Social capital and maternal health practices in rural Ethiopia

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Warsaw 2020

Word count: 101 001

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Abstract

The main aim of the thesis is to explain the role of social capital in the health practices of mothers in rural Ethiopia. To reduce high maternal mortality, the Ethiopian government has implemented a range of policies to expand medical services and empower women to better manage their health. National policymakers have organized female social networks to function alongside traditional ties in the communities. Despite the rich and diverse landscape of local social organizations, little is known about their links with developmental health policies. Applying Bourdieu's definition of social capital, I addressed three research questions concerning (1) the forms and factors of women's creation of social networks (2) the links between social capital and health, and (3) the broader environment affecting care-seeking and the position of health workers. Using the case of a rural community in the Southern Nations, Nationalities, and Peoples' Region (SNNPR), I conducted 50 interviews with ordinary women and policy stakeholders, and analyzed longitudinal data about the community, which was complemented by desk research and field observations. The results indicate that overlapping bottom-up and state-inspired social networks educate women and provide them with material, spiritual, and psychological support, but also control their maternal health practices. Institutional norms, gender, and material situation condition networking opportunities. The state's effort to transform traditional habits regarding pregnancy and delivery in the name of modernization is hampered by structural factors that prevent women from accessing biomedical health care. Consequently, although state-led pressure utilizing local social capital contributes to better maternal health, it also reproduces gender inequalities and may, unintentionally, draw attention away from the circumstances in which Ethiopian women live.

Keywords: social capital, local networks, maternal health, Ethiopia

Acknowledgements

My PhD studies and this thesis would not have been possible without the funding I received from the Graduate School for Social Research in Warsaw.

I cannot express my gratitude to all the women who kindly allowed me to enter into their homes and discuss experiences of their everyday lives, pregnancy, and childbirth. I will never forget my opportunity to be in Aze Debo.

I am grateful to my supervisor, Izabella Łęcka, for substantive and emotional support. At the Graduate School for Social Research, I am indebted to John Fells, Aleksandra Filipowicz, Aleksandra Wójcicka, and Lidia Wójcicka, who helped me in many situations, especially since doing research about Africa from Poland was a challenge. I would also like to express my sincere appreciation of the methodological guidelines I received from Magdalena Grabowska and Marta Olcoń-Kubicka of the Institute of Philosophy and Sociology of the Polish Academy of Sciences. Great thanks go to Maja Grabkowska, Błażej Popławski, and Joanna Stępień for reading my thesis and giving me a valuable advice on improvements.

I am indebted to Małgorzata and Andrzej Rzepecki of the Innovaid Foundation – thank you for your trust during the medical project with Polish Aid.

In Ethiopia, I was fortunate to work with a wonderful WIDE team: Philippa Bevan, Catherine Dom, Mulugeta Gashaw, Alula Pankhurst, and Sarah Vaughan. My heartfelt thanks go to Catherine Dom, who ensured I had a home away from home in Ethiopia and shared a lot of thoughts and perceptive insights. Agazi Tiumelissan, Kiros Berhanu, and Hilina Kebede gave me their friendship and let me know Ethiopia better. I would like to thank Kelemwork Tafere of Mekelle University and Tesfaye Semela of Hawassa University for providing letters for my fieldwork. I would like also to thank the research officers – Alexander Amsalesh, Asmeret Gebrehiwot, Bizuayehu Ayale, and Shiferaw Fujie – for sharing invaluable knowledge and experience. I am grateful to Yemane Taye, who welcomed me in Ethiopia since my first arrival in 2011.

This thesis would not have been possible without my beloved husband Jan, who always stands by me. His sense of duty and passion are exemplary.

This thesis is dedicated to all women of Aze Debo. Faults you may find in this thesis are my own.

Acronyms

CSA	Central Statistical Agency of Ethiopia
DA	Development Agent
DFID	Department for International Development UK
EPRDF	Ethiopian Peoples' Revolutionary Democratic Front
ERHS	Ethiopian Rural Household Survey
FGM	Female Genital Mutilation
GTP	Growth and Transformation Plan
HEP	Health Extension Programme
HEW	Health Extension Worker
HSTP	Health Sector Transformation Plan
KMG	Kembatti Mentti Gezzima-Tope (Ethiopia)
MCH	Maternal and Child Health
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
ODA	Overseas Development Assistance
PM	Prime Minister
PMNCH	Partnership for Maternal, Newborn and Child Health
PSNP	Productive Safety Net Programme
SNNPR	Southern Nations Nationalities and People's Region
SIDA	Swedish International Development Cooperation Agency
TBA	Traditional Birth Attendant
TGE	Transitional Government of Ethiopia
TPLF	Tigray People's Liberation Front
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WIDE	Wellbeing and Illbeing Dynamics in Ethiopia

