

Husbands' Roles in Prenatal Care in Addis Ababa

By

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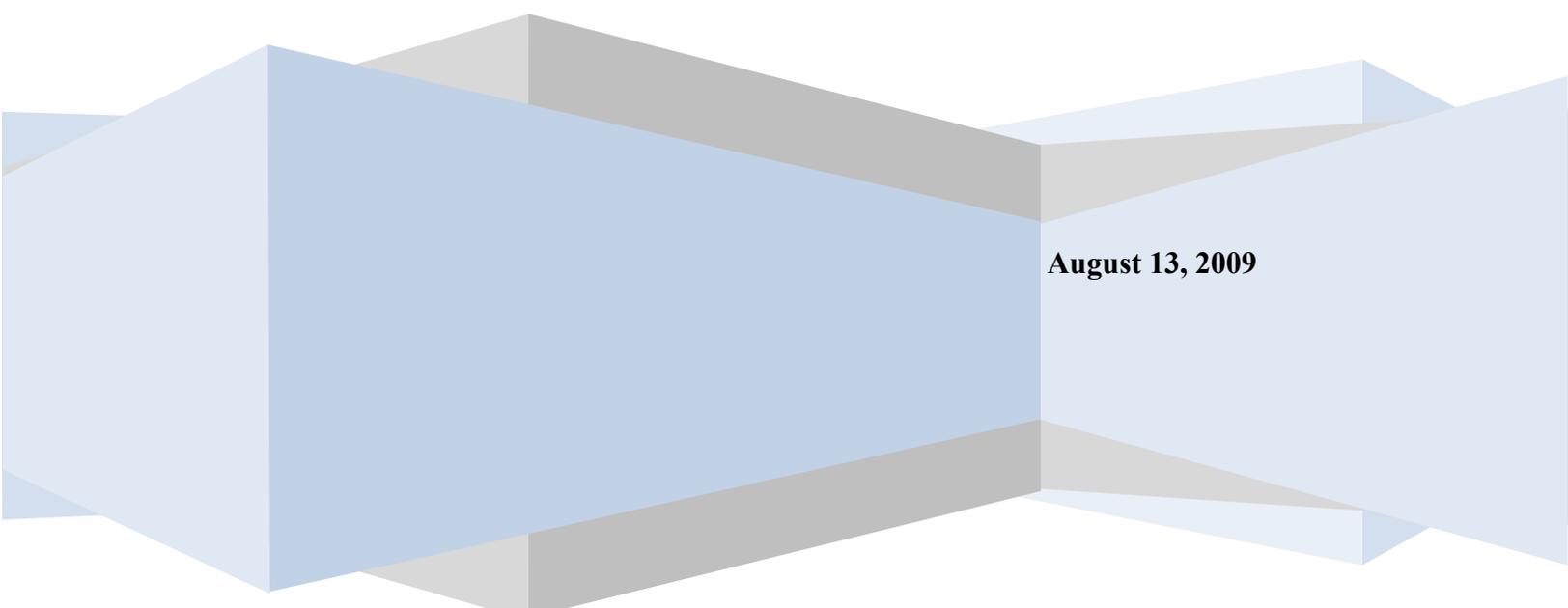
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To Dinkitu Gudisa, Birra and Gifti Mekonnen

To my late father Muleta Debel

TABLE OF CONTENTS

Abstract	5
Acknowledgement	6
I. Chapter one: Introduction	8
1.1. Review of previous studies	9
1.1.1 Involvement of Men in Reproductive Healthcare	10
1.1.2 Effect of Male’s Involvement in Reproductive Healthcare	11
1.1.3 Barriers towards Husband’s Involvement	12
1.1.4 Socio-economic Barriers	13
1.1.5 Gender Roles	14
1.2. The structure of the thesis	15
II. Chapter two: Fieldwork and Methods	17
2.1. Study design and field sites	17
2.2. Data collection methods	19
2.2.1 Observation	19
2.2.2 Semi-structured Interviews	20
2.2.3 Focus Group Discussions	20
2.3. Study samples: the husbands	21
2.4. Reflections	21
2.5. Research Limitations	22
2.6. Ethical Consideration	22
III. Chapter three: “Pregnancy is a big agenda”	23
3.1. Pregnancy Concerns	25
3.1.1 Pregnancy worries	25
3.1.2 Demand for food	26
3.1.3 Cultural Implications of Sickness	27
3.1.4 Man’s Family	27
3.2 HIV Test Concerns	28
3.3 Delivery Concerns	29
3.4 Economic Concerns	30
IV. Chapter four: “I am to some <i>extent</i> like my father”	34
4.1. Clinical spheres	34
4.1.1 Modern Healthcare Only as a Last Resort	36
4.1.2 Presentation of Self as a Modern Man	37
4.1.3 The Quality of Healthcare is Discouraging	39
4.2. Domestic Spheres	40
4.2.1 Nutritional Support	40
4.2.2 Household Tasks	40
4.2.3 Spiritual Support	46

V. Chapter five: Husbands' roles in prenatal care in modern urban society	48
5.1. "Time (modernization) demands"	48
5.2. Conclusion	58
References	61
Photographs	65

Abstract

This study was performed in Addis Ababa and presents an ethnographic narrative of multiple view points and accounts of husbands regarding their roles and tasks in prenatal care. The study used a qualitative exploratory and descriptive methodology including interviews, focus group discussions, researcher participation in and observance of actions pertaining to husbands' roles in prenatal care. The field sites were a private hospital; NGO clinic and public healthcare centre that offer prenatal care services to pregnant women. The study reveals that the utilization of these healthcare facilities for prenatal care by husbands and their pregnant wives reflects their socio-economic status in the society.

In this study, I have tried to investigate the whole range of views of husbands about prenatal care and how socio-economic and cultural factors are shaping their roles in prenatal care. The findings show that prenatal care as a modern healthcare practice is a shared domain by husbands and their pregnant wives. The urban husbands followed cultural practices and norms regarding prenatal care because of the traditional model expected from them in the society. Husbands held major external tasks at clinical spheres (for example, paying medical bills) as well as to some *extent* domestic chores (for example, making dishes) during the pregnancy and delivery period of their wives. On the other hand, this study shows how husbands were introduced to these new spheres and practices (prenatal care) both from the local and the wider global contexts.

The findings also suggest that husbands of pregnant women in particular and men in general should be considered in the family and men's health programs and interventions in Ethiopia. There are limitations that are intrinsically present in this kind of study due to a number of factors such as the limited number of husbands interviewed, and the short period of the research, and the singularity of the study location. However, the findings of this small scale medical anthropological study may provide insight that helps others to plan meaningful interventions for reproductive health programs in Ethiopia, and in particular in Addis Ababa.

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“Let us thank God for his priceless gift” (2 Corinthians, 9:15)

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Chapter One

1. Introduction

I am to some *extent* like my father. On my part of course, I cannot say that I am a totally changed modern thinking husband. I share some practices and outlooks similar to those of my father. I do them unconsciously or traditionally without realizing their harmfulness. I cannot say that these days I do not practice the traditional beliefs about gender roles. It is in my blood because I inherited them from my father. Most of my father's views and beliefs are reflected within my practices even though they have been improved and shaped by modernity. It does not mean that they are all totally replaced and everything I do is modernized and changed. You can find some of my father's older practices in my home. (Birhanu, 42, BA in Business Management)

In recent decades, Ethiopia has undergone a series of major social, cultural and economic changes and profound transformations in family structures in large urban centers, e.g., Addis Ababa. Although the impact of these changes on gender and power relations remains to be further studied, there is agreement that they have affected the roles of husbands in the reproductive health of their wives during pregnancy and delivery periods (Biratu and Lindstrom 2000). Studies have also consistently demonstrated that husbands' role in prenatal care is the most essential factor in promoting the health of pregnant mothers and infants and also reduces maternal and infant mortality during pregnancy and delivery periods (Groenewold et al 2004; Nwokocho 2007). Husbands' involvement in prenatal care is therefore considered to be a crucial step in scaling up use of prenatal care by women.

In 2005, according to the Demographic Health Survey performed by the Ethiopian Department of Health Services (DHS), only five percent of Ethiopian women gave birth in a health facility (WHO 2009). One quarter of this small percentage had received at least one prenatal care check-up in a modern health facility while approximately 10% had four or more visits during their pregnancy. It is likely that the vast majority of women who deliver at home chose to follow traditional prenatal care (WHO 2009). The low number of Ethiopian pregnant women who access modern healthcare for delivery contributes to maternal and infant mortality rates to place among the highest in the world 871 per 100,000 live births and 77 per 1,000 live births respectively (WHO 2009).

Husbands' influence on the utilization of prenatal care services at modern healthcare facilities has hardly been studied to date. This is also still the case in Ethiopia. Given the traditional male decision-making role in Ethiopia; I was interested in studying the perceptions and experiences of husbands whose wives access prenatal care in modern health facilities. This was an ethnographic study examining the influence of husbands' roles, perceptions and experiences in prenatal care during their wives' pregnancies and delivery periods in the urban setting of Addis Ababa, the capital city of Ethiopia. Therefore, I conducted an explanatory and descriptive study: the methodology included semi-structured interview, informal conversations, focus group discussions, and observations of the activities that pertain to husbands' roles in their wives' prenatal care in Addis Ababa. In this thesis, I address the following question: Why have husbands of pregnant women receiving prenatal care at a modern health facility agreed to this choice? For the practical medical anthropological purposes, the main research question was further subdivided into the following specific ones:

- What are the socio-economic back grounds of these husbands?
- What assistance or support do husbands give to their pregnant wives' and
- How do the modernization of urban Addis Ababa and the medicalization of pregnancy and delivery affect the husbands' decision-making process for his wife's prenatal care?

In order to answer the question, consideration was given to the socio-economic backgrounds of the husbands, as well as modernization and medicalization (the expansion of modern healthcare facilities and reproductive technologies) in shaping a husband's role in prenatal care in the context of contemporary urban Addis Ababa. It is my hope that insight gained from this research will help policy makers, NGOs, and health professionals to create interventions to increase the use of modern health facilities by pregnant women and thereby reduce maternal and infant mortality.

1.1. Review of Previous Studies

Research studies have shown that the role of a man during the pregnancy of his wife is critical in Ethiopia. However, the evidence demonstrates that many barriers remain for husbands' involvement particularly in developing countries. These barriers include issues such as socio-economic, cultural and the social contexts. The husband's role in prenatal care from available literature based on studies performed in Ethiopia, Sub Saharan Africa and a global context will

be presented according the following themes: involvement of men in reproductive health care, effect of male's involvement in reproductive healthcare, barriers towards husband's involvement, socio-economic barriers, and gender roles.

1.1.1 Involvement of Men in Reproductive Healthcare

Traditionally in Africa, a husband's authority on matters of reproductive health has been paramount. Numerous studies have found that this situation continues today. In fact, at the UN International Conference of Population and Development (ICDP) in 1994 it was stated that

[m]en play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and program decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life. (ICDP 1994:51)

The 1994 ICPD final document described males' roles in sexual and reproductive health, emphasizing the man's involvement in parenting, and measures that could lead men to taking greater responsibility for their own sexual and reproductive behaviours, including family planning, maternal and child health and the prevention of STIs. WHO recommends that men's involvement in sexual and reproductive health should also include aspects such as engaging in all forms of domestic life activities (caring for children, cooking, shopping and cleaning) and providing resources and transport, sharing decision making with their wives during pregnancy and delivery periods if improvement in this area is to be realized (WHO 2007).

In recent years the limitations of the 1994 ICDP model have been identified and reformulated in such way that Sexuality and Reproductive Health should be situated within a broader development-oriented concept of health rather than the earlier narrow focus on service delivery and women's health issues. As a consequence, social relations that constrain health more fully are emphasized and the right and capability of the entire family to choose freely and responsibly in the domain of reproductive health are recognized (Groenewold et al. 2004; Nwokocha 2007). Notably, social relationships influence family's ability to manage their sexual and reproductive lives, with implications not only for men's health, but also for a numerous women's choices.

However although men's involvement is recommended, the intervention programs to date have devoted less attention to male involvement in reproductive health, but are centred and directed towards women's perspective and empowerment. Comparatively few programs focus on men's roles related to prenatal care, though the need of men's involvement in the areas of pregnancy and prenatal care is essential. Less emphasis has been placed in the policy and reproductive health related interventions and programs on the men's sexual and reproductive rights and involvement in reproductive health issues due to cultural and social factors such as gender ideology and the patriarchal traditional systems in the country (WHO 1999).

1.1.2 Effect of Male's Involvement in Reproductive Healthcare

A few studies investigated husbands' involvement in their wives' pregnancy care. In general, these studies showed a positive outcome for the wife and related to this participation. For example, a recent study from Nepal shows that husbands' involvement in the prevention of ill maternal health during pregnancy and delivery was a vital contribution. It was noted that husbands provided supports such as fetching water, bringing nutritious food, arranging and accompanying their wives at prenatal care visits, advising their pregnant wives not to carry heavy loads and providing money for transport and medical costs (Groenewold et al. 2004). In this study the authors also identified the ongoing existence of gender and social-based practices such as social pressure and religion of the family as barriers to the husbands' involvement in household chores and support to their pregnant wives.

Most research in the field of male involvement in reproductive health in Africa has shown a significant improvement in pregnancy outcomes when women were supported by their husbands during the various stages of maternity (Nwokocha 2007). In Nigeria, for instance, researchers notably showed the importance of men's role in emergency obstetric care and other domestic chores (Odimegwu et al. 2005). The authors noted husbands' positive contributions and involvement in activities like prohibiting their pregnant wives from engaging in heavy physical tasks and the majority of husbands encouraged their pregnant wives to eat fruits and foods and to do physical exercise during pregnancy.

A study performed in southwest Ethiopia, found that husbands' approval of formal prenatal care at modern healthcare facilities for his wife was based on their exposure to modern healthcare

practices, the age of the husband and the individual husband's interpretation of religious values, tribal identity, and adherence to traditional norms and beliefs (Biratu and Lindstrom 2000). The authors emphasized that interventions that target men have the potential to make a significant difference in the use of antenatal clinics by their pregnant wives. The husband's approval for modern prenatal care was stronger if the pregnancy was wanted. The researchers found that the impact of a husband's approval on prenatal care was greatest among women under the age of 20 in Ethiopia. In this study the authors examined women's decision-making processes concerning their health without involving their husbands. However, the study did not examine the husbands' experiences in taking part in prenatal care during pregnancy and delivery times. Moreover, the authors seemed to have been most interested in identifying the socio-economic and cultural factors governing the use of contraceptives for family planning methods in Ethiopia (Biratu and Lindstrom 2000).

A study by Mesfin (2002) in the northern part of Ethiopia demonstrated that men's fertility intentions; reproductive preferences and their attitude towards family planning seemed to influence the fertility behaviour of their wives and their attitudes towards the use of modern contraceptives. Socio-cultural norms, economic and property ownership status of men in Tigray (Ethiopia) dominate decision-making at all levels of the reproductive process. Men's attitudes towards family planning which were assessed in terms of partner approval and discussion were important in determining the role of husband in the use of family planning methods by women, and on the fertility level of the family (Mesfin 2002).

1.1.3 Barriers towards Husband's Involvement

Socio-cultural barriers to husband's participation in reproductive health programs have been identified. The fact that most reproductive health programs and services are targeted towards women excludes men; who are, in most cases, responsible for making reproductive health decisions (Tuloro et al 2006). The need for improved communication between partners has been recommended. A study by Green et al (1995) has indicated that a supportive male spouse encourages his female partner to use contraceptives. This study showed that major obstacles to expanding male-involvement programs revolve around socio-cultural considerations (e.g., men's fear of losing control), lack of political commitment, policy barriers (e.g., strict eligibility criteria for vasectomy), provider bias (e.g., programs oriented to women), and inadequate information.

The study further indicated well-targeted, focused male involvement programs can have positive influences on both male and female reproductive health behaviours: more responsible sexual behaviour, increased contraceptive use, and greater spousal communication between partners (Green et al 1995).

A lack of knowledge and information regarding reproductive health, particularly for husbands as well as economic constraints has been documented as a barrier to their wives accessing modern health care. In Ethiopia, the knowledge of reproductive health is very low among the general society. Most husbands consider pregnancy (and delivery) to be a natural event and generally do not take their pregnant wives to hospital for prenatal care or delivery. Pregnant women are advised by husbands to go to a traditional birth attendants, *wagesha* or *ogeetti*, if they face problems during pregnancy and delivery rather than going to modern care facilities (Terefa 2000).

1.1.4 Socio-economic Barriers

Studies report that the economic status and social situations of husbands of pregnant women in developing countries in Africa are major factors that determine their involvement in their wife's prenatal care. A poor family that is living in a rural area should not be expected to attend a modern health care service for prenatal care due to restricted finances according to a large study in Nigeria (Odimegwu et al 2005). In this study approximately 6/10 informants (husbands and wives) reported that it is the husband who decides on the use of prenatal care. The husbands make the decision for their pregnant wife's prenatal care at modern healthcare based on their financial capability and power. According to the authors, most husbands' involvement in prenatal care is limited by poverty and ignorance about pregnancy due to social taboos about teaching children about pregnancy. One male informant highlighted the importance of addressing husbands' roles in during their wives pregnancy. He stated, "The current hospital programme for pregnancy concentrates on women without reference to men. If men are seen as agents of change and for improved pregnancy outcomes, they would have no choice but show commitment" (Odimegwu et al 2005:7).

In Ethiopia the healthcare system requires that people pay on the spot for medical fees. Pregnant women are more vulnerable to live in poverty due to gender subordination to their husbands and

these two issues have a double effect on their ability to access prenatal care services (Mekonnen and Mekonnen 2002). In Ethiopia, the Ministry of Health found that utilization of available maternal health services remains low despite efforts to improve accessibility and affordability of health care facilities (MOH 2006). For example, obstetric (delivery) services are often unused even when they are accessible because of high cost. Although most of primary health care services (prenatal care, delivery and postnatal) for the poor rural population are subsidized, there may be informal fees or other costs that pose significant barriers to pregnant women's use of the services (TGE, 1993; Mekonnen and Mekonnen 2002).

1.1.5 Gender Roles

One socio-cultural dimension is gender, a result of early childhood socialization of male and female in a society into different spheres, which eventually leads to the dichotomizing of masculine and feminine roles (Tefere 2000). Most Ethiopian women do not go to prenatal care services due to the burden of their household activities: cooking, cleaning and shopping. Men and women perform different activities or have a division of labour which is endorsed socio-culturally. Child rearing is viewed, in most of Ethiopian society, as the sole responsibility of women and this in turn limits and restricts their movements to seek prenatal care services. Women's status is low in terms of control over and access to and utilization of information, education, and income and more generally speaking over their sexual and reproductive health issues such as prenatal care services. Men are generally responsible for fulfilling the family's needs for food and resources (Cherinat and Mulugeta 2002).

Moreover, the lesser decision-making power of women is influenced by extended families in which older women who have had the experience of pregnancy and childbirth, influence the younger ones not to use maternal health care. For instance, proof elsewhere from developing country indicates the significant effect of mothers-in-law. A mother-in-law puts considerable pressure on young women on the non-use of maternal health care (Gossaye and Deyassa 2003). In nuclear families husbands make most decisions regarding pregnant women access to modern health facility (Shakya and McMurray 2001).

The current health policy addressing health and development programs was originated at the national level in 1993: *Health Policy of the transitional Government of Ethiopia*¹. The Federal Government continues to advocate and promote healthcare programs and interventions. One of the priority areas and focuses of the policy is maternal and child health. In addressing family healthcare priorities and attentions, the policy recommends:

Special attention shall be given to the health needs of the *family particularly women and children*. Family Health Services shall be promoted by assuring adequate maternal healthcare and referral facilities for high risk pregnancies through intensifying family planning for the optimal health of the mother, child and family...provision of healthcare for the population on a *scheme of payment* according to ability with special assistance mechanisms for those who cannot afford to pay...promotion of the participation of the private sector and nongovernmental organizations in healthcare... (The Transitional Government of Ethiopia 1993:25-26)

While there is an emphasis on a women in the government health policy the fact remains that most reproductive health interventions to date have been directed to change women's attitudes and behaviours norms in Ethiopia. These intervention programs have devoted scant attention to male involvement in reproductive health, but are centred and directed towards women's perspectives and empowerment. Comparatively no reproductive health programs focus on men's roles related to prenatal care, though the need for men's involvement in the areas of pregnancy and prenatal care is essential.

1.2. The Structure of the Thesis

This thesis is structured and presented in five chapters. This first chapter discussed certain critical issues related to maternal health and focused on the cultural, socio-economic barriers and other factors affecting the health of pregnant women. It further outlined the need for men's involvement in reproductive health, the significant contributions of husbands' in prenatal care and in contraceptive use and the healthcare system of Ethiopia. In chapter 2, I outline methods used to collect data; the three sites of the research design and study samples (husbands). I also discuss the challenges I faced in getting my informants to cooperate and be interviewed during fieldwork. In chapter 3, I describe the responsibilities that husbands shared with their pregnant wives during pregnancy and delivery times (mentioned during interviews and discussions). I also

¹ Italics by Mekonnen Muleta

present the views of husbands on the importance of prenatal care and the emotions and stresses experienced by husbands themselves about their pregnant wives during pregnancy and delivery. In Chapter 4, I discuss the two prenatal care spheres namely *clinical* and *domestic* often discussed by the husbands as they are defining their major roles during the pregnancy and delivery times of their wives in Addis Ababa. In this chapter, I also present the views of some of the pregnant women on the cultural practices, whether they were involved in decision making on the household activities or not and domestic supports they received from their husbands during pregnancy and delivery. Lastly, in chapter 5, I discuss the influence of modernization, urbanization, UN and Global reproductive health policies and initiatives on the role of husbands in prenatal care in Addis Ababa (Ethiopia). The conclusion presents my personal views based on the information I have obtained in the field and attempts to offer suggestions aimed at enhancing prenatal care services and information to husbands' of pregnant wives in Ethiopia.

Chapter two

2. Field work and Methods

The anthropological production of knowledge has at least two elements; fieldwork and analysis. Some might want to add a third one, namely description; one first collects a body of empirical material through various field methods, one then describes whatever it is that one has discovered, and finally, one analyses the findings (Eriksen 2004: 42).

Introduction

In this chapter I describe and explain the methodology of the research, which includes the study design and data collections techniques. I explain about the three study sites and the socio-economic background of the study participants. I also present the challenges I had in getting study participants willing to be interviewed and ethical considerations. Finally, I discuss the limitations of the study will be discussed.

2.1. Study Design and Field Sites

This is an ethnographic study in which qualitative data were collected on the perspectives and experiences of husbands of pregnant women who were receiving prenatal care at *Dinborawa*² hospital, Merry Stopes International Ethiopia (MSIE) *Arada*³ clinic and *Yeka*⁴ healthcare centre in Addis Ababa. Initially, there were only two sites where I intended to conduct my research in Addis Ababa. I had decided to do my research in *Dinborawa* hospital and Marie Stopes International *Arada* clinic; however, I noticed that most husbands I met at these two sites were either from an upper or an average socio-economic class. After doing some of the interviews and my observations at these two sites, I decided to add one public healthcare centre, *Yeka* healthcare centre, to view the situation of poor husbands coming with their pregnant wives. Moreover, the health facilities at the two original sites are sophisticated and use reproductive technologies (like ultrasound), they deliver the greatest number of children and employ the most well known gynaecologists and specialized nurses in the city. For this reason they attract wealthy and

² *Dinborawa* is a private Gynecology and Obstetrics Hospital

³ *Arada* is the local name where the clinic is located in Addis Ababa

⁴ *Yeka* is North-Eastern Sub-city in Addis Ababa

educated couples for prenatal care services. *Yeka* healthcare centre was selected because, *Yeka* sub-city, where the healthcare centre is located in Addis Ababa is nearest to the poorest couples coming from semi-urban places of the city.

The study design is explorative and descriptive since I sought to gain an insight into the topic of the study by examining the participants' viewpoints about husbands' experiences and roles of prenatal care through exploratory open questioning. The research includes a description of what I was able to witness during the actual prenatal care husbands give to their pregnant wives during my stay in Addis Ababa.

My fieldwork started with a preliminary field visit to the research sites to get a better understanding of the actual study settings in Addis Ababa. I explained the purpose of my study to the staff in the hospital, healthcare centre and clinic. At the beginning of my visits to the study sites briefings were organized by the head nurse of the clinic, medical director of the healthcare centre and the matron of the hospital with the staff on my research mission and my field work methods before I commenced the data collection process.

After staying one week in the community, I began the recruitment of study participants at the study sites. I introduced myself as a postgraduate student studying medical anthropology, to all participants. In fact, most of the study participants' recruitment was done with the help of the nurses working at the three study sites. Before recruiting participants for my study I tried to narrow the gap between the research participants and myself by making informal talks not only with them, but also with the hospital and clinic managers and staffs and other community authorities. Most of participant recruitments were made by the nurses while they were registering the pregnant wives or while they were attending the prenatal care services. I explained the purpose of the study, the processes, and confidentiality issues concerning their profiles. There were some men who refused to participate in the interview because they were busy and in hurry to go for their work places. A total of eight husbands refused to participate in the interviews and a focus group discussion.

After establishing rapport with the staff (mainly nurses and doctors) at the study sites, I was able to gradually shift to conducting semi-structured interviews with the study participants in the separate rooms I was given in each of the study sites. Field notes were taken throughout the

data collection period. Daily reflection on data collected was documented to guide modifications or elaboration of interview questions.

2.2. Data Collection Methods

This study included various data collection techniques such as observation, semi-structured interviews and focus group discussions. There were also some incidents of general informal interviewing at the private hospital, healthcare centre, clinics, home setting and offices.

2.2.1 Observation

Observations are important sources of information in ethnographic studies: “Observational methods allow the researcher to record the mundane and unremarkable (to the participant) features of everyday life that interviewees might not feel were worth commenting on and the context within which they occur” (Green and Thorogood 2008:132). During the first week I spent most of the time in the compounds of the *Dinborawa* hospital, Marie Stopes International Ethiopia *Arada* clinic and the *Yeka* healthcare centre in Addis Ababa. I often stayed in medical wards and reception rooms where the husbands and their pregnant wives sit and wait for their queue to get into the prenatal care rooms. Usually in the reception rooms at *Dinborawa* and MSIE *Arada* clinic husbands and their pregnant wives sat or stayed to pay medical bills and to watch television until they were called to enter into the prenatal room. I observed various activities and prenatal care support efforts delivered by the husbands in the hospital, healthcare centre and clinic to their wives. I had also conversations with doctors, nurses, midwives and pregnant women themselves about the current trends and old day practices of prenatal care in Addis Ababa. Through observations when visiting the homes of the husbands, I tried to obtain information about husbands’ household tasks and so on. I observed and recorded every conversation, daily life activities, public discourses and adverts related to prenatal care and reproductive health in mass-media such as TV, movies, radio and newspapers in the Addis Ababa. I used notebooks to jot down my short notes and memos in the field during my observations. I elaborated on my field observations at night after returning to my home and wrote my reflections on each day’s observation.

2.2.2 Semi-structured Interviews

Semi-structured interviews were conducted to ensure optimal coverage of relevant issues and they served as a major source of information in this study. My data collection began generally with introducing the objectives and application of the study. I introduced myself as a student of medical anthropology, interested to study the role of husbands in prenatal care in Addis Ababa. The interviews, which covered a wide range of issues, were tape recorded and later transcribed. The husbands interviewed were from 23-52 years old. Interviews were usually conducted at the hospital, clinic and healthcare centre in a separate room in order to keep the privacy of the respondents. Initially I had intended to interview only husbands, but later I also interviewed some pregnant wives, who came alone, to know their views and to find out why their husbands had not come with them. Hence, interviews took place with sixteen husbands of pregnant wives and four pregnant wives at the three study sites. The duration of interviews ranged from twenty-five minutes to one hour. All the interviews were recorded in Amharic based on the consent of respondents. Later on, the recorded data was transcribed and translated into English.

2.2.3 Focus Group Discussions

Focus group discussions (FGDs) are an important tool in health research through which a researcher is able to speak with larger numbers of participants, observing lively interactions and dialogues between the participants. In addition, FGDs produce extensive information as detailed investigation of different issues may be collected. Sensitive issues related to the study themes may also be handled through FGDs related to the topic of study (Carey 1994). In FGDs the participants through their interactions also introduce topics related to the subject the researcher hadn't thought of. A total of two sessions of FGDs were conducted for the study. FGDs with husbands were conducted during the final week of the field work. For each FGD, a group of four husbands who had a more detail experiences in prenatal care were invited for discussions. The FGDs took place in a setting the participants had chosen, one at a separate room in a cafeteria and the other in an NGO office, where my friend works. The focus group discussions took from two to two and half hours. Husbands shared their experiences regarding cultural beliefs and practices during pregnancy and delivery mainly by comparing the rural and urban practices in Ethiopia. Discussions with these husbands helped me to get a better understanding of husbands' role in prenatal care in Addis Ababa.

2.3. Study Samples: the Husbands

Once in Addis Ababa, I set out to begin my field work with a strong plan to interview twelve husbands of pregnant women at private hospital and NGO clinic. After several interviews and observations in the private hospital and the NGO clinic, it became clear that I needed to recruit participants from government healthcare centers to increase my study sample and include also low socio-economic status husbands. I then formally managed to interview sixteen husbands in total from all three study sites. It was not at all difficult to get husbands of pregnant wives as participants, yet getting husbands who actively engaged in prenatal care and who were also interested in being interviewed and participating in discussions was a tricky story. In the end, I was able to conduct sixteen interviews and two focus group discussions with husbands. However, four husbands I approached refused to participate in the study at all. Later when I recruited for a focus group, four different men left the room when one realized I was going to record the group discussion. Three other men immediately got up and followed him out. Most of the husbands in this study grew up in the rural setting in Ethiopia before moving to Addis Ababa. They shared and compared detailed experiences and information about the traditional practices among rural husbands with urban husbands' practices in prenatal care. Most of the husbands are either from Christian (from both Orthodox and Protestants) or Muslim religions. Most importantly, husbands in the study were drawn from the upper (wealthiest), middle classes as well as the poor societies in Addis Ababa. The majority of participants from the first two sites (*Dinborawa* private hospital and MSIE *Arada* clinic) had completed their grade twelve and five of them had graduated from universities with master and bachelor degrees. Three out of the six I met at *Yeka* public healthcare were illiterate and had not gone to school at all.

2.4. Reflections

When I started the field work, I had two major worries; the first was how I would get permission for my study sites, and the second was whether I would get the willingness of the informants to participate in the study. Fortunately, I was warmly welcomed and gained access to all study sites. One focus group discussion session was dispersed at the beginning of the session due to an objection by most of the participants about being tape-recorded. Some husbands seemed more suspicious due to the fact I looked like a journalist and they always asked me if it was aired on radio and TV programs. Some of the husbands also asked me if I could interview them on the

weekends, because this was the only time they were free and available. As far as the privacy of the respondents was concerned, some of the interviews were interrupted, especially at the MSIE *Arada* clinic because the staff knocked on the door of room where I conducted the interview. I must state here that the head nurse (coordinator) of the clinic was not supportive of my study at this site and as a result I was able to interview only four husbands. All said and done, I came to the conclusion that despite the challenges I faced in interviewing and group discussions I was able to collect data for the study.

2.5. Research Limitations

The present study has certain limitations that need to be considered. The major limitation of this study lies with the fact that most of husbands who contributed their views and knowledge to the research were recruited in a hospital or clinic setting. Hence, the external validity of this study is threatened by the selection process in that husbands were not randomly selected. Another limitation has to do with the small number of informants, which constrain generalisability. Further, as a small-scale study, my findings are mostly representative for that particular area (Addis Ababa), and it is also hard to generalize to all husbands in Ethiopia. I do not intend to draw a general picture of the “typical” husbands of pregnant women in Addis Ababa. In addition, the time allocated for the fieldwork did not allow for rigorous data collection.

2.6. Ethical Consideration

Concerning ethical considerations, participation was wholly voluntary and all activities of data collection were on the basis of study participants’ informed consent. Accordingly, a detailed explanation was provided to all participants including the aim of the study, the interview process, tentative time spent, and confidentiality issues. In addition, all participants were informed that they were free to withdraw from the study if they were not comfortable. In this study, privacy and anonymity were very important and I assured the participants by letting them know that pseudonyms would be used in the writing of the final thesis although many did not object to my using their real names.

Chapter Three

3. “Pregnancy is a big agenda”⁵

I spend a lot of time worrying about my pregnant wife and feeling stressed because this is our first pregnancy. I do not know what will happen, as not all pregnant women delivery peacefully and normally. This worries and frightens me; I always worry about her pains and delivery times. I am waiting for what will happen that day [delivery]. I always think how peacefully she will deliver. I give all her matters to God and listen to him. (Minale, 30, Diploma)

Pregnancy and delivery are perceived as both a risky and an exciting phenomenon in the life of the husbands and their pregnant wives in Ethiopia. Both pregnancy and delivery can change the couple’s lives in positive or negative ways. In this chapter I show how pregnancy and delivery periods are experienced as complex matters in which social, emotional, cultural, and economic contexts are interconnected. The findings in this chapter are generated from individual interviews with research participants, informal conversations, focus group discussions, and from researcher’s observations. I present the findings according to four themes: 1) pregnancy, 2) HIV testing, 3) delivery and 4) economic concerns.



Figure 1. A husband (seated on the right) demonstrates his worries and feelings about his wife’s pregnancy (crouching on the left) outside the Reproductive Health Clinic (on left).

⁵ Note : the quote is from one of the focus group discussant

During my first weeks in Addis Ababa I anticipated watching a movie that I had heard about two years ago. The movie was created and written by a well-known Ethiopian comedian Kibebewu Geda, Shemisu. It is entitled as *Amaragn* (crave or desire for food or something) in Amharic. What is interesting about the move is that it reflects the general nature of the lives of the majority of husbands during pregnancy, delivery and post delivery times in Addis Ababa. In the movie when Shemisu was asked about his problems by the elderly man, Abaye (father), he was more concerned about how he could satisfy the daily needs and desires of his pregnant wife than the health of his pregnant wife and the foetus. The drama explains the situation of migrant husbands working in Addis Ababa and reflects the experiences of these husbands (mainly poor) of pregnant wives. The socio-cultural norms and values, the socio-economic problems (poverty) of husbands of pregnant wives, sexuality and reproductive issues, and political dimension of the country were reflected in the drama. Shemisu portrayed a characteristic of a husband of pregnant wife and Abaye displayed a characteristic of an elderly father in the community in Addis Ababa. When Abaye asked Shemisu what worried him, he responded looking down at the floor.

Shemisu: I came across a bit of problem. And I came to see you on this....

Abaye: What happened to you, Shemisu? Please tell me! Do not be frustrated!

Shemisu: I have a wife [pregnant wife]. I am in terrible state and stress. One day, she says I want this and the other day she says I desire that...her behaviour is changing. I cannot understand what happened to her. .. And he cried and said I should kill myself.....and regret having had sex with his wife that resulted in pregnancy.

Abaye: Oh, *indeye!* Stop! Stop! It is not good to interfere with the will of God.

Shemisu: you know Abaye, referring his pregnant wife. Every time she says, 'I desire these and that...and I want that...'. If she desires something from a shop such as bread (*dabo*) and biscuits (*koshoro*) [as he is the owner of a shop], I can bring it for her but she wants and desires something beyond our income (economy).

Abaye: Let me tell you Shemisu, This is pregnant women's natural behaviour to desire different food during pregnancy (*Ihe Yenefisaturi wegu newu! Tefetiroyechewu newu!*). Let me tell you

also my experience, my wife when she was pregnant, she said to me: bring me kale (*gommen*) and tomato (*timatim*). Please do for her what she wants and as much as you can!

The message is clear that Shemisu is poor and seeks social support from an elder (Abaye) in the community. Additional information extracted from the drama is Shemisu's lack of experience and ignorance about pregnancy and its impact on the physiology and behaviour of pregnant wives. Though it seems a joke, a comedy, it is important to note the influence of economy on the role of husbands to give prenatal care in both domestic and clinical spheres in Addis Ababa. From the movie it is surprising to note how poor husbands are frustrated by their insufficient economic power (poverty) to support and accommodate their pregnant wives' food desires. The message from the movie also reveals how the health of a pregnant wife and foetus was not a priority for poor husbands due to their economic constraints.

3.1 Pregnancy Concerns

3.1.1 Pregnancy worries

Many of the husbands spoke about their wives' sicknesses during pregnancy and their fears for her health. The descriptions of the sicknesses were very different and included examples such as: sleeping problems, vomiting, coughing, exhaustion, or found certain odours caused nausea. The husbands reported a variety of explanations for their wives' sickness. Some associated the sickness with misfortune, some with their wife having eaten something bad, or pregnancy was too hard for their wife to bear and she got sick. It didn't matter what the husband thought the cause was in relation to their concern; all husbands of pregnant wives who were sick were highly anxious. For instance, Samson, a husband of an eight-month pregnant wife, described his emotional distress during pregnancy and expressed his experiences as follows:

I love my wife very much. When she feels sick I do also feel sick like her. Her sickness is my sickness (*himamawa yene himami newu!*). If she gets sick I feel pain and sick like her. I worry more than her even if she carries the baby in her body. Even if she is pregnant, my concern and feeling about pregnancy is by far more than her. For instance, if she is sick during night times that night I do not totally sleep. Even at normal times during her pregnancy every night I wake up and see whether she slept in a conformable sleeping position. If she slept on her back or stomach which is dangerous for her health and the infant, I tell her to see sleep on her side. (Samson, 36, grade 12)

It appeared that expressing worries and concerns was a way for the husband to take responsibility for the pregnancy in their own hands. When asked, “Why you want to be involved in prenatal care?” most husbands responded that they wanted to shoulder the burdens and hardship of pregnancy with their pregnant wives. As Samson said above, Tesfu also expressed similar feelings of concerns when I asked him, do you have a role in prenatal care? Then he answered:

Yes, I think the greater concern is mine. May be she worries but my concerns and feelings exceed that of my wife. When the doctor told us she needs fruits. Then I always buy for her mango juice. Maybe that could have contributed to the big weight of the baby. I just say always what shall I do? --- and she needs that and this-- The doctor told us the baby is big and she may give birth by operation (*be operashini litiwelidi tichilalachi yelanali*). Beginning from the day of conception I am with her even at work place. And I meet her there and see what she feels since her conception. Sometimes she interrupts the work and goes home. Then I feel more responsible and think about the pregnancy. Even she gets tired and could not go to work. Of course she knows more about her insides but I feel and think more than her about the pregnancy (*ineni kefitegna simeti yisamagnal*). Sometimes, for example, I do not know what to do at home especially when she tells about her pains and sickness for me. I want to bring her to hospital frequently even before our prenatal care appointment day. If the doctor does not tell me that there is no problem I would bring her before the appointment day. I am in hurry to see that [delivery] day. (Tesfu, 52, grade 12 complete)

3.1.2 Demands for Food

It is not uncommon for pregnant women in Addis Ababa to have strong cravings for unusual and expensive food during their pregnancy. Husbands find this a burden/worrisome because they want to accommodate their wife and believe that nutrition is important but may not have the money to pay for what she asks for. Yared, for instance, said:

My wife craves odd substances and likes the smell of burned fuel gas from cars and vehicles and black soil. I cannot purchase burned gas released from cars. She does have the desire for bananas and oranges which can be easily purchased. There is a traditional Ethiopian belief if one pregnant woman does not get what she desires during pregnancy, there would be black mark on the skin of the child after birth. Even I talked to a doctor to know the cause; I do not get explanation for this condition. (Yared, 34, Diploma holder)

A poor, daily labourer, husband involved in this study was also expressed concerns and problems because of his financial incapacity to cover the costs of the food desires of his wife.

I could not afford all the food desires of my wife during her pregnancy time. I can only buy small and cheap foods with less cost....sometimes if I do not have money I lent from my friends to fulfil her interests to some extent. It is difficult for me; I cannot pay for all foods she wanted. (Solomon, 28, illiterate)

He gave voice of the feelings of distress, there by highlighting how difficult for the poor husbands to fulfil the food desires of their pregnant wives in Addis Ababa.

3.1.3 Cultural Implications of Sickness

Some husbands, who lived in semi-urban areas of Addis Ababa a bit far from the rural villages, expressed more concerns and feelings about the sickness of their pregnant wives than about taking their pregnant wives for prenatal care. For instance, Lemma, told me about social pressure he felt from the people in his community, who considered him as a misfortune (*idelebis*) to his pregnant wife. Lemma explained why he worried:

My pregnant wife has been sick for six months [during her pregnancy time]. She has been sick in her abdomen and also coughs every night. My mind thinks and I fear a lot and have concerns that some bad thing may happen. I do not sleep every night. The electricity bulbs light the whole night every day. She is very sick...she has problems like vomiting and frequent coughs every night since her conception. It begun with allergy (*michi*) followed by her serious sickness. She has been sick and remained at home and on a bed for the last six months. I always beg my father's ancestral spirit (*ayyanna abba kootii*). I beg God (*Waqqayyoo*⁶ in Afan Oromo) to hide me from a bad misfortune and protect her from bad things. I fear and worry what people may say about me...they [people in his community] say he is a misfortune because of her sickness. That is why now; we came to visit this [Yeka] healthcare centre. (Lemma, 34, illiterate)

3.1.4 Man's Family

When a woman marries in Ethiopia, she is the responsibility of her husband's family. If a woman becomes ill (even before a pregnancy) a husband takes counsel with his father and perhaps his mother about what they should do. If pregnant women become sick, her husband would seek the same advice from his parents. It is normal for his parents to counsel him to take his wife to a

⁶ *Waqqayyo*(*Waqqa*) in Oromo (Ethiopia) approximates to the English word God

traditional healer locally. Therefore, a woman (pregnant or not) has no free will or decision-making power for herself; her husband and his extended family decide what happens in regard to her health and that of the foetus. Botoli, who lived in the same place where Lemma lived, had another concern about his wife pregnancy. He also explained about the sickness of his four-month pregnant wife. His worries and anxiety are related to their previous bad pregnancy experience and outcome. Being a bit worried and scared he told me the following:

Six months after our marriage three years ago, my wife had her first pregnancy. At that time, we did not think too much about pregnancy and delivery difficulties. Nine months later, during her first labour, my wife laboured almost for one day. Although we called a traditional birth attendant, *ogaitti*, who helped her to deliver the child, my wife was not able to continue labouring. Then, we [the husband and his relatives] decided to take her to the hospital [in Addis Ababa]. At that time she was almost dying. In the hospital she had an operation [by Caesarean section] and the dead child was taken out. ---with that bad experience I feared and decided to visit this [*Yeka*] healthcare centre as she is sick in her abdomen. (Botoli, 28, illiterate)

When I met them at *Yeka* healthcare centre, she was 17. I suspect that the failure and the complication of first delivery is at least as a result of the early marriage of the wife of Botoli, who three years ago was 14 years old and too young for a risk free birth. I heard this while she was telling her medical history to the nurse who registered her in the prenatal care room.

3.2. HIV Testing Concerns

In addition to pregnancy and delivery outcomes, an HIV test is also a central concern of couples in Addis Ababa. One day when I talked with S/r Alemitu, VCT (Volunteer Counselling Test for HIV) counsellor and nurse at *Yeka* healthcare, she told me, ‘There are cases when one of the partners was diagnosed as being HIV positive that resulted in a marriage break-up or in serious relationship problems between the partners.’ In another conversation the same nurse told me that ‘I knew a case of a couple where the pregnant woman tested positive for HIV and aborted the pregnancy. The couple subsequently was divorced and the woman joined a *Gedem* (monastery) to devote herself to truly fasting and praying to God to cure her and she started to drink *tsebel* (holy water). The nurse continued, ‘There were also times when I came across pregnant women refusing VCT because they feared the virus as well as their husbands. I knew also pregnant women who refused to undertake test for HIV due to a fear of her husband as she had not consulted him’.

Indeed, some husbands were worried about their own HIV status and they were fearful until their pregnant women disclosed the good news to them. In this regard, my observation in the prenatal care room at the public healthcare centre gave me an indication of how a pregnant wife and her husband reacted to VCT, one of the routine components of prenatal care. When I was in the room the husband of a pregnant woman was hesitant to be tested and negotiated with the nurse that his wife's test would be sufficient to know their status. In addition to pregnancy worries, Tesfu had similar experience. He told me that, at his absence during the prenatal care visit his pregnant wife was tested for HIV. At *Dinborawa* hospital husbands are not compelled to have an HIV test like they are at the *Yeka* public healthcare centre where both husband and wife are expected to test for HIV. Tesfu continued telling his experiences as follows:

For your surprise, let me tell you one interesting story also; then he continued one day my wife told me that she tested for HIV. They [hospital nurse and a doctor] told her to undertake HIV test and then she did that at the hospital. And the next day I asked her about the result of her test. Then she told me she will go to the hospital to get the test result. Then when she came back home and I asked her about it [test result] then she laughed at me and said why you are suspicious yourself? Then I replied you do not know how you acquire it ... you may get it without sexual intercourse. Then one day I decide myself... If my wife is negative then I should also know my status and assure myself. Then I myself decided to go for a laboratory test in the city. When the result of mine was also negative I cannot tell you how my happiness was that day! (Tesfu, 52, grade 12)

3.3 Delivery Concerns

Delivery is one of the central concerns in the lives of husbands in Addis Ababa. Husbands are usually excited to know their wives' and infant's health status. They ask the doctors and nurses about the sex and normal position of the infant in the womb. Good information from the ultrasound alleviates their stress and fears about an abnormality of the child in the body of the mother. Unlike in western countries, husbands in Addis Ababa do not attend their wife's delivery. Husbands are compelled to stand outside and in front of the delivery rooms where they usually listen to the screaming and shouting of their wife experiencing delivery and labour. In most cases the husbands in this study told more about their worries stresses and fear about easy or difficult labour and delivery. Birhanu, a university graduate recalled his similar memories about his experiences during the first delivery time of his daughter as:

Observing and listening her being inconceivable irritation and pain was the worst thing that's ever happened to me during her first delivery, he says. I better experienced the labour myself than to hear her shouting and screaming in the delivery rooms. (Birhanu, 42, BA in Business Management)

In their study about delivery and fatherhood, Coley and James (1976) stated that there were varied emotions about pregnancy and delivery: fear of impending financial and emotional responsibilities, worry, happiness, excitement and this statement is true in Addis Ababa as well. One day, during my field work in Addis Ababa, while I was chatting with the guard of MSIE *Arada* clinic, I asked him why husbands' of pregnant women who are in delivery are so horrible and restless in the clinic. This guard has worked for a long time at the gate of the clinic and I considered him a valuable source of data. I understood that he observed the husbands' behaviour and actions on a regular basis. He told me that 'they [the husbands] are in tension and stress during delivery because it is a frustration and critical time for both the husbands and their wives'.

During my own observations, I saw that husbands during the delivery were so emotional and one could discern from their facial expressions their stresses and worry and fear. Their faces were pale and they looked like they were thinking and lost while talking. When I approached them, they were not willing to be interviewed and they told me that they were busy and occupied in arranging for their pregnant wives. Most of them were busy running here and there, talking with their relatives and family about the status of delivery and labour with cell phones.

3.4 Economic Concerns

Even though not all of the men mentioned the preparations made during preconception, pregnancy and delivery, some husbands confirmed having made plans for prenatal care and pregnancy. Most husbands I met and talked with at *Dinborawa* hospital and MSIE *Arada* clinic had planned and made preparations for pregnancy and delivery and even for postnatal roles and responsibilities. This was perceived as a duty and responsibility of the husband to make preparations for psychosocial, financial and fatherhood supports. In this regard, Minale, for example, shared his experiences as follows:

I want to tell you the truth, on our part we held discussions and planned on everything ahead of our marriage and conception. We talked over the pregnancy matters ---who will do dishes during pregnancy andwhen to have a baby and

which hospital we go to for prenatal care (*kititil lemehedi ina qideleni*)⁷.
(Minale, 30, Grade 11)

In addition, the husbands in this study expressed that planning in pregnancy enabled them to know about abnormal and normal pregnancy. In this case, they had consulted their doctors before conception of the child in order to conceive a health foetus. Some described how they read and gathered information ahead of pregnancy from books, websites and friends. Some of the husbands mentioned that pregnancy should be budgeted for and programmed. This insight was supported by information from focus group discussions with husbands. The husbands said their reasoning for planning ahead was to be emotionally committed and to make prenatal care preparations ahead of pregnancy. Talking about the objectives and goals of pregnancy and prenatal care planning, Negash, a focus group discussant, who had already had one child, said:

By prenatal care we mean that couples should plan on pregnancy and make the necessary preconditions and preparations including from psychological readiness to financial, time and others. A husband has a responsibility towards his pregnant wife, as in pregnancy she needs a balanced diet, medical treatment and -----others. My wife and I arranged everything ahead of the pregnancy and during the pregnancy. (Negash, 39, M.Sc in mathematics)

According to my conversation with the husbands, they often mentioned how these days life is expensive as food, school and healthcare costs are rising. In Addis Ababa, most husbands talked about the preparation for the delivery times and previous delivery experiences when wives gave birth by caesarean delivery which costs up to six thousand Ethiopian Birr (\$600). Even a normal delivery requires two thousand Ethiopian Birr (\$200) in the private hospitals like *Dinborawa*, one of my study sites. Today, due to global economic recession and poverty in the country the economic status of couples is incapacitated. I remember stories, from two husbands similarly told, about how they wanted to have two consecutive children, for the youngest can use the clothing of the elder and they can go to school together to reduce the cost of a taxi. Gizaw, whom I met in a Korean hospital in Addis Ababa, when I took my daughter to the hospital, told me about a similar situation. Gizaw was also a relative of mine and his first child was a daughter. His wife, Abel, was pregnant again with a boy (she'd had an ultrasound). This second pregnancy had been planned and the couple wanted a son. My wife living in Addis Ababa told me that Abel gave birth to a boy a

⁷ *Kititil* in Amharic is literally to mean as going for prenatal care at modern health care

week after I came back to the Netherlands from my field work in Ethiopia. The conversation with Gizaw illustrated a familiar situation in Addis Ababa:

My wife and I decided to have two children consecutively in a two year interval; for one thing she will look for a job to earn money and the other is to bring up the two kids together at the same time with minimum expenses. By doing this we share the burden through economic cooperation to lead our life. (Gizaw, 34, BA in Economics)

In summary, in this study all of husbands involved in prenatal care had shared pregnancy and delivery times with their pregnant wives differently. Readiness and preparations included budgeting for food or something their wife might desire and crave during pregnancy, planning for a delivery and prenatal care at a hospital for their pregnant wives. One focus group discussant, Ademu, explained his role in pregnancy planning as:

I will buy new beds and take annual leave to emotionally and socially support my pregnant wife during labour and childbirth. (Ademu, 35, MA in psychology)

Therefore, this study suggests that there is a relationship between the role of husbands in prenatal care and their socio-economic backgrounds in Addis Ababa. It is clear from the above discussions that husbands' worry about pregnancy is helpful for their role in prenatal care. According to Bowers (2001) worries and concerns are essential and useful in pregnancy as it may motivate husbands to take more care of their pregnant wives and encourages them to seek prenatal care services. Husbands' (fathers') emotional reactions and anxiety during labour implies that birth is a critical turning point in the transition to fatherhood (for similar account in Sweden see Premberg and Lundgren 2006). In view of the fact that husbands' are engaged with the emotional care of their pregnant partners and ownership of prenatal care issues in Addis Ababa, I would argue that they are right at the forefront in reducing mothers' mortality risks associated with pregnancy and delivery in Ethiopia (elsewhere) and especially in developing countries in sub-Saharan African countries where mothers' mortality rates are the highest in the world.

In general, husbands' worries and concerns have to be seen from wider macro-social levels and different contexts in Ethiopia. Husbands' roles in prenatal care are entangled within socio-cultural and economic contexts. I found that pregnancy and prenatal care are related with

husbands' socio-economic status. Husbands who were illiterate and poor seem worried about their financial insufficiency regarding the cost of pregnancy and delivery. In contrast to these husbands, the ones from a higher class worried more about the labour pains of their wives and feared pregnancy and delivery complications. It appears therefore that although the sources of fear and worries varied, most of the husbands I spoke with said that they feared and worried about "their" HIV test results.

Chapter Four

4. "I am to some *extent* like my father"⁸

⁸ Quote from one of the focus group discussants

In this chapter, I discuss how husbands' religious views and traditional upbringings are interacting with 'modern' ways of thinking about men's role in society and how this is informing their actions toward their pregnant wives. I also present the two prenatal care spheres namely *clinical* and *domestic* often discussed by the husbands as they are defining their major roles during the pregnancy and delivery times of their wives in Addis Ababa.

4.1. Clinical Spheres



Figure 2. Husbands waiting at the front of the delivery room while their wives are delivering.

My own personal observation of husbands attending prenatal care appointment at *Dinborawa* hospital was as follows: it was around 10:00 o'clock in the morning when I saw a couple (a husband and his pregnant wife), both young, jolly, dressed prettily in jeans, standing in the compound of the hospital. I sat on a bench behind them and looked at their facial expressions and body movements. Then I watched them talking and laughing to each other. The husband was also holding the neck of his wife and he was carrying her bag and her coat in one hand. After talking and chatting in front of me for about fifteen minutes, they then went to gynaecology ward to have the prenatal care consultation with the doctor.

Every morning, while I was doing my study in this hospital, there were crowd of couples (husbands and their pregnant wives) coming to the hospital between 8:30 and 9:30. I met them while they were sitting and chatting in reception room of the hospital. In this hospital, in many instances I often saw the same husbands queuing for their pregnant wives to pay medical bills and bringing their wives' laboratory specimens and results to laboratory rooms and from the laboratory room to the medical ward. The men accompanied their pregnant wives either with their family cars or taxi to the hospital. Sometimes I saw the husband leave their pregnant wives to go to their job. One day in the morning at 9 o'clock, on my arrival at this hospital, a pregnant woman asked me to call her husband so that he could pick her up from the hospital to return home⁹. During their conversation with my cell phone I heard '*ahun nana wusadagn* (please come and pick me)'. This observation illustrates the general level of a husband's involvement in Addis Ababa in prenatal care nowadays.

While it is common today to see a couple (a husband and his pregnant wife) going and visiting the prenatal care services offered at modern care facilities together, this was not the case in the past. Men never would accompany their wives to the clinic. Husbands made important decisions concerning the family affairs including allowing (or not) to let their wife visit the modern healthcare facilities. In addition, earlier days a husband also never went into a kitchen even not when his wife was pregnant. Women were expected to run the household activities and reproductive issues were their sole responsibility. However, these days especially in urban setting like Addis Ababa, husbands are engaged in domestic tasks during the pregnancy time of their wives. However, as became clear throughout the current research, the extent to which husbands are involved depends on for great part on their socio-economic background. This is well illustrated by the conversations I had with S/r Mesert, the head nurse (matron) of *Dinborawa* hospital in Addis Ababa. During our conversation over the situation of husbands' role in prenatal care she related the type of prenatal care sought and the level of husbands involvement to the socio-economic backgrounds of the couples. Medical costs and the socio-economic background of hospital clients became the core topic of our conversations. 'You see,' S/r Mesert said, looking at me, 'our customers know that they are expected to pay many medical costs before they come here'. She also added that the costs they are expected to pay are also

⁹ This a common situation in which one who has no cell phone asks for the assistance of a person with a phone to call his or her relatives

higher than that of the public hospitals and NGO clinics. She continued, ‘the wealthiest couples visit our hospitals together’ whereas she said ‘*daha irguzi seti* (the poorest pregnant women) ‘go to healthcare facilities alone with the absence of their husbands’. This story reflects what I saw at the public healthcare centre. There were very few husbands who accompanied their pregnant wife for her appointment at the public healthcare centre. Based on my field work I found people gave different reasons why their husbands had come or had not to come to their prenatal care appointment.

4.1.1. Modern Healthcare Only as a Last Resort

While in the public healthcare system I rarely saw husbands with their pregnant wives, it was common to observe couples visiting prenatal care facilities at private hospital and NGO clinic. Husbands’ involvement in prenatal care is mediated by several factors. It has to be noted that their participation in prenatal care depends on the socio-cultural backgrounds of the couple and also on education and household incomes. Most husbands were not appeared with their pregnant wives at *Yeka* healthcare centre. It seems their participation is limited because of time constraints and socio-cultural factors influenced their involvement in prenatal care. Often their participation is limited because of their occupation (most were daily labourers), lack of transportation and medical costs, or lack of education and information on the importance of prenatal care. Poor pregnant women (together with their husbands) visited prenatal care either when they were seriously sick or if all possible traditional means of treatment had been sought or tried. A story and an explanation from Lemma, who lived in semi-urban part of Addis Ababa substantiates my argument.

In the family her mother is *qallitti* (divinely inspired women Oromo priest). She told her [his pregnant wife] that she should not go to a modern medical healthcare facility. My wife was told to consult her mother [*qalliti*] at her home place that is far from our home. And she gave her a traditional medicine (*Habesha medihanit*). But that did not cure and prevent her from illness. (Lemma, 34, illiterate)

4.1.2. Presentation of Self as a Modern Man

The other most interesting story about husbands’ role in prenatal care at *Dinborawa* hospital and MSIE *Arada* clinic is the expression “I follow doctor’s advice!” During my hospital and clinic

days, I often heard this expression from informants I interviewed at both these study sites. For instance, Biruk, discussed his experience when I interviewed him:

I treat my wife in all respects. While she is sleeping I wake up to see whether she is sleeping properly or not. If she does not sleep as the doctor's advises, then I tell her to sleep in a proper way according to the advice we got from the doctor. On her appointment day I remind her about prenatal care appointments and make the necessary arrangements, leaving my job in order to accompany her to the hospital visit. In the hospital with her I attend the doctor's advices and follow up his recommendations. (Biruk, 34, Diploma)

This quote from Biruk illustrates how husbands are engaged in prenatal care and it shows a clear picture of their accounts during my fieldwork in Addis Ababa. It seems to me that they were quite proud of the fact that they are going to these appointments and they are following the doctor's advice. It is their way to take more active roles in their wife's pregnancy and they seem to get almost an ego boost from it, e.g., it makes them feel modern man to be able to take care of their wives in this way. So in some ways the men's more active role in prenatal care is actually a quite "traditional" one in which they are providing the doctor's advice. One educated middle class, adult husband (FGD) reiterated his roles in prenatal care as follows:

My personal practice is that we go to prenatal care service beginning with the fourth month of a pregnancy. From this pregnancy time onward I would accompany her to the hospital every month according to the prenatal care appointments and I would remind her of her prenatal care appointments; I register her at the hospital and pick up her client identity card from the hospital. In the hospital I attend the doctor's advice. Then when my wife and I go back home I share the information and knowledge I gained during medical checkups with my wife. -----If there are also ultrasound procedures, I will also attend the procedure with our doctor. (Taddesa, 45, BA in Law)

Similarly, most of the husbands involved in the study at *Dinborawa* hospital and MSIE *Arada* clinic expressed a related phrase '... *kititli ihedalahu.*' literally meaning 'I visit the healthcare facility for prenatal care checkups'. The fact that the majority of these husbands mentioned going to modern facilities for prenatal care with their pregnant wives indicates in the first place, the desirability of husbands' involvement in prenatal care during pregnancy and delivery times. Another husband, middle class, who had also a similar experience and roles in prenatal care at modern healthcare added:

At this clinic [Marie Stopes International Ethiopia *Arada*) husbands pay medical bills and follow up the laboratory results. As for me, husbands should give full support from the time of conception to delivery period. We [he and his pregnant wife] have our doctor who permanently follows her during her pregnancy and delivery times. I follow his advices. Whenever he tells us he wants to check the baby with ultrasound, I say okay and attend the event. She will give birth at the presence of this doctor. This is an obligation for husbands to carry out. This has a positive contribution and a moral satisfaction for her. Husband's presence and accompanying her is very essential in case she might get sick and face a problem on her way to the clinic and when she comes back home. (Solomon, 30, Diploma)

Many husbands told me that they believed that accompanying their wife to her prenatal care appointments was the modern thing to do. They had seen television shows, had higher education and lived in a social environment where they saw a more “modern” style of marital relationship. Therefore they believed that their behavior was consistent with a modern husband and were proud to be seen in this role. In contrast, healthcare providers (nurses and doctors) I met at MSIE *Arada* clinic mentioned a different scenario. They said that, in their experience, husbands consider going to the hospital or clinic during pregnancy a women's issue. They consider sitting in waiting rooms with pregnant wives as occupying the spaces of pregnant wives in the clinic. While sharing his experience with me, Dr. Hailu, a gynaecologist at the MSI Arada clinic, told me what he has been observing during prenatal care and delivery times as follows:

Quite few husbands who are educated could attend the prenatal care of their pregnant wives. The majorities of husbands who visit modern healthcare facility with their pregnant wives leave them in the medical ward and stay out somewhere near cafes. Most husbands visit prenatal care facilities to pick up their pregnant wives and child. The problem with low involvement of husbands is related to their low awareness and knowledge of reproductive health issues. This in turn limits their participation in prenatal care at modern healthcare services. (Dr. Zeleke Hailu, Gynaecologist, MSI Arada Clinic)

Likewise, while I had an informal conversation with one male nurse in the *Yeka* healthcare centre I asked him “Why do you think most husbands do not come with their pregnant wife during her check up for prenatal care?” Here is his answer:

Even those few husbands visiting the prenatal care only accompany their pregnant wives during the first prenatal care checkups and visit. They come here to pay the medical bills and to show them the location of the health centre. They consider it [going to prenatal care facilities] as a suffering and losing their time. After the first visit they come also during the last term, to know the labour and delivery situations of their pregnant wives. (Male nurse, *Yeka* Healthcare centre)

The stories above from the health professionals therefore indicate that husbands' roles in prenatal care are shaped by a wide range of contexts and dimensions. Groenewold et al (2004) argues that the husbands' roles in prenatal care and reproductive health do not unfold in a social vacuum. According to the authors, wider dimensions of societal and individual factors shape, and often hamper, men's aspirations as husbands portrayed by poverty, and by social pressure, an unequal view on gender relations, and lack of sufficient knowledge on maternal issues.

4.1.3. The Quality of Healthcare is Discouraging

[Medical] anthropology considers the significance of a socio-culturally processes and approaches within the territory of modern healthcare systems. For example, it offers a critique of practices and attitudes of health care professionals while they provide healthcare services to clients (Shand 2005). Likewise, during the field work I observed that some of the nurses were unkind and intolerant towards the visiting couples. When pregnant women (couples if they came together) came late after 10:30 o'clock in the morning, one of the nurses especially shouted at them for delaying and instructed them to come the next day. I may say, that this kind of health professionals' behaviours may frighten the pregnant wives and their husbands thus they may not voice their problems related to pregnancy and ultimately avoid modern prenatal care services. Furthermore, the time pregnant women were given for the consultation and counselling was so brief and their verbal interchange was short. My other observation was the status of the clients is also limited to accepting suggestions from the nurses. In this case, I would like to agree with Kleinman (1980: 264), who notes that ".....a great doctor need ask nothing. Thus, for clinician the pressure is on from the outset to make as rapid as a diagnosis as possible and to do so with the smallest amount of information he can get away with. ---doctor is the authority." It is my impression that health professionals need to understand the wider socio-cultural and economic contexts of patients (pregnant women) in Addis Ababa.

4.2. Domestic Spheres

Apart from their role at modern healthcare services, the husbands in this study also claimed that they provided supports at domestic chores. There are also other roles of husbands in prenatal care

I came across in the course of interviews, discussions and my observations at home settings. These roles are included under three major chores: *nutritional support*, *spiritual care* and *household tasks*.

4.2.1. Nutritional Support

It was found that one of the critical supports pregnant women received from their husbands was nutritional support. Although none of the husbands in the study reported the prohibition of food for their pregnant wives due to cultural restrictions and food taboos during pregnancy, most participants shared their experiences about their pregnant women's desire for different new foods, odd foods and something else. The role of husbands in food support to their pregnant wife was emphasized time and again, most of them expressed 'my wife craves and desires for ...food or ... I bought her ----'. These kinds of narratives, for example, were strongly pronounced during my interview with Tekalign, as follows:

Most of time during her pregnancy my wife desires foods such as fish and fruits. Thus I usually keep her desires of these foods even if I could not get a fish at market, I buy sardine from a supermarket and bring home to my pregnant wife. (Tekalign, 33, grade 10)

Mekonnen, who lived in semi-urban Addis Ababa, also told me his nutritional support and about the types of food he bought for his pregnant wife as follows:

I buy any food she craves and desires. I buy things such as meat, bread, orange, yoghurt and *kolo*(roasted barely) . She wanted sometimes to drink soft drinks (*laslesa*); I buy for her coca cola (*laslesa*) for her when whenever she asked me. I also buy for her powder soft drinks (*star*) with minimum costs. (Mekonnen,23, illiterate)

Researchers who believe that cravings are physiological argue that it is a mechanism to protect the foetus and the mother from nutrient deficiencies and suggest that cravings are triggered when a deficiency in one or more nutrients arises. And also, they argue that pregnant women who experience desire for food increase dietary intake (Tierson et al 1985). This view appears to be supported by my own observation and conversation with a trainee nurse from the National Health College in Addis Ababa whom I met at *Yeka* public healthcare centre. We talked about the black mark that I frequently saw on the face (cheeks) of poor pregnant women (*Yeka* healthcare centre). I started our conversation by asking the nurse what was the black mark on the face of these pregnant

women which I had not frequently come across among pregnant women at the *Dinborawa* hospital and MSIE Arada clinic. She answered my inquiry with a biomedical explanation as follows: ‘It is a mask of pregnancy (*chloasma*) which is more common among the poor pregnant women due to lack of balanced nutrients such as green vegetables and fruits’. When I hinted that poverty also affects pregnant food cravings, she reacted with the Ethiopian proverb: “a person looks what he eats” (*sewu yemibelewun yemaslal*). Based on my own experience (I worked with children under five and lactating in a pregnant mother health project as a nutritionist in Ethiopia with World Food Program), I would argue that pregnant women’s desires and craving for different foods and odd things in Addis Ababa could be a reflection of Ethiopian women’s nutritional status, which is low as malnutrition is widespread among lactating and pregnant mothers. Pertinently, in addition to malnutrition induced by poverty, poor husbands and their pregnant wives are not knowledgeable about balanced diet and lack information. Therefore, public health programs and interventions designed to reduce mothers’ mortality rate during pregnancy caused by malnutrition requires addressing men in Ethiopia. I also found that most husbands in this study were knowledgeable about pregnancy and feeding precautions, and by their own ideas, husbands did not want their pregnant wives to eat raw meat and vegetables. Most of the study participants from interviews and focus group discussions explained their support for their pregnant wife’s non-consumption of alcohol based on the information and advice they obtained from doctors or nurses.

4.2.2. Household Tasks

In addition to the above idiom, husbands also referred to the following tasks related to their roles in prenatal care in domestic spheres. Most husbands’ accounts included tasks such as taking care of children, cooking, washing clothes, cleaning rooms, bathing, and advising their wife not to take on heavy tasks or lift heavy items. Talking about his role in domestic tasks, a husband in one focus group discussion said:

Although I do not bake *injera* ---I do dishes. I make coffee, wash clothes and clean the house. I bathe my wife and buy food stuffs from market and shops. Although from the Ethiopian cultural perspective, husbands do not pick up the plate after they have eaten....however, in my house I help my pregnant wife in picking the plate we have eaten from, wash the dishes and clean the table. This time I do not want her doing heavy tasks. I should reduce her tiredness. I do this for our love and I feel so happy in doing so. (Bekele, 30, Diploma)

Merid, who grew up in rural Ethiopia had told me his experience on how he had helped his pregnant wife and even supported his mother when she was pregnant with his brothers and sisters. In that case he said:

I want to frankly tell you that in our house there is no division of work and duties between me and my wife. After I moved to Addis Ababa from my birth place, I have been doing all households except baking *injera*. My wife does not do heavy activities or even wash clothes. I bathe the body of my pregnant wife and also wash her legs. I am the eldest child of my family. In rural place where I grew up, there are still backward and harmful traditional practices perpetuated for many years. I am the first child for my mother. She gave birth to six children. I knew the challenges and pressure on my mother. When she was a pregnant, I did everything, even making dish, baking *injera* and grinding a cereal on traditional stone-mill in the rural. That time I carried my sisters and brothers on my shoulder. (Merid, 23, Grade 7)

Despite husbands sharing more tasks in the household chores, this does mean that gender roles and expectations have totally changed in the life of husbands and wives in Addis Ababa. Most husbands spoke of complementary domestic chores such as caring for children and washing clothes. For instance, Mubarak described his domestic tasks during the pregnancy time of his wife as follows.

Most of the time my duty is out of home that needs intensive follow up and hard work. I spend most of my time there and come back home lately in the evening. However, when I am at home while my wife is working at home activities, I do care for our children. I also wash clothes and clean rooms. (Mubarak, 41, grade 12)

At the hospital, clinic and health centre most husbands told me that they do the majority of household activities. In order to see the actual domestic roles of husbands in prenatal care, I also made a home visit to a house of a couple (the woman was eight months pregnant) near my home in Addis Ababa. This pregnant woman was a member of my wife's staff and the home visit was arranged through my wife. One day in the evening (7:00 PM) we went to see how a husband of a pregnant woman supported her at their home. On arrival we were welcomed and there was *buna tatu* (coffee ceremony) invitation from them. There were a lot of social issues raised and discussed at that time. While we chatted over all these topics, Mr. Gebisa was sitting on a sofa when we arrived at their home and soon he went out to buy soft drinks for us. I saw Mr. Gebisa's main duties were to look after and care of their first boy, 1year and 9 months old. The mother of the pregnant wife served us with the coffee at their home.

Gender power relations

Though most husbands told me that as a couple they made decisions for using prenatal care services; husbands were still exercising the decision power at the household levels. Husbands argued that though there were changes, the women themselves did not exercise their rights because of the way the society constructed their responsibilities and that still has an impact on their current practices and attitudes towards decision making in the family. For instance, Birhanu described his experience on the decision making on household affairs including prenatal care in the following way:

Even though we decide all matters together my wife brings all house hold issues to me for approval. I think this is associated with maleness where in our tradition men are supposed to have more responsibility over women. Men can decide alone and apart from their wives and then do what they like and want without consulting their wives. The majority of decision making is done by husbands because this has been practiced for many years and is culturally acceptable at societal level in Ethiopia. (Birhanu, 42, BA in Business Management)

Likewise, some husbands who were asked about their role and work in the domestic chores during the pregnancy and delivery times of their wives told of similar perceptions and experiences. Tolesa was also one of those husbands who was not involved in the domestic tasks to help their pregnant wives and also lived in semi-urban and extended family in Addis Ababa. His account is a good example:

The reason why I am not baking *injera* and doing dishes is firstly; my mind does not accept it. Secondly, I think it is beautiful on the hands of women. I also do not have experience doing dishes and baking injera in the kitchen. We have a servant to work in the house. If we do not have a servant, women from our neighbours help us or girls in neighbours [relatives] help and support us at home. (Tolesa, 33, illiterate)

These views and practices were also shared by the pregnant women I talked with at *Yeka* healthcare centre in Addis Ababa. In the traditional Ethiopian society, husbands and women do different tasks and there is division of labour in their daily lives (Terefa 2000). Some of these divisions of labour that women are supposed to handle themselves are reproductive health and household matters. The way the pregnant women expressed their experiences demonstrated the gender role expectations from women in the society. For instance, I asked Kebebush why her

husband was not accompanying her during her prenatal care visits to modern healthcare facility. She said..

I thought coming here [prenatal care service] is not his concern and affairs. I have no idea that my husband needed to come with me. I do not know that my husband should come with me. She herself asked me; does he need to come here? And I said yes, okay, if I tell him, he would come with me. (Kebebush, 35, illiterate, housewife)

On the other hand, I asked her if he had helped and supported her during the pregnancy and delivery times at home. She replied:

My husband works outside. He works his own work. Throughout our marriage years (10 years) he has never helped me with the household activities. And also he never worked at home throughout the six pregnancy times before. He never even finishes his own work at the shop at *Merkoto* [the biggest market place in the city]. My husband is a business man and he never works my work in the house (*isu yenen sira minm ayseram*). (Kebebush, 35, illiterate, housewife)

I was not surprised to hear Kebebush's side of her story. In fact, it is more likely that she was telling me the reality of her situation despite her husband's claim that he had taken over many of her household tasks. Kebebush's attitude was that pregnancy was her responsibility and domain of the woman. This is reflected also by Gammeltoft (1999:187) who states, "women reason that since it is women who get pregnant and give birth and this is a sphere of life in which women should in authority".

Another kind of experience a pregnant woman told me was pointing out her lack of a right to decide in the household and over family resources. When I asked about the role her husband in the clinical and domestic chores during pregnancy and delivery times, she strongly criticized husbands' attitudes and practices. While sharing her emotions and unhappiness in the marriage, Rahima told me that her husband made decisions in the household without her choices and interests. In her words:

I did not want even this pregnancy. However, my husband wanted me to give birth to child. He told me that there is no problem. Then I decided not to bother about it. Now, he tells me to go for prenatal care and checkups to this healthcare centre. Last time, we [her husband and she] came together to treat our first four year old daughter. This time I came with his sister. Today when we [she and his sister] came here he went to the business place at *Megenagna* [a local name in the eastern

part of the city]. Now, I am in the nine month. I am not involved in any household decisions. Even I do not know the type of our income. My husband never tells me whether the business has a profit or not. I do not know whether it is a big firm or it is a small business. When I told him that I want to work in businesses outside the home, he never let me go out. Sometimes when he gives me money I go to a market to buy foodstuffs. I am not involved in any household decisions. My husband never works inside the house. I am primarily accountable for taking care of the household and first child (our daughter). Husbands do not work in the house. They consider it as a shameful activity. They also fear to work in the kitchen. They feel superior to women and household activities. In the society also husbands are not compelled to do work in the house. I want to work outside with him but he refused to allow me to go out to work. Husbands have chauvinist attitudes towards household works. (Rahima, 24, Muslim, illiterate, housewife)

The story from Rahima bears the fact that women are still subordinate to men's impositions as they exercise their power using traditional norms (even religion) as an excuse to exclude them from making decisions over her rights and family resources. In line with this, Almaz (1997) argues that belief systems, mainly religion, also reflect and reinforce the subordination of women in many sub-cultures of Ethiopian society. Although Rahima wanted changes in her roles and challenged her husband not to get pregnant, like most Ethiopian women as she was financially dependent on her husband and was forced to accept his choices. While she was sharing her experience, I asked her why she had agreed to such a marriage arrangement. She explained that her family in Southern Ethiopia (*Gurage*) made the decision for her to marry him.

In general there appears to be a dichotomy in how pregnant women in Ethiopia view the role of a husband. It can be like Kebebush who thinks that pregnancy is entirely her responsibility or it can be like Rahima who suffers and wishes her husband would allow her to participate in decision-making in general and especially during her pregnancy. There is no single gender role for pregnant women or women overall in Ethiopia today. Researchers must take care to determine what the wife's expectations are for her husband's role as well as hear the story from the husband since traditional gender roles are changing.

4.2.3. *Spiritual Support*

In some cases, husbands told me they had been involved in the spiritual care of their pregnant wives during pregnancy and delivery times. I asked Mubarak, for instance, if there was any spiritual support he delivered to his pregnant wife. Contrary to his religion, Mubarak, accounts his experience as the following:

With regard to our religion, I am a Muslim and my wife is a Christian (Orthodox) and I do support her interest regardless of my religion. For example, if she desires a beer during pregnancy I buy it for her even if my religion prohibits doing so. Furthermore, after the birth of our children, they had to be baptized according to their mothers' religion without my interferences and influences. Hence our first boy was baptized and took a ritual bath on the fortieth (40th) day after his birth at the Orthodox Church. This is to protect the child from frightening dreams, evil eyes and spirits. Even the name of the first boy is a Christian name. Whenever she asks me for baptizing and similar practices I said no problem. I know that the children can have their own religion and choose either from Christianity or Islam when they will grow up. (Mubarak, 41, Grade 12)

The narrative presented above was taken from an interview when I asked Mubarak about his role in prenatal care for his pregnant wife and is indicative of how individuals' cumulative experiences and behaviours can influence a husband's role in prenatal care. Pregnancy and childbirth, like other sexuality issues, are embedded in the wider socio-cultural context of Ethiopian society. Religion like many social values and norms has had a strong influence on everyday life of Ethiopian society for thousands of years. Therefore, I asked the husbands if they saw any relationship and influences of religion on their prenatal care roles. Surprisingly, almost all of the husbands from both religions (Christian and Muslim) argued that their religion never prohibited them from supporting their pregnant wife. A husband pastor, Abera, interviewed, from *Hiyot Birhan* (protestant) Church, argued that their church teaches that as a husband should love his wife by quoting from the bible saying, 'This is now bone of my bones, and flesh of my flesh, she shall be called woman, because she was taken out of man.' Though according to the participants, there was no objection from churches and their faith towards their role, nevertheless, in some Christian Orthodox believers, husbands do not come in contact with their wives before the ritual takes place on the 40th day after delivery in the contexts of Addis Ababa.

While the stories show that husbands are more involved in prenatal care nowadays it also became clear that socio-economic factors (like level of education, income status and exposure to modern

healthcare facilities) and cultural factors (like traditional attitudes and beliefs) still play an important roles in shaping husbands' experiences in prenatal care. These matters will be explored in depth in the next chapter, which deals extensively with the impacts of modernization, globalization and medicalization on the roles husbands in prenatal care.

Chapter Five

5. Husbands' roles in prenatal care in modern urban society

In this chapter, I want to trace how the changes in the role of husbands in prenatal care have been occurring in the contemporary urban city of Addis Ababa both from a macro-level and local context. This is because almost all of the participants argued that husbands' involvement in prenatal care has shown great change over the last twenty years. What became interesting to know during the course of interviews and discussions was how these 'big changes' and 'greater differences' are brought about and occurred over the last two decades from the past and the present days. Most of the respondents attributed the changes to the socio-economic transformation the country has been undergoing as a result of the expansion of modern education, urbanization, globalization, the boost of mass media coverage and expansion of modern healthcare system.

5.1. "Time (modernization) demands"¹⁰

One day, during fieldwork in Addis Ababa, I went to Marie Stopes International Ethiopia (MSIE) head office to get permission to conduct my fieldwork at one of their clinics. It was a rainy and humid afternoon in Addis Ababa. I asked the secretary of the organization permission to do my work and introduced myself, saying that I had come from the Netherlands to study husbands' roles in prenatal care in Addis Ababa. Then I was welcomed and told by the secretary to sit at a table in front of her. She read the letter and directed me to Dr. Melaku, Coordinator of Reproductive Health Programs. I was also told that I should come back the next morning to meet him. On the same day, while she was reading the letter, I read a logo written in Amharic on an opened umbrella: 'Patriots of change: men's partnership in reproductive health' (*'Yelewuti Arbenga: Yeweondoch agarnant*). The next day on my arrival at the organization, I met a proactive guard from the organization, Kebede, stopping people coming and out at the entrance of the main gate. I asked him whether Dr. Melaku was in the office or not. He told me that he was out of the office, but that I could wait for him. I sat next to Kebede and began an informal conversation asking him about the meaning of the logo that I had read on the umbrella the day before in the secretary's office. This man knew a lot about reproductive health issues

¹⁰ Quote from one of the interviewees

and had a lot information about men's roles in family planning and pregnancy in Addis Ababa. He is a father of one daughter and involved in prenatal care and was aware of the reproductive health situation in Addis Ababa. I started talking with him about modern day men's involvement in reproductive health in Addis Ababa [Ethiopia]. When talking about the logo, this is what Kebede told me:

...in earlier days reproductive health was not considered a men's matter in Ethiopia, instead it was considered the sole concern of women. The logo promotes and advocates that men need to change their attitude and practice towards reproductive health and equally share the responsibility with their partners. Hence they are patriots. (Kebede, Guard at MSIE Head office)

Kebede also told me about what he thought the modern day husbands should be doing in the issue of reproductive health and prenatal care. He argued that the earlier [old] husbands [men's] practices and attitudes towards reproductive health should not continue and suggested that the change of the Ethiopian patriarchal tradition was necessary. Critiquing the older [men] generations attitudes towards women he made the following remark:

I am against the complacency (*mekofes*) of Ethiopian men towards their pregnant wives. Husbands [men] have to rid themselves of prejudices which compel women to complications of health. Husbands need to render support at the household level which gives the pregnant mother the opportunity to get both physical and mental rest during her pregnancy period. (Kebede, guard at MSIE head office, young husband)

The next area of discussions and questioning concerned how the husbands viewed the influence of global programs and actions on the role of husbands in prenatal care in Addis Ababa. Ademu, a husband who works for an international NGO (German Foundation for Population (DSW)) in Addis Ababa in the area of reproductive health of mothers and young adolescents shared his experience as:

By the way I am an employee of an international NGO [German Foundation for Population] that works in the area of family planning and mothers' health. We work in the area of reproductive health of mothers and young. Therefore, these kinds of issues [husbands' roles in prenatal care] are our programs and concerns. International situations have been contributing to the changes in husbands' roles in prenatal care in Addis Ababa. We should say that globalization has contributed to these changes. For instance, African countries [Ethiopia] together with other international countries signed and recognized [agreed to] the Millennium Development Goals (MDG) and

International Conference on Population and Development (ICDP) [of 1994] which are programs of actions to address the socio-cultural values and norms that harm both men's and women's reproductive health. Governments are strictly required to fulfil these goals and standards by 2015. These are international standards. All African countries are expected to sign and then implement these program actions. They [governments including Ethiopian] are expected to achieve the targets and indicators set at an international (macro-social) level. International donors like the IMF [International Monetary Fund] and World Bank do not give donations or funds to a given country without prerequisites. Governments are expected to fulfil these international indicators [health standards] to get donations or funds from these international agencies. For instance, very recently the government [Ethiopia] has started urban healthcare extension packages where nurses are delivering only the software [health education] services instead of the clinical services. There is pressure from the international agencies on the Ethiopian government to fulfil the key international reproductive health indicators, including prenatal, safe delivery and postnatal care services. Therefore, globalization [global health policies and initiatives] has been strongly influencing male's involvement in reproductive health [prenatal care]. (Ademu, 37, MA Psychology)

It is pertinent to note that knowledge and information about the influence of global health programs on the role husbands in prenatal care is getting around to the husbands who have had exposure to international NGOs and conferences. During my fieldwork, I realized that when it comes to male's involvement in reproductive health issues often International NGOs (UNFPA, MSIE, UNICEF, USAID and *Population Council*) have been important promoters and implementers of the new programs in Addis Ababa (Ethiopia). However, when I attended health education sessions between 9:00-9:30 in the morning at the three study sites a number of times, I never came across topics related to males' involvement in reproductive health including prenatal care issues.

One day, being impressed with these new initiatives in Ethiopia, I read a newspaper at MSIE¹¹ head office regarding reproductive health issues related to the topic of my study. The daily monitor reported about the launch of new campaign to promote reproductive health, the "Leave No Women Behind" campaign that promotes a holistic vision of women empowerment. United Nations Population Fund (UNFPA) country director, Dr. Rakotomalala, called for the following:

"Women's social status and reproductive health cannot be treated without treating the other. Most notable about the Leave No Women Behind campaign

¹¹ MSIE is Marie Stopes International Ethiopia

is that it seeks to engage not only women and girls, but entire communities. It is clear we need the support of men and boys to see change” (Daily Monitor March 5, 2009)

This was one of the public discourses I came across in the field about men’s contribution to gender equality and their partners’ reproductive health in Addis Ababa. A poster on Sexual and Reproductive Health was also found at MSIE *Arada* clinic. It was one of the public announcements promoting and disseminating brief information about males’ reproductive rights and involvement in Addis Ababa. Though the pictures on the poster are predominately women and children, the title and the messages it delivers encompassed a holistic approach to reproductive health conceptualized by the Cairo International Conference on Population and Development in 1994. The title of the poster is “the five guiding principles”. Among the five guiding principles recognized by MSI to improve and promote reproductive health of individuals and couples [husband and wife], are those listed as guiding principles numbers two and four:

Couples have a right to the information and counselling required and access to the means to exercise their choices. (*Guiding Principle 2*)

SRH [Sexual and Reproductive Health] programs cater for the needs of all sexually active people including adolescents and *men*. (*Guiding Principle 4*)¹²

¹² Italics is by Mekonnen Muleta

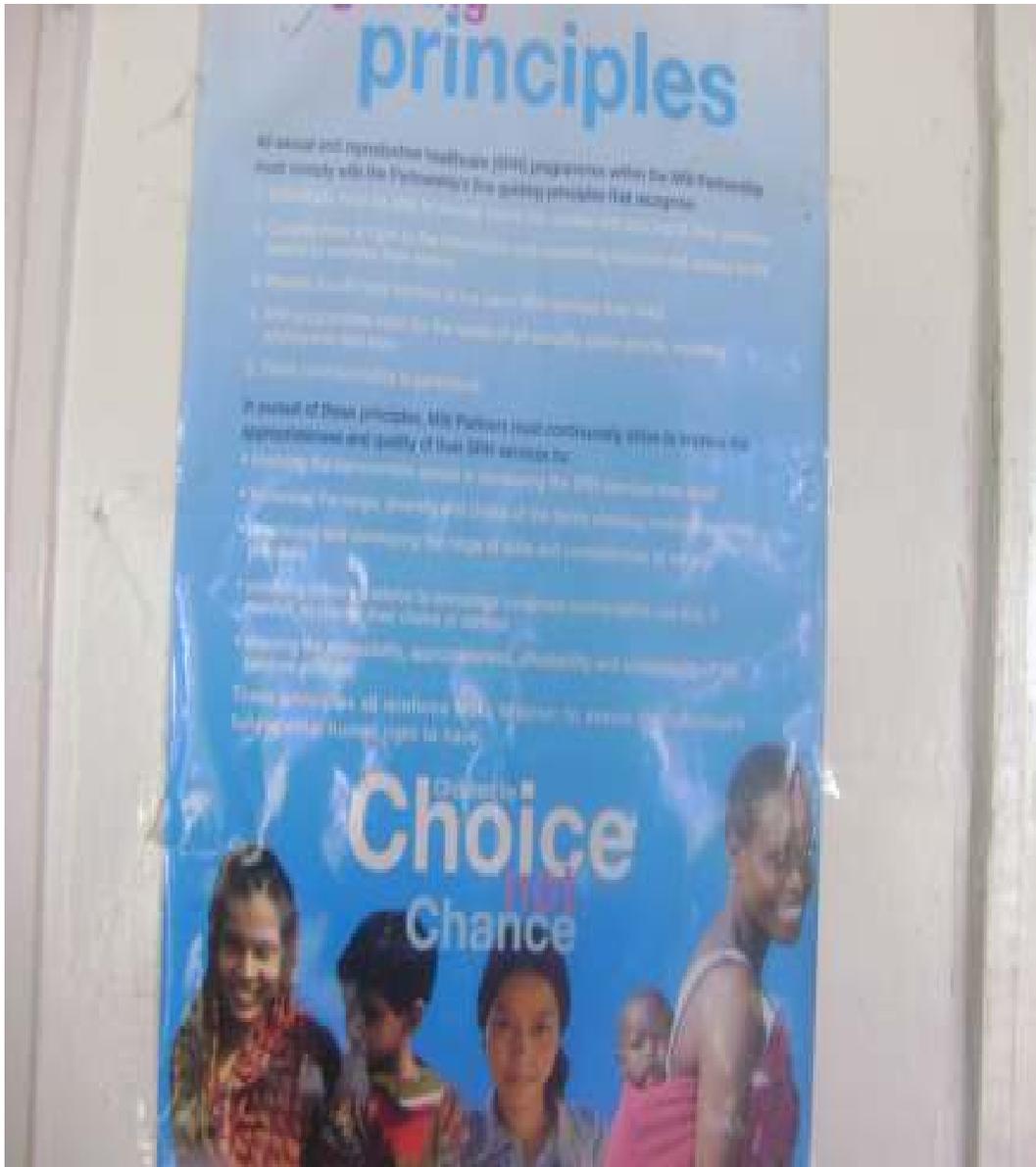


Figure 3. A poster promoting couples [husbands and wives] reproductive health right (source MSIE *Arada* clinic)

Many husbands participating in this study highlighted also how an expansion of mass media has been playing and shaping husbands' (men's) roles in prenatal care. For instance, one husband I interviewed at *Dinborawa* hospital described how mass media and intergenerational differences are having an implication on change of husbands' roles in these days in prenatal care in Addis Ababa. He said:

Men's involvement in reproductive health has been changing through time in Ethiopia. This has to be associated with the expansion of media in the country, mainly in the urban settings. Before twenty to thirty years ago men's involvement in reproductive health at the family level is incomparable with that of these days. Today there are about five FM radio stations and many newspapers in different languages. Older husbands cannot even keep up with the modern reproductive technologies. Even if they are exposed to it they cannot use it and they avoid it. Younger husbands are easily acquainted with these technologies unlike the older once. (Minale, 30, Grade 11).

A more or less similar opinion was expressed by a young husband about the importance of modern technology such as ICT (Information Communication Technology) in the changing the role of husbands in prenatal care in Addis Ababa:

I am happy to be born these days when through technology and education harmful cultural practices are declining and being eradicated. Although I have a lower education, I know much more than those older men even those who have higher education because I got more knowledge and information through technologies like computer and the Internet. These days I am exposed to modernity and civilization so I do not accept the earlier harmful practices. The other important technology expanding in the country is mobile telephone, and as husbands are using this technology it has been leading society to get healthcare (prenatal care) information. As husbands get the information they get involved more in prenatal care. (Merid, 23, Grade 7)

Almost all of the husbands in the study were convinced that the husband's role in prenatal care has been influenced by the expansion of modern healthcare and reproductive technologies [medicalization] such as ultrasound and amniocentesis. Let me give an illustrative explanation from a participant:

On the other hand, the expansion of healthcare facilities, modern healthcare practices and health education in Addis Ababa has helped those who want to be involved in the prenatal care of their pregnant wives. For instance, my wife follows her prenatal care and checkups at *Dinborawa* hospital. The first child was also born here. There are both 'software' [the knowledge of health professionals] and 'hardware' [hospitals and clinics] in Addis Ababa. Urban

health extension workers deliver software [health education] packages including health education on prenatal care services. It is because of the time and technology. Health service coverage more or less has been expanding along with new health technologies like reproductive and family planning packages. In urban areas husbands usually take their pregnant wives to modern healthcare facilities, so they know the status of the infant using these technologies. There is modernization and time [globalization]. There are also both governmental and non-governmental networks [partnership] and efforts that contributed to the increase of husbands' involvement in prenatal care services. All these added together has been bringing a slight changes let alone in Addis Ababa and even in rural Ethiopia. (Negash, 39, MSc, Mathematics)

In this sense, Birhanu gave a similar explanation for the gradual transformation of husbands' roles in prenatal care in Addis Ababa and why he himself decided to participate in it as follows:

Both of us (my wife and I) have had exposure to modern healthcare and on the importance of prenatal care during pregnancy period. Then we began to come to this clinic for check-ups and follow-ups. I was born in an average educated family in Southern Ethiopia [Hadiya]. I grew up with missionaries and we lived with missionaries. We have strong relationship with them. Some of them were also nurses and doctors. Currently, I am working for an NGO in a healthcare service development organization. I know about the importance of modern healthcare services. I believe the times [modern days] demand my involvement and no husband can avoid it [prenatal care]. If one wants to act like our parents he cannot lead his life properly. All the way through there may not be a divorce, however, their marriage cannot be smooth. I think husbands' involvement will increase further in the future than even these days. Time has brought changes in our practice in prenatal care. (Birhanu, 42, BA in Business Management)

I wondered if the husbands were relating and linking the expansion of modern education with the changing husbands' roles in prenatal care, so I asked the husbands to share their views on this topic. Almost all of the participants in the study said that modern education had a significant influence to bring greater changes on husbands' practices and roles in the present days in prenatal care than the past times. In this respect the following account from Deresse is interesting:

There have been big changes in the role of husbands which we [focus group participants] should admit. But what are the reasons for that? One is that education has been expanding in the country. The education and knowledge gained through it at least enable them to send pregnant women to healthcare stations and centers. I do not mean that all husbands in Addis Ababa are changed. Husbands' educations change their behaviour and attitude towards harmful traditional practices. Through education patriarchal attitudes and practices do change and are then followed by a change in the husbands' attitudes

which in turn change the lives of women. I believe if patriarchal ideology and practice changes husbands engage more in reproductive health. For instance, husbands discuss sexuality [which was a taboo] with their wives openly. This brings consent to go together to prenatal care services or approve pregnant wives to visit the service. As many husbands are educated they take the information [health] back to their family. Many years ago if someone graduated with a degree it was considered as big news, but now there are thousands of graduates in the society. So there are more educated husbands these days in comparison to some years back. There are big differences between educated and uneducated men in their involvement in prenatal care. As men get education and live in the urban areas [Addis Ababa] they are bringing promising and encouraging changes. (Deresse, 37, B.Sc in Agriculture)

It was interesting to see that, in Addis Ababa, husbands' attitudes are changing and they are showing more interest in getting involved in the reproductive health matters of their pregnant wives particularly during pregnancy and delivery times. According to the husbands in this study, the more people are educated and exposed to urban life, technologies and mass media, the more they are involved in the prenatal care of the wives. It is also my impression that husbands involvement in prenatal care in Addis Ababa is in a transitional stage and there is still a lot to do to include husbands in the alleviation of mothers' and infant's mortality in Addis Ababa (Ethiopia) .

It is clear in the above discussion that men themselves have begun to reflect and argue against the traditional perception of men's superiority in a society. To get a better understanding about current [modern] roles of husbands in prenatal care, I think it is good to look at marriage practices among the couples visiting the modern healthcare facilities. From my observations and participants interviews, husband were freely married to wives they loved based on their own arrangements. Minale, living in a nuclear family, elaborated on how he got married to his current pregnant wife. He also shared his emotions and feelings about their marriage.

My wife and I fell in love almost one year ago. I was born and grew up in Gojam [North-West Ethiopia]. We met [my wife and I] each other when I came here last year. We were married by *qurban* [sealed marriage practiced by Orthodox Church] last January (*Tir*). (Minale, 30, Grade 11)

Traditionally in Ethiopia, marriages were controlled and arranged by families (Terefa 2000). However, during my field work, most of the husbands told me that their marriages were only based on their own choices, like Minale, which I may say is adopted from Western practices. This, in turn, can influence husbands to adopt other Western practices such as those related to

prenatal care in Addis Ababa. For example, it was common to see husbands carrying flowers at *Dinborawa* hospital and MSIE *Arada* clinic. It was a surprise for me to even to see a flower gift for delivered mothers. For instance, one focus group discussant compared past and presented husbands' [men] roles in prenatal care in Addis Ababa by exemplifying flower gifts after delivery to mothers. Reflecting on the flower gift, a western practice, after delivery, he told us a story:

Most relatives and friends of husbands of delivered wives come with flowers to congratulate for the safe birth. But when a wife of my brother gave birth I bought a sheep for her instead of flowers. They bought flowers with expensive money. For me to give a flower, it is nothing. I bought a sheep for 110 Ethiopian Birr [\$11] and took it for her. At that time my brother was not at home. He went to Djibouti as he is a driver of transport vehicle. When he was came back to his home from Djibouti he asked about the gifts his friends and relatives had brought to his wife. Who brought flowers... how about Taddessa?... he brought a sheep...that is good (*egale min amata ,ababa...*, *Tedaesa min amata taboti, tadiya ababa yibalal wayi*) and my brother asked again, Is a flower edible)? I know in our cultural practice that we slaughter sheep when a pregnant woman gives birth. That is why I bought a sheep when a pregnant wife of my brother gave birth instead of a flower. (Tadessa, 42, BA in Law)

The discussion showed an introduction of new cultural practice alongside the past traditional practices by different generations of men; the first one is a modern practice where a flower is given as a gift for a woman after delivery and the other one is a traditional practice that emphasizes the importance of sheep taking for a delivered women as a gift. It appears that in modern healthcare facilities, husbands who bring their wives flowers are demonstrating a decision to adopt western cultural habits.

In summary, from an anthropological perspective, it is possible to speak of the influence of macro-social initiatives and policies since 1994 at the local level in husbands' experiences and roles in prenatal care in Addis Ababa. Besides, with support from international agencies and NGOs, women's movements and advocates mainly since the late 1990s and beginning of 2000s, have strongly influenced local men's perception and attitudes to gender equality. Therefore, I argue that the greater changes in husbands' involvement in prenatal care and pregnancy related issues in Addis Ababa is a reflection of a wider macro-social context and practice brought up by modernization and medicalization of pregnancy and delivery. Bearing this in mind, governmental and non-governmental organizations engaged in maternal and child

health programs and interventions need to explore ways to scale up men's involvement in reproductive health in Ethiopia

5.2. Conclusion

‘When I see this issue [husbands’ role in prenatal care] it is good to see from two points of views. One if we look at the general national level, it is evident that we see a very low level of husbands’ participation in prenatal care. Even if husbands have a higher level of education and are economically capable to engage in prenatal care, there are still lower levels of husbands’ involvement in prenatal care in Ethiopia. This is because we inherit these [prenatal care] practices from our parents. When we come to see the situation in Addis Ababa, I think the trend is similar as the majority of husbands in the country. However, I believe there are some cases [changes]... In my opinion, pregnant women want many supports and care from their husbands. They need psychological attachments and have emotional needs. They have to be granted these supports by their husbands. Pregnant women want to know everything about their pregnancy from their husbands. Hence, I believe husbands should support their pregnant wives economically, emotionally (psychological), and socially. In practice what we see is totally different and few husbands do that. (Ademu, 37, MA in psychology)

With this study I tried to explore the experiences of husbands who have involved in the prenatal care using qualitative research methods of individual interviews, conversations, group discussions and my observations. At this stage of the study, I have come to understand husbands’ experiences in prenatal care as an important agenda embodied around their changing roles in prenatal care and going beyond the traditional expectations of the society. Many husbands in this study had internalized the pregnancy situations of their wives through expressions of worries and sharing of pregnancy burdens in a number of ways. I discovered that husbands had four types of concerns: pregnancy, HIV, delivery and economic concerns. In other words, “men [husbands] experience many emotions during pregnancy as they try to adjust their new role as expectant father. Most expectant fathers want to be involved in pregnancy experience and are eager to attend prenatal care visits” (Bowers 2001:33).

Furthermore, the husbands carried out a number of tasks at both the clinical and domestic spheres. Just like Ademu, husbands in the study articulated their experiences and roles in prenatal care including what they thought and perceived to be pre-eminent for the well-being of their pregnant wives. However, husbands’ experiences did not reveal a similar trend; instead it was a reflection of their particular histories, behaviours and the context of the level of the society from which they came. The same way Ademu illustrated, there were a variety of determinant forces for husbands: socio-economic and traditional patriarch beliefs and practices seem to be responsible for a low availability of husbands in prenatal care. Of all the factors,

illiteracy, poverty, social [peer] pressure, gender inequality and traditional taboos and beliefs contributed the most to the low participation of husbands in prenatal care. It is clear from the previous discussions that husbands' worries and problems related to pregnancy and prenatal care differed with the socio-economic backgrounds of the society to which they came from. For the poor husbands, the problem of financial insufficiency to support their pregnant wives' desires during pregnancy was the preoccupation while prenatal care, as an important practice, was not getting attention. In contrast, it is interesting to note that the wealthiest husbands were more concerned about pregnancy related risks and complications during labour and delivery times. I learned that despite HIV/AIDS' intricate link with poverty, it is an important and a pressing source of worry and frustration in the daily lives of most husbands of pregnant wives in Addis Ababa, irrespective of their socio-economic status.

I have also come to understand that the experiences of husbands are marked by reconciling and transiting (bridging) practices between what is traditional and what is modern practice for prenatal care. In this respect, I recognized that some husbands reported exercising their power in making decisions over the family resources without the consent of their wife although they accounted to be involved in prenatal care and other reproductive health aspects of the family.

I learned that despite the low involvement of the larger segment of husbands in prenatal care in Ethiopia in general, most of the participants of this study argued that there were changes in husbands' roles in prenatal care in Addis Ababa. For the husbands in this study, these concepts and sense of greater changes in the roles of husbands in prenatal care came from the wider macro-social and local policy and program contexts. Husbands' arguments and justifications for the acceptance of these changes relied more on the acknowledgement of the influence of globalization, modernization, urbanization and medicalization of the healthcare system being responsible in husbands' perceptions and attitude changes in prenatal care.

Though there have been changes in men's role in reproductive affairs, the absence of many husbands from prenatal care visits, especially from the public healthcare (*Yeka*) centers was something that should be seen as an indication that these changes are not promising and widespread. Anthropology conceptualizes and considers gender as a learned and changing social construction varying from culture to culture, which changes through time in line with the advancement of human technological progress (Kottak, 1991). I must also add that gender

dichotomy, as a result of history and cultural contexts of Ethiopian society will continue to exist to some *extent*, as many of my respondents said, for many years. This is despite changes that are shaping gender roles and relationships through local socio-economic development and from the wider hegemonic impacts and processes. This implies that husbands' roles of in prenatal care continue to change reflecting the socio-economic, political (women's rights) and cultural dimension of society in Addis Ababa. Likewise, arguably, prenatal care is a learned practice through technology, mass media and education.

On the part of policy makers and healthcare providers, therefore, it is vital to establish public healthcare services for husbands that diminish all forms of the invisibility of husbands (men) in reproductive health issues. Husbands like their pregnant wives need emotional guidance and help to share their burden at the time of prenatal care and as main actors for whom reproductive health it is also their own individual right and should not be neglected in public discourse and healthcare programs and policies. All actions need to be harmonized with all actors from macro-social level to national level. Follow-up research should take account of pregnant women's and husbands' views jointly to explore comprehensive perspectives and to understand the situation of husbands' roles in prenatal care from the standpoints of couples.

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