on the pregnant women and her health in this study. The reason for this is simply that it is the women who are *being pregnant,* and that it's the body and mind of the women that goes through a transformation when being pregnant.

In addition to this general biological dimension during pregnancy, the everyday life situation in a specific context has impacts on many aspects related to being pregnant. This concerns both the personal life situation of the women and the official and collective expectations and responsibilities related to bearing forth a new life in the community/society/cultural context.

Thus, in addition to the physical transformation which can be both incredible and challenging for pregnant women, she also encounters a social transformation in her specific cultural context which can be as lifechanging and challenging. Together, these points make pregnancy a big, important and influential part of women's life in all aspects, and that's why I have chosen to focus on pregnant women's health.

The motivation that relate my thesis work to Ethiopia is due to the curiosity of the relationship between globalization and local life that grew out of my bachelor thesis, which examined how family life could be influenced by the forces of globalization in Ethiopia.

In addition, my Ethiopian heritage from my mother and the interest to learn more about my second home country and women's life situation there. The decision to conduct my fieldwork in Aira, Western Ethiopia, is because of accessibility and already established relationships between the Mekane Yesus Seminary, Aira Hospital and VID Specialized University (Previously Misjonshøgskolen).

1.2 Limitations

It is important to acknowledge the limitations and scope of this study before preceding any further. Primary, this is neither a medical nor a political or a policymaking study.

I don't have a starting point in which politics and the government, or the political situation in Ethiopia, affect pregnant women. This aspect could be relevant because several hospitals and health facilities are state-run, and some of my findings show that this can affect women's actions when seeking care. However, it becomes too extensive to go into an analysis of how this exactly unfolds. I also consider this to be related to a macro perspective, while my thesis assumes a micro perspective.

My study does not have any medical or curative ambition. I have no medical background and my intention is not to assess what kind of medical health challenges the pregnant women encounter, or to give any diagnose or solution to potential health issues. It is primary about highlighting and understanding how social and cultural aspects may impact maternal health. Also, I will solely focus explicitly on the pregnant women. The fetus and future baby is not the centre of this assignment.

Measuring health is a tricky matter and I have no intention in giving a general picture of the health situation of the pregnant women in Aira Woreda. The aim is simply to capture how socio-cultural environments affects pregnant women's health. This is done by trying to capture the life situation of pregnant women in Aira Woreda, Western Ethiopia. It is also important to stress that intentionally this study was not analysing how religion leads people's lives, but after conducting fieldwork in the given area it is clear that religion has major impact on people's lives. Therefore, even if my emphasis is on how socio-cultural environments impacts pregnant women's health, religion will be strongly integrated into this.

A further important limitation relates to that I was in the field and able to observe and participate in the pregnant women's life for a very limited period and won't get insight into the whole course of events of a full pregnancy. Therefore, many situations that may be crucial for understanding the social processes behind certain events and decisions may be missed. The danger of losing important parts of the context and reality is therefore present. I therefore strongly emphasize from the start that my intention is not to cross a normative boarder by my description of the pregnant women's reality and legitimize my findings as basic values.

1.3 Definition of important concepts

1.3.1 Socio-cultural environments

As I want to view how socio-cultural environments affects pregnant women's life, a definition of the use of socio-cultural environments in *this* thesis is necessary. Generally, sociocultural environments include behaviour, practices, beliefs and traditions within a population. The adjective of sociocultural environments is of "relating to or signifying the combination or interaction of social and cultural elements" (Dictionary, 2018).

The most common understanding of sociocultural environments regards cultural differences due to differences in social status, such as "the different groups of people in society and their habits, traditions and beliefs" (Cambridge Dictionary, 2018). This is however not my point of departure because I did not limit myself to a particular social group when collecting data.

My concern of socio-cultural environments builds on the issue that social relationships and culture together affects pregnant women's health. Culture is facilitated by social relationships, and vice versa. Thus, the insert of a link between the words social and cultural (=socio-cultural) to emphasize this use of the term. This angle in socio-cultural environments is also highlighted by scholars, for example Cohn, Schatz, Freeman and Combs, (2017) in the book "Sociocultural Influences on Decision Making".[1]

Building on this, brief definitions of culture and social relations are needed. There are multiple definitions on what culture is. Mainly, it's about the values and norms that shape people's behaviour within a society. Hall (1998) writes that "in essence, any culture is primarily a system for creating, sending, storing, and processing information" (53). This is done on the individual, relational and the institutional level (Cohn, et al., 2017). Tuyizere (2007) further defines culture as "both transmissible and cumulative and the traits are cultural in the sense that they are transmitted by the society, not by genes... Culture is a way of behaving, thinking and reacting to situations… Culture refers to the norms and practices of a society" (44).

Social relations mainly regard the invisible threads created between two or more people when interacting. Wadel and Wadel (2007) highlight that social relationships shape

[1] I want the reader to be aware that I was in doubt of using this term due to this, and want the highlight my extra attentiveness on this detail and therefore chose to insert the link between the words. The choice of term was based on the meaning of both the words and their composition. It made sense to my interest and the content of this field.

people and their actions and decisions, and that one individuals' actions affect other people's actions. This will be further explained in Chapter 4 – Theoretical approaches.

The aspect of *Environments,* in socio-cultural environments, includes how discourses on family, gender roles, sexuality, pregnancy, reproductive health etc. is formed from both external forces such as globalization and modernization, and internal forces such as worldviews. This will also be further elaborated under my theory-chapter as this is my theoretical perspective.

1.3.2 Maternal Health

My definition of health is based on WHOs (2017) definition of health, which is "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Health institutions regards health facilities with medical personnel.

The notion maternal health (MH) is in this thesis functioning as an umbrella concept covering antenatal care, maternal mortality and deliveries. This also includes diseases and conditions that appear during or after pregnancy, due to pregnancy. Family planning is not an obvious part of this since I am focusing on already pregnant women, but aspects concerning it might be implicitly discussed throughout the paper.

Antenatal care (ANC) regards "the routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery" (NFOG, 2018)

Maternal mortality is when a woman dies during pregnancy, childbirth or up to 42 days after delivery of reasons related to the pregnancy (Austveg, 2006).

Deliveries regards the process of labour and giving birth to a baby.

Sexual and reproductive health (SRH) is an even more comprehensive term that encompasses all of the above-mentioned aspects. The UNDP (2018) defines good SRH as "a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so". SRH is a major part in MH and is tacitly highlighted throughout the whole thesis.

Important abbreviations:

These terms will be frequently used in the thesis and are therefore shortened to give the reader a better flow in the reading.

Pregnant women – PW

Maternal Health – MH

Globalization and modernization – G/M

Worldviews – WV

Sexual and reproductive health - SRH

1.4 Thesis structure

I will start Chapter 2 – Research Issues by laying the fundament of the thesis by presenting my research question followed by previous research on MH from a medical perspective, a G/M perspective and a socio-cultural perspective. Lastly, I present what I may contribute with to my chosen field. Chapter 3 – Methodology, presents methodological approaches and reflections of my study. Ethical considerations are also highlighted here. Chapter 4 – Theoretical approaches, explains the motivation behind my theoretical perspective and present the tools I will use in the analysis. Further, my collected data is presented, both primary and secondary data, in Chapter 5. Chapter 6 – Analysis, consists of three parts that will highlight my primary data findings based on the theoretical foundation presented in the theory chapter. Finally, in Chapter 7, a concise conclusion is presented that highlights the sensational findings in my study and suggestions for potential future research.

2 Research Issues

2.1 Aim of my study and research question

The common essence in the majority of previous research concerns obstacles in access to information, access to hospitals/health stations and the treatment of/access to the correct service and care at the respective health institutions. One model that is presenting these barriers is the "three delays" model which explains 1) delay in the decision to seek care; (2) delay in arriving at a health facility and (3) delay in the provision of adequate care at the facility (Thaddeus and Maine, 1991, in Filby, Mconville and Portela, 2016). This may be related to Kwast (1998) Quality of Care in Reproductive Health Programmes: Concepts, Assessments, Barriers and Improvements. This model has been frequently used to find problems and solutions regarding health through a medical and technical perspective (infrastructure, service and financial situation). All three barriers/obstacles are integrated and coherent and are all very relevant for understanding the vulnerable and difficult situation many PW are in. Decisions are taken at all these levels and a crucial aspect to understand the outcome of these decisions is to examine what forces affect and enables implementation of these decisions. However, a limited perspective, addressing the first barrier - the decision to seek help, is necessary for this work. The motivation for this is based on how the grassroots of society are anchoring values and norms that set guidelines for decision-making and patterns of action. Therefore, the aim is to focus on how context and culture affects the utility of ANC/MH in the sense that social relationships and culture in a society, for a safe and successful pregnancy and childbirth, plays a big part.

I am well aware of the technical obstacles that go under the umbrella concepts of economy, infrastructure and education and that they have big importance for understanding hindrance concerning ANC/MH. However, I chose to explicitly leave these out from this thesis due to my focus on socio-cultural environments and the knowledge that there are women, who have access to health facilities that still have troublesome pregnancies and births because of aspects related to decision-making. These technical aspects will however be processed and reflected upon implicitly when including the globalization and modernization perspective.

2.1.1 Research question

Building mainly on the motivation of the UNs (2015) evaluation of the unachieved previous MDG5 (now called the Sustainable Development Goal 3 – Improve global health and well-being), and their new measures to improve the actions and implementations for future success including social and cultural aspects more seriously, the aim of my study is therefore to capture and present a snapshot of how social-cultural aspects may affect PW's decisions and how this actually may affect their health.[2] My aim is simply to present what hinders PW in Aira in receiving and/or using ANC/MH from a socio-cultural perspective, even though the possibility is present and technical aspects (infrastructure, service) is facilitated.

To summarize: I want to analyse how the people's daily life, behaviour, relationships and understandings (culture) affects PW's health in Aira Woreda

The research question has developed to be:

"How socio-cultural environments affects pregnant women's decisions and correspondingly their health, even though there are medical health facilities present within reach?".

Further, sub-questions are:

- How is a PWs health affected by the duties and expectations she is exposed to daily?
- How does the culture and social relations create challenges for understanding the health challenges a PW is exposed to?
- How are PW reasoning when taking decisions regarding their health?

2.2 Research related to Maternal Health...

Before formulating my research-question and doing my fieldwork I discovered there was a sea of relevant literature, previous research and projects empirically, regionally and theoretically on Antenatal Care (ANC) and Maternal Health (MH), as well as globalization and modernization processes (G/M) and its impact on people's lives and health. Having respect for all the previous research done and keeping these in mind I am still required to omit

[2] A further explanation of the SDG 3 is not given in this thesis due to practical limitations. I have my starting point in the unachieved MDG, and will therefore continue to refer to the MDGs throughout the thesis.

the majority of these contributions from this current thesis and have chosen what I find relevant for my study. Nevertheless, I am aware of the relevance of having knowledge of the above-mentioned dimensions individually to understand the importance of interdisciplinarity, and how this affects my object of study. Below, I briefly present a small selection from the different categories of what I considered to be relevant to remember and lean on of previous discoveries and research. The categories are research related to MH, medically and regionally, and studies related to G/M impact on people's lives. I encountered a rather limited spectre of research directly related to socio-cultural influences on pregnant women's (PW) health, however a small section on relating socio-cultural influences to PW's health will be presented.

2.2.1 ... Medically and regionally

To mention something in relation to the medical dimension of my study, I have found relevant previous in journals such as "Health care for Women International", "Pan African Medical Journal", "Journal of Best Practice & Research Clinical Obstetrics.

Dugassa (2007) writes about human rights versus the Oromo women's rights and health and tries to highlight how the health of Oromo women are affected by unfulfilled rights.[3] Also, Dugassa (2007) emphasizes how socio-cultural situations affect the sexuality of women and that women's health is closely linked to little social, economic and political autonomy.

Ejeta, Dabsu, Zewdie and Merdassa (2017) present an article that looks at what affects PW's use of maternal care. It's a quantitative study with just over 400 women that aims to present what factors make women late for consultation. They highlight that around 80% are late to receive consultation and conclude that education and providing relevant information on time is important in raising awareness of the community. However, they emphasize that its surprisingly little information about what hinders women in taking/receiving ANC and advocate for further research in the field.

Berit Austveg (2006) is addressing maternal health very specifically in relation to risks and challenges for women's health globally. In her book "Kvinners helse på spill – Et historisk og globalt perspektiv på fødsel og abort" she is describing the situation of PW in

[3] I´ve chosen to present this article here because the article gives an insight into the history of Oromo women's situation in Ethiopia.

many developing countries as well as in Norway.[4] She highlights what has been done in relation to reproductive and maternal health, what global conferences have addressed problems related to maternal health and what resolutions have been successful and which hasn't. This book turns out to support many of my findings and also gives alternatives on how to improve the health situation of pregnant women in the world. The book also functions as a very good overview and a springboard with references and recommendations to further relevant research and literature for my study.

Projects such as Healing Hands of Joy (2017) in Tigray, Ethiopia, and the "Safe Motherhood Project" have also contributed with inputs and ideas for my research aim.

2.2.2 ... and globalization and modernization

Literature, research and theories regarding globalization-and modernization processes in general are based on what I have obtained through my studies at VID Specialized University. There will be some more focus on globalization than modernization because this is what my obtained course-literature has weighted. However, I am aware that both are equally important in societal and developmental research.

Most of the literatures I have encountered relating G/M influence on health aspects, have considered medical campaigns for health improvement and spread of medical supplies and treatments (Scholte, 2005).[5] But also vulnerability concerning disease spreading and increased health risks due to greater global mobility (Eriksen, 2008). The affects are mixed and might not have been evaluated under the perceptive of globalization thoroughly enough, yet (Scholte, 2005). Besides this there's been a rather limited presentation of how globalization and modernization have direct impacts on women's decision-making and health. This regard both practical and theoretical perspectives (Scholte, 2005). Scholte (2005) even states that "global public health has received even less attention in contemporary policymaking than the other areas of human security discussed so far" (399).

The book "Utvikling – En Innføring I utviklingsstudier" by Tore Linné Eriksen (2013), highlights the magnitude of cultural, gender, historical, financial and political aspects

[4] Title of the Austvegs (2006) book translated to English "Women's health at stake – a historical and global perspective on birth and abortion" (my translation).
[5] Scholtes book is written in 2005, which makes it over 10 years old. Certain content might therefore not be updated. I am aware of this but have still chosen to use this book as a springboard and overview of globalization research since its the book in the curriculum in the course MGS 302 – Approaches to Global Studies, VID Specialized University, both 2017 and 2018.

actually have in development work.[6] He highlights many examples where development projects haven't received the desired outcomes due to the overthrow of these aspects. This may also function as a support theory on which I build my master thesis that can be related to the UN's (2015) New Global Strategy for Every Woman Every Child (presented briefly below).

2.2.3 ... and socio-cultural environments

It's of course obvious that "skilled care before, during and after childbirth can save the lives of excepting women" (WHO, 2018), but there's more to the health dimension than modern medical facilities.[7] Bunton and Macdonald (2002) have gathered different kinds of research disciplines and in this way highlight the importance of a multidisciplinary approach to health care delivery and health promotion. They present the importance of sociology, psychology, education, politics, social policies etc., in the book "Health Promotion - Disciplines, diversity and developments". Don Nutebean formulates this very precisely in the foreword of the book:

> … health promotion may be seen as having more complex and radical roots, representing a reaction to the medically dominated, individually-focused health systems that evolved in recent decades. (ibid.,viii).

From an academic and theoretical point of view, Filby, Mconville and Portela (2016) have presented an analytical framework that looks at what prevents quality midwifery care. The authors present a systematic mapping of literature on the social, economic and professional barriers preventing midwifery personnel in low and middle-income countries from providing quality of care. Concluding that:

> It has recently been recognised that the complexity of access to quality of care goes beyond a health and development issue and requires a broader human rights approach, thinking beyond the practicalities of health systems to include human relationships, desires and values, roles and norms, and power structures (ibid.).

[6] Title of the Eriksens (2013) book translated to English; "Development – An introduction to development studies" (my translation).
[7] The word "modern" is here used to highlight an analytical difference between local and native health facilities and practices vs. Universal, newly developed and standardized health facilities.

Both Bunton and Macdonald (2002) and Filby et.al (2016) are both further supported on a global and international organization scale when related to the not achieved Millennium Development Goal 5 (improve maternal health) by 2015 (WHO, 2017), and the UN's (2015) New Global Strategy for Every Woman Every Child, which incorporates a social point of view of gender equality, justice and humanitarian aspects as pillars of success for antenatal care and maternal health.[8] Here, women's health problems are highlighted in relation to *social* barriers in low to medium income countries as a central challenge. It's written that:

> Gender-based discrimination leads to economic, social and health disadvantages for women, affecting their own and their families' well-being in complex ways throughout the life course and into the next generation. Gender equality is vital to health and to development (ibid.).

A fairly recent publication by Cohn, Schatz, Freeman, and Combs, (2017), emphasizes precisely socio-cultural influences on decision-making. The book doesn't provide any concrete previous research but represent a highly relevant literature and support for my study. They highlight the importance of including sociocultural influences for understanding the world today and are providing models and theoretical frameworks for the analysis of sociocultural influences on decision making, primarily related to peace and conflict studies. However, I believe that these models and theories can and should be applied to other aims. For example, understanding health developments. Under a section called "Why is this book important" Cohn et.al (2017) write:

> [the book] contributes to the scientific foundation for better understanding cross-cultural behaviour … culture-based behaviour models promise more resilient insights into societies across the globe. These insights promise to help humans better anticipate conflict and cooperation. This situational and predictive intelligence can foster wiser decisions and increased collective progress (xv).

2.2.4 My contribution to the field of socio-cultural impacts

My study can be considered a practical exemplification of how important social and cultural aspects may be in technical aspects, even though technical aspects are facilitated. My contribution will be valuable for showing how important culture, relational and societal aspects are for implementing improvement and change in general, but specifically for PW and

[8] A further presentation of the MDG 5, is presented in chapter 5 – Data presentation.

their health status Also, how culture and religion is closely connected and have unexpected ramifications on MH. As far as I know, I was the first one who did this kind of research in my research area.[9].

As noted in relation to Ejeta et.al (2017) article above, there's not enough research done on the actual reasons why women are late in receiving ANC. Just providing relevant information is not enough and I believe my research complements this because it tries to view how PW reason.

With a globalization and modernization perspective I include technical aspects such as infrastructures, technology, finance, education and how the impacts/non-impacts of the social and cultural dimension in society can trace the reasons for utilization/non-utilization of health care.

Based in Ethiopia, an important objective of this work that could concern Stavanger University Hospital (SUS) and other hospitals around the world is to understand the meaning-production and decision-making processes of women in Ethiopia, and thus be able to save lives by influencing decisions.[10] Ethiopia is country with a low rated local and national health and - educational systems, marked by humanitarian and political crises and economic constraints, but also a country with flourishing natural recourses, tremendous recent financial growth and hospitable population, affected by regional and global aspects. This makes the Ethiopia an extremely dynamic country in many aspects and therefore very interesting and relevant for this kind of research.

I believe that this study can be strategically beneficial for Stavanger University Hospital, other hospitals and global health in general because it contributes to increased understanding, prevention and design for reproductive health from local to global context. By respecting and acknowledging the social and cultural dimension of gender relations, women, pregnancy and MH at a deeper and qualitative level, the gained knowledge and results from this study can both contribute to the improvement of reproductive health locally in Ethiopia, regionally in Africa, and globally for international organizations.

By understanding under which conditions the women take decisions in Aira, a positive effect from local to global health may develop. In addition, Stavanger University Hospital receives new qualitative knowledge that can be used locally and nationally in Norway. There are Ethiopian women in Stavanger and Norway who do not seek or receive the information or care they are entitled to or need because of different social, cultural or

[9] My study gave me concrete examples indicating this.
[10] This thesis is written in cooperation with Stavanger University Hospital.

traditional guidelines or delimitations. Therefore, more concrete and profound understanding of this (their considerations) is desirable

3 Methodology

The purpose of my fieldwork was to capture the life situation of PW in Aira Woreda and thereby present examples of how culture and social relations can affect PW's health. My intention was to look at how and why local cultural attitudes and practices may affect PW's lives. Accordingly, obtaining information about the quality and diversity of these ordinary women's life situation was very important to my study. This would give me potential answers and reasons behind PW's decision to act in certain ways regarding their health.

This shows my desire to conduct an empirical study of the repercussions of culture and social relations on the conditions surrounding antenatal care and maternal health. Consequently, the chosen method of primary data collection for this study became qualitative methods. This involved a six-week fieldwork in Aira Woreda doing in-depth interviews, shorter interviews, focus groups, observations and various informal ways of gathering data.[11]

Furthermore, I am also trying to supplement my primary data from the fieldwork with literature studies in the field of health, globalization, modernization, culture and decisions.

This chapter will give an explanation of what qualitative methods are and further an explanation on how I methodically processed my research question and gathered data.

3.1 Qualitative Methods

When one works with social science methods, both qualitative and quantitative methods are used when collecting data. I will here only present qualitative methods because of its relevance for my research. The purpose of qualitative methods is to produce new knowledge of meanings and understandings. It's about finding the "qualities" of a phenomena. Thus, characteristics or prominent features of the phenomenon.

A general perspective on qualitative research methods is that it gives a deeper and more particular understanding of a social phenomenon rather than highlighting a broader or

[11] Aira Woreda basically means Aira Municipality or area.

general dimension such as given from quantitative research. This means that one is studying a few environments and that they are studied holistically with its nuances (Repstad, 2007). Qualitative research aims to find the specific in the general and wants to highlight the diversity of life (Schiefloe, 2011). One can say that qualitative methods makes social science and understanding science.

Qualitative methods give me the opportunity to reach a more genuine and nuanced understanding of how local surroundings affects PW's health. It's not desirable or possible for me to go wide and find generalizations and representativeness. I want to underline that my thesis is giving an interesting snapshot of PW's reality. Through a qualitative study, I could find the official version or the understanding of what the interviews/focus group do, and most importantly *why*. It simply gave me the "actors point of view" (unknown).

3.2 The qualitative interview and observations

Before proceeding I will explain the characteristics of observations and qualitative interviews. These are the main tools for gathering data in qualitative research. There are plenty of subcategories and practices within these core tools. Nevertheless, principally the qualitative interview concern asking *and* talking with people about why they act in certain ways. Observation mainly concerns instant access and outlook to social actions and interaction.

3.2.1 Observation

Hammersley and Atkinson (2004) present a figure showing theoretical social roles in the qualitative fieldwork. This shows the spectrum of different ways to gather data by observation. I have recreated and translated the figure to English. [12]

[12] Hammersley and Atkinson (2006) has brought the figure form Junker (1960,36) with approval from the University Chicago Press.

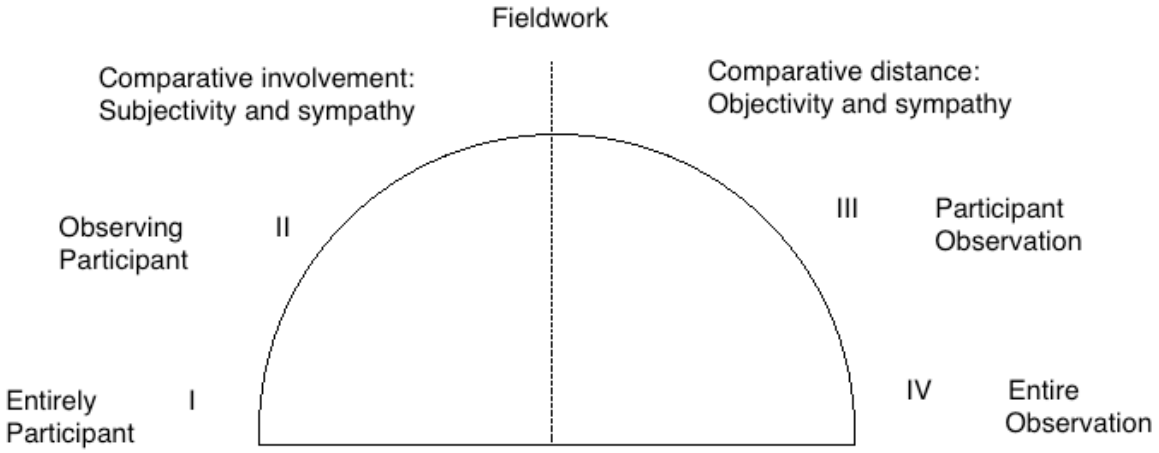

Figure 1 Theoretical social roles in qualitative fieldwork.

Easily said; the left side shows the role of an insider and the right side shows the role of an outsider to the field of observation.[13]

For my research I focused on the right half circle, the outsider roles. The reason for this was because, according to my assessment, it was unrealistic to get a true insider's perspective during my limited fieldwork. Just as Repstad (2007) emphasizes in the title of his book on qualitative methods in social science research, "Närhet och Distans", the dynamics between being close and insider, and having a distance and being outsider is important for obtaining different types of fundamental information.[14] An important methodological goal was to take an insider perspective with regard to "coming close" to the interviewees and the focus group (Byrman, 1999). Consequently, I mostly had the role of a participating observer. With participatory observation, I can participate in the context while retaining the research role therewith. For example: I gradually developed a closer relationship to doctors and nurses I interviewed, observed at the hospital and interacted informally with. This resulted in previous information being adjusted and additional unsolicited information and stories was given (Hammersley and Atkinson, 2004). Trust was gained and I got a more nuanced, genuine and subjective understanding of the interviewees' and my fields reality. Simultaneously I understood and respected the reality of that I was an outsider with limited access even more.

[13] There is an ethical dimension connected to being an insider or an outsider. This is briefly presented under the section Practical/methodological and ethical reflections on my role as a researcher

[14] The title of Repstads (2007) book in English is "Closeness and Distance".

3.2.2 Interviews

Firstly, I want to emphasize that interviews are a sort of participatory observation. Hammerslay and Atkinson (2004) even points out that:

> The difference between participatory observation and interviews are not as big as its sometimes claimed. Both techniques need to take into account the context and the researchers influence [on the research subject]….[also] both the participating observer and the interviewer need to establish a relationship to the research objects (167).[15]

That said, qualitative interviews were the main tool for data collection in my fieldwork. Therefore, the stages I went through in relation to my qualitative interviews are further presented below.

Inspired by *Figure* 1 I have sketched a corresponding figure for the spectrum of different ways of gathering data through interviews and conversations. This was helpful for me to understand how different types of interview guides and questions will give different kinds of answers and data. I call this figure "Theoretical variations in qualitative interviews".

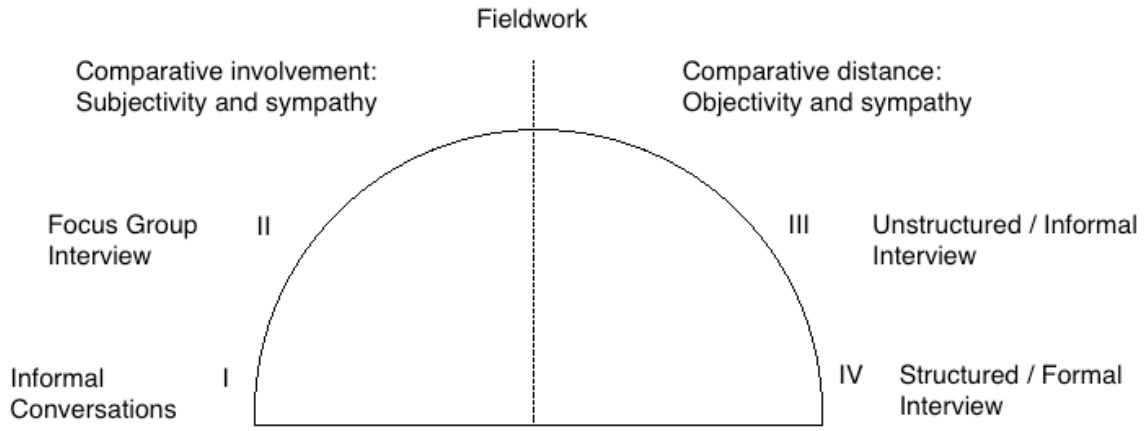

Figure 2 Theoretical variations in qualitative interviews.

In *Figure 2* we see that there are different ways of interviewing. The left side represents looser ways of interviewing, while the right side symbolize more fixed ways. The goal is that the interviewer and the interviewee discover new knowledge together. For my data, I wanted open questions and the opportunity to interact with what I wanted to investigate and examine (Fuglestad & Wadel, 2011). I therefore mainly used unstructured interviews and informal conversations to gather data. I also managed to have one focus group.

[15] My translation to English. The original quote is in Norwegian.

Through qualitative interviews I was able to get information about the people's situations, experiences, understandings and opinions. In addition, this was explained with their own words and highlighting what they found important. This is a unique and valuable feature for qualitative methods because it provides exclusive unfiltered primary data. Hammersley and Atkinson (2010) underlines the significance of interviews as a method when stating "Interviews can represent a very important data source: one can get information that it would be very difficult, if not impossible, to obtain in other ways″ (p.158).[16]

3.3 What, why and how – Thematising and Designing

Kvale and Brinkmann (2014) have presented "Seven's stages of an interview inquiry" that I choose to follow for my research. These stages are: Thematising, Designing, Interviewing, Transcribing, Analysing, Verifying and Reporting. These steps have helped me to methodologically realize my research and will therefore serve as hooks for the further elaboration in this section.

Thematising and Designing are step one and two and are fundamental and lays the foundation on why, what and how to conduct a qualitative study. For my research Thematising and Designing revolved around *why* the usage of maternity facilities still remains rather unsatisfactory and *what* the potential social and cultural causes could be contributing to this. In this case, the Thematising resulted in the research question – how does social and cultural environments affect pregnant women's health?

Designing the study concerns thorough planning of the research before conducting it. This includes visualising all seven steps, understanding how they are intertwined and how to carry out the research. Also, becoming aware of ethical challenges and taking these into account is central in this step. This basically means answering *how* I will manage and realize my investigation. I wrote a project description where I also presented a progress plan. This was meant to systematize my work and give me, my supervisor and the contributors an overview and a timeline of my work. Broadly, the overview and timeline included the 1) preparations before travelling to Aira, 2) my fieldwork, 3) the analysis, thesis writing and

[16] My translation to English. The original quote is in Norwegian.

finalizing. However, it was challenging to foresee and plan the fieldwork in Aira before arriving there. Therefore, the specific planning of the fieldwork was done while in the field.

3.4 Implementing/Doing – Interviewing and observing

3.4.1 The interview-guide

Before going to the field, I scripted a semi-structured interview guide that consisted of thematic issues (research questions) that was elaborated to concrete questions to ask the informants (interview questions) (Kvale and Brinkmann, 2014). For example; Theme issues: Pregnancy and personal feelings, Interview question: What did you do when you found out that you were pregnant?

In addition, I strove to achieve a thematic and dynamic dimension in the interviews. This means that both "what" questions related to concepts and themes will help to create knowledge, as well as "how" questions that acknowledge a relational dimension in the interview and includes that the interviewer can talk about feelings and experiences. For example; Thematic question: *What* is normal to do here in your community when you find out that you are pregnant? Dynamic question: *How* is your husband helping you during your pregnancy?

My core interview guide was directed towards PW. The questions I asked were related to the physical, emotional or mental aspects when being pregnant. Also, how PW was living, thinking and treated by the people in the community, how they themselves and people around them viewed pregnancy. I developed additional interview guides directed towards resource people, husbands and a focus group from the main themes addressed in the original guide. The guides were continuously elaborated, modified and adjusted as a consequence from the gathered data to fit the context and get more specific information.

The interview guide was initially in English and needed to be translated to Afan Oromo, the mothertounge of the people in Aira. This was done with the help of a retired, but acknowledged, history teacher who was fluent in English. To insure quality in the translated questions a third part also viewed the questions.

3.4.2 Sampling/selection and informants

My selection of informants consists of PW, husbands of PW and resource people. The sample size stretches up to 29 individuals giving in total 31 interviews, including one focus group. This constellation consists of:

Resource people – 11
Interview-subjects – 18. (3 husbands) (3 (4) women in a focus group, one was interviewed individually also) (7 short interviews with women from the market) (5 in-depths interviews in the suburbs).

Resource persons are persons that can provide general and overreaching information regarding my topic and were selected with the help of inputs from Åshild Berg, hospital staff and the resource people themselves.[17] These can be categorized into health workers and hospital staff, governmental representatives and acknowledged people who know the history and culture of the area. The information I received from interviewing people in these categories broadened my understanding of the context and gave me more solid information about the environment in Aira.

The resource people I interviewed had decent English and no translator was needed. When I did my in-depth interviews, the interview-subjects were very limited in English, and I needed a translator.

The main interview-subjects, PW, were chosen based on where they lived. I tried to find places that didn't have any health centres or clinics.[18] This criterion gave me two interesting cabales (suburbs); Homi Suchi and Lalo Suchi.[19] Both of these had a common market in a bigger district called Bondawo (also under the name/cabale Wara Kuraa Suchi). Thus, the plan was to go to the market with my translator and an organizer/helper solely to mingle and familiarize myself with the people from these suburbs.[20] Nonetheless, the market visit resulted in seven random interviews with PW who were at the market. These interviews

[17] Åshild Berg is a former missionary midwife who functioned as my primary gatekeeper in Aira. She accompanied me from Norway to Aira and helped me settle in the area for my fieldwork.
[18] The difference between health stations and clinics are that health stations are governmental and clinics are NGOs driven mainly my the Mekane Yesus Church. I will not highlight this difference in my thesis due to practical limitations. Both health institutions represent some kind of modernity and the point in my task is that these together are an element that represents modernization. The point is not to separate them.
[19] I originally chose two additional suburbs that were highly recommended for me to visit also, but insufficient time and lack of clear planning hindered me of going there. The suburbs were Kurree and Warra Babo Suchi.
[20] The helper was a pastor who studied at the institution my translator worked at.

lasted from 20 to 40 minutes. Useful and interesting information was gathered and I viewed this as a good start and preparation for my in-depth interviews. The women got biscuits as compensation for their time.

3.4.3 The interview situation

All interview subjects were briefed before conducting the interview. I told them about my motivation, my research aim and that I was neither doing a political nor a medical study. I asked for their willingness to participate in advance and asked for their permission to record the interview. I chose to record the interviews because this would give me the possibility to participate in the conversation more freely and it was timesaving in the sense of avoiding constantly taking notes.

Interviews with the resource people took place either at their work place, their house or my house.[21] None of the resource people were given any compensation for their information.

My in-depths interviews were conducted in the two suburbs Homi Suchi and Lalo Suchi. The pastor who helped during the market day served as a gatekeeper when I was going to these suburbs. He came from the area and had good knowledge of the people and they trusted him and contacted the PW in advance to hear if they approved being interviewed. I did two individual in-depth interviews in Lalo Suchi. These were done in the interviewees' homes. In Homi Suchi, I did an individual in-depth interview and a double in-depth interview - meaning that there were two PW who participated in the same interview. These interviews were done at the Health Post Office and the women came here solely for being interviewed.[22] I compensated the women who participated in my in-depth- interviews with a package of sugar.

I had a focus group interview with four women. However, there were only three present simultaneously at all times. The interview was held at the district office in Bondawo. The women either came from Bondawo or districts close to Bondawo. Hammerslay and Atkinson (2004) notes that "a group interview might make the informants chattier and could

[21] Since I was living at the hospital compound some of the hospital staff members that I wanted to interview also lived at the compound. They preferred coming to my house for an interview because that would demand less from their household.

[22] I am aware that conducting the interviews in the Health Post Office can be considered as partly biased and maybe not representative, since it was only women who actually came to the health post.

encourage to more conversation and information exchange" (170,171). My approach was therefore to present a theme and ask a related question, and then and let them talk as freely as possible with each other about the matter. I treated the participants a nice meal at a local restaurant after the interview.

The husbands were selected at the hospital. They were accompanying their pregnant wives but were not patients themselves. The intention was mainly to get a small insight in the male perspective on reproductive health and pregnant women. No sensitive information about their wives was given. The men didn't receive any compensation.

3.4.4 Translation

My Afan Oromo language skills were non-existing and I therefore needed a translator for conducting my interviews. It was very important for me to have a female translator because I would interview women about things related to the women's body, women's decisions and women's everyday lives. I wanted to create an interview situation where women could feel as safe, comfortable and honest as possible, to open up as optimally as possible. I emphasized this because women have generally had a "secondary status in family and society" (Pusewang, 1990, 58). Therefore, much information might have been left out if the translator was male due to power positions in the society and privacy of the women. I also emphasized that the importance of the translator not being connected to the hospital or other health facilities. I didn't want the information from the interview-subjects to be influenced by the interpreter's medical background.

I got contact with a female theologian in Aira who could be my translator for my fieldwork.[23] She was decent in English and very compassionate and helpful in relation to my fieldwork. She understood my question well and was good at interviewing the women. She provided examples for the PW to reflect on and asked good follow-up questions on her own initiative.

[23] I am aware that my translators profession as a pastor also could create biased answers from the PW. However, this reflection and consideration must be left out if this thesis due to practical limitations.

3.4.5 Observations

I consider my stay in Aira to include both entire observation and participant observation (See figure 1). For my role as an entire observer, I tried to observe the daily life of both women and men while travelling between suburbs and towns. These were still quite distant and shallow observation since I was either in a car or walking. However, I could see similar daily activities repeatedly everywhere and everyday. For example, almost everywhere I went I saw women fetching water and wood on their backs. Also, I could see people walking long distances and in the streets all the time. From my own porch, I observed people working in the cornfields and heard people gather for religious meetings daily.

I was additionally invited to participate and observe different gatherings and celebrations, both formally and informally. Formally, I participated in a women's cooperation meeting regarding micro finance arranged by the governmental office in Bondawo. Furthermore, I participated in a women Empowerment project fighting female genital mutilation in Boji, directed by the Norwegian Mission Society.[24] Informally, I was invited to participate in different celebrations for new-borns and their mothers and families. For example, Marqa (maternity porridge), that was only for women, and a dinner that was both for men and women to celebrate the new-born.

Relating my observations to the information I was given in my interviews made me understand the importance of putting the verbal information into a physical and cultural context. Things made more sense and I could comprehend why I received certain answers Hammerslay and Atkinson (2004) write:

> "…the data gathered by one method can be used to highlight the data gathered from the other method…What people tell us in interviews might make us view things differently when we observe it" (158,159)[25] .

I tried to write in a field diary consistently, which helped me to process my findings and observations, but also my everyday encounters and challenges. The information I got could be expected and sometimes very unexpected, both in a positive and a negative way. For instance, it was inspiring to see how socially supporting the people in Aira are towards each other, and other times it could be chocking to see how strong the social sanctions could be for certain individuals not following the rules of behaviour.

[24] Women Empowerment project in Wester Ethiopia, NMS.
[25] My translation to English. The original quote is in Norwegian.

3.4.6 Informal conversations

Hammerslay and Atkinson (2004) say it might be tricky to distinguish a line between participant observation and informal conversations. I choose to understand this as the researcher, me, is participating on an equilibrium with my conversation partners in the sense of not having a hidden agenda for getting specific information, but still being aware and observing where the conversation goes and what information is given.

There were many times I was a participating observer who was talking freely without my research cape consciously put on. A typical example was when people asked me about my fieldwork and what I was doing. This appeared to lead in to casual discussion of my method and my research aim with people. They were curious and wanted to help and contribute. Consequently, even if I was not ”at work”, people provided me with plenty of information regarding everyday life in Ethiopia, Aira and of women and health of PW. People tended to be a bit looser and talked more frankly about my topic. Correspondingly, I got more interesting and honest answers.

I want to mention that I when was in Aira for nearly six weeks I naturally couldn't do interviews or officially do observations all day long. I developed friendships with a handful of people in the area whom I could talk freely with and ask about everyday matters as well as things I couldn't fully understand in relation to my fieldwork. While interacting and spending time with these people on my "free time", I didn't actually reflect upon our conversations as a means for data collection. The true impact these informal conversations had on my material properly came to mind when I skimmed my field diary after returning to Norway. I realized the true value of coming close to the locals (Byrmann, 1990), and showing them trust and putting myself in the same terrain as them. I got a deeper understanding of the cultural and causal context that provided me with a "thicker description" (Geertz, 1973), which I otherwise would not have received. This has been a great help and incredibly useful for my understanding, reflections and analysis of my collected data. It also contributed with even more valuable material for my study.[26]

[26] I was, and still am, stroked with a speechless fascination of how much information was around me, but also a devastation of not taking/processing this information as actively as I could have done. Wow, information is really everywhere. One just has to be alert enough to revise it to useful knowledge

3.4.7 Anonymity

This project has been approved by the Norwegian Centre for Research data (NSD) and therefore fulfils essential criteria to process personal information and respect privacy of my informants.

All my informants and interview-subjects were offered to state their name if they wanted to. This applied in particular for the resource people where some informants gave their name and consent for being listed as references in my study. My main group of informants, the PW are not referred to by name or cabale (suburb). This is to guarantee the anonymity I assured them when agreeing to be interviewed. Information received from informal conversations is also handled so that it can't be traced and the informants are insured anonymity.

As mentioned before, this is in not a medical or a political study and my aim was not to gather or evaluate anyone's health status. Issues' relating to their social relationships and established patterns of action is of interest. No sensitive, personal or medical information that can jeopardize the interview-subjects anonymity will be presented.

3.5 Knowledge production – Verifying, Transcribing, Analysing and Reporting

3.5.1 Crosschecking

I tried to verify the information as much as possible while I was in Aira. This concerned crosschecking the data I got from the interview-subjects and observations by asking the same questions to different people, but also about the answers I got. I experienced this as very useful since the information differed depending on whom I asked. After a few crosschecks I started to see the red thread and could understand the information a bit better. Additionally, the informal conversations I had with people I trusted, and who trusted me, were very valuable crosschecking tools. For example, different information about statistics of deliveries in the hospital was given to me by nurses and doctors. When I investigated this closer while casually conversating, I was told that some wanted to hide the truth and tell me what they thought I wanted to hear, and others wanted to play down the truth, being ashamed of the

reality, and some dramatize the truth with an aim to get more aid from foreigners. I quickly learned that there could be an agenda behind the information they gave and therefore I had to be critical.

I also crosschecked my observations by asking the interview-subjects about what I had seen and heard in different settings. For instance, I saw women carrying wood and water, so I asked a pregnant lady if they did this when being pregnant also. She confirmed that some women did and some didn't. In her case, said her husband helped to some extent but had other chores also.

My understanding is that the combination of different methods of gathering data was a truly great tool to crosscheck and assure the quality of my data.

I want to mention that recording the interviews was able to provide quality assurance of the information I received from the translator. This turned out to be a necessary and valuable procedure because valuable information was sometimes omitted in the translation. I discovered this both during the interview situation and the transcription process. Multiple sentences were translated with only one word. To secure correct information, I used an additional translator who worked with me while transcribing. This person turned out to be crucial for verifying and supplementing the translation and interpretation of the interviews.

I have no possibilities to return to the interview-subjects with follow-up questions. However, some of the recourse persons are reachable through email.

3.5.2 Transcribing, Organizing and Analysing data

Transcribing is putting speech into text and preparing my interview material for analysis (Kvale and Brinkmann 2014, 129). Thirty-one interviews were recorded and transcribed into 194 pages(computer). During the transcription I wrote analytical notes and highlighted different quotes I found interesting and extra relevant for the future analysis (Hammerslay and Atkinson, 2004). After the transcription process was completed the recorded interviews were deleted to assure the anonymity of my informants. From the 30 interviews there are only a third that I will use for my in-depths analysis. These consider first and foremost my target group – PW. However, some interviews with resource people are analysed also. The remaining interviews are from resource people and husbands and is used as supplementary information in my thesis work.

Besides transcriptions, my registered data consist of field notes. These consist of my observations from the encounters with my interviewees, observations from different health facilities and projects, the everyday life I could observe of the people in Aira Woreda and my informal conversations. The notes made it easier to remember the situation and non-verbal language that was relevant for understanding my gathered data.

For organizing my data I tried to "de-contextualize data, and there after "re-contextualise" data into thematic files" (Tesch 1990, in Hammersley and Atkinson 2006, 226). [27] This involves fragmenting the data into codes and categories to make it easier to bring forth for the analysis. Also, I choose to understand re-contextualisation as a way of reporting. Ergo, to communicate the findings to a broader public in a scientifically and ethically appropriate and approachable way.

3.6 Literature Studies

Repstad (2007) writes that written documents can be considered as "background material of a written character" (103), and this is how I have chosen to use litterateur for my study. [28] Therefore, literature will not be viewed as a source of data in the same sense of my interviews and observations (ibid.). Data from literature will function as a supplement and support for my data. Also, academic literature is used as the analytical concepts and/or theoretical perspectives applied in my assignment.

There's plenty of relevant literature within the individual fields of antenatal care and maternal health, as well as culture, globalization and modernization processes and its impact on people's lives and health. With respect and awareness of the copious scope of relevant literature related to these themes, the horizon of literature for my study is preliminary focused on literature and theories regarding globalization and modernization processes and cultural environments related to gender and maternal health. I find it valuable to mention that I had a rather limited encounter with literature directly related to women's health (specifically pregnancy), and culture in Ethiopia.[29] My thesis is not a medical study but concerns cultural

[27] My translation to English. The original quote is in Norwegian.
[28] My translation to English. The original quote is in Norwegian.
[29] This might make my research question a bit more challenging, but at the same time it shows the necessity of introducing this dimension to culture and globalisation literature more than it has been done per today. But I am in no sense saying that there's a gap in the literature considering this field. I am however hinting that the litterateur and research that already exists could be further elaborated and supplemented.

understanding of the considerations and decisions women take - and I haven't come across very much of this kind of literature.

3.7 Practical and ethical reflection on my role as a researcher

I arrived to Aira and Aira Hospital with Åshild Berg, a former missionary midwife who functioned as my primary gatekeeper in Aira. She introduced me to important resource people for my topic and advised me how to interact with the locals. This was very helpful since the actions and the codes of conduct differ greatly from Northern European behaviour.[30] This shows that cultural barriers were something that needed to be taken into consideration from the very beginning in almost every aspect of my fieldwork and the interpretation of my data. My methodological challenges were both about cultural barriers and ethical considerations. Kvale and Brinkmann (2014) sums this up clearly:

> "When doing cross-cultural interviewing its difficult to become aware of the multitude of cultural factors (habits, practices, positions, narrative resources) that affect the relationship between interviewer and interviewee. In a foreign culture, an interviewer needs time to establish familiarity with the new culture and learn some of the many verbal and nonverbal factors that may cause interviewers to go amiss…. In addition to this, the linguistic and social issues of translation are important" (127).

In relation to *and* because of the cultural barriers, the problem of being an "insider" or "outsider" emerged (Hammerslay and Atkinson, 2014).

The most demanding factor of my fieldwork was feeling incompetent in my language proficiency. It (Afan Oromo) was a completely foreign language to me and I couldn't understand anything without a translator. This made me experience being an outsider both in a positive and a negative way. It made me notice and question many everyday behaviours, nonverbal communication and taken for granted and latent actions and practises. This gave me fundamental insight about the community that I might have overseen if I was used to the environment and understood the language. In addition, it legitimized me asking questions about certain taken-for-granted-to-be silenced topics with locals, e.g SRH.[31]

[30] We were staying in Aira Hospital compound. Here missionaries, foreign teachers and important hospital staff stayed.
[31] SRH = Sexual and reproductive health.

However, being an outsider was also a disadvantage because many things were beyond my understanding and therefore beyond my control or access. For example, a huge problem for me as a researcher was that I wasn't able to select my main informants (PW) by myself. This doesn't need to be negative but the issue concerns that I couldn't know what they were told on the beforehand of meeting me. For instance, the interviews in Homi Suchi were done at a Health Post Office because it was insisted to be more convenient for the informants. I was told that the women were brought there solely for being interviewed by me. I was therefore asking myself; Why did they agree to come to the health post solely for an interview with me? Did somebody say they would get something from me? Did somebody tell them to not tell me certain things? What did the gatekeepers say about me? I couldn't know for sure what had been said or promised to the women and that made me insecure of their motivation and information. Also, that the women came to the health post indicates that the majority of the PW I encountered were the ones that had contact with health workers and therefore actually represent the minority of PW in Ethiopia as only approximately 26% (2016) give birth at health facilities (CSA, 2016). Information about women who doesn't have contact with health workers were almost completely unreachable during my fieldwork. However, I did meet and interview women that didn't use the medical health services.

Considering this, it's obvious that my gatekeepers and translators had a very crucial role, for better or worse. My role as a researcher was therefore in certain aspects not mine to define and this might have influenced the information I got.

Bearing in mind the above-mentioned situation, an internal ethical and methodological challenge regarding me reflecting upon how to behave emerged.[32] I think that people initially didn't understand me as a master student doing research. I therefore suspected that my role as a researcher was not taken seriously to start with. Maybe it was a combination of looking young and being a woman. People were consistently commenting on me looking young and I suspect that this influenced some of the practical activities concerning my fieldwork in the beginning. Neumann and Neumann (2012) highlight how this situation can be reflected upon with "fieldpositioning" (feltsituering). This concerns "reflection on how others experience my role as a researcher…and how it affects the data collection" (ibid., 18).[33] Not getting a research role immediately mostly considered ascribed features of my

[32] Internal meaning a process of reflections primarily "in my head".
[33] My translation to english. The original quote is in Norwegian.

identity, such as being a women and looking young and this I couldn't do very much about, which was a bit frustrating (to be honest).

Field-positioning is about how we are experienced by the actors we collect data from (Neumann and Neumann, 2012), and I believe that people initially experienced me as a high school girl not doing "proper research". I had to work hard to acquire the role as a researcher. Of course, this is also much related to me being an outsider to the community and not at the start fully trusted by people. I am not certain how this affected the information I received.

After sometime, people I developed closer relationships with gradually took my topic, my study and me very seriously and could discuss various shortcoming and subjects with me. These discussions were informal conversations and were the key of balancing and using the marginality of being an insider and outsider. Also, I got the role of being "acceptably incompetent" (Hammersley and Atkinson, 2004) or a trainee (Skjortnes, 2017) in relation to learning about the life of the people.[34] That means that people accepted me being an outsider but still included me by inviting and explaining situations, without me asking. I could openly take notes most of the time because people knew I was there to gather information and it became a natural activity for me.

One permeating external/ explicitly ethical challenge considered the compensation of the interview-subjects.[35] My translator and helper were anxious about me taking valuable time from the women and that they therefore had to get some compensation.[36] I tried to emphasize that they should not receive any payment because it might generate the wrong motivation amongst the informants. Nevertheless, because I was there for such a limited time, I agreed upon giving sugar or biscuits as compensation to the PW to ensure getting interview-subjects.

Another external ethical challenge I encountered regards the interaction with the field and informants. Mæland (2017) say that ethics is the core of research and that ontological ethics are an absolute requirement in qualitative research because it respects the freedom, confidentiality and dignity of the interviewees, and is sensitive to any vulnerability in the situation (Silverman, 2014).[37] Ethical aspects can regard how my presence, my appearance, my questions, behaviour and methodological tools can/will affect the individuals I interact with. This has briefly been touched previously above but now I want to mention the

[34] Skjortnes, M. (2017) Lecture notes from MGS 306, Participant observation. 24/3-2017.
[35] External meaning the challenges primarily emerged in interaction with others.
[36] This actually shows how valuable their labour is, even if they are pregnant. Additionally, I was there during the corn-harvesting season so the majority of the women were in the field and were difficult to reach.
[37] Mæland, B. (2017) Lecture notes from MGS 306, Ethics and qualitative research. 10/3-2017.

moral dimension in the relationship between me and my interviewees, questions and observations.

My topic about maternal health and reproductive health turned out to include SRH and responsibilities as a fundamental aspect.[38] This discovery revealed a bias in me that I had not expected, namely the antipathy of some practices putting PW in massive health risks. For example, I was surprised of how much was accepted and legitimized because of tradition and religion. The challenge for me was lying in not showing my chock or bias when given unpleasant or chocking information, and also to reflect upon if my questions will create moral problems. Mæland (2017) states that all interview situations are transactional relationships. This means that both parties are expected to give and take something, by own initiative without pressure or expectations.[39] I had to be careful when formulating my questions due to the risk of showing my bias and creating uncomfortable situations for the interviewees and unfavourable conditions for me. Simply I had to show my respect to be trusted. Nevertheless, this created some moral contradictions for me as a researcher who was an outsider wanting to get inside information.

Hammerslay and Atkinson (2004) highlights that the insider and outsider issue also regard the moral sides of interfering or not interfering in different situations. For example, there might be an ethical consensus that all PW should be equally respected, but the moral reality is that some women are treated very badly due to different social and cultural circumstances. Should I just accept what is going on so I can be more like an insider, but risking they might believe I legitimize the practice? Or should I ask critical questions that might be understood with an undertone give new understandings/perspectives or liberalize?

These moral contradictions forced me to become aware of what I as a researcher brought to the situation. I really had to self-position (selvsituere) (Neumann and Neumann, 2012), myself in the context to avoid showing my bias or me being startled to avoid unnecessary impact on the conversation. Concluding on this reflective process, I attempted to be neutral when having my research cape on and talking with my main interview-subjects. Though, I believe I might have raised moral considerations in some of my interview-questions and informal conversations, when asking and discussing about improvement and reasons behind practices.

[38] SRH = Sexual and reproductive health
[39] Mæland, B. (2017) Lecture notes from MGS 306, Ethics and qualitative research. 10/3-2017.

I want to briefly also mention a reflection on ethnicity and my Ethiopian heritage. I was advised not to talk about ethnicity because of the political situation in the country. Some instated it could be dangerous subject that could easily stir up feeling or animosity. I did therefore not take up the matter myself, but if someone asked me I told the truth which was that I am half-Ethiopian. It was completely unproblematic and did not affect any of my data to my knowledge.

All in all, I accepted my bias because it motivated me to go deeper in my research. To what extent my data collection was affected by this is difficult for me to evaluate. However, I noticed that people started to supplement or correct their information towards the end of my fieldwork. This was unexpected for me, but I imagine that this was partly due to my genuine interest in the field and my honest questions and open agenda.
I hope that my short presence in Aira contributed to boost more awareness regarding maternal health and SRH and responsibilities, especially amongst the women. I experienced my fieldwork as truly exciting and interesting, but also challenging and chocking. I learned very much and I felt that everybody around me genuinely wanted to help me.

3.8 Hermeneutics and conclusion

Considering all dimensions mentioned above: cultural barriers, my role as the researcher, the expectations, the relationship to the field and moral issues that came up with this, I believe that my fieldwork experience can in summary be explained by Gadamers hermeneutical spiral (Krogh, 2004). That my experience alternates between these parts creating a whole and that the whole could be divided, and that I constantly developed and revised my understanding. For example, I couldn't avoid that the expectations would affect my actions and me. At the same time, I constantly had to self-position myself because I continuously gained new insight in my surroundings and myself. I got new and revised understanding of my topic, new insight in my actual attitudes and biases, new awareness of my behaviour and therefore also a new awareness of moral issues related to it.

With the help of Gadamers hermeneutical spiral (circle) (Krogh, 2004), I could expand my understanding of the context and gained a holistic perspective on how important all the conditions are to the answers I receive and how I interpreted the answers (Neumann & Neumann, 2012).

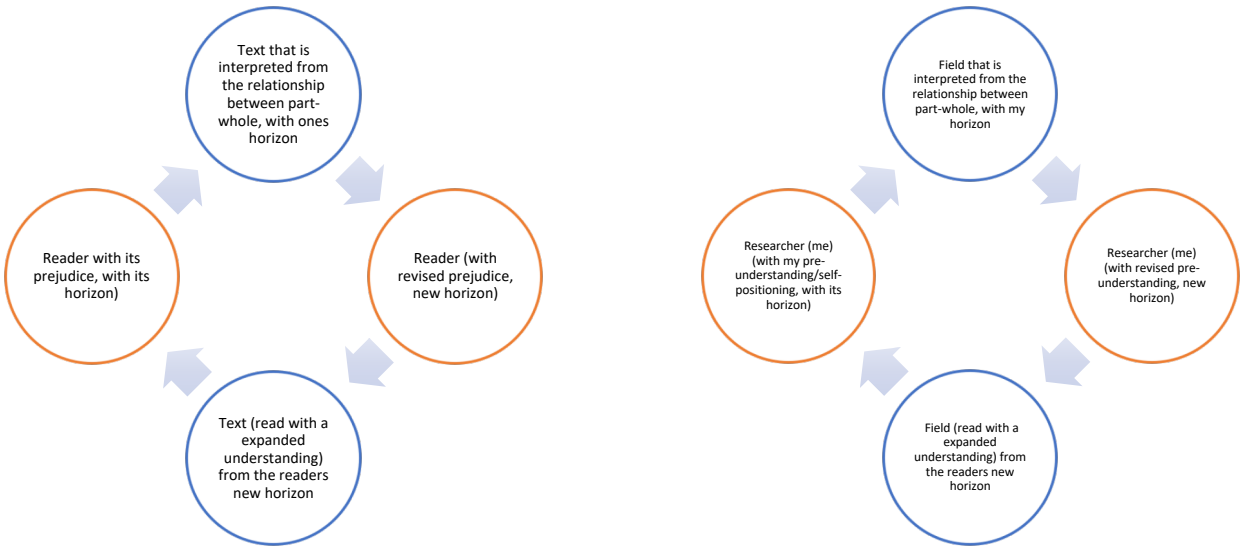

Figure 3 Hermeneutical spiral (circle), inspired by Krogh (2004, 249). Original content to the left, my content to the right.

4 Theoretical Approaches

The conceptual basis for my study and analysis builds on literature provided throughout my Bachelor in Social Sciences and Master in Global Studies. As noted in the second chapter, I want to see how decisions are made in relation to the first delay in the famous three delays (Thaddeus and Maine, 1991, in Filby, et.al., 2016). The first delay concerns the decision to seek support and care during pregnancy and childbirth. My starting point is that the women are individuals that take decisions on the grassroots within a cultural environment. They adjust themselves to other individuals' attitudes and collective values and follow norms – there off I want to explain the incentives, the social patterns and the cultural reality that show which forces affect the PW. Simply explained – I want to view the abstract aspects of life, and not the concrete and physical.

There are two fundamental categories my theoretical approach rises from. These concern the concept of "worldview" (Hiebert, 2008), and the "the eight key concepts of globalization" (Eriksen, 2008). Worldviews function as my primary theoretical perspective and the key concepts of globalization as my secondary perspective. The reason for this is that my thesis is focusing on how they socio-cultural environments have "invisible" affects and not explicitly as much on the technical influences. Simply explained - I look at the abstract and cognitive, and not the concrete and physical.

Besides this, the elementary anthropological and social science prospect of "relational explanations" (Wadel and Wadel, 2007) is an essential scientifical approach for the cultural analysis, which is strongly integrated in both approaches.

4.1 Worldview (WV)

Shiranto and Webb (2003) write "society provides us with a number of models of good subjectivity and good behaviour, and 'summons' us to identify with them, and shape our behaviour and sense of self according to those standards" (136). In this thesis, I choose to interpret these kinds of models as worldviews. Accordingly, my main theoretical approach is how worldviews affect people's interaction and culture, and how culture affects human behaviour.

The concept of worldview can be explained both as easy as how people view the world, and as complicated as the invisible and underlying understandings of reality. Still, these descriptions represent two sides of one coin.

Even though the concept might appear to be obvious, the philosophy of worldview is as wide as the world and no specific definition has been agreed upon so far. A few common definitions are: "[worldview is] the fundamental cognitive, affective, and evaluative presuppositions a group of people make about the nature of things, and which they use to order their lives" (Hiebert 2008, 15), and "Basic to the idea of [worldview] is that its a point of view on the world, a perspective on things, a way of looking at the cosmos from a particular vantage point" (Wolters 1985 in Hiebert 2008, 13-14). Charles Kraft (1978) in Dahl (2013) says that worldview is "a set of more or less systematized beliefs and values that a group of people use to assess and to make sense of their environment"(240).

According to Øyvind Dahl (2013) worldview is one of three main categories in contextual factors for people's behaviour and actions. The other two categories are social and individual factors as context. These contextual factors define our cultural frames of reference and thereby determine everything connected to how people understand, communicate and interpret reality. Dahl (2013) writes that these contextual factors are "frameworks for interpreting communicative actions" (239). This explains how people with different cultural frames of reference might understand the same situation very differently.

4.1.1 Theory[40]

I find this approach relevant because it makes me go to the root of the culture and social forces that impacts PW's health in Aira Woreda. Hiebert (2008) writes: "Worldviews are the elements and rules of a culture that generate cultural behaviour" (50) which consist of the cognitive, affective and evaluative dimension (as mentioned above). The cognitive dimension emphasizes the ideas, mental constructions and categories, knowledge, assumptions of reality and logics a given group shares. The affective dimension relates to how worldviews contributes to designing all kinds of feelings and taste. This includes the expression and attitudes towards everything from taste in food to feelings as sorrow, worship and relationship goals. The evaluative dimension, also called the moral and/or normative dimension focuses

[40] This section (Defintion worldview) is brought from my assignment in Culture and Communication – MGS 301a – The concept of Worldview. Author: Anna Rosa Rudin, paper submitted 01.11.16.

on social and moral order. What is right or wrong and true or false, and how things are justified is found in the evaluative dimension.

These dimensions are useful for analysing the data I gathered in my fieldwork. The intention is that it provides me a tool for understanding why certain attitudes and practices still live on and are legitimized in the area affecting maternal health, even though there are many health facilities present.

Narratives are also a conceptual basis that is important to keep in mind in relation to people's behaviours, decisions and actions and are closely related to cognitive(think), affective(feel) and evaluative(act) dimensions of worldviews. I will however not explicitly distinguish between narratives or worldviews further in this thesis. [41]

I am convinced that this will help me to get insight into how socio-cultural environments validate certain attitudes and behaviours on how society should function related to what is right/wrong, or what is and is not socially acceptable within the local cultural frame regarding PW in Aira Woreda.

4.2 Globalization and Modernization (G/M)

My second main theoretical approach considers globalization and modernization (G/M) processes and their impact on local communities, such as Aira Woreda, and PW's situation in relation to health. These perspectives will facilitate in understanding how certain aspects of G/M tries to PW's possibilities and decisions in Aira Woreda.

4.2.1 Globalization

To define globalization is a tricky endeavour. There are, have been, and will most probably be plenty of debates of what it is/what it's not. Both the concept and the discussions are very dynamic and constantly evolving in different directions. These aspects are highly interesting and relevant for all globalization studies, but will not be presented in this paper due to

[41] I find it important to inform the reader that narratives in themselves are very important for analysing, explaining and understanding decision making on micro, meso and macro levels of society. I am humble over this importance and will implicitly consider narratives in my analysis, as the concept is integrated with my chosen theoretical approach – worldview.

practical restrictions. However, to give a simple and overreaching definition, I have chosen to present one given by Scholte (2005). He writes that ”Globalization is the spread of transplanetary and supraterritorial connections between people” (ibid., 60). This basically means that the world is interwoven and that time and space is no longer relevant for interaction across the world. Shiranto and Webb (2003) also supplements this by writing:

> Globalization could be understood as a set of technologies, institutions and networks operating within, and at the same time transforming, contemporary social, cultural, political and economic spheres of activity (6).

Globalization is not a teleological process or about imperialism, westernization, internationalization, liberation or homogenization/ universalization (Eriksen, 2008) and (Scholte, 2005). It’s a multifaceted and copiously complex concept that consists of dual processes, dichotomies and dynamics that tries to comprehend the different aspects and dimensions created and facilitated by a transplanetary and supraterritorial world.

4.2.2 Modernization

Explanations of what modernization is or should be are plentiful. There are also ample modernization theories connected to many different disciplines. Generally, it has largely concerned implementing changes to develop political, economic and technological aspects of a society. Britannica (2016) writes that modernization through a sociological perspective is to ”transformation a traditional, rural, agrarian society to a secular, urban, industrial society”. Eriksen (2013) describes modernization as “industrialization according to a western model and focuses primarily on economical and material development. ” (122).[42] Today, there’s great consensus that there’s no “grand theory” (Smukkestad, 2008) for improvement that is universally applicable, neither does it need to be negative to be traditional or native (Eriksen, 2008). [43]

[42] My translation to English. The original quote is in Norwegian.

[43] Due to modernization, the concept of modernity has arisen. This considers the cultural changes and dimensions modernization processes bring with them. Anthropologists are using the concepts of modernity to explain the counterpart traditionality, when studying change and modernization in developing countries (Eriksen 2013). Modernism, Postmodernism, postmodernity and other kinds of modernities will not be presented in this definition because this is only a basic presentation of modernization processes

4.2.3 Theory

Something important that tend to be overlooked is that "globalization and its effects do not exist in a vacuum, and nor do they affect only governments and corporations. Ultimately their impact is on the lives, aspirations, understandings and bodies of everyday people" (Schirato and Webb 2003, 131).

The penetrating theoretical perspective of the impact of G/M on antenatal care and maternal health is inspired by my bachelors thesis focus; "T*he impact of globalization on certain middleclass Ethiopian families"* and how globalization processes unfolds and can be detected on a micro level in family life. The theoretical framework regarding globalization was in my bachelor thesis, and will currently be based on Eriksen's (2008) eight key concepts for explanation of globalization. Eriksen tries to make the concept of globalization more comprehensible by formulating these eight key concepts. These brief explanations build on Eriksens (2008) book, but the brief formulations below are drawn from my bachelor thesis[44]:

- "Disconnection: Location and distance have become less important, relative or irrelevant. Explanations of phenomena and situations are separated from the local context. Disconnection conceptualizes the transition from the concrete and local to the abstract and global
- Acceleration: The world has become smaller due to faster transport and communication. Information is spread more quickly through direct communication via the Internet, mobile phones and television. Acceleration explains a continually increasing speed in the world.
- Interweaving: Compression of distances generates easier impact from the outside world. Interweaving clarifies opportunities created by globalization, while also explaining how the world's relationships are dependent on each other.
- Standardization: Increased trade, transnational activities and global integration require common denominators and bridge holders for communication. English, money and politics have become standards that

[44] Bachelor thesis in Social Science written by Anna Rosa, (2015) *Globaliserade familjeliv. En exemplifiering på globaliseringens inverkan på enskilda etiopiska familjer.* Bacheloppsats i samhällsvetenskap – SAMF- 200. Stavanger: Misjonshøgskolen

enable transnational interaction. Standardization mapping and enabling benchmarks and comparison for a interwoven world

- Mobility: The world's blood circulation is increasing. People move between cities, countries or continents because of opportunities and impossibilities created by both national and transnational processes.
- Blending: Greater diversity and combinations of goods, people, cultures, values and views of life are created through global interaction. Mixture illustrates the outcome of this interaction.
- Re-connection: Represents processes that counteract disconnection trends, as well as representative of counter-reaction concepts for the respective key concepts. Re-connection conceptualises how local identities, cultures, traditions are valued and reinforced.
- Vulnerability: A world of relationships and contexts is also unpredictable. Conditions for human life are no longer defined by local, but global. Dissemination of diseases, climatic effects, economic fluctuations are examples of vulnerable situations created by globalization. Vulnerability explains globalization processes that may be negative for people and countries.

These concepts are not comprehensive and should not be considered as covering or complementary explanations for the situation of my informants. All concepts consist of many analysis and understanding branches, all of which have an impressive perspective"

Concerning the conceptual basis for modernization, I have my starting point in Smukkestads (2008) statement that:

> "Cultural understanding and development as dialogue are new honorwords and imply that the new narrative, i.e. the stories and versions of the others, must be given their rightful place as a basis for development cooperation ... Cultural knowledge and rollback of the recipient's experience with is important "feedback" to improve development work" (235).

By looking at modernization processes I address how concrete facilities and technology in the local area is available. Whereas globalization processes address more abstract influences on information and knowledge about health and life situation.

To give an example; Modernisation and development aims to improve the standard of living conditions and globalization highlights how the world is becoming standardized as an outcome of this. An example is that Aira Hospital can be considered a symbol of modernisation, globalisation and development. Plenty of foreigners and missionaries have been working there or contributed to the hospital in various ways, for many years. This has had its impacts on the community, for example in the sense of creating a better health standard for people close to the hospital and its clinics.[45] Also, the hospitals presence creates more health awareness in society. However, there might still exist principles in the community that does not concede of the standardized medical dimension the hospital, and other health facilities, provide. This means that people in Aira Woreda can't avoid globalization forces. However, simultaneously, they most likely also follow many traditional practices and stand for many traditional values.[46] There's still a traditional dimension standing strong. Therefore, it's desirable to look at how globalization and modernization affects/doesn't affect the social structures that maintain women's decisions in relation to maternal health. Its relevant for me to understand how globalization processes are influencing the culture and lifestyle, and the decisions and responsibilities of people in their community.

4.3 Relational Explanations

I consider it relevant to (very) briefly mention the centrality of relational explanations in social science because it is an analytical method that penetrates my whole study. The analytical method of social science is relational thinking.

This analytical and scientific concept in the social sciences comes from the social anthropologists Cato Wadel and Carls Cato Wadel, and looks explicitly and solely on interaction and relations in human life (Wadel and Wadel, 2007).

The whole human social reality is constructed by interaction with other people and hence relationships. This means that the basic unit of culture and society is interpersonal relationships (ibid.).

Relational thinking illustrates that human behaviour is shaped by interaction and relationships, based on the groups we are part of and that we live together in a society.

[45] Aira Hospital has a few clinics located around an hour away from the hospital.
[46] The distinction between traditional and modern is not a real distinction, but I use these remarks as an analytical distinction to organize my information and task. The reality is that there are no pure traditional values in the world anymore. Everything is affected by globalization to some extent.

Relational explanations explain how other people influence us in our environment and how we take into consideration other people when we act and think (ibid.).[47]

4.4 Combining the theories

I want to briefly explain why perspectives worldviews and globalization/modernization are supplementary and how I will combine them for my analysis.

As my aim is to analyse how socio-cultural environments impacts PW's health in Aira Wordea its important to consider both worldviews and globalization and modernization as aspects that influence social relations, culture and society. One can't avoid these societal forces because the whole world is operating under different worldviews and is in someway or another affected by globalization and modernization processes. They are fundamental for understanding human behaviour everywhere in today's world.

I have made a simple model/sketch showing how I view the relation these theories have to socio-cultural environments and impacts on PW's health, and why they are perfect for my study.

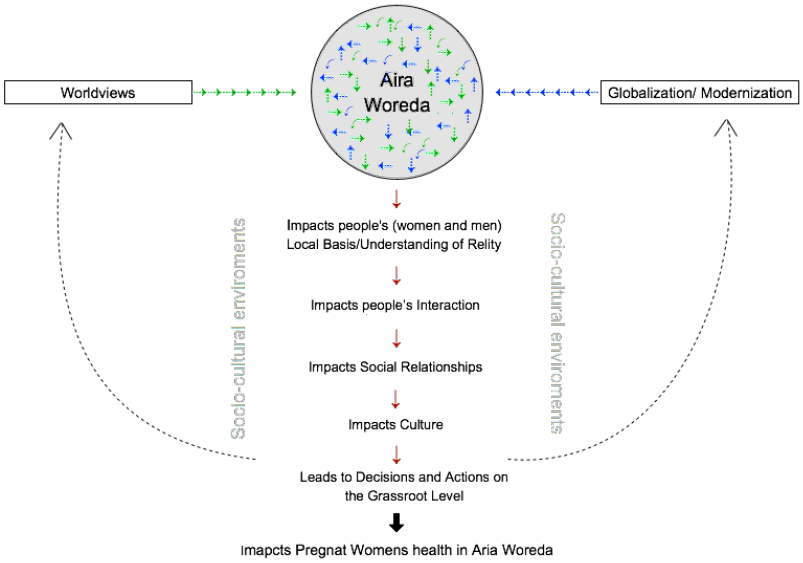

Figure 4. Theoretical approach

[47] Opposite perspectives on humans are character explanations and system explanations (Wadel and Wadel, 2007.). Here interpersonal influence is excluded and it thus becomes a less holistic perspective. These perspectives can be considered "everyday perspectives" that most ordinary people use. Simply put: Character explanations and system explanations are *explanations* of action while relational explanations are *analysis* of action (ibid.).

With a globalization and modernization perspective I include technical aspects such as infrastructures, technology, finance, education and how the impacts/non-impacts of the social and cultural dimension in society can trace the reasons for utilization/non-utilization of health care.

With the worldview perspective I aim to examine the forces of the cultural doxa and the taken for granted and implicit assumptions and attitudes that are established in a community (Shiranto and Webb, 2003).[48] How this make women take certain decisions due to unconscious (maybe also involuntarily) patterns of expectations and values is highly relevant to gain insight to for understanding utilization/non-utilization of health care.

By analysing the different dimensions in the worldview and looking at how the eight key concepts of globalizations might impact / not impact these it might highlight the controversies or similarities concerning, for example, global and local views on health or global and local rights. As the relational explanations are basically what social science is about, it's an incredibly valuable scientific tool for my analysis as it explicitly highlights the social influences on people's behaviour and decision-making. Put Shortly: These perspectives combined tells me how the women's cultural environment affects her and how the cultural environment is affected by globalization and modernization. And this knowledge is necessary to for getting a "thick description" of the women's decisions and actions (Geertz, 1989).

Also, this kind of combination finds academic support amongst different social science scholars. Cohn et.al, (2017) implies that it's important to explore the relationship between social sciences and the advances in information and technologies as they write that this kind of combined perspective "can be leveraged to better understand socio-cultural decision-making processes, providing an alternative means for gaining a shared understanding in today's high-tech and globally interconnected world" (xxvi).

[48] A Doxa is "as the effect of something coming to seem true and necessary, so that people will accept that its 'just the way things are' "Schirato and Webb (2003, 131).

5 Data Presentation

Regardless what you study or try to examine from a social science perspective, it's grown obvious that understanding of the dynamics and influences from the various disciplines in the social sciences (e.g. historical studies, cultural studies and political science) are fundamental to actually get an honest and realistic picture of reality. Gray (2013) clearly underlines in his book about organizations that one cannot see how people participate in society and organizations without looking at economics, politics, culture and vice versa. Møller (2004) points out that including history, politics and culture is very important for understanding the socialization processes that affect people's attitudes, actions and mentality.

Therefore, I have chosen to divide this chapter into three parts. Part 1 offers the reader brief and general information about Ethiopia. This part might seem misplaced in this chapter, as it functions as background information and not data-presentation. However, it was most natural locate this section in relation to the data presentation to give the reader a background to the cultural context of the data. Further Part 2, consists of national and regional statistics on MH. This also includes information about Aira Woreda and the cabales I went to for collecting information.[49] Part 3 presents my core primary data on PW's life situation in Aira Woreda, which is the data gathered form my fieldwork.[50] Besides the general introduction of Ethiopia and the general statistics, the whole chapter builds mainly on primary data I collected from my fieldwork.

5.1 Part 1 – Ethiopia

5.1.1 History, politics, economy and demography

Ethiopia is an ancient country that uses catchphrases as; independence, never colonised, the cradle of humankind, great emperors, kings and queens, great traders (to name a few) to explain and express its pride over its unique history. Zewde (1991, 7) highlights that Ethiopia has an over 3000 years old acknowledged history which makes it one of the oldest countries in the world.

[49] Woreda = Municipality/area. Cabales = suburb

Politically the country has undergone turbulent periods such as Italian occupation (Marcus, 1994), liberation movements, feudal social structures, communism, civil unrest, famine and corruption (Milkias, 2011). Many Ethiopians have emigrated because of human rights and freedom of expression. The country has lately been under political unrest and recently been in a state of emergency to facilitate a peaceful transmission of power to the recently elected prime Minister Abiy Ahmed who is the first leader from the Oromo ethnic group (BBC, 2018) and (BBC, 2018a). Ethiopia is currently a federal republic ruled by the Ethiopian People Revolutionary Democratic Front coalition (EPRDF) (Milkias, 2011)

Despite these recent turbulent political events, Ethiopia has been acknowledged as a central and up-and-coming political and economical junction in Africa, and allay with western countries by international organizations such as the UN and pan-African Organisations as the African Union (AU) (FN-Sambandet, 2018). The headquarters of the African Union is even located in Addis Abeba (African Union, 2018), and thus the inhabitants call Addis Abeba, the capital of Ethiopia "The capital of Africa". [51]

Ethiopia is located in the middle of the Horn of Africa. With its 435,186 square miles it facilitates diverse topographic features from high peaks to deep valleys and rainforests resulting in very diverse climates such as tropical rainy, dry, and warm temperate (CSA, 2011). However, its classified as a highland country.

Consisting of over 80 ethnic groups, the population of Ethiopia is 107,534,882 which makes Ethiopia the second most populous country on the continent (Worldometers, 2018). Milkias (2011) notes that the population could reach 140 million by 2030.

The country's population consist of over 80 ethnic groups (Milkias, 2011). The national language is Amarigna, but in each region, as well as in each ethnic group, the inhabitants communicate their ethnic language (FN-Sambandet, 2018).

Ethiopia has tremendous natural resources, which naturally results in the majority of the population being farmers (approximately 80%), making agriculture the bedrock of the country's economy resulting in 60% of GDP in the country being maintained by agriculture (Milkias, 2011). Coffee is the biggest agricultural commodity. From another perspective, this indicates that Ethiopia is very dependent of the import of necessary goods, such as oil and machines (FN-Sambandet, 2018).

[51] This expression was presented to me both during my fieldwork in Ethiopia for my bachelor thesis in 2014, and for my fieldwork for my master thesis in 2017. It shows that there's a common pride amongst Ethiopians although disparities and tensions between ethnic groups and political interests.

Since the majority of the population are farmers and live on the country side it also makes Ethiopia one of the world's poorest and most dependent countries with one of the lowest GDP / person (PPPs) in the world, which in 2015 was $ 619 (FN-Sambandet, 2018). Ethiopia is therefore a country depending on aid from other countries (ibid.). China has played a central role to strengthen, streamline and develop agriculture, infrastructure, industry and production (ibid.). This has created great accumulation for many sectors in Ethiopia

5.1.2 Religion and Culture[52]

Already approximately 1,700 years ago, in the mid 4th century, Christianity was the official religion of northern Ethiopia in The Christian kingdom, ancient Aksum. Ethiopia is therefore one of the world's oldest Christian countries (Höglund, 2015a and 2015b).

Within the Christian belief system there are three main denominations; the Ethiopian Orthodox Church (EOC) constitutes 44 % of the total Christian population, Protestants constitutes 18 % and Catholics make up 0,6 % (International Religious Freedom report, 2015).

In Aira Woreda it was mainly followers of the protestant denomination Ethiopian Evangelical Church Mekane Yesus (EECMY) and the sub-denomination of EECMY "Full Gospel". EECMY is the largest protestant group and has its foundation in Lutheran mission work in the 19th century (Worldmap, 2011). There has been prominent impact from Pentecostal denominations and movements on Ethiopian Protestantism (ibid.).

Ethiopia is home to a mosaic of over 80 ethnic groups and languages which also constitutes a mosaic of cultural behaviours celebrations and belongings (Milkias, 2011.). I will not present all these, but a brief description of the Oromo culture will be given further down this chapter.

It's however worth mentioning that even though there are religious and ethnical disparities its expressed a common pride over the countries culture, nature and history. As mentioned, Ethiopia is one of the oldest Christian countries in the world. The EOC influences both cultural and religious aspects in all religious and ethnic groups.

[52] The information about religion mainly builds on an excerpt from my Assignment in the Christian Church in a Global MGS 301c – Christianity in Ethiopia. Authour: Anna Rosa Rudin, paper submitted 18.10.16.

In addition, Ethiopians history is understood differently than the rest of Africa's history because of written sources from 2600 years have been found inscribed in stone (Milkias 2011, 294).

5.1.3 Family life and gender roles

Since my topic considers socio-cultural impacts on women, the gender perspective is mainly directed towards women's life and roles. As in most African societies there's a quite clear gender division regarding most of the work, chores and responsibilities in a society.

Both my observations in Aira Woreda and facts presented by Milkias (2011) confirm that this explanation on gender divided responsibilities matches the situation in Ethiopia as well. However, one observation of mine is that nowadays, women are not solely working with reproductive chores such as "family subsistence needs" (Momsen, 2010), which in addition to the above quote means to be responsible for the health, social education and socialization of the children. Women are actually being further integrated to productive labour through for example NGOs who encourage women to work for "cash income" (ibid.), though micro-finance projects.

Regarding marriage, women's consent it not necessary required. It's the families and the men who decide whom to marry and when (this primarily concerns the rural areas of Ethiopia) (Miklias, 2011). In relation to this there's still a conviction that a girl is not applicable for marriage if she is not circumcised (ibid.). [53]

5.1.4 Oromo

Since my fieldwork was done on Oromo people, a small explanation of the Oromo ethnic group is preferred. The information given is a synthesis of primary data from my fieldwork and secondary sources. The Oromos are the largest ethnic group in the Horn of Africa and correspondingly, the largest ethnic group in Ethiopia (Milkias, 2011). Today, almost 95% are farmers and spread throughout all of Ethiopia except in the far north. The majority lives in the region called Oromiya which covers parts of mid-west and southern Ethiopia. Previously the Oromo people "lived under a complex indigenous democratic system known as *gada"* (ibid.,

[53] Circumcision or Female Genital Mutilation (FGM) is further presented under the section concerning maternal health.

208). It was an egalitarian democratic system that facilitated the political, economic, social and religious spheres of life and embraces(ed) all Oromo, young and old, for many years and has today "become a valuable and political symbol for the Oromo people" (Dahl 1996, 113).[54] It was characterized by continuous and peaceful replacement of leaders, organized military and structured civilization (ibid.). The Oromos are currently facing many problems due to that the political situation today is complicated and difficult in relation to the national political administration and leaders. Currently, the liberation movement Oromo Liberation Front has and are gaining Oromos who wants to fight for self-governance. This makes the relationship towards governmental facilities in the region a bit ambivalent and some Oromos refuse to use or communicate with governmental institutions.[55]

The family constellations are by tradition big with a patrilineal extension. (Encyclopaedia, 2016). Also, the neighbourhoods and community as a whole is intertwined in the family structure. The husband is the head of the family and has authority over the rest of the family. Children are valued and PW are highly respected because they "might be carrying a king or a doctor".[56] However, women are in general inferior to the man and have little power.[57] This has also been measured CSA (2016) indicating that "spousal violence (physical, sexual or emotional) is most prevalent in Oromiya (38%)" (295).

Keywords in the Oromo culture are respecting elders, social responsibility, bravery, compassion and hard work (Encyclopedia, 2016).

5.2 Part 2 – Maternal Health in Ethiopia and Aira Woreda

5.2.1 Health facilities

A key fact presented by the WHO (2018) is that "every day [worldwide] approximately 830 women die from preventable causes related to pregnancy and childbirth". Millennium Development Goal 5 (MDG5) was about improving the health to pregnant and birth giving

[54] While doing my fieldwork in Aira Woreda, I ways told that the Gadas system has been prohibited in Ethiopia for 68 years (Since 1942, Ethiopian calendar). But when during my fieldwork there was a renewal of the system. The Oromo people had a big gathering in relation to the Gadas system for the first time due to political circumstances.
[55] Finding from my fieldwork.
[56] Quote from my fieldwork.
[57] The section on family and gender roles presented above is applicable for the gender roles in the Oromo.

women. The original goal was to reduce the maternal mortality by 75 % in 25 years (from 1990 to 2015). The actual reduction was 64% in Southern Aisa, 49% in sub-Sahara n Africa between 1990-2013 (MDG Montir, 2016), and worldwide 44% (WHO, 2018).[58] Its highlighted that the biggest reason for maternal mortality is related to poor access and utilization of skilled health personnel and services. In Ethiopia health facilities have been, and still are to a large extent, inaccessible and inadequate (Milkias, 2011). Even though I have continually emphasized that my assignment is not focusing on health facilities per say and their accessibility or quality, I find it important to highlight some brief data regarding the health system in Ethiopia (and Aira Worda).

The governmental health services consist of three levels. The primary, secondary and tertiary levels of health care. This tire system concisely illustrates the responsibilities of the three levels (AOH, 2018).

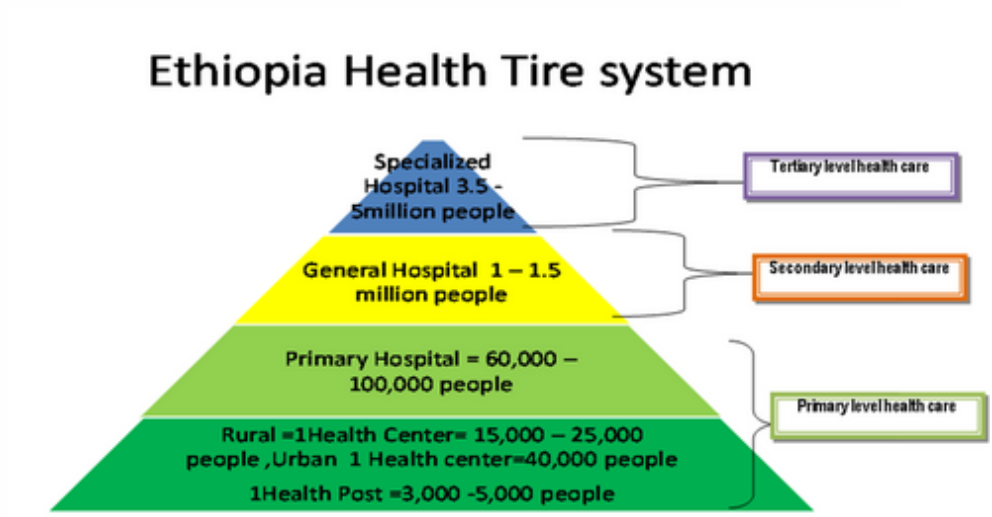

Figure 5. Ethiopia Health Tire System.

There's a referral linkage system between these levels starting at the bottom with health posts (HP) and the health centres (HC) continuing up to the Primary Hospital (PH), General hospital (GH) and lastly to a Specialised hospital (SH). There are different guidelines for treatment at each level. I emphasise an explanation of the primary level here since my assignment considers the grassroots of society in Aira Woreda.

[58] Between 2016 and 2030, as part of the Sustainable Development Goals, the target is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births (WHO, 2018)

The primary level starts with the HP that is facilitated by the health extension workers (HEW). This service grew out of the MDG related to health, with the focus on prevention and treatment from the grassroots level of society and have been active for 12 years. The HEW are mostly working on prevention by providing health education to prevent diseases. Their responsibility also concerns close follow-up of all fertile women between the age of 15-49, pregnancies and birth ratios in the specific cabale.[59] The strategic plan is to visit every household in the cabale for both educative and health purposes. One can say that the HEW function both as educative and social actors trying to create awareness in addition to being health assistants.

The primary level also includes the HC. The HP refers to the HC they belong to for more complicated procedures as childbirth and medical treatments. To prevent and decrease travelling for the people, midwifes and nurses travel to the HP monthly to support the HEW with treatment and education.

The secondary and tertiary level considers the further referral linkage system between the HS and the primary hospital.

This whole service system have the aim to generate easier access to secondary and tertiary levels of health treatment (African Health Organization, 2018). Easily put: Government ←→ Hospital ←→ Health centres ←→ Health posts and Health extension workers ←→ Community and families.

There's also a set of privat hospitals driven by NGOs. Aira Hospital and its clinics are facilitated by EEMYC and has therefore a different organisational breakdown. Aira hospitai is the main hospital and has clinics related to the nearby cabales and also some woredas. To summarize: Mekane Yesus church ←→ Aira hospital ←→ Clinique (Synod → Parish).

There's an open collaboration between Aira hospital and the governmental health centres and health posts. In addition, the government is trying to attract women to give birth at the health centres by providing free services, sleeping accommodation and supplements whereas in the private clinics and hospitals they have to pay.

[59] According to the governmental health office in Aira Woreda, this service have made a great improvement regarding the health situation in the cabales.

5.2.2 General statistics for Maternal Health in Ethiopia

General statistics for the maternal health situation in Ethiopia is brought from Demographic and Health Surveys conducted by the Central Statistical Agency in Addis Ababa, Ethiopia.[60] Here, current estimates of demographic and health indicators and relevant information about women's decisions, maternal health, maternal death, family planning etc., are presented. The quantity of participants is limited but gives some kind of representatively for the country and functions therefore as scale to measure the development in the country and success of the MDGs (CSA, 2011). I have below listed a few variables that I found relevant for my study. I've set the different years up against each other to emphasize the success/process. I have also added a column showing figures for the Oromo population in total, to try to anchor the statistic in the local Oromo context I was conducting my fieldwork in.[61] Statistics from the Health Office in Aira Woreda were given to me personally and might be fairly vague because of their limited resources for data-gathering, processing and documenting. However, these will still function as primary data for my analysis and research as far it's possible.

Table – General Statistics for Maternal hHalth in Ethiopia.

	2011 (Ethiopia)	**2014 (Ethiopia)** (women only)	**2016 (Ethiopia)**	**Oromiya 2016**
Participants (total)	30 625	8070	28 371	-
Women (age - 15-49)	16 515	8070	15 683	-
Men (age – 15-59)	14 110	-	12 688	-
Education (Primary)				
Women (age - 15-49)	39,1%	41,5%	39,9%	**31,8%**
Men (age – 15-59)	49,3%	48%	49,9%	**42,1%**
Marriage			65%	-
Women (age - 15-49)	58%	-	65%	-
Men (age – 15-59)	52%	-	56%	-
Fertility Preferences	3 children/ woman	-	-	**3,8**

[60] The Sruveys used in my thesis are: *Ethiopia Demographic and Health Survey* (2016), *Ethiopia Mini Demographic and Health Survey (2014)* and *Ethiopia Demographic and Health Survey* (2011).
[61] I am not presenting how the data was gathered. I guide readers who are interested in this to the reference list where you can find direct links to the original documents.

Fertility Rates	4,8 children/ woman	4,1 children/women	-	**5,4**
Contraceptive use married women*	28,6%	42%	36%	**28%**
Contraceptive Use all women **	-	28,8%	58%	**-**
Contraceptive knowledge (women)	97%	97,5%	99%	**99,3%**
Usage Antenatal Care (any kind) * **	34%	41%	62%	**50,7%**
Usage Delivery Services ****	10%	16%	26%	**19%**
Home Deliveries	90%	84%	73%	**80,5%**
Usage of Traditional Birth Attendants	-	37%	42%	**45,4%**
Protection against neonatal tetanus *****	48%	-	49%	**41,4%**
Problems in accessing health	94%	-	70%	**82,9%**
Problems with getting permission to go for treatment	-	-	32,1%	**58,3%**
Problems with getting Money for treatment	-	-	54,8%	**70,1%**
Problems with distance to health facility	-	-	50,3%	**68,9%**
Pregnancy related Mortality******	676/ 100 000	-	412/ 100 000	**-**
Female Genital Mutilation	-	-	65%	**75,6%**

* 2011: 27 % using modern methods and 2 % using traditional methods. 2016: 35% using modern methods and 1% using traditional methods.
** 55% using modern methods and 3% using traditional methods.
*** "32% had at least four antenatal care visits during their last pregnancy "(CSA 2016, 133).
**** Institutional, such as Health centres or Hospitals.
***** "Neonatal tetanus, a major cause of early infant death [and maternal mortality] in many developing countries, is often due to failure to observe hygienic procedures during delivery" (CSA 2016, 136).
****** Within 7 years before the survey(s). "The risk of maternal death is 21 in 1000 (2016)" (CSA 2016, 249).

5.2.3 Maternal health in Aira Woreda

Aira Woreda is located in West Welega, Oromiya, and consists of 15 cabales and hosts approximately 66436 inhabitants. [62] Aira has a long history of missionaries and health services and Aira Hospital has been a symbol of both.

Aira Hospital is a private hospital facilitated by EEMYC and is one of the Birbir Dilla Synod Development and Social Service Commission (DASSC). Its the last church-owned hospital in Ethiopia and has been runnig for over 50 years and a central host for

[62] Numbers form are from 2013. Information given to me by the Woreda Office.

foreign medical missionaries (GHM, 2015). In 2015 there were 162 employees, 49807 outpatient visits, inpatient stays 8778 and 2800 surgeries. There are five clinics connected to Aira hospital located in various cabals within 1-3 hours away from the hospital with car. These facilitated 8900 patients in 2015.

5.2.4 Antenatal Care (ANC)

As nationally in Ethiopia, focused antenatal care is central also in Aira Woreda. This means that the PW has to come at four expected times to the HC for check-ups. Here, blood and urine samples are taken, and food supplements are provided to avoid malnutrition. This has been a big contributor to bring change and improve maternal health and deliveries. Women are informed when their due-date is and they can plan ahead to go to a health facility to give birth.

ANC is a currently a free service at Aira Hospital. The reason for this is to eliminate the direct financial obstacle for the PW. However, all of the 15 PW I interviewed were familiar with this service but not everyone used it. The ANC service utilization is varying very much between years. This might be due to the staffing at ANC service points. Even if contact with ANC is encouraged it cannot be traced any consistent improvement of the habit. Appendix 8 - table 8 shows that it can even be noticed that there is about 10 % less contact with ANC from 2014 to 2015.

5.2.5 Deliveries

Previously there was a selective approach towards on whom was recommended to give birth at a health facility. Today a new slogan prides the wall in the health office stating that "Every Women is at Risk", which implies that all PW are strongly advised to give birth at a health clinic. However, its not forbidden to deliver at home and home delivery is still very common, especially in rural and remote areas. Relating to this the usage of traditional birth attendants (TBA) has decreased since the HEW have started to provide education for individual households and families on maternal health. However there are still "resting" TBAs that get contacted if there's any emergencies or complications. The MCHC said:

> "The TBA still have influence. Before there were many, but now there are some and in emergency the PW call them. When they get difficulties, they call them.

> When the women get a difficult labour they call them, they try, and after some hours delay they may refer to health centres…. So, its when she comes to the hospital, it will be a complicated delivery. So, this maybe on neonatal or maternal death, this may happen. the last quarter, we had a complicated delivery and she died on the way. This is because of their culture, they are Muslims there. And they wait, they will not accept what is told by the health extension workers. It takes time to teach these people and change their attitude to the health service. They are still not accepting this health education by the health extension workers." (MHCC)

Both midwives and MCHC are highlighting that the community are embracing the importance of deliveries attended by skilled personnel. However, there's still a communal mindset with another perspective. One midwife note:

> "They understand the disadvantage of giving birth at home. But they say the house is empty and our children are alone. It's difficult to stay in the Health Centre before delivery but we can go when the delivery time is arrived." (Midwife Bondawo)

In Appendix 9 - Table 9. That presents statistics of the delivery service utilization at Aira Hospital we can notice that total number of deliveries has increased with about 60 % between years 2009 and 2015 the percentage of abnormal deliveries has decreased from maximum 53 % to 32% during 2015 which is highly encouraging. C/section has been on a relatively high level around 30 % during years but has dropped drastically to 20% 2015. Other factors seems to have a relatively even and low %.

In relation to MH, Aira hospital is acknowledged for treating patients with cleft palette, vaginal fistula, vaginal prolapse and eye surgeries (GHM, 2015). During my fieldwork I was told that Aira Hospital facilitated around 275 troublesome delivery cases in total. The Gynaecologist noted that:

> It's around 16 fistula case over 4 months. For 4 month we did around 145 patients including the uterus prolapsed. The uterus problems is around 130 and the fistula cases are around 15 cases. Other surgeries, which were worked on for around a year which is around 100 cases. Totally the plan is to treat up to 275 cases this year. (Gynaecologist)

There's no registered data to my knowledge regarding Maternal Mortality, neither did any of my interviews or observations confirm any maternal deaths during my fieldwork or in the recent year.

What is special with the development around Aira Hospital is how its history of missionaries and its fundamental value base as a Christian Hospital have increased the inhabitants' preferences for treatment at the hospital instead of going to health centres or governmental hospitals, even though its privet and costs more for the patients. The Mother and Child Health Coordinator at Aira Woreda Health Office (MCHC) said[63]:

> Mostly they prefer the hospital because the hospital has been giving service for many years and have been established for many years. So, people are adapted to go and they use it for everything; sickness, family planning and deliveries. They also get more services there. The health centres are only about 6-7 years now since we started. I don't have any statistic on how many people are using the health centres at hand now. But gradually its increasing and people are adapting to go there. Its still processing. (MCHC)

In addition to the continuity of the hospital, one midwife stated that the impact of foreigners working in the hospital is big on the selection for the health services:

> They prefer foreigners much more because they are thinking for that, they have higher education than Ethiopian people. (Midwife Aira Hospital)

Besides this, I was curious how the hospitals religious core impacted the choice of the people. Dr Takele Dagebe, The Gynaecologist at Aira Hospital, explained how this could be a contributing force for choosing health facility[64]:

> The love we show for the people attract the people. Every religion. We show the love that God shows.

5.2.6 Female Genital Mutilation (FGM) /Circumcision

[63] Further The Mother and Child Health Coordinator at Aira Woreda Health Office will be referred to as MCHC.
[64] Dr Takele Dagebe gave me his consent and wish to be referred to. He will further be referred to the Gynaecologist.

FGM is in this thesis considered as an additional category to maternal health because of its actuation on maternal health, specifically related to childbirth, and will therefore not be further explicitly discussed. However, I stress my awareness of its fundamental impacts on especially childbirth. A concise explanation of FGM praxis is given by CSA (22016): " FGM involves removing some of the clitoris or the labia for non therapeutic reasons, usually as part of a rite of passage into adolescence. The practice is widely acknowledged as a violation of human rights, and serious medical complications can result" (316). Austveg (2006) further underlines that FGM cause a risk factor for increased prevalence of bleeding at childbirth and neonatal and maternal death.

5.2.7 The Cabales (Suburbs)

Before preceding to the presentation of the main interview-subjects, I will briefly explain the 3 cabales I conducted my main intervenes in.[65] This is to provide concise context to the interview-subjects resident situation. A picture of a table of the demographics for the cabales in Aira Woreda is found in Appendix 10.

Map of Aira Woreda

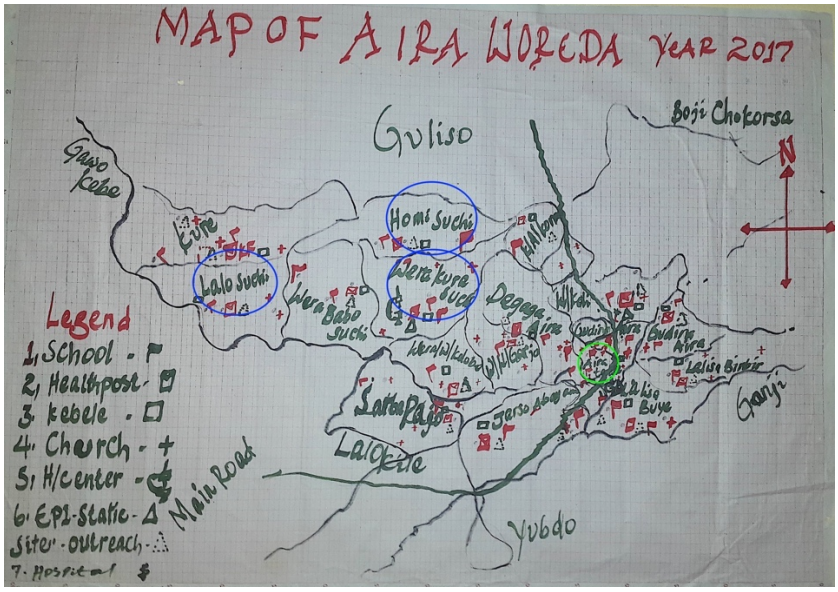

Figure 6. Map of Aira Woreda.
This was the best map available of Aira Woreda during my fieldwork. The blue circles show where I conducted my interviews, the green circle shows Aira.[66]

[65] The selection of these cabales are explained in Chapter 3 - Methodology.
[66] Map provided at Aira Woreda Health Office.

5.2.8 Lalo Suchi

Lalo Suchi is located approximately 1 hour and 30 minutes with car from Aira Hospital. The population is 1922 men + 1975 women = 3897 in total. There's one HP and one HEW. However, I didn't visit the HP, neither meet the HEW since she was on maternity leaf.[67]

Lalo Suchi represent the most remote area in my fieldwork and correspondingly, the biggest challenges related to maternal health. The MCHC stated that the HEW cannot reach all the households and therefore not provide health information or services. This creates in problems and conflicts with cultural behaviour and practices.

> … They know about family planning, and health service and service delivery at the hospital and health centre. But because they are very remote from the hospital and health centre they are still not getting services at the health facilities.. Also, they will not accept family planning because of their culture dominates their preferences. They want to have many children and we can see that this comes from social impacts in this area (MCHC).

5.2.9 Homi Suchi

Homi Suchi is around 1 hour from Aira with car. The roads are decent and relatively well facilitated. With a population of 1749 men + 1796 women = 3545 in total, its smaller than Lalo Suchi, but with better facilities. With an active HP and one HEW the community can receive health education and easy health follow-up. According to the MCHC the challenges in the area are minimal because of its close location to the HC in Bondawo and the presence of the HEW, and that 80-90% visit the HP if needed. However, the HEW pledge opposite:

> When we teach the people have difficulties to accept the information in the community (HEW, Homi Suchi)

5.2.10 Bondawo/Warra Kuraa Suchi

[67] This resulted in that there was no HEW in Lalo Suchi for some time.

Bondawo, as highlighted on the map, is in the middle of many of the cabales and is a 45 minute drive from Aira Hospital. Here there's a weekly market for all the surrounding cabales, a woreda office and a HC which makes Bandawo the centre for these more peripheral cabales. The HC haveboth nurses and midwifes who facilitate around 50 patients/month, whereof around 50% of these are PW. Men 1848 + women 1898 = 3746 in total.

5.3 Part 3 – Pregnant women in Aira Woreda

This part attempts to present my primary data as systematically as possible. I have chosen to organize the main data in very simple tables according to the different themes from my interview guide. These tables are added as attachments to this paper. Below I am giving a brief summary of the information presented in the tables. The aim is to give the reader an overview, not to detailed, of the PW life and situation in Aira Woreda. Richer explanations are given through my interpretation of these data is presented in the analysis.

The women were asked questions on the following topics:

- Personal Background
- Pregnancy
- Social relations
- Tradition, Culture and Religion
- Globalization and Modernization
- Childbirth
- Other

5.3.1 Personal Background

From the Appendix 1 - table 1. Personal background, the age, profession, family situation and education is presented. The age ranged from 18 two 35, whereof 10 out of 15 have reached 9th grade or higher. It can be seen that 13 out of the 15 informants are farmers. All the women

were the only wife in their husband was married to, and four out 15 were carrying their first pregnancy.

The PW are coded with numbers to assure anonymity. In the following they will for example be referred to as IS-28 (IS = Interview-subjects).

5.3.2 Pregnancy

The general assumption drawn here is that the PW I interviewed had similar physical (backpains, tiredness), mental (worrying about childbirth and finance) and emotional (happiness for being pregnant) experiences with being pregnant. Two expressed a sadness over their pregnancy due to previous bad experiences with pregnancy. The reason for this are related to location and work.

> It feels like someone that is in prison, because I cannot work as before. I cannot run and get money as before. (IS-4)

> If we don't work, the seeds that are going to be planted are less so the harvest will be less. So, this will indirectly affect the income. So instead of going to health centre I have to work…. We try our best to manage and work. (IS-8)

There's a variation in how they get treatment or follow-ups during pregnancy. The table also shows that TBAs are still active and that two of the women used their service. Four women had no check-up so far, and the remaining said that they were followed up by the HEW.

As briefly noted in the section about Oromos, PW are treated with respect in the oromo society. One PW confirms this when sayin:

> When people use to see me before and now its different because a lady who is carrying a child in her stomach has respect in the society. People around her help her to prevent activities that are harmful for her. If I want to move around to do activities, they help me to do activities. The community has a good view on pregnant ladies because she can hurt easily, so they help her more and give her priority. For example: when I go in the bus, they give me their seat, they help her when its slippery, they know she cannot carry heavy things, they know she cannot do many activities. (IS-15)

5.3.3 Social Relations

The information given in appendix 3 – table 3 concerns the interaction with the people around the PW, regarding her pregnancy. There are some variations in whom they seek advice from. Usually this is the husband, the mother-in-law, or mother. Sometimes friends and relatives are also counselling and supporting. The general advice given to the women is that they should not work too hard because it may create problems for the featues, but not explicitly for the PW.

> My mother advised me advised to keep myself from work. Because sometimes when you work hard, an abortion may come after some 3-4 months. (IS-6)

The husbands' role is very central for married PW, and the majority of the women I interviewed stated that their husband was happy when they received the news that she was pregnant. Also, they were helping with chores around the house and advising the women to rest. However, the majority of the PW didn't have decision-making power in the household and didn't confirm that they could talk to him about being pregnant and that he made financial decisions in front of health beneficial decisions. Three of PW stated they were discussing and taking decisions together with their husbands, and one claimed to make all the decisions herself. Three of the women are working almost as normal during pregnancy due to financial matters.

> He forces me to work…. Because we don't have money. (IS-10)

5.3.4 Tradition, Culture and Religion

The community and cultural environment and the religious practises in the area are to sides of one coin. These aspects are integrated and mutually enforcing regarding accepted practices and behaviour. It is therefore a challenge to distinguish what was culture and what was faith. The reader should have this in mind for the continuation of the thesis.

Table 4 in the appendix highlights how the women are participating and interacting with the world outside the household, when being pregnant. All the PW indicated they were not explicitly aware of the previous practices of PW, when asked if they knew what

their mothers did when they were pregnant. Regarding FGM/circumcision the practice still lives on underground due to traditional beliefs concerning female purifieness and behaviour.

There was a solid consensus amongst the individual women that religion was fundamental for enduring their pregnancy, primary trough prayer.

> I want them to pray for me. I need them to come and encourage me.. When I go to church the pastors pray. And they say to me "don't be worried, don't be afraid. You will be fine, the baby will be fine". So, I will be happy and I will be safe. … Before I used to be worried, but after they have advised me – I felt safe. (IS-7)

However, one women pointed that this is just implicit in the congregations and church:

> Pregnant ladies are included in the general prayer. But there's no special advise just for pregnant ladies. No separate advice or meetings (IS-8)

The interaction beyond the closest family about pregnancy was limited. People could talk indirectly about pregnancy but not directly about how a PW feels or has the right to.

The PW were treated with respect but underlined that there it difficult to talk about their life as PW because they were to some extent embarrassed of admitting that they were pregnant. In addition, certain expectations towards a PW could make it more difficult for women if they were not lived up to.

> I am not proud because I have big children now. The community thinks I am old and don't know if they will support me (IS-12).

5.3.5 Globalization and Modernization

As mentioned under the section *Pregnancy*, the women were all aware of that there were health facilities and knew that they medically all had the same right to get care. However, the practice shows that they didn't use it frequently.

> Nowadays the government have opened many health centres in different places so anyone who need to be checked up, can go and be checked. And they go for ANC follow up and they check there. If there's any problem they get follow up there. (IS-F1)

Not everybody had the access to a modern means of communication, but they used their social network to arrange ambulance or transport for delivering women/transport to HC or hospital. I observed how a woman in early labour was sent with our car to Aira Hospital instead of ambulance to make sure she could get to the hospital more safely.

Regarding education, the general opinion was that it was very little education given in the community and school on reproductive health due to shame and taboo related to SRH. However, all of the women were aware of modern contraceptives and most of the utilized it.

5.3.6 Childbirth

The aim of this table is to highlight the social and cultural aspects related towards the end of the pregnancy and childbirth. Its revealed that most of the women expressed a wish to give birth at a health facility. However, the reality is hard to anticipate since many of the women had ambivalent answers and had conducted homedeliveries previously which made it easier to give birth at home once again.

The women expressed that there's not any physical or mental preparation or motivation for the act of giving birth. However, there's a lot of preparation for the ceremonies and celebrations after the child is born. For example preparing Marqa, which is the equivalent of "barselgrøt" in Norway.

The table also shows that there are some officially un-active TBAs, who still help and assist women during pregnancy and childbirth under circumstances of homedeliveries. The information here is also spread and indicates both their current influence, but also the how women prefers health facilities instead.

The TBA does not like when people go to the health centre…because they earn money when PW come to them. (IS-2)

I was hurt, injured, when I delivered at home. Now I understand that giving birth in hospital or health centre is good. I feel that, and I prefer to go to hospital….(IS-2)

5.3.7 Other

To get an idea of what the women I interviewed was concerned with themselves, I asked the women what made them feel safe during pregnancy, what they thought was good/bad and what they wished could be improved for PW in their area. A very interesting answer regarding the acceptance of education and knowledge and how it could be improved was given to me:

> …. there are heath extension workers. They go to their homes and they advise about her hygiene and health, and other different things. But people are feed up of them, so the health institutions has to discuss about what they should do and the health workers from the institutions has to talk with the extension workers. They should prepare conferences and they have to advice the pregnant ladies about their health and hygiene with them (the health inst). And the community will accept them more (the health workers). … Its very good when I saw you [me – the researcher] at the market and heard about this. I advised the other pregnant ladies to go there "its good, you have to listen". Our people here need such kind of things, to take in the advice. When people hear new things, they take the advice. They need new faces to accept these things. (IS-7)

5.4 Unexpected, important finding

I had an interesting, unexpected but important discovery during my fieldwork. This was originally not information given to me by recourse-people or gate-keepers but was mentioned by one of the PW I interviewed. It concerns *unwanted pregnancies*. An unwanted pregnancy has it origin in an unintended pregnancy which can be defined as: "pregnancy is a pregnancy that was not wanted at the time conception occurred, irrespective of whether or not contraception was being used" (Wado, Afework and Hindin, 2013, 4), and can be called many things.[68]

For my topic, unwanted/unsupported/illegal/unintended are still pregnancies affecting women's health. And I want to be very clear that my assignment is not solely related to PW within marriage or with wanted pregnancies and I therefore quickly developed an

[68] I am not distinguishing the reason for why the pregnancy occurred. It can be related to both rape and premarital sex. The point, is that the pregnancy is unwanted.

interest to this "hidden" or "silenced" dimension of maternal health in my fieldwork. [69]This issue will continue to be addressed as "unwanted pregnancies", but it focuses mainly on pre-martial pregnancies.

The presentation of this data will be brief, but is highly relevant for my study and research-aim and will be given more priority in the analysis.

MCHC stated that this was not as common as in previous years but my findings prove that this is still a practice that affects PW's health. The midwife in Bonawo explicitly stated that this is a present-day social problem:

> There's also unwanted pregnancies, so every institutions or governmental policies should stand together on solving the unwanted pregnancies, since there are allot of problems related with unwanted pregnancies. If a woman is pregnant, she is a mother whatever the case is. And the government has to support the mothers with the unwanted pregnancies, since its a social problem. The institutions have to give them education and to have a support for these ladies, since its a big problem nowadays. (Midwife Bondawo)

In CSA (2016) its mentioned that 17% of registered pregnancies the past five years were mistimed and that 8% were unwanted. These numbers are mainly related to "open" pregnancies and married women, which might make these numbers misleading. My findings prove that the majority of these unwanted pregnancies were hidden and neglected, and therefore unregistered.

The reasons for this, is that these pregnancies are illegitimate and not accepted in the community is related to that sexual activity before marriage is a sin and shameful according to the local culture and interpretation of religion. The women who get pregnant before marriage are judged, shamed, ignored, unaccepted, neglected, complained on by friends, family and society and is further not attractive as a future wife. Accordingly, the women who is impregnated is hiding the pregnancy to avoid the shaming.

Another, fundamental dimension related to unwanted pregnancies is the question of abortion. This races many ethical dilemmas and is strongly related to religion. I will not address this thoroughly, but its necessary to acknowledge that dimensions concerning

[69] I learned that there's also a dimension concerning unwanted pregnancies within marriage, but this will be left out of this analysis since these are to some extent still legitimate because they are within marriage. Which makes it easier for the to seek care.

abortion is also fundamental for PW's health. The paradox putting women in a fragile situation regarding abortion and unwanted pregnancies concerns that neither parts are socially acceptable. In relation to unwanted pregnancies, women seek out to traditional methods of termination, neglect the pregnancy and try to terminate the pregnancy themselves, which may create difficult complications

I was provided many examples from midwifes, nurses and doctors when I started to openly ask questions about this issue. One summarizing answer was given by the gynaecologist at Aira Hospital:

> We have unwanted pregnancies in the hospital and we are treating equally as other PW. Culturally and cognitively, the female should have a baby after marriage. The family will otherwise ignore her and the baby. They can even abandon they neonate and also the mother. Because they stay at home, they will not have ANC – follow up. They will not have attention from the family. So even when they came to the hospital, nobody will support them because her family does not want to have that baby. Therefore, they have major complications. We have many cases such things. By court, the neonate who is born has the right to grow and live as other people, or another neonate. But culturally the family will ignore it, even they want to kill it. They will go this far. The other option is that they will throw the baby to some place and they will say its not mine. Or throw it to the hospital, besides the hospital and the government should take it. This is a huge problem during unwanted pregnancies. The other is that the lady want to drink some chemicals to kill the baby inside. It has big complication, big affect of the survival of the mother. Also, most of the time, the father is unknown and they will ignore it. (Gynaecologist)

One kind of cultural explanation of this issue was given to me by a retired history teacher:

> The culture itself it hinders problems of women in so many different ways, specially concerning the health. Our culture doesn't see women as equal, but somebody lower in the status. 20-30 years ago, they were considered as properties. The man pays daury to marry her. After that he always say that I paid much and now you are mine. That problems made the role of women not equal. Even if she is educated, she will accept the tradition. But nowadays, it looks like a "social revolution" because we are mixing up with globalization, modernization and evangelism, and church roles. And within that you can see so many difficult things. For example, the number of women is higher than the number of male. And at this moment, there's a competition – not to be without a boyfriend or a husband for the future. So specially girls from grade 12 and above, 20-25- If a boy asks them, they can go with him to any place. Without knowing what the consequences are. Without out knowing that pregnancy is coming. Without knowing proper care for what problem is coming. (Retired teacher)

5.5 Summary of data on socio-cultural findings and maternal health

In the Oromo-culture, symbolically a PW is carrying the future, and can be carrying something valuable. This has always been the mindset for Oromos, and still is. A PW is respected in the community. However, years back, women had to grind corn themselves, prepare food and fetch water and firewood. Today, husbands and family help and encourages the pregnant lady more than before. Increasingly, PW come to the health facilities for medical check-ups, support and advice. All PW have the right to receive medical attention and the right to decide where to give birth. Nevertheless, as both the statistics and the interview-subjects has expressed, home deliveries are still the most common place to deliver and also the most common cause of complications. The social-cultural reasons are related to gender-dynamics, power, faith and awareness/education.[70] Ethiopia, and accordingly Aira, is a patriarchal society which means that the men/husbands have the authority and provides/not providing permission to the women/wives regarding both productive and reproductive aspects of life. The husbands mother is also very important and has certain responsibilities that affect the decisions in the household. Decisions are made on the basis of knowledge or experiences, which is gained through different kinds of education and culture. In relation to education on maternal health it's been indicated to me that an open discussion in the family and community on reproductive health is very strained and taboo. Its taboo talk about sex and the outcomes of it, both in the privacy of a family and in the public school. Technical aspects of reproductive health are taught and women are aware of the menstrual cycle. However, advice to the PW is given privatly and the pregnancy might not even be announced because of the shame of admitting intercourse.

Both expected and unexpected findings related to my research question are registered. What I expected and found was that many women didn't have the authority to make their decisions by themselves regarding their health, but had to ask the husband for permission, and that it was the husband and the mother-in-law who decided over the PW. One important finding per today is related how uncertain statistics over PW and childbirth are. This is a big finding because the PW that are registered are decidedly mostly women close to

[70] The technical reason for compromising the possibilities and rights of women is related to infrastructure and economy.

health facilities, and in addition with *wanted* pregnancies and. When I write wanted pregnancies, this is generally pregnancy within marriage. The challenges for these women are mainly related to the workload during and after pregnancy. However, the prime discovery from my data is related to *unwanted and/or hidden* pregnancies. Broadly speaking, this means women who get pregnant before marriage. When pregnancies are hidden, they are thereby not registered and included in the statistics.

It turns out that the health consequences for women with unwanted pregnancies are the biggest because the women don't receive the maternal care they should have and have the right on because of social and cultural factors. One reason for this is that many of these pregnancies are hidden because of the big shame connected to being pregnant before marriage. Women neglect and try to hide their pregnancy and disappear to give birth. Sometimes the family even kicks the women out of the household because of becoming pregnant before marriage. This turns out to be a practise still today, even though health facilities and services have blossomed the past years in the region.
The government has implemented a system of health extension workers who are supposed to educate, prevent and give easy care to PW in each suburb, but this hasn't functioned as well as intended. So, even though Aira Woreda is better off regarding antenatal and maternal health care than many other parts of Ethiopia, there are still harmful practices that exists today due to the power of traditional mindsets.[71]

Furthermore, what also really struck me in relation to this was that both unwanted pregnancies and abortions were socially unacceptable and the family and community shamed women who experienced either circumstance. The men seemed to have no responsibility whatsoever if a woman became pregnant outside marriage, but they had the moral free ground to shame her. This creates a very difficult and fragile situation for the women in general, but especially for women who become pregnant before marriage. Being pregnant before marriage and/or doing abortions are not socially acceptable mainly due to their religious beliefs and how religious practices are practiced the cultural context.

[71] Aira is much better off than neighbouring regions because of a long tradition of missionaries and foreigners contributing to health education and promotion. Also, the health extension workers are nowadays present in all suburbs.

6 Analysis – Reflections and comments on how ideas' feeling' and values may impact pregnant women health in Aira Woreda

The thesis has now arrived to the point where the methods, theories and data of my study is going to be mixed to attempt providing and answer to my research question: *How socio-cultural environments affects pregnant women's decisions and correspondingly their health, even though there are medical health facilities within reach?* Information from all the previous chapters will be considered, but especially information from chapter 4 and 5 are the fundament for the analysis. The analysis will not be presented in categories, as in the chapter 5, since I consider that the categories *together* constitute the socio-cultural everyday life. I am rather integrating my data into my theoretical framework, taking my starting point in the three dimensions of worldviews; cognitive, affective and evaluative. These will serve as overreaching categories for the analysis, with an attempt to differentiate between their influence on PW's health. However, with awareness of and respect for that these are mutually dependent and influencing each other at all times. Within the dimensions, selected notions from the eight key concepts of globalization are presented.[72]

Figure 7 – Analysis Skeleton, shows very simplified skeleton of the structure of my analysis in this chapter. The grey-dotted arrows indicate there's an interplay between the features but that it will not be explicitly analysed, explained or emphasized in this analysis or thesis. There are more interplays that are not explicitly highlighted in the illustration, e.g: the direct interplay between the cognitive dimension and the evaluative dimension.

[72] Explanations of the key concepts of globalization are presented in the chapter 4 – Theoretical approaches, page 45-46.

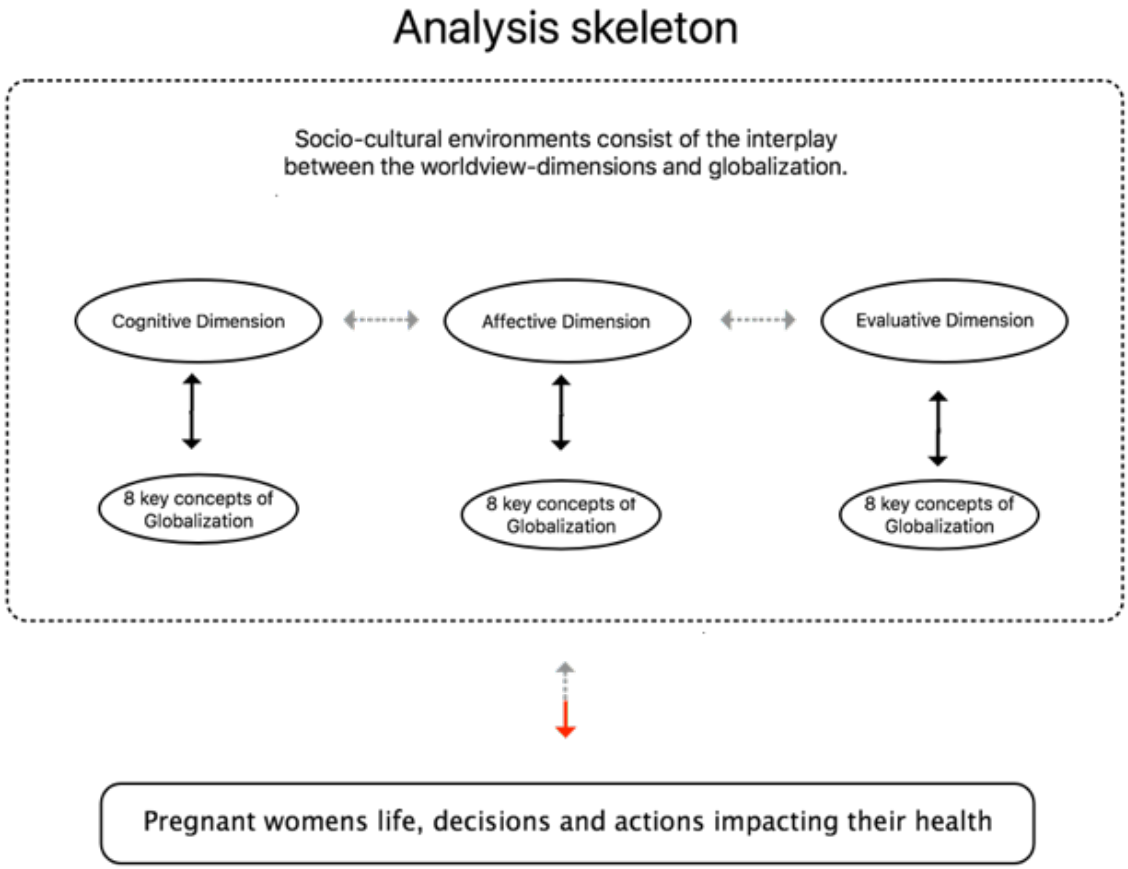

Figure 7 – Analysis skeleton.
The figure shows three analytical categories used in this analysis chapter

To present my findings analytically and on a more general level so that the reader can see the different stages my analysis take in, I am attempting to provide the reader with three analytical categories that underline how socio-cultural environments affects PW's health; 1) the pregnant woman's situation, 2) worldview and 3) globalization and modernization. At the end of each section I will clarify and summarize each analytical category with the help of a simple formula. This formula helped me to systematically process my findings into more general categories and explanations:

$$F = WV + G/M$$

Explanations of the formula:

F = Pregnant women's situation and/or actions
WV = Forces of the Worldview
G/M = Globalization and Modernization forces
Outcome = Exemplification of how socio-cultural environments affects PW's health

My aim is to analyse and exemplify what social and cultural factors have affect on the PWs situation with this three-peace-model. First "F" presents the pregnant women's situation and actions. Secondly, "WV" tries to present the forces from the relations, community and cultural sphere affecting her situation. Thirdly, "G/M" includes the impacts from aspects of globalization and modernization at the grassroot level.

To five an example: F (The PW choose not to go to the hospital) = (WV = PW prioritize to go to the TBA because of trust and tradition) + (G/M = The hospitals wants more money). The outcome highlights how socio-cultural influences such as established practices at TBAs are preferred due to trust and tradition, and expensive services at medical health facilities.[73]

Before proceeding, I want to highlight that the selected analytical presentations have been analysed from multiple perspectives. Nonetheless, due to practical restrictions of this thesis I am forced to limit myself to a few analytical presentations. I have therefore chosen to highlight a few different cases from one perspective each to show a variety of the situations where socio-cultural impacts are present.

I will use selected extracts from my data combined with relevant litterateur during the analysis. Due to the content of my data the overreaching issues discussed are gender roles, education, work, religion and social relations. The dimension of unwanted pregnancies has grown to be an interesting finding to consider throughout the analysis and is therefore often given priority in most of this analysis.

[73] This is a fictive example.

6.1 Cognitive Dimension – Gender roles and priorities

The cognitive dimension emphasizes the ideas, mental constructions and categories, knowledge, assumptions of reality and logics a given group shares and systematizes the premises about the world and our position in it. Geertz (1973) in Hiebert (2008) points out that worldviews are both models of reality and models for action.

One penetrating aspect of society in general, and very explicitly in my study, is the impact of gender roles. I consider gender as central in the cognitive dimension because it illustrates the implicit mental constructions, assumptions and logics of responsibilities, possibilities and chores in the everyday life of men and women in Aira Woreda.[74] This is supported by Tuyizere (2007) who writes that: "Gender myths are socially and culturally constructed beliefs or ideas about men and women, which explain the origin, personalities and mental capabilities of men and women, and which control sexuality, access to food, roles and responsibilities" (4).

Related to gender, I investigate aspects of education and work and how this might affect PW's life. The choice of these two aspects is based on my understanding that education and work is done formally, informally, openly, hiddenly, consciously, unconsciously, publicly, privately, traditionally (respected elders) and in a more modern way (schools).[75] Additionally, it may highlight the content in the knowledge-transfer and narratives in a society, and how the transfer is made.

6.1.1 Informa Education

How education is related to and affects MH can be viewed from two educational perspectives. The first is the informal education given by the family and community which is closely related to the primary and secondary socialization processes in society (Schiefloe, 2011).[76]

[74] There's difference between gender and sex. Gender refers to the socially constructed implications of what *masculinity and femininity* is and should be. Sex refers to the biological autonomy and hormonal profiles a man or a woman is born with, referring to *female and male*.
[75] The further sections, presenting the affective and evaluative dimensions, will naturally consider this also.
[76] Shortly about socialization processes (Schiefloe, 2011): Primary socialization referees to the influence children and youth get from their immediate environment, such as parents and family. Here basic values and norms are being thought. Secondary socialization referrers to how school, job, organizations, friends, everyday

The second considers the formal education, given by schools and modern health facilities and personnel.

Let me start with the informal education, or the socialization process'. Starting from when a woman is pregnant, everybody hopes that the firstborn is a boy because he can provide for the family in the future. A girl will be married away and will therefore contribute to her in-laws. I was told that the day of delivery is therefore a big day, and the accompanying relatives announce the gender of the new-born with a longer celebration "sound" if it's a male, and a shorter if it's a female.[77] This indicates that already from birth, the male is the superior gender in society and that Aira Woreda is a patriarchal society.

Correspondingly, a main finding of mine is that the men take the decisions on what, when, where and how things take place in the family. Kiar (2007) confirms my findings that the father is the main source of information in the household, while the mother is the main source of homemaking matters, such as cooking, childcare etc. Since 95% of my interview-subjects were farmers, this was a reality for the PW I talked to. The general conception of women in Ethiopia is still that" women have a secondary status in the family and the society" and get no explicit credit for their contribution (Pusewang 1990, 58). Milkias (2011) writes that "Ethiopian tradition expects a woman to be totally submissive" (223) and that women's "worth is measured not in terms of their humanity but rather in terms of their roles as mothers and wives" (222). Further, this affects women's independence since the tradition that men have the last word in all decisions (ibid.), and dominates the women is still prominent (Milkias, 2011). However, it's important to acknowledged that these habits are slowly changing when women get their own income by work outside their homes, which is a tendency that was noticed in my fieldwork.

Continuing on the educational perspective and relating it to MH, one can ask how a dialogue concerning pregnancy, family planning or SRH is viewed and/or initiated by the source of information in the house, the husband. Information about the menstrual cycle is given from mothers to daughters when they are becoming sexually mature, but more information or dialog around its shameful because there's a fear that it will generate unwanted sexual behaviour amongst adolescents. The answer I got regarding this was:

surroundings etc. teach us how to behave. This is refining and supplementing the primary socialization. There's also tertiary socialization which highlights how e.g. media and politics shapes our behaviour.

[77] This celebration sound is a traditional sound women do when celebrating, and can be written as "ililili".

> The culture says its taboo and a shame when a family talks about this idea to their children. If someone talks about this in the family they will think that the child will be led in the wrong direction about this. They think that their child will go t to places that are not good, practicing sexual activities etc… It is more important to teach the girls how to be good girls and take care of the house and family (IS-7)

This extract shows information that pregnancy or responsibilities related to SRH are taboo to talk about and are hidden behind the chores and everyday responsibilities. Building on this informal aspect of education and linking it to MH is interesting association. Namely, because of how the informal education of gender roles and responsibilities might make women chose to trust these cultural priorities more than what the health facilities teach them about their own body and well-being, and because of that not always act upon the HEW advices.[78] One HEW stated:

> They don't listen to what we say 100%. For example, when you teach the pregnant ladies not to deliver in the home and what the consequences are like, on both mother and child, they listen but they don't put into action because they really don't give it priority. They care mostly about their houses, caring for the kids, preparing food, raising the kids … since they are busy doing this they don't it 100%. (HEW)

The HEW represents G/M and in many ways standardization and acceleration when considering the vaccinations, information and medicines and the direct reference system to HC and Hospitals. They basically function as peripheral posts connected to metropole hospitals. The use and acknowledgment of these new standards of health are not implemented at the grassroots of society yet. I consider this being related to priorities concerning cultural beliefs embracing gendered responsibilities and emphasising the husbands' decisions and information as more valuable.[79]

Summary of this analysis[80]:

F(Staying home instead of going to health facilities for delivery and follow-up) = (WV= Women's priorities based on respect of men's authority) + (G/M = HEW)

[78] HEW = Health extension worker.
[79] This priority issue will be looked upon from the work perspective also.
[80] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

The outcome of how socio-cultural environments impacts PWs health is due to informal learning women learn to be caregivers for house, husband and family women oversee and/or don't get the possibility to understand how to acknowledge their health when pregnant.

6.1.2 Formal Education

Informal education is laying the fundament for how formal aspects of life are organized, which naturally includes the formal education both at school and, in this case, health facilities. Naturally, I primary focus on health education in relation to MH. As mentioned above, sex education is not a favoured topic in society in general, and correspondingly not favoured by the teachers at school or health workers as well as the general public who receive the information.

> The teachers are ashamed when they teach it. They only talk about the technical things about menstrual cycle, and female and male genitalia. (Informal conversation)

This shows that the gender roles of society affect how teachers and the educational system include different aspects of girls/women and boys/men and the relationship between them. The adolescents will not be prepared for what is coming in the future marriage and have the first deeper understanding of pregnancy after marriage.

> …nobody tells the youngsters about sex and the role of the husband and the wife. Most about marriage they have to "find out" on the way… But sometimes they teach about this in the church before the wedding (6 month). (IS-7)

Even the Woreda Health Office stated that knowledge about pregnancy is not a part of the official health education.

> We are not considering the pregnancy as part of health education. Education about pregnancy is considered only for those who are married because to be pregnant before married is shame. And the other thing is that most of the people of ours are church members. In the church they are preaching no sex before marriage. Otherwise nobody teaches about pregnancy for the unmarried lady. Its not good because culturally its not acceptable. In the congregation its not acceptable. For the lady to tell her these things, its shame. They are not listening. Unexpected pregnancies happen but that is because we are not teaching details, like what signs are seen on PW. We teach only for those who are married. If they are not married, its shame to tell them the signs of pregnancy. And even, they don't want to listen! (Health office)

Relating this to MH, I noticed awareness about implications before, during and after pregnancy is neglected. This neglect is maintained by cultural continuity that supports a "shame-frame" regarding SRH, which naturally is the starting point of maternal health. The forces of the church are also central here. In a positive way by preparing couples before marriage but simultaneously neglecting sexuality and its role in women's and men's life, also before marriage.

Considering these statements, I additionally find a strong association with MH of the women with unwanted pregnancies. The constrained relationship of teaching about SRH and MH might be an important reason for why many women hide and deny their pregnancies. Perhaps because they aren't aware of the indicators for pregnancy, neither of the physical dangerous related to neglecting it, or their strong association to church and faith, which makes the PW neglect the pregnancy due to religious implications.

This highlights the most common dynamic of G/M and WV: Namely, how something like education, that represents standardization in the sense of trying to provide and achieve a minimal standard of knowledge to be equal and competitive to the rest of the nation and world together with church and faith that intertwine the locals with Christianity in general (globally), is simultaneously holding on to the traditional preferences regarding reproductive understanding. This may illustrate the concept of a negative re-connecting and how the educational system might be reproducing unfavourable health situations for PW by teaching them that an open conversation about pregnancy is neither desired or appreciated.

Summary of this analysis[81]:

[81] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

F(Neglecting pregnancy and not talking out it due to embarrassment/shame) = (WV = Taboo to talk, accordingly teach/learn about SRH and pregnancies) + (G/M = Health education)

The outcome of how socio-cultural environments impacts PWs health in this case regards the collective and official consensus that pregnancy and everything connected to is a private matter, only to be encountered within marriage.

6.1.3 Work

Even though I was mainly talking with famers it was clear that these ladies were hard-working women that still had a central role as farmers, market goers and housemakers while pregnant. With eight out of 15 women who completed 9th grade, my findings show that women are slowly moving towards the productive sphere of society. However, the reproductive sphere is still dominated by women which creates a big burden for women's mental, physical and health, especially during pregnancy.[82]

As shortly mentioned above (under the section about informal education), women in Aira Woreda has got new possibilities in the productive sphere which can make them accumulate money.[83] These possibilities were given through education and microfinance projects. The outcome is that men are not any longer the only one contributing to the economy in the household.

The intentions are and will be to empower women but it's important to see the paradox here. I observed this during my fieldwork, and reflect upon this before, during and after my fieldwork and my analysis was supported by scholars who highlighted the same issue. Namely, this combination of productive and reproductive activities creates massive work pressure on female (mainly farmers), making them "probably the busiest people in the world" (FAO 1993:37 in Momsen 2010, 161), without the closest community explicitly acknowledging it. Women's time is therefore almost invaluable which forces them to prioritize labour, both in the productive and reproductive sphere, neglecting their own health. Women are not only poor on money, but now also even more poor on time. (Austveg, 2006), because they have to many duties to fulfil.

[82] Productive work is the most visible and accumulates income. When it comes to the reproductive work the general conception is that reproductive work is only about having children. *But* it is also about reproducing the everyday life (Eriksen, 2013).
[83] The analysis also draws from the quotation from HEW on page 79.

This illustrates how the key concept blending may look at the micro level of society. It shows a blend at a cultural level between men's and women's tasks in society due to G/M. Also, vulnerability due to rigid cognitive beliefs that support that women are still responsible for the majority of household-chores are clearly illustrated by this situation for women. This can, in turn, create great vulnerability for PW's health when prioritizing work chores. The PW in Aira seem not view or prioritize pregnancy or birth as high as labour responsibilities. Their main problem lies in the uncertainty and financial vulnerability that comes with losing valuable working hours in the field if they have to visit health facilities. This is further also an example of how modernization processes that have had good intentions have created even more vulnerable situations for women due to little consideration of cognitive ideas of responsibilities in a society that hasn't evolved at the same pace as the technical dimensions. However, this has a positive effect on MH also, which is stressed by Woldemicael and Tenkoran (2009). They present how the women make decisions because of more autonomy and money to pay for health services.

Summary of this Analysis[84]:

F (prioritizing work chores in front of health) = (WV = assumptions about social responsibilities) + (G/M = productive work possibilities outside home sphere)

The outcome of how socio-cultural environments impacts PWs health related to work is that women prioritize financial gains in front of health. This is both due to new possibilities generated by G/M and due to an attempt to uphold congenital demands and expectations as a woman by ascribed work responsibilities in the cultural context.

6.2 Affective Dimension – Feeling or fleeing support

The affective dimension relates to how worldviews contributes to designing all kinds of feelings and taste. This includes the expression and attitudes towards everything from taste in

[84] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

food to feelings as sorrow, worship and relationship goals. It provides survival possibilities, strength and emotional security in crisis.

Hiebert (2008) explicitly states that "Most people make religious decisions on the basis of emotions as much as on the basis of rational argument" (60). I have therefore chosen to mainly look at how faith and religion plays a part in PW's life, although issues concerning religious teachings and alike are not emphasised here. Further I will discuss the pregnant ladies' relationships with the surrounding world and how this might affect women's well-being.

6.2.1 Religion

Religion and culture are two sides of one coin, especially in African societies (Bompani, 2015), and religious teachings are providing guidance, support and encouragement during challenges of life (Bradley, 2011). Phiri and Nadar (2006) underline that "religion influences women's thoughts, emotions, personalities and social relationships as they seek communion with God" (9).

I have witnessed and heard how prominent this is in the life of PW in Aira, as well as for people in Aira in general. It became very clear to me that it was through their faith PW got the support they might have been missing from their closest relationships, the community or elsewhere. There was a well-defined consensus amongst PW I interviewed that they used their faith and prayer actively for motivation, support and overcoming challenges during their pregnancy. Besides food, money and cloths praying made them feel safe and listened to. Both by praying themselves and when friends, family, congregation and religious leaders prayed for them. This shows that its natural for PW to make a religions decision based on her emotions when she is feeling worried and unsafe.

The congregations and religious leaders also provided the women with advice to go to the health centre for ANC. This was however not a well-established praxis amongst the women. The interesting controversy here is one regarding childbirth. Many women put their faith in that the delivery would be complication-free and not prioritize going to the hospital. To some extent one can say that they found more support in their faith and God in the health facilities.

Additionally, I want to stress that the questions that I had, which had completely different thematic interests, received answers with religious dimensions to them. This

accordingly highlight how essential and fundamental faith is for PW in all aspects of life. For example (I = Interviewer, IS = Interview-subject):

I: What was your reaction when you found out that you were pregnant?
IS: I feel happiness because it's a gift of God. (IS-B3)

I: Is something more important to you now when you are pregnant?
IS: Prayer. I ask people to pray for me. (IS-B4)

I: Where do you plan to give birth?
IS: I delivered at home before…. I believe that God will help me to deliver safely. (IS-L1)

At the same time women with unintended pregnancies were discouraged and ashamed because of their personal religious beliefs. They were ashamed before God and the people around them. Since I never had the chance to talk with a woman carrying/carried an unwanted pregnancy I was solely told about their situations and thoughts form a second part, such as resource people or women carrying "wanted" pregnancies. However, it was a consistent tone that these women didn't get the attention they needed spiritually, medically or socially because of the sanctions, shame and isolation accompanying unwanted pregnancies. These women don't feel they have the right to attend church, to be prayed for or to be under God. [85]

They will hide they pregnancy and themselves from everybody because they think they are sinners. Because in our religion it is a bad sin to be pregnant before marriage. (Informal conversation)

However, one pregnant lady had this comment about women with unintended pregnancies:

[85] This topic is further addressed in the next section.

> God listens and knows everything. He will help the ladies in difficult situations…. even if they did wrong. (IS-B5)

This shows that religion both creates feeling of belonging and support, and vulnerability and the feeling of being outcasted. Religion has therefore both positive and negative effects on PW's health that are crucial to understand.

Relating religion to G/M, the concept of mobility and blending can be stressed here. This highlights an interesting analytical observation which concerns a key controversy of religion and development. Namely that religion has been one of the earliest indicators of globalization and can be understood as slow globalization (Drønen, 2013), spreading ideas and contribute with development, both spiritually and technically, over a very long period of time. Especially to Aira have missionaries come with biblical teachings that has been emphasizing women's health and worked with women empowerment projects. Women get to be themselves and find support because of this, but simultaneously they put all faith for their future health outcomes into religion and prayer. Also, if the pregnancy is unwanted, the religious community is contradicting its purpose and affect since these women become officially ignored by the religious society.

Religion has a big influence on how PW make their decisions and, most importantly why. Therefore, it's so crucial to understand how closely intertwined religion and culture is and that the impacts of these together cannot be separated from MH or SRH. They affect how the PW's feelings of being valuable.

Summary of this analysis[86]:

F (Feeling/not feeling of support and belonging) = (WV = finding support and putting faith of health into God) + (G/M =Congregations and biblical teachings)

The outcome of how socio-cultural environments impacts PWs health related to affiliation and religion concerns how fundamental faith is for both the induvial PW, and that religious institutions creates collective consensus for guidelines accepted practices related to pregnancy with inputs from Christian traditions and missionaries.

[86] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

6.2.2 Social Relations

Bunton and McDonald (2002) highlight socio-psychological theories and communication theories as important for understanding people's health habits and potentially improving them. In this section, I want to look at how PW life is about the concrete relationships and how these might be supportive/non-supportive environments. The G/M perspective is modified in this section due to the emphasis on local the interaction between the PW and her surroundings.

The PW I interviewed mainly got advice and support from their mother-in-law's, husbands, relatives and neighbours. One stated she got advice from a traditional birth attendant and two considered the HEW as important advisors regarding their pregnancy.

Largely, again, the husband was the head of the house and made the decisions regarding most of the issues. But the women also underlined that the husbands were supportive and helping around the house. A few women even said that they discussed together with the husband and made the decisions together. The majority of women stated that the men took the decision on where the women would give birth and it seemed as the men prioritized the health facilities in this aspect. This presents a relatively supportive system for the PW as they manage to communicate with the closest family and get certain support, where she can feel acknowledged. However, there was consent that the general support given to PW was still limited. Some extracts exemplifying this is presented below:

> Women are respected. But community thinks pregnancy is easy. Nobody talks with the PW or give her emotional or mental attention (IS – B7)
>
> Women are afraid of talking about being pregnant in the community (IS-H1)
>
> People are only talking indirectly about pregnancy (IS-H2)
>
> Community does not do anything during the pregnancy. But afterwards – There are celebrations (IS-H2)
>
> The way the community sees us is different. They have the respect for us. Positive attitude for women. Boys does not teas the PW or call after her (IS-H1)

These extracts also confirm that women are respected in the society when being pregnant, but simultaneously that the discourse around pregnancy and SRH is still slightly "hushed-up". This is in the sense of not being taught or talked about without an accompanying sensation of shame or taboo. I consider this an outcome of the socialisation that supports the "shame-

frame" around SRH and MH.[87] However, the response given to me after doing me focus-group interview with four pregnant ladies was that they usually don't talk to other PW or anybody else about the issues that were brought up during the interview. Neither did they have any similar gatherings before. They found this very good and encouraging because they didn't have any other place to ventilate these concerns of being pregnant.

In addition, it was expressed that there's an expectation that the women still have a social responsibility over the husband. With social responsibility I mean that she is responsible for taking care of and respecting the husband and his family even though her health might be at cost of it.

> The husbands help the women, but she is still responsible for making most of the food, taking care of the house, him and children. She cannot stop being a wife and a mother when she is pregnant. Especially the mother-in-law pushes her and say they shouldn't complain, but also supports her. (Informal conversation)

The women therefore get a double burden when being pregnant, namely being the carriers of the family both mentally and physically. One very important aspect, again, is how these PW were all wanted and openly pregnant. And even when they were that and got certain support and respect from their surroundings, they had challenges related to their health generated by expectations from their environment to uphold certain responsibilities.

A consideration I drew from this emphasizes how PW who hide their pregnancy do not get the opportunity to get this social support as pregnant from the local environment. My reflection is that these women has to hide their difficulties from the public world and does not get the support they need. This naturally affects their physical health since they probably won't attend ANC during the pregnancy or seek professional help during delivery. The mental health is most likely also provoked due to the cultural sanctions, hiding and isolation, which finds support in Austveg (2006) statement that "mental problems should be viewed in closer collaboration with sexual health" (59).

I find it important to highlight another thing related to unwanted pregnancies, namely how the responsibility of the men is not taken seriously and that the women actually choose to protect the men because of the troubles the men would get if they made a woman pregnant before marriage. Besides that, this was a very difficult process because the men

[87] Socialisation processes was further elaborated under the section on the cognitive dimension, page 77.

could deny that the child belong to him. Laws and regulations make it difficult for women to put the men in trial because they are afraid of men. This puts the PW in a dilemma because of the relationship she has with the man whom made her pregnant can further sabotage her social status and life. PW are therefore taking the decision not to receive the support they actually have right to get due to the underlying contradicting local social responsibilities and patterns. In a way, women with unwanted pregnancies don't get the possibility of feeling supported because they choose to flee it due to fear of further social sanctions.

Summary of this analysis[88]:

F(Passivity and self-suppression when getting pregnant unwillingly) = (WV = Responsibilities of social relationships) + (G/M = Laws and regulations)

The outcome of how socio-cultural environments impacts PWs health, specifically regarding women carrying unwanted pregnancies, is an avoidance of support and neglect of a potential crucial health consequences, which is a result of the fear of not respecting the man and generating processes that will become unnecessary and more energy-consuming for the woman.

6.3 Evaluative Dimension – Are there illegal pregnancies?

The evaluative dimension, also called the moral and/or normative dimension focuses on social and moral order. What is right or wrong and true or false, and how things are justified is found in the evaluative dimension. It legitimizes and validates values and norms, and therefore guides behaviour and how to handle what is righteousness and injustice.

I want to fully dedicate this dimension to my unexpected, but to my opinion most important, finding – unwanted pregnancies. It will include both cognitive aspects such as education and affective aspects such as religious affiliation, since both these dimensions lay the fundament and/or facilitate values and norms regarding women and pregnancy.

[88] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

As I have learned from my fieldwork, PW are generally accepted and respected in Oromo culture. However, this only applies for women who are married. Women who get pregnant before marriage are defined as carrying unwanted pregnancies, illegitimate pregnancies (Hendrix, 1996), and as I was told in the field, illegal pregnancies.[89] I will in this analysis prioritize the more illegitimate dimension of unwanted pregnancies, the ones outside marriage.

6.3.1 Education

As mentioned previously, girls and boys are from early age socialized differently into a gendered doxa, where women are inferior to men and can't contradict or disagree with a man. This quickly becomes girls' habitus (Bradley, 2011) and affects how girls view themselves, both as individuals and as girls/women in general, and in relation to boys/men. Alemayehu (2007) underlines that different criteria are ascribed to boys and girl's expectations and tolerance of behaviour. Boys are from an early age more tolerated when they "tell lies, break things and refuse stuff" (ibid., 108). If girls attempt to make justice or tries to speak up, they are not taken seriously or get threatened.

This seem to create an underlying logic that girls are more valued if they respect and obey boys and men, which is something girls strive for also when being adults. This was furthermore confirmed during one informal conversation:

> Women are afraid of the man regarding many things. Sex, the money…. Everything. They can't say no… (informal conversations with a nurse) .

This shows that girls are having troubles expressing themselves amongst men from a young age. Relating how this socialization process at school affects MH, one outcome is that women's SRH are not respected by men and further overlooked by women themselves. The possibility to say "no" or speak out about difficult situations regarding SRH is constrained from early childhood, and they are "trained to keep up their families' honour at the cost of their own physical and psychological well-being (Milkias 2011, 225).

[89] This book might be printed a couple years ago, however it touches my topic and encountered problems in my findings quite specifically when related to how culture and social environments affect the health of .

In addition, as the public discourse of this topic is put in a "shame-frame" it even further hinders pregnant ladies to express themselves if they have been mistreated. The outcome is that they are ashamed and hide or deny their pregnancies. Since there aren't, to my knowledge, any established "*safe*-frames" for safe and secure ways to express issues concerning MH, perhaps women who get pregnant unwillingly don't know how to talk about it.

One of my other analytical observations shows how this actually highlights the most common dynamic or G/M and WV. Namely how something like education, that represents standardization in the sense of trying to provide and achieve a minimal standard of knowledge to be equal and competitive to the rest of the nation and world, is simultaneously holding on to the patriarchal preferences in most aspects of society. This may illustrate the concept of reconnecting and how the educational system might be reproducing women's undermined position in society from before.

Also, this highlights how universal human rights are not implemented at the grassrootlevel of society due to local moral orders. For instance, the universal human rights that every woman should be treated equally when she is pregnant is principally implemented at the health facilities. However, in the local context of Aira Woreda, where other kind of rights are in praxis for women, it affects the way they get these universal human rights.

Summary of this analysis[90]:

F(Not taken seriously or listened to when speaking up) = (WV= Treatment and teaching of girls and boys differently due to gender) + (G/M=Education)

6.3.2 Religion

As a fundamental institution in Aira, Christianity sets a moral code by which to live, which in turn "affects decision making processes and human actions" (Bradley, 2011, 2). Incredibly many values linked to SRH builds on religion and society's religious anchoring (Arousell and Carlbom, 2016). Moral order, accepted behaviour is taught by church, preaching's and other religious gatherings. One major theme is that sexual activities are only behold for marriage.

[90] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

> In the church they are preaching no sex before marriage. This is adultery. We teach only for those who are married. if they are not married, its shame to tell them the signs of pregnancy. And even, they don't want to listen. That is why its not good to say for the lady who is pregnant to tell to somebody else…. Sometimes the mother [of the pregnant lady] care for the pregnant lady but they hide it form the father in the house. Maybe they send her to a relative until delivery. Or if possible, they will get rid of that pregnancy by an abortion or something else. They are trying this thing, and if she get rid of the pregnancy either by delivery or abortion she comes back to the family. (MCHC)

This quote has many dimensions to it but relating it to socio-cultural issues it confirms that the honour of the family and the fathers (and men's) aim to control is related to their daughter's virginity (Tuyizere, 2007), and that religion has a central role for societal structures which influences values and norms (Bompani, 2015). Religious leaders are giving a kind of very respected informal education (Chuta, 2007), that is further spread through prayer groups or religious meetings. In Aira, they had "religious programs" twice a week. This was something voluntarily where location, preacher and topic rotated from house to house each week aiming at religious and moral teaching. This shows its incredibly important to understand the relationship between religion and fellowship. Continuously, the influence of religion on what is shameful/illegitimate and how this really affects PW's view of themselves and correspondingly their health by understanding women's participation and decision-making about their health based on a religious affiliation perspective (Beacher, 1991). [91]

Building further on the reflection of G/M presented in the section about religion under the section of the affective dimension, I choose to highlight how G/M are both promoting and holding back health seeking behaviour in PW's life's in Aira by the influence of religious leaders and influential religious people in the community and missionaries.[92] In Aira, missionaries working in various health facilities have been present up to 100 years. From a G/M perspective, this has made PW's life safer because they have more possibilities to receive health care, as well as education and MH has always been a core issue but with different values in the base. One nurse stated:

[91] Even though this book (Beacher, 1991) is highlighting issues from the 1980ies, its actually still highly relevant today. In some aspects even more relevant due to the re-connetion to religion and strong identification with religious denominations.
[92] Se page…

> There was this great nurse [missionary], she helped everybody and worked day and night. But she refused to help any kind of abort-cases because of religious reasons. (Nurse at clinic)

This further shows that respected and well established religious people project their values in a way that might affect PW's health or decision to seek medical advice. And further implies how religion has a big influence on how PW make their decisions and, most importantly why.

Summary of this analysis[93]:

F (The PW situation and actions build on how religion forms foundations for social relationships) = (WV = Influences from missionaries) + (G/M = influences from missionaries)

The outcome of how socio-cultural environments impacts women's health is highlighted as an interesting paradox in this formula. The informal education is fundamental for the facilitating worldviews, and is actually generated from G/M affects. Namely that missionaries have been there. This is a good example of how impacts from G/M can change the latent worldview.

This can also be a typical example of "glocalization" of religion (Robertson 1995 in Drønen 2013). When something is glocal it basically means that a global and/or superior system has developed to suit the local circumstances with a local distinctive character and expression.

6.3.3 For clarification – Example of moral impacts on the health of pregnant women

Because of both informal and formal teaching, it is not morally or socially acceptable with pre-marital pregnancies, there off the unwanted or illegitimate pregnancies. Women are sanctioned with the whole responsibility of the pregnancy and are placed on a moral underground. As a consequence, women deny their pregnancies towards themselves and others, including health facilities. For instance, they neglect their pregnancy and instead insist that they have stomach aces, at the health facilities. As noted before, some of the unintended pregnancies are carried on to birth because of little knowledge of being pregnant or failed

[93] F = exemplification/analysis of how socio-cultural environments affects 's health. WV = Forces of the Worldview. G/M = Globalization and Modernization forces.

attempts of traditional termination. I was told multiple cases where women denied their pregnancy, refused to give birth and even neglected they were pregnant up until the delivery date. Some examples were given to me through interviews and informal conversation[94]:

> A lady went to the hospital unconscious and with eclampsia during pregnancy. So these eclampsia is due to lack of follow up. The family they say malaria. The family they say malaria. Another people they say that there's head trauma, nobody will understand that she is pregnant. They had to do a c-section and after the delivery her mother said [about the baby] "I don't want to touch this baby". The father left the hospital….. Another lady went to the hospital with fatal bleeding, and it turned out that she was in labour. She refused to push out the baby because she wanted the baby to die in the uterus. Because if it died she should come out of the hospital without neonate. And even she wanted to kill the neonate and she wanted to throw it someplace

This highlights the very complex situation created by that its neither socially acceptable with abortion nor pregnancy before marriage. Therefore, PW try to hide their pregnancies and attempts for abortions to "escape the repressive sanctions for illegitimacy" (Hendrix 1996, 65). Women do not want to, nor can't they abort the hospital. Abortions are facilitated at governmental health centres and hospitals, but I was told that "people notice" if a woman goes to the health centre to conduct an abortion, and that she will get shamed because of that. The health centres are new and not that many people are using them, therefore the clientele becomes quite clear to the environment, especially in such a collectivist culture as in Ethiopia, Oromo and Aira. In that sense, measures for improving MH by offering abortions are creating greater possibility for the public to pay attention to what she is doing and hence vulnerability for the women seeking out care.

The influence of G/M is reflected in the health facilities, and how these create vulnerability simultaneously as their goal is standardization and acceleration. Vulnerability is also one of the key concepts of globalization, and here unfolded in the sense of creating more social problems thatn eliminating medical problems. For instance, women has to choose between being publicly shamed because of their choice to about instead of being pregnant. This almost criminalize women who get pregnant before marriage. Especially, when it's called illegal pregnancies.

This analysis of the evaluative dimension further supports Dugassa (2007) who

[94] The content is slightly modified to ensure the anonymity of the potential women.

writes about human rights versus the Oromo women's rights and health. He wants to highlight how the health of Oromo women are affected by unfulfilled rights due to culture, which essentially means that local rights contradict universal human rights. This can, again, be related back to the G/M Everybody has the right to healthcare. This is considered a universal standard right by the western countries. However, there are local rights that contradict these universal rights. And the contradiction may sometimes become stronger because of the strong standardization. Eriksen (2008) calls this "re-connection".

Let me end this section by underlining my greatest outcome of this analysis. This highlight clear health problems based on women's socio-cultural situation. I almost want to say that this is a excellent example of how socio-cultural environments affect PW's health. Things that are hidden in the relationships and interactions also create hidden health situations. Invisibility of this group of PW creates an invisibility of MH problems and women's well-being as a whole.

6.4 Summary

By viewing how ideas, feeling and values may affect pregnant women's life and their health seeking behaviours it is prominent that we are learning, feeling and thinking creatures. My analysis shows how G/M have been present with an intention to improve and develop. At the same time, reflections and examples show why they have not always had the desired outcomes due to learned underlying cognitive, affective and qualitative aspects of human life in Aira. What is important to acknowledge is that the cultural factors that illustrate *women's* understatement also impacts the health of women when they are *pregnant* too.

Religion, education and gender roles cannot be seen separately from pregnant women's health, or sexual and reproductive health for that matter. Building on my analysis, the local discourses connected to these aspects are fundamental for the impact of socio-cultural environments. These are shaped both by internal and external forces and can both benefit and disadvantage PW.

In sum, drawing on this analysis I can briefly conclude that Ethiopian girls and women are still vulnerable to culturally sanctioned violence, both physically and mentally due to paternalistic and patriarchal structures in society and that this affects their health when getting pregnant or being pregnant.

7 Conclusion

The process of producing this thesis has turned out to encounter multiple unforeseen, but important aspects of pregnant woman´s heavy and complicated social, cultural and religious networks. These aspects, are to my opinion, not given justly enough attention for a solid conclusion. I am humble over this and will try to draw the overreaching lines from the thesis and put the spotlight on my major findings.

7.1 Was a proper answer to the research question provided?

Research question:

"How socio-cultural environments affects pregnant women's decisions to take and correspondingly their health, even though there are medical health facilities present within reach?".

I dare to say yes, and conclude that this study has highlighted how actual, concrete social relations and cultural surroundings have impacts on PW ideas, feeling and values and accordingly affect pregnant women's (PW) health in Aira Woreda. Let me highlight this by providing a very simple recap of my findings.

A PW in Aira Woreda is a highly appreciated person provided that she became pregnant within marriage. She knows that she has the right to get medical care during her pregnancy both at the Health Post (HP), Health Centre (HC) and the Hospital. However, four out of 15 did not utilize this service at all. This was due to prioritizes growing out of reasons related to the distance to HC, too much duties in the home sphere or economic constraints decided by the husband, who is by tradition and culture the head of the family. Their personal and collective faith was central for enduring the challenges and providing the PW with feeling of support, advice and encouragement. Additionally, the women were facing both possibilities and pressure from globalization and modernisation processes who continuously changed their micro environment (and meso and macro environment). Besides medical health facilities and development work, this can be related to education and work possibilities.

My most striking finding regarding MH health concerns a group of PW who are more or less dismissed by the community. These are the women who got pregnant outside marriage. They get terribly shamed and try by all means to hide their pregnancy. They put their lives at risk by not contacting any HC for antenatal care (ANC) because of their considered shameful situation. Sometimes an attempt to abort the fetus, either by themselves or by the help of traditional methods, is performed. This is a practice even if the HC are present to assist them with safe abortions or similar conditions. These women are the big loosers in the otherwise socially caring and supportive community of PW. One reason for them to reach their situation might be the almost total lack of any well-planned education about sexual and reproductive health (SRH) or family planning methods, either from their families or school education. Health personnel do to some extent educate on family planning, but the issues regarding SRH are still under the "shame-frame" and not as appreciated to highlight.

In total, I would like to say that PW in Aira, in spite of available health services have a very hard life because of many traditional expectations and duties. Even if caring husbands, mothers, mothers-in-law, family, neighbours or congregations and religious institutions sometimes lift off some of their burdens and support them. The real terrifying situation is concerning pregnancies outside marriage. This should be considered much more thoroughly in the future. Locally, nationally and globally. Well-planned education in schools about SRH and responsibilities is fundamental to eliminate the "shame-frame" and create a "safe-frame" discourse regarding Maternal health (MH) and SRH. Knowledge about SRH is proven to be basic information for a pregnant woman's well-being, and maternal health in general.

The examination and discovery of these two dimensions of PW (women carrying wanted vs. unwanted pregnancies) and MH shows that it has been emphasized that several social, cultural and religious aspects are affecting pregnant women's ideas, feeling and values. This in turn impacts their decisions and actions in relation to their health. Under these aspects, categories such as understandings and constructions of social expectations and responsibilities related to gender roles are highlighted. There are clear socio-cultural differences between the men and women in society which has direct impact on women's health This regards both duties and behaviours.

Collective understandings on what the content of education (both formal and informal) related to SRH and MH includes, and to whom it should be/should not be directed is also central. To accentuate my finding here, I have to admit that before doing my fieldwork,

I did not reflect upon how much of MH is related to sexuality. Discovering this, I learned that there was broad lack of openness and education around SRH.

Religion and its teachings is manifested through cultural practices. As highlighted throughout the thesis, religion has a massive effect on understandings of MH and the rights of PW, and have therefore impacts on most of the aspects of the PW life. In Aira Woreda it creates moral codes of conduct related to SRH, MH and PW. It creates support, encouragement and emotional security for PW. Simultaneously, it facilitates illegitimacy of and social sanctions for women for carrying unwanted pregnancies.

Hopefully, the reader has got an understanding of how the cognitive – ideas. Affective - feelings and evaluative – values impact's' PW life in Aira Woreda. It is by viewing how these ideas, feelings and values may affect pregnant women's life it is prominent that these pregnant women's decisions regarding their health are taken due what they learn, think and feel is right in their socio-cultural environment.

Just as Buton and MacDonald (2002) are trying to highlight in their book about health promotion, health seeking behaviours of PW should be understood though a holistic lens. However, to do something holistically, one has to start with understanding the parts of the whole. The parts consist of people who have social relations to each other and participate in different spheres of society for example, religious meetings or labour and market activities. A holistic perspective also includes aspects we can´t see. Socio-cultural environments are precisely aspects we explicitly can't see. That does not mean that they don't exist or have an impact, it is actually the opposite. Hall (1998) writes "Culture hides much more than it reveals" *(*109), and it is therefore crucially important to recognize and acknowledge these "unconscious" aspects of life as guiding decisions and actions. When realizing what one doesn't realize, one truly reaches the golden moments of understanding (Dahl, 2003).

7.2 My main case-conclusion

As mentioned above, my prime finding and the most evident example of how socio-cultural environments impacts PW health is related to PW carrying unwanted pregnancies. These pregnancies are not only unwanted, but they are classified as illegal pregnancies by some in the socio-cultural context of Aira Woreda. It is not socially acceptable to get pregnant before

marriage, neither socially acceptable to do an abortion. These PW make the decision to hide their pregnancies, deliver alone or even try terminating it by themselves to avoid sanctions.

I am well aware that a positive spiral is developing regarding these issues, and that cases like these are declining. However, due to my findings, this is still a prominent issue that is overlooked and most certainly affects PW health and their decisions to seek care. It must be recognized as a social and cultural problem that includes both women *and* men, and the relationship between them. It is socio-cultural problem that should be addressed by making both local women and men responsible, and both religious institutions and modern health facilities accountable eliminating the "shame-frame" and creating a "safe-frame" for the discourse concerning SRH.

7.3 Suggestions for future research

As mentioned before, a topic like maternal health requires multiple perspectives. Two perspectives that I found very interesting and relevant are related to work and gender, and religion. Both these perspectives can be applied to maternal health and women's health in general. They have been acknowledged in my analysis, but are to my opinion, main topics in themselves.

7.3.1 Productive and reproductive work

In relation to worldviews and especially the cognitive dimension, there is a possibility to examine a gender perspective in relation to reproductive work. There are two kinds of work in society; productive and reproductive work (Eriksen, 2013). Productive work is the most visible and accumulates income. When it comes to the reproductive work the general conception is that reproductive work is only about having children. *But* it is also about reproducing the everyday life. The gender dimension is how the workload is divided. This is not as much viewed, evaluated or dealt with as the productive work (ibid.). However, as I found out in my fieldwork, the women seem to have the absolute biggest workload but they also seem to get least credit for it. During my fieldwork I learned it has been done allot when it comes to gender equality in productive work for women. Micro finance is a good example

for that. Women start to generate their own money and could contribute financially. However, reproductive responsibilities and expectations are mainly on women even if both men and women are facilitating the reproduction of family and everyday life.

A potential general research question could be formulated: How is reproductive work viewed and valued by regular people?

A question relating to maternal health could be: How are the responsibilities of both women and men in the household affecting pregnant women's health?

7.3.2 Religious socio-cultural environments

The evaluative dimension of worldviews is closely intertwined with religion, and Bradley (2011) write that "religion has always been there and is unlikely ever to disappear as a dominant structural force in our lives" (219). The role of religion, religious leaders and spiritual life is very important to acknowledge. No matter how much an external actor attempts to participate and engage, one must respect and acknowledge the centrality of religion and culture in people's lives. It gives insight into the lives of local people and how they reason. This is something future health promoters, educators and workers should recognize. I believe that a fundamental respect and understanding of the religious aspects in pregnant women's life will improve maternal health. Future research could therefore perhaps have diaconal outlook with a research question as: How **religious** socio-cultural environments affects pregnant women's decisions and correspondingly their health, even though there are medical health facilities present within reach?

A further definition would include how religion defines legitimacy and illegitimacy regarding SRH and how ramifications in the general public is unfolded.

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7.4 Closing words

This study has been beyond instructive and exciting, but at the same time overwhelming and challenging. I have had possibilities that a master student only could dream about and I have had struggles which are a master-students' worst nightmare. Overall, this study has given me knowledge and experiences I am truly grateful for. Most importantly, it has given me the possibility to feel I have been doing something valuable for others than myself. Let me give you a brief example why/how.

As briefly mentioned in chapter 2, I was told form different independent sources nobody had talked with pregnant women about their everyday lives and their challenges. And nobody had gathered them to talk together, like I did in my focus group discussion. This shows that this is an area that is relatively unexplored, both by insiders and outsiders of the community, and implies that this could be much further developed and the start of something new and positive for pregnant women's health locally in Aira, nationally in Ethiopia and maybe even globally. It is both frightening and encouraging for me as a master student to learn this about my field. It gives me strong motivation to continue. However, it also overwhelms me because of the outcome this study might engage just by planting this small seed.

Is it something I surely have learned, then it is that I have so much to learn (unknown).

8 Reference list

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ATTACHMENTS - TABLES OF DATA

Since this is s a qualitative study, these tables are not symmetrical or as systematically presented as if it would be a quantitive study. The aim is to give the reader an overview of the information I received and to some extent be able to compare it. I want the reader to keep in mind that the information in these tables are based on what the interview-subjects told me and might therefore not be as fulfilling or elaborated as one expected.

Information from the focus-group interview is not presented in tables 2-7 due to the different structure of the interview and accordingly different outcome of information. However, the personal background of the interview-subjects in the focus group is presented in table 1. Personal Background, and extracts from the focus group discussion will be presented in relation to each theme.

Abbreviations in the tables:

IS = Interview-subject
- = No clear answer.

Appendix 1 - Table 1. Personal Background

	Personal Background			
	Age (approximately)	**Profession**	**Family situation**	**Education**
IS-1	25 (Warra Kuraa Suchi)	Farmer: Cultivation and Cowbreeding	Only wife. 1 child Came to the area by marriage	10th grade + Collage diploma level 4.
IS-2	18 (Lalo Suchi)	Farmer	Only wife. 2 children From the area	None
IS-3	20 (Warra Babo Suchi)	Farmer. But because of pregnancy – only housework.	Only wife. 1 son. Came to the area by marriage	9th grade
IS-4	22 (Lalo Suchi)	Farmer	Only wife, 2 daughters From the area	5th grade
IS-5	20 (Warra Babo Suchi)	Farmer	Only wife, 2 sons Came to the area by marriage	2nd grade
IS-6	18 (Bondawo)	None. Only cooking at home.	Only wife, First pregnancy. From the area	10th grade
IS-7	26 (Bondawo)	Working in Laboratory at HC.	Only wife, 1 son Came to the area by marriage	Collage Diploma
IS-8	18	Farmer – No money earned.	Only wife, First Pregnancy Came to the area by marriage	9th grade
IS-9	30	Farmer – No money earned	Only wife, 1 daughter From the area	7th grade
IS-10	30	Farmer – No money earned	Only wife, 1 son. Came to the area by marriage	None
IS-11	25	Farmer – Earning money	Only wife, 2 children. Came to the area by marriage	4th grade
IS-12	35	Farmer – Not earning money	Only wife, 4 children. Came to the area by marriage	2nd grade
IS-13	25 (Bondawo)	Farmer – Earning Money	First pregnancy. Came to the area for work.	10th grade
IS-14	22 (Bondawo)	None	First pregnancy. Came to the area by marriage.	10th grade
IS-15	23	Cashier	First Pregnancy. From the area.	Collage diploma
IS-7	Same as IS-7	Same as IS-7	Same as IS-7	Same as IS-7

Appendix 2 – Table 2. Pregnancy

	Pregnancy				
	Physical	**Emotional**	**Mental**	**Treatment/Follow – Up**	**Wanted actions for health**
IS-1	Tired in the body	Happiness	Worried about where to give birth.	HP/HEW	Work less and balanced diet.
IS-2	Tiredness	Happiness because it is a gift from God.	Worried about where to give birth. Pregnancy is a difficult time.	TBA	-
IS-3	No problem	Happiness and sadness because of stress for future.	Worried about where to give birth. Long time ago.	No check-ups.	Rests. But difficult with nutrition.
IS-4	Difficult, but no choice.	Happiness	Tiredness. Worried about birth because of previous c-section for unexpected twins. (Felt sorrow for getting twins).	No check-ups, but planning to go to HC. Have been talking to HEW.	Keeping away from heavy lifting, and hard work.
IS-5	Pain.	Scared and Happy.	Worried because of previous neonatal death (twins)	After 5 months – check-up at HP.	Sleeps and rest, and then try to work again.
IS-6	Dizziness and stomach ache. Sensitive to smells. Tired.	Sadness, hate towards myself.	Dissatisfaction	Focused ANC at HC in Bondawo.	Balanced diet. Fruit, meat etc.
IS-7	Discomfort and loss of appetite. Sometimes pain.	Happiness	Worried when seeing PW in pain.	Focused ANC at HC in Bondawo.	Prayer, resting, eating.
IS-8	Pain, difficult with activities and plant seeds.	Happiness	Worried about money and birth	HEW/HP.	Not walking long distances.
IS-9	-	Happiness	-	HEW/HP	Eat as much as I can.
IS-10	-	Happiness	-	HEW/HP	Nothing. Don't have the possibility for a balanced diet.
IS -11	-	Happines	-	TBA is helping if the baby is misplaced.	Keep away from hard work and eat
IS -12	Back pain.	Sadness because I am old.	Worried about not getting the chores done. And enough money for the new baby.	Planning to go to HP.	Sleep or take a rest.

Appendix 3 – Table 3. Social Relations

	Social Relations			
	Advice	**Support**	**Husband**	**Decisions in general**
IS-1	Mother-in-aw and equal women	-	Head of the house	Husband
IS-2	Neighbours and Mother-in-law: “Go to clinc”.	Husband and children	-	Husband
IS-3	Husband and female neighbours	Husband	-	Husband
IS-4	Neighbours give advice.	Husband and adopted children	Head of the house, but listens and helps.	Me. My husband can say his idea.
IS-5	Husband and mother in law.	Husband and Mother in law.		Together with husband.
IS-6	My mother. Not work or carry heavy things.	Husband and mother	Encouraging and calming.	Husband
IS-7	Nobody is advising me. I advise other women about hygiene.	Husband.	Helping in the house. Washing my feet. Supporting	We discuss together.
IS-8	HEW. (Living close to the HP). From friends and family with experience with pregnancy. Nobody else can advise me. Neighbours are far. Family is far	Same responsibilities. No help, but stopped the hard work since a month. Husband helps with house chores	Encouraging to go to HP, rest, helps around the house.	Husband
IS-9	HEW and women I have close relationship with. Changing experiences and advice.	Need to work anyway. Some support from family.	Helping by fetching water and collecting wood. He does not decide – I tell him.	Husband
IS-10	-	My mother helps with housework.	Forces me to do work.	Husband
IS -11	TBA, moter in law.	Relatives and husband.	Supports me.	We discuss and decide together.
IS -12	Talking with relatives and friends.	Working as before. No support.	Helps me with hard work and advices me to rest. Tell the children to work.	Togheter.

Appendix 4 – Table 4. Tradition, Culture and Religion

	Tradition, Culture and Religion			
	Previous practices	**Religion**	**Community**	**FGM/ Circumcision**
IS-1	Not familiar	Prayer is important for the feeling for support.	-	-
IS-2	Not familiar	Help and support from the community	-	Yes
IS-3	Hard work. No support from husband.	Prayer and advice from congregation to go to health centre.	Encourage me. (Congregation organises help and support.)	Yes -
IS-4	Not familiar.	Prayer. Also others pray for me.	-	Stopped, but are a few.
IS-5	Not familiar.	Prayer. Also others pray for me.	-	Depends. Some practice it hiddenly, others not.
IS-6	Not familiar.	Prayer is very important to overcome the challenges.	Nothing special is done.	Yes, hiddenly.
IS-7	TBA massage. Is forbidden now.	Prayer and the support from the congregation is important.	Women are respected. But community thinks pregnancy is easy. Nobody talks with the PW or give her emotional or mental attention.	Not 100% stopped. But more people have knowledge of the negative impacts of the practice.
IS-8	Not familiar	I believe that God will help me to deliver safely. Prayer and church helps me.	Afraid of talking about being pregnant in the community. But community respect and help the pregnant ladies.	Not familiar with it in the area.
IS-9	Not familiar	Prayer is good because God know everything.	People are only talking indirectly about pregnancy. Community does not do anything during the pregnancy. But afterwards – There are celebrations	Yes.
IS-10	Not familiar	God listens.	-	Yes.
IS-11	Not familiar	I pray and my relatives pray	-	Yes.

IS-12	Not familiar.	Prayer groups.	Not talking openly. I am not proud because I have big children now. The community thinks I am old and don't know if they will support me.	Yes.

Appendix 5 – Table 5. Globalization and modernization

	Modernization and Globalization			
	Health Facilities	**Modern Contraceptives**	**Transport/Communication**	**Education/information (in addition to health facilities).**
IS 1-B	Using	Yes	None.	My mother.
IS 2-B	Aware. Not using.	Not using	None	None
IS 3-B	Aware. Not using during this pregnancy.	Yes – tablets/syringe	None. (2hours to walk to HC for PW).	None.
IS 4-B	Aware, but not using so far during this pregnancy.	-	None. Will go to Aira 2 weeks before delivery.	My mother.
IS 5-B	Aware, not using during this pregnancy.	No, Previously Pills.	Telephone. Calls ambulance when labour starts.	Friends, mother
IS 6-B	Using	Yes	Telephone	Basic in school
IS 7-B	Using	Yes - Syringe	Telephone	Basic in school.
IS 1-H	Using	Yes	We contact someone, that contact the HEW and she contacts the HC/Ambulance.	School. Girls get education from female teachers.
IS 2-H	Using	Yes- Syringe	Can contact somebody with a telephone.	No.
IS 3-H	Using	Yes - Syringe	-	-
IS 1-L	Aware. Not using. during this pregnancy. Saying there is No HEW in the area.	Yes – Syringe.	Ambulance in Bodawo.	No education in school. We only hear from people. Otherwise nobody teaches us. We don't know anything before marriage.
IS 2-L	Aware, Not using so far during this pregnancy.	Yes - Syringe		

Appendix 6 – Table 6. Childbirth

	Childbirth			
	Desired delivery place	**Who take the decision on where you should give birth?**	**Support/preparations**	**TBA**
IS-1	Uncertain	Husband	Husband follows, Preparing food.	-
IS-2	Hospital	Husband - Hospital	-	Active in the area. Not fund of modern health facilities because they earn money.
IS-3	Hospital	Husband - Hospital	Husband follows Preparing food	Yes, but don't want support from them because of bad practice that can be lethal.
IS-4	Hospital	Me.	Relatives follow. Husband needs to work and take care of the children. Will call on delivery day.	Active in the area, but not using because of recommendations from Hospital.
IS-5	Hospital	Me	Husband follows, Preparing food	Used for previous delivery of twins. Resulted in neonatal death. Will not use anymore.
IS-6	Hospital with C-section	Husband	Husband and mother follows, preparing food	Not active
IS-7	If God wants, Hospital.	Gods plan.	Husband and mother in law.	Not Active
IS-8	In my birth place so my family can help me.	Me and my husband	Family. Preparing food and where to rest.	-
IS-9	HC in Bondawo	Husband	Mother in law.	One women, but nobody goes there.
IS-10	HC in Bondawo.	Husband	Nobody	There are two women, but they are not TBA. They can try to adjust small things. Position of the baby etc. But people do not go there.
IS-11	I am going to listen to Gods plan.	Me	I prepare where to sleep and what material I need for that time. Razer-blades.	Yes. Sometimes we call them, sometimes we go to their house
IS-12	Previosly, at home. Now at HC.	Husband	Mother follows. Preparation of food and drink.	Yes. But nobody goes to their home because the government made it illegal.

Appendix 7 – Table 7. Other

	Other		
	Safe and Secure	**Improvements**	**Poitive/negative**
IS-1	Balanced diet and possibility to rest.	-	-
IS-2	Be able to go to the hospital to give birth.		-
IS-3	-	Nutrition	-
IS-4	Rest and not work at all.	More support from the community during pregnancy.	-
IS-5	Eating balanced diet.	More encouragement and help during pregnancy.	-
IS-6	Nothing	Nothing	-
IS-7	Balanced diet and information about pregnancy and childbirth.	Start early with education about pregnancy. Give recommendations on what to do/not to do. More support and advise in general. Continuous teaching, and differentiation of work	
IS-8	-	A good education has to be giving for the PW.	The way the community sees us is different. So I like that. They have the respect for us. Positive attitude for women. Boys does not teas them, call after them etc. They respect them
IS-9	-	More possibilities to get a balanced diet.	There are no new challenges from before.
IS-10	-	Good cloths and balanced diet.	-
IS-11	-	About education: It is good if they know before marriage. It is necessary if they know what is in it. Is is good if the girls know what it is in it. And if they themselves prepare a service for that. To help them.	Life situation is more difficult. But we survive it.
IS-12		I wish all PW could get rest and refreshments.. I don't want to talk. I am afraid.	Pregnancy is a gift of God so we just have to be happy. But work is difficult.

Appendix 8 – Table. 8 ANC service utilization at Aira Hospital.

Table borrowed from ”2015 Annual Activity Report Aira Hospital”, page 5.

ANC	2009	2010	2011	2012	2013	2014	2015
ANC new	2,070	1,621	1,733	2,284	2,042	1961	2363
ANC repeat	2,226	1,702	1,664	1,998	2,088	2102	1289
visits / client	**2.0**	2.0	2.5	2.5			
Av. daily load	17	13	13	17	16	16	15
TOTAL ANC	**4,296**	**3,373**	**3,397**	**4,282**	**4,130**	**4063**	**3652**

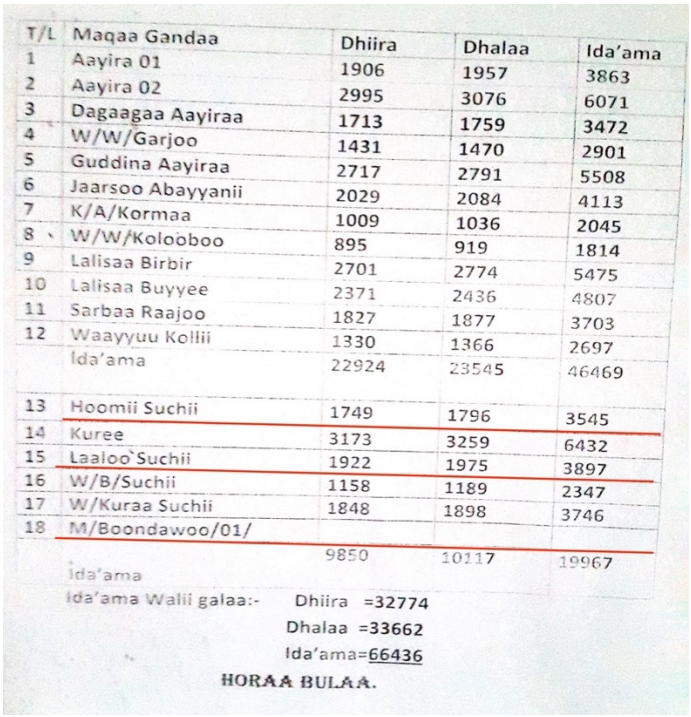
Appendix 9 - Table 9. Delivery service utilization at Aira Hospital

Table borrowed from ”2015 Annual Activity Report Aira Hospital”, page 15.

	2009		2010		2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Deliveries Total	1095		1183		1095		1183		1,461		1395		1601	
SVD (Spontaneous Vaginal Delivery)	612	56%	552	47%	612	56%	552	47%	760	52 %	729	52%	1088	68%
C/section	411	26%	419	35%	411	26%	419	35%	554	38 %	520	37%	320	20%
Ruptured Uterus	27	4%	35	3%	27	4%	35	3%	13	0.9 %	15	1.1%	17	1.6%
Vacuum	37	8%	112	10%	37	8%	112	10%	94	6 %	113	8.1%	129	8%
Forceps	-		13	1%	-		13	1%	4	0.3 %	4	0.29%	36	2.2%
Craniotomy	4	1%	24	2%	4	1%	24	2%	7	0.5 %	6	0.4%	11	0.7%
Ret. placenta	4	1%	28	2%	4	1%	28	2%	29	2%	16	1.1%	19	1.2%
Abnormal (%)	483	44%	631	53%	483	44%	631	53%	701	48%	520	37%	513	32%

Appendix 10. Demographics Aira Woreda.

Demographics Aira Woreda



T/L	Maqaa Gandaa	Dhiira	Dhalaa	Ida'ama
1	Aayira 01	1906	1957	3863
2	Aayira 02	2995	3076	6071
3	Dagaagaa Aayiraa	1713	1759	3472
4	W/W/Garjoo	1431	1470	2901
5	Guddina Aayiraa	2717	2791	5508
6	Jaarsoo Abayyanii	2029	2084	4113
7	K/A/Kormaa	1009	1036	2045
8	W/W/Kolooboo	895	919	1814
9	Lalisaa Birbir	2701	2774	5475
10	Lalisaa Buyyee	2371	2436	4807
11	Sarbaa Raajoo	1827	1877	3703
12	Waayyuu Kollii	1330	1366	2697
	Ida'ama	22924	23545	46469
13	Hoomii Suchii	1749	1796	3545
14	Kuree	3173	3259	6432
15	Laaloo`Suchii	1922	1975	3897
16	W/B/Suchii	1158	1189	2347
17	W/Kuraa Suchii	1848	1898	3746
18	M/Boondawoo/01/			
	Ida'ama	9850	10117	19967
	Ida'ama Walii galaa:-	Dhiira =32774		
		Dhalaa =33662		
		Ida'ama=66436		

HORAA BULAA.

This is a picture of the original demographic overview for the cabales in Aira Woreda. Dhiira = Men, Dhalaa= Women, Idaáma= Total. The red lines underline the demographic numbers of the cabales I conducted my interviews in. These numbers are from 2015 and were provided to me at Aira Woreda Office, Womens Empowerment section.