Glossary

Areke	A distilled, local Ethiopian drink
Bajaj	Indian auto rickshaws
Baito	Local government in TPLF controlled areas
Dergue	Literally 'committee', a military government in 1974–1991
Enset	False banana, a staple food in some parts of SNNPR
Equb	Rotating credit and saving association
Gemgema	Community evaluation
Got/Tabia	Sub-kebele structure
Iddir	Funeral association
Kebele	Smallest unit of government administration, used in the meaning of village
Sebsabi	Chairperson (for a meeting)
Tef	Ethiopian indigenous cereal
Timad	A traditional area measurement unit in Ethiopia (0.25 of a hectare)
Wereda	District level administrative unit between the kebele and the zone
Zemecha	Campaign

Names and transliteration

Ethiopian names

Ethiopians do not have family surnames. The first name of an Ethiopian is her/his given name, followed by the father's name. I will follow the common practice of addressing of a person with her/his first name.

Transliteration

Citing Young (1997), while geographic names have common spellings, there is no consensus on the means to transcribe other Ethiopian words, including names of people, into the English language. Therefore, Ethiopian terms are transliterated according to the most commonly-used spelling in English.

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Introduction

Background of the study

On 28th October 2019, UNICEF Ethiopia published a video entitled "Lib Yaleh" ("If you have heart"), showing the realities of high maternal and neonatal mortality in Ethiopia. The video presents a man who lost his wife and a child because she had not attended a health center during pregnancy. The video provides a rapid overview of the official approach to childbirth in rural Ethiopia. It illustrates that choice of place of birth is severely limited by the structural constraints of poverty and heavily depends on the pregnant woman's interactions with her nearest family and neighbourhood circles.

The story reflects and reinforces a narrative within the global health literature that highlights the importance of emergency obstetric care and skilled delivery for mothers' and children's survival in the Global South. Indeed, the issue of maternal mortality in Ethiopia and in other developing countries is a serious challenge. In the official WHO discourse, maternal mortality means 'the death of a woman during pregnancy or within 42 days of pregnancy termination, irrespective of the duration and site of the pregnancy, and from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes' (WHO 2019:8). Often maternal mortality has been treated as an indicator of maternal health, an issue that has triggered a lot of debate and discussion as this indicator has focused attention to mothers' health on the short pregnancy, childbirth, and post-partum period. This focus has not considered the health of women who are not mothers (Knaul et al. 2016) and has structured women's sexual and reproductive health around being a mother (Johnson 2016).

Maternal mortality has shown very significant discrepancies between developed and developing countries. Around 94% of all maternal deaths occur in low and lower middle-income countries. The indicator measuring maternal mortality, the maternal mortality ratio (MMR), was 462 deaths per 100,000 live births in low income countries in 2017 versus 11 deaths per 100, 000 live births in high income countries (WHO, 2019). On the basis of these numbers, it can be argued that the number of maternal deaths reflects inequalities in health services, highlights the gap between rich and poor, and raises questions about human rights to life.

Reduction of maternal mortality has been at the core of WHO activity since its establishment in 1948. Commitment to this aim has been reiterated at various points: during the Alma Ata Declaration in 1978, with the establishment of the Safe Motherhood Initiative

in 1987, in the UN Millennium Development Goals, and most recently in the UN's Sustainable Development Goals. In the period from 2000 to 2015, only nine out of 90 countries achieved the MDG targets of reducing maternal mortality by 75% (MDG 5a) and achieving universal access to reproductive health services by 2015 (MDG 5b). The Sustainable Development Goals, established on 25th September 2015 for the next 15 years, recognized maternal health under SDG3: Ensure healthy lives and promote well-being for all at all ages. The target adopted for the MMR in the SDG period was the reduction of global preventable maternal mortality to less than 70 deaths per 100,000 by 2030 (SDG target 3.1).

Direct obstetric causes accounted for 73% of all maternal deaths from 2003 to 2009 and indirect causes accounted for 27%. Haemorrhage, hypertensive disorders, sepsis, abortion, and embolism were the medical reasons responsible for maternal deaths (Say et al. 2014). Despite the fact that the causes of maternal death are seemingly well understood, consensus in the global public health community about what to do about it has been hard to reach (Hammonds and Ooms 2014). Various groups working on maternal and reproductive health have struggled with the prioritization of different strategies over time. The WHO has recommended facility-based strategies such as the provision of emergency obstetric care and skilled delivery. These strategies are facilitated by other reproductive and health services available for all over the life cycle.

Studies have indicated that the maternal death rate is closely related with mothers' level of education, hygiene facilities, and the distance from mothers' homes to health facilities. Scholars have argued that preventing maternal mortality goes beyond a simple transfer to facility-based services and requires well-functioning health care systems (Shiffman and Smith 2007). Moreover, as a subset of health, maternal mortality depends on the so-called social determinants of health, such as stress, social exclusion, working conditions, and social cohesion and support. The difficulty of creating an 'enabling environment' in which maternal mortality can be reduced is further complicated by cultural context – what pregnancy and childbirth means for a woman. For example, the recent return of privileged women in the Global North to 'natural birth' seems to be in contradiction to official moves towards medical intervention as a way to eliminate maternal deaths in the Global South (Johnson 2016). While some women are declining a medicalized approach to pregnancy, others are turning to medical technologies. This seems to confirm that pregnancy is not a universal experience and cannot be fitted exclusively into the domain of advanced medicine or traditional women's identity.

Ethiopia's maternal mortality ratio achieved high values in various historical periods. In 1991, when the country transitioned from the poverty and famine of state socialism to a form

of capitalism within the standards set by the Ethiopian's People Revolutionary Democratic Front (EPRDF) (Weis 2015), the MMR amounted to 1,250 deaths per 100,000 live births, which positioned the country eleventh among 53 African countries. For comparison, in sub-Saharan Africa, the MMR in 1990 amounted to 987 deaths per 100,000 live births (WHO 2015a). As a country with such MMR scores, Ethiopia participated in the framework of the Millennium Development Goals. At the end of the MDG period in 2015, Ethiopia had achieved most of the health MDGs: a 67% reduction in under-five mortality, a 90% decline in new HIV infections, a 73% decrease in malaria-related deaths and a more than 50% decline in mortality due to tuberculosis. However, the country did not manage to achieve Goal 5: reducing maternal mortality by 75%. Instead, the MMR was reduced by 71% to 400 deaths per 100,000 live births. Moreover, Goal 3, related to the promotion of gender equality and women's empowerment, was not achieved (Yibeltal et al. 2017). These gains were also not equitable, displaying significant discrepancies between rural and urban areas, as well as across regions. This poses a question about the factors that prevented Ethiopia from achieving the goal of reducing maternal mortality.

In order to improve maternal mortality indicators, the Government of Ethiopia devised a number of technical programmes. The most important one was an expansion of the health care infrastructure throughout the country and the biomedical model of care during pregnancy and delivery (FMOH 2015). Recognizing the need for the deployment of health workers, Ethiopia also launched the Health Extension Programme (HEP), which has been widely praised for being a model for other developing countries in how to train local health workers (Gates 2012). Dr. Teodros Adhanom, the former Ethiopian Minister of Health (from 2005 to 2012) and the former Head of the Health Bureau in the Tigray Region, directly connected the HEP with the universal health care paradigm (Maes 2015). The HEP assumes the training of local health workers whose aim is to provide primary care to the rural population, most notably women and children. Since 2002 when the HEP was launched, more than 38,000 Health Extension Workers (HEWs) have been trained and deployed all over the country. HEWs are tasked with transferring knowledge and skills to the families they serve, so that households "have better control over their own health" (FMOH 2015:12). They have become responsible for a wide range of primary health care services, including preventive, promotive, and curative health care, as well as data collection and reporting for monitoring and evaluation.

HEWs were initially linked to the community through 'volunteer community health workers', or 'health promoters', whose number has been never publicly tracked. These positions were replaced in 2012 by a Health Development Army – a female community support group that should include most of the women in rural Ethiopia. This model assumes that one woman from

a neighbourhood leads four other women in adopting healthy lifestyles, creating a small 1-5 network. All the leaders of these groups are unpaid volunteers. Thus, ordinary women from the community are actively involved in taking care of themselves through participation in the Health Development Army, which should ensure that they are referred to higher levels of the health care system if needed. A number of the HEWs' and Health Development Army's tasks are related to maternal health, such as encouraging women to attend antenatal care and to reach health centers ahead of delivery, conducting postnatal care follow-up, promoting family planning, and providing nutritional advice.

The Health Extension Programme with the Health Development Army is a part of the interventions that have been implemented in Ethiopia since the early 2000s in an effort to modernize the country. These interventions have been fueled by an influx of development aid (Feyissa 2011). This modernization process has been described by scholars as "one of the most remarkable developments in post-war Africa" (Weis 2015:6). Ethiopia has been praised for "achieving steady economic growth and for its good prospect in meeting the MDGs" (Feyissa 2011:173). The development interventions fit into the broader philosophy of structural change orchestrated by Prime Minister Meles Zenawi, who practically ruled the country from 1991 to 2012. Inspired by ideas about the developmental state and revolutionary democracy, Meles had a vision of a highly interventionist state that delivered tangible development results to the rural population. The changes foreseen for this particular development project included both qualitative material changes as well as changes in the attitudes of the population: people were to become active participants of development in the sense that they should actively contribute to it.

In his vision of the developmental state, Meles proposed the idea of building strong social networks at the local level. Referring to the idea of social capital in Northern Italy as described by Robert Putnam, Meles assumed that local communities should be involved in the Ethiopian development plan by releasing their own energies and maximizing the impact of their own assets (Meles no date). Networks such as the Health Development Army serve as examples of this theoretical thinking that Meles described in his unfinished Master's thesis. The assumption that women can be convinced to deliver at a health center by other women and to change their practices related to their own health is at the core of the mission of the Health Development Army and also the HEW.

In sociological terms, the idea of building strong networks, to which Meles referred, resonates with the concept of social capital. This concept was proposed by scholars working under different academic traditions: James Coleman, coming from rational choice theory; Pierre

Bourdieu, working under a class-based understanding of actors' practices; and Robert Putnam, who represented a community approach to social capital. In broad terms, scholars have used the term 'social capital' to highlight the importance of networks and associations in increasing the returns of social actions, whether it be in health, economics, or education.

Different definitions of social capital underline different aspects of this notion. Over time, it has become an umbrella term that includes terms such as networks, norms, trust, and associations. The popularization of the concept caused has led it to become a buzzword that travelled a lot across different disciplines. It has been applied in political science, suggesting that habits of cooperation, trust, and participation in public life make it more likely that people will actively participate in institutions of government (Putnam 1993); in economics, where scholars have investigated the relationship between social capital and economic growth (LaPorta et al. 1997; Knack 1999; Whiteley 2000; Zak and Knack 2001; Rupasingha et al. 2002; Beugelsdjik et al. 2004; Beugelsdjik and van Schaik 2005; Iyer et al. 2005; Bjørnskov 2012), in educational outcomes (Coleman 1988; Sun 1999; Teachman, Paasch, and Carver 1996); in innovative outcomes (Akçomak and ter Weel 2009); in the labour market (Granovetter 1973); and in management and organizational studies (Adler and Seok-Woo Kwon 2002; Borgatti and Foster 2003).

Social capital has been cited as a factor that can influence health outcomes (Story 2013). The social capital and health theme appeared together for the first time in the late 1990s in the Kawachi study (Kawachi et al. 1997), which focused on links between social capital, mortality, and income inequality. The Kawachi study was followed by a body of other works that became increasingly nuanced as the general social capital literature progressed, with different definitions and research strategies. However, these studies focused mainly on the Global North, rather than including the Global South context (Agampodi et al. 2015).

Later studies about social capital and health can be divided in two types. In the first type, social capital has been conceived as a property of individuals that can be found in the networks of individual social actors. The second type of studies has been concerned with the possible links between collective social capital and health. The term 'collective' has often been described as vague. Under Putnam's concept, it can denote an association or a voluntary organization, or a neighbourhood in which people trust each other. In these studies, social capital has often been depicted as a mediator between economic inequality and health outcomes (Islam et al. 2006; Kawachi et al. 1997; Kawachi and Kennedy 1997, 1999; Marmot 2005; Wilkinson 1996, 1999; Wilkinson and Marmot 2003). There has been a persistent tension between conceptualizations of social capital as an 'individual' or a 'collective' asset, and it has been even argued that assumptions

about how social capital influences economic prosperity have been transported to health studies (Fine 2001: 106).

State of the knowledge about social capital and health

Two broad categories of literature, one about social capital in general and one about how health is related to social capital, are relevant to this study. This literature informs and locates the contributions of this study, but also displays certain limitations.

Firstly, critical assessments of social capital have pointed out that mainstream conceptions of this term have not adequately grasped the issue of human agency (Cleaver 2005). Some scholars have pointed out that social capital, especially under Coleman's understanding, is an extension of rational action theory, in which people are social entrepreneurs, consciously investing in relationships of trust (Ostrom and Ahn 2003). The issue of how social capital is mobilized by people of different socio-economic positions has often been sidelined (see studies by Berkman and Kawachi, 2000; Wakefield and Poland, 2005). In other words, the social capital debates have often omitted the issue of inequality and power relations (Ishihara and Pascaul 2009; Molyneux 2002). Critical assessments of social capital have indicated that often its application does not consider the political and historical processes that led to its formation (Fine 2001), including the central role of the state in this process. Social capital has also been described as being positive, in the sense that it focuses attention on the positive consequences of sociability, putting aside its less desirable features, such as the exclusion of outsiders, excess claims on group members, and restrictions on individual freedoms. It has also been argued that social capital research problems consider the consequences of social capital, without taking into account its sources (Portes 1998).

Secondly, although the literature on social capital and health has acknowledged that social capital is an important factor affecting health, in developing countries this impact has been studied only to a limited extent (Story 2013). Also, there is very little literature about the relationship between social capital and maternal health in the context of low-income countries (Agampodi et al. 2019). The available studies on social capital and maternal health have associated better social capital with higher levels of self-rated health (Lamarca et al. 2013) and better health-related behaviours (Elsenbruch et al. 2007). However, these studies have examined social capital by looking at indicators of psychological processes rather than at indicators of social relations *per se*. To my knowledge, there have been no qualitative studies on the association between social capital and maternal health in Ethiopia that have taken a comprehensive approach by looking at different kinds of social capital. This is surprising, given

the fact that Ethiopia has a vast spectrum of networks, both bottom up and state-led, that have influenced the everyday lives of rural populations at the local level. Previous studies have investigated the impact of Health Extention Workers and the Health Development Army – state-led networks (Jackson 2014, 2016a; Ruth Jackson et al. 2016; Maes et al. 2015b). However, these studies have not concentrated on the whole spectrum of women's social relations, with the exception of Helen Pankhurst's study (1992). Political aspects of the work of medical state-led networks were explicitly mentioned in Maes's studies about the Health Development Army (2015, 2015a, 2015b, 2016) and Melberg et al.'s study about the politicization of maternal health deaths (2019). However, in general, politics has been sidelined in health studies in the Ethiopian context (see Østebø et al. 2018), which can be seen as a potential weakness and methodological bias in the existing research.

Main study objective and research questions

Given the identified gaps in the existing literature, this study aimed to explain the role of social capital in the health practices of mothers based on the example of a rural community in Southern Ethiopia. To address this objective, this thesis considers the following research questions:

1. What are the main forms of women's networks, and what are the factors influencing their formation?
2. How does social capital affect maternal health practices?
3. What factors affect mothers' decisions to seek care and the situation of health care workers?

The first and second questions are proposed because of the postulate to explain the consequences of social capital in relation to their sources (Portes 1998). The emphasis of these questions is to explain the sources and consequences of social capital for maternal health practices on their own account, rather than against generalized concepts from the theoretical literature on how social capital is formed and what are its consequences for health. The third question arises from the fact that understanding the factors that affect decisions to seek care during pregnancy and childbirth as well as the institutional situation of health services is essential to understanding maternal health policies, which assume that women *should* give birth at a health facility.

Studying health practices: A methodological overview

The focus of this study was on the health practices of mothers during pregnancy and childbirth, what means that, in this thesis, I will discuss issues related to reproductive health over the lifecycle to a limited extent.

I used Bourdieu's definition of social capital as a reference point for research interpretation:

> *The totality of resources (financial capital and also information, etc.) activated through a more or less extended, more or less mobilisable, network of relations which procures a competitive advantage by providing higher returns on investment.* (Bourdieu 2005:194–95)

Bourdieu's conceptual system proved to be an essential tool for addressing the limitations of the mainstream conceptions of social capital (Cleaver 2005), which understand it as social resources in the context of its ability to satisfy individual needs (Coleman 1988, 1990) or see it as public goods (Putnam 1993, 2000). Bourdieu's approach deals with the structure-agency debate that has been sidelined in the dominant discourse around social capital and choices of health care. This approach avoids perceiving actors as rational agents or as obedient followers of community norms. Instead, it explores how actors' strategies are shaped by the social, economic, and political structures that dominate a local social space. Moreover, applying Bourdieu's conceptual system allows me to point out the differentiated power relations of people within communities and indicate how norms, solidarity, and reciprocity are promoted by various actors, who, as per Bourdieu, at certain times "have an interest in the universal" (Bourdieu 1991: 33). Finally, the definition cited above acknowledges that social capital consists of (1) social networks and (2) the resources mobilized through them. Therefore, it addresses the postulate to study social capital consequences in relation to their sources (Portes 1998). This definition underscores that the overall returns on social capital depend on the volume and quality of resources available thanks to networks, and also on social capital's interaction with the actors' initial amounts of other types of capital. Bourdieu noted: "This conception of social capital differs from the definitions which have subsequently been given in American sociology and economics in that it takes into account not only network of relations, characterized as regards its extent and availability, but also the volume of capital of different species which it enables to be mobilized by proxy" (Bourdieu 2005:246).

This study was conducted in Aze Debo – a kebele in Kedida Gamela wereda in the Kambata Tembaro zone, in Southern Nations, Nationalities, and Peoples' Region

(SNNPR) in Ethiopia. The community has been a part of the WIDE research – a longitudinal study of 20 rural communities since 1995. The 20 WIDE communities are examples of the major types of agricultural-ecological systems found in the four central regions of the country.

There were several reasons for choosing this particular community. Firstly, I identified SNNPR as a potential site for the research based on its political stability, which guaranteed safety while conducting the research. Secondly, Aze Debo represents one of the major types of agricultural-ecological systems found in the major regions in Ethiopia, which led to its selection as part of the WIDE study in the mid-1990s. WIDE communities were chosen as illustrations of different types of rural communities (Dom and Pankhurst 2019). Therefore, there is a likelihood that patterns found for selected types of communities can also be transferable to other communities of the same type. Thirdly, logistical issues were also taken into consideration: it was possible to get to Aze Debo from Addis Ababa (in one day by road) or from SNNPR's regional capital, Hawassa (in half a day). Finally, the village was selected due to practical issues: there were WIDE qualitative data available about Aze Debo which were collected in 1995, 2011, and 2018 and embraced a wide range of changes that had unfolded in this community. Therefore, I could have immediate access to a rich set of information about the contemporary history of the community. It is worth emphasizing that, although there are much more remote kebeles in Ethiopia, the women I interviewed in this study were still not an easy-to-target group. In addition, the fieldwork phase was conducted alongside major political changes in Ethiopian society related to a state of emergency that did not make the research process easier.

Data was collected using a mix of qualitative research techniques (interviews, observation, and document review). The timeframe of the study spanned from 2015 to 2018, but I also used data from previous rounds of WIDE. Moreover, while I widely used various resources to gain an understanding of the health practices of mothers and their social capital, the main source of information were the interviews conducted for this study.

Contribution of the study

By combining the literature about social capital in general and social capital as it relates to health, and using the case study of a rural community in Southern Ethiopia, this research hopes to contribute to (1) the body of critical studies on social capital and (2) the understanding of maternal health care policies and systems in developing countries.

Firstly, this study joins other critical studies of social capital in arguing that mainstream conceptions of social capital have not adequately grasped the issue of human agency.

In the mainstream conceptions of social capital, presented in Coleman's and Putnam's works, people make decisions as 'rational actors' who purposefully undertake different activities in pursuit of their goals or are submissive to common norms in the process of the production of public goods (Cleaver 2005). However, this study showed that women establish relationships in conscious and unconscious ways. Further, it proved that women's agency to establish relationships is frustrated by inequitable social and economic structures that are channeled through institutions. The study proved that social capital, which is an intangible asset, cannot be equally available to everyone people in a community. This has consequences for health policy practice: any development of health policies that assume the use of the existing social capital in a community should consider the ability of different people to access this capital and address the underlying reasons for certain people's lack of involvement in social networks.

Secondly, the study contributes to the understanding of the role of social capital in social action and asks about the limits of state power to intervene in the lives of citizens in the name of modernization. By showing that social networks are crucial channels of information and norms about care during pregnancy, this study proved that social networks can contribute to the creation of 'common knowledge' about proper practices during pregnancy and childbirth. This common knowledge is not an aggregation of the preferences of members of the community, but it is rather a collection of certain arbitrary forms of preferences, which can be regarded as the symbolic power of biomedical health care. In this way, this study nuances previous literature on public health (e.g. Kawachi et al. 1999) that presented activities such as health promotion as neutral events that are inherently positive and do not imply an unequal power relations between actors. This case study proved that Ethiopia's aim of improving maternal health using women's social capital has been driven by a double imperative that, on the one hand, is concerned with women's empowerment through delivering health education but, on the other hand, encompasses control over women's behaviours. This has been done for the sake of a broader idea of Ethiopian modernization, which implies bringing health care infrastructure closer to local communities as well as creating a new, responsible citizen through education delivered by state-sponsored networks. The interaction between these two imperatives is complex: to be empowered means making independent choices, but it is difficult to make such choices in highly controlled circumstances. The study posed a question about how far a state can move forward by controlling citizens in the name of delivering 'modernization', 'tangible effects of development', and 'empowerment'. Another question also arose: even if women have access to certain resources from their networks, we need to ask not only what kind of social capital resources women demand, but also what these resources allow women to do and to be.

The study contributes to the scholarship on mothers' health-seeking behaviours in a developing country context. It showed that compliance with a biomedical health care system is a complex interaction among material situation, knowledge about health status and lifestyles that can lead to better health during pregnancy, and also the meaning of pregnancy. Compliance with a modern health care system can be assigned to a combination of factors: the actions of social networks, health education, women's identities, and the increased availability of medical infrastructure. This study also points out that, although health education is often a factor that enables women to compare 'old' practices (which are perceived as negative for their health) with 'modern' health care (which can prevent complications and save their lives), education alone is not able to improve maternal health. There are a number of factors, such as individual poverty or distance from a health facility, that can influence women's ability to move to a health center for medical advice and delivery.

Finally, the study contributes to the body of studies on the Ethiopian health care system. By showing the political nature of the work of health workers at the local level, it nuances studies about the technical efficacy of maternal health interventions, which have often framed this sector as free from politics. It adds a case study to the body of literature arguing that even the most morally desirable values, such as health, are not politically neutral (Østebø et al. 2018, Melberg et al. 2019).

Thesis overview

The thesis is organized into seven chapters and in total takes up 209 pages not including the introductory pages (p. i–viii), appendices (p. 210–224), and bibliography (p. 225–252). It is enriched by photographs from the fieldwork, figures, and maps.

The main aim of Chapter One is to present the major theoretical debates about the concept of social capital and present the definitions of social capital that are most important for this study. Later, the chapter provides an overview of the empirical studies about social capital and health. As such, this chapter also sets the stage for the selection of the theoretical lens applied in this thesis.

Chapter Two elaborates on Bourdieu's theory of practice and the main conceptual aspects of his work that are relevant to this thesis.

Chapter Three explores how health policies directed at reducing maternal mortality have been developed at the global level as well as in Ethiopia. The chapter consists of two parts. Firstly, I present how health policies aimed at reducing maternal mortality have been developed at the global level. Secondly, I show how the Ethiopian health care system was developed

in particular institutional and political contexts over three regimes: the imperial regime of Haile Selassie, the socialist regime of the Dergue, and the developmental state.

Chapter Four discusses the methodology used in this study. It presents the rationale for choosing the qualitative and case-study approach, the fieldwork site, the data collection process, and the techniques devised for data analysis and interpretation. It also explains the data analysis procedures and reflects on the validity and reliability of the research. The chapter ends with a reflection on ethics, my position as a researcher, and the study's limitations.

Chapter Five presents the results of the study conducted in Aze Debo. It introduces the community and provides an account of its historical background. It also describes the material conditions of the inhabitants and the main sources of income that prevail in households' livelihood portfolios, as well as the biomedical health care system. This will serve to contextualize the data in later sections, where I present data in line with the sequence of three research questions. In Section 5.2, *Forms and factors of women's social networks*, I describe how women in Aze Debo established connections. Section 5.3, *Links between social capital and health*, discusses various health-relevant resources that women accessed through social networks. The last Section of the chapter, 5.4, *Factors affecting care seeking and health workers' situation*, discusses factors that influence women's decision to seek care at biomedical health care facilities and the institutional situation of health service.

In Chapter Six, I discuss the results of the study. The discussion is framed using the three research questions, and refers to contemporary studies about social capital health in Ethiopia as well as other developing countries. Chapter Six leads me into presenting the conclusions arising from this work in Chapter Seven.

1. Researching social capital

The term social capital has been used across different disciplines, and so far a single definition of this term has eluded scholars (Durlaufs and Fafchamps 2004; Hyyppa 2010). Scholars have proposed different explanations for this situation. Firstly, one of the reasons may be that major social capital theorists have represented different epistemological schools. As such, Pierre Bourdieu, who has been regarded as the first to propose this term, derived his ideas from Marxist theory, while James Coleman and Robert Putnam have represented more liberal thought. Secondly, social capital as a concept has often seemed to be a remedy for all kinds of social problems. Therefore, it has often been used and misused, which has led to its exhaustion (Portes 1998).

The lack of a clear-cut approach to the concept has had several consequences. The fact that the major social capital theorists have represented different schools has led to different definitions of the term. Such a situation has also led to different approaches to naming and framing research problems. As a result, there is no finite theory of social capital, and the concept is located in different theoretical traditions and analytical models.

As such, social capital has been applied in various fields has begun to be regarded as an umbrella term that can be transported across many disciplines, which has generated different emphases on particular dimensions of social capital and different understandings of this term (Wakefield and Poland 2005). In political science, social capital understanding has centered on civil society and interaction with formal political institutions (Jackman and Miller 1998; Couto and Guthrie 1999; Paxton 2002; Halpern 2005). In economics, scholars have investigated the relationship between social capital and economic growth (LaPorta et al. 1997; Knack 1999; Whiteley 2000; Zak and Knack 2001; Rupasingha et al. 2002; Beugelsdjik et al. 2004; Beugelsdjik and van Schaik 2005; Iyer et al. 2005; Bjørnskov 2012). Social capital was linked also to educational outcomes (Coleman 1988; Sun 1999; Teachman et al. 1996), innovations (Akçomak and ter Weel 2009), the labour market (Granovetter 1973), and management and organizational studies (Adler and Seok-Woo Kwon 2002; Borgatti and Foster 2003). In Polish discourse, the topic of social capital has been studied by Piotr Sztompka (Sztompka 2000, 2007, 2016). Other studies on social capital in Poland have concerned many areas, among

others regional development (Janc 2009), civil society (Czapiński and Panek, 2015), the social capital of older people (Klimczuk 2012), and general modernization[1] (Zarycki 2004).

Due to its interdisciplinary character, the concept of social capital has started to catch on influential policy-making bodies. This term has been considered a useful policy leverage in organizations such as the Organization for Economic Cooperation and Development, the World Bank, and the World Health Organization (Narayan and Pritchett 1997). These organizations have put particular emphasis on the potential use of social capital in community development, and have adapted a community empowerment perspective.

As the term has been used in many disciplines, every scholar conducting research on social capital faces a challenge related to their choice of literature to investigate. The existing definitional chaos and meta-theoretical discussion make the choice of approach to analyzing social capital more difficult in practice. In this area, it is important to note that certain language related to social capital has emerged in particular institutional settings, which enables the interpretation of this language. In this thesis, I have derived my ideas mostly from the literature about critical studies of social capital (Fine 2001; Bebbington 2007, 2008), which has kept distance towards literature that treats social capital as an inherently positive thing. However, I agree with scholars who have argued that social capital can be a promising new term in social science, but that little attention has been given to its intellectual history or its conceptual or ontological status (Woolcock 1998; Fine 2001).

Having noted the ambiguity of the concept of social capital at the outset, my main aim in this chapter is to elaborate the major theoretical debates about this concept in order to make clearer the current state of the theoretical debates in the field, keeping in mind also the aim of the thesis. The chapter is structured in the following way. Firstly, I present the most important definitions of social capital. Later, I discuss empirical studies that have employed different approaches to social capital and have applied this concept in empirical research. The chapter ends with a summary of the most important points. As such, this chapter also sets the stage for the selection of the theoretical lens applied in this thesis.

1.1. Definition of social capital

There are different schools of thought dealing with the notion of social capital. They have various relationships to the work of classic scholars such as Alexis de Tocqueville, Emile Durkheim, Max Weber, and Karl Marx (Putnam 2000; Halpern 2005). The term of social capital

[1]As this thesis concentrates on social capital in a developing country context, I am omitting a more detailed literature review of the Polish discourse.

in the sense in which it is used today was proposed by Lyd J. Hanifan in the work "The Rural School Community Centre" in 1916 (as cited by in Woolcock and Narayan 2000). Hanifan related the concept of social capital to the values such as 'good will', 'fellowship', 'sympathy' among the families and individuals within one social unit. According to Woolcock and Narayan (2000), the idea of social capital has been used only after several decades by Homans (1961), Jacobs (1961), Loury (1977). It was Pierre Bourdieu who produced the first systematic contemporary analysis of social capital (Portes 1998). However, it has been widely recognized that two American scholars—James Coleman and Robert Putnam—are the ones who made social capital a popular concept (Berkman et al. 2000; Berkman and Kawachi 2000; Campbell 2000; Fine 2001; Carpiano 2006; Ferlander 2007; Abbott and Freeth 2008; Derose and Varda 2009; Amoah, Koduah, and Gyasi 2018). The concepts of social capital as proposed by Putnam and Coleman, which have travelled to policy circles, have been sometimes termed as the 'mainstream' ones (see Fine 2002; Cleaver 2005).

Pierre Bourdieu defined social capital as the potential networks of relations that actors have at their disposal. In "The Forms of Capital", Bourdieu distinguished three basic forms of capital: cultural, economic, and social. Bourdieu defined social capital as:

> *The totality of resources (financial capital and also information, etc.) activated through a more or less extended, more or less mobilisable, network of relations which procures a competitive advantage by providing higher returns on investment.* (Bourdieu 2005:194–95)

In Bourdieu's approach, social capital has a potential to be translated into other benefits. Two factors influence this potential. The first one is the social relations that allow one to access resources. The second one is the number and quality of these relations. The potential comes from belonging to different groups and the actor's relationships within these groups. In Bourdieu's conception, relations are instrumental in achieving other benefits, like economic or cultural capital. Although this definition gives a sense of the Bourdieusian definition of social capital, it needs to be considered in the theory of practice, of which it is a critical element. This theory is described in greater detail in Chapter 2 – *Social capital within Pierre Bourdieu's theory of practice.*

The definition of social capital was introduced to the broader academic and public audience by James Coleman (1988, 1990). Before discussing Coleman's work in greater detail, it is worth noting that his works from 1988 and 1990 did not occur in a vacuum. It should be brought to mind that Coleman was concerned with issues related to social capital much earlier in the context of the social exchange debate, to which Coleman was a major contributor

(Coleman 1966). Therefore, Coleman's use of social capital in his 1988 and 1990 works should be regarded as a continuity of his earlier studies (Coleman 1972, 1973, 1975).[2] Coleman also made a link to neoinstitutionalism by acknowledging that social structures condition the transaction costs that shape the exchange of economic agents (Willamson 1985). One of the serious issues that was raised by the critical social capital scholar Ben Fine was Coleman's approach to a question in the structure-agency debate: how to derive the social from the individual. Fine argued that Coleman believed that all social science other than psychology can be reduced to the rational choice, because psychology relies on biological rather than social systems (Fine 2001). In reconciling the structure-agency debate, Coleman was committed to identifying the social with consistent aggregation from individual interactions (Fine 2001).

Coleman's approach relied on the assumption that social capital refers to the features of the social environment that facilitate the organization and effectiveness of actions. One of the results of his work was the following definition of social capital:

> *Social capital is defined by the function. It is not a single entity, but a variety of entities with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors – whether persons or corporate actors – within the structure.* (Coleman 1990:302)

This argument continued that it is social organization that creates social capital, facilitating the achievement of aims that would not be possible to achieve if social capital were not there, or that could only be achieved at higher costs (Coleman 1990:304).

Coleman enumerated three forms of social capital that are useful resources for individuals. The first form is obligations, expectations, and the trustworthiness of social structures, which concerns the scope of obligations people have towards each other. This form of social capital is determined by the trustworthiness of social structures, which refers to their effectiveness in enforcing reciprocal obligations, and also "the actual extent of obligations held" (Coleman 1988:102). In light of both these dimensions, social structures may differ. Differences in social structures in both dimensions may arise for a number of reasons: different needs; the presence of other aid sources, for example, from government; differences in degree of affluence; cultural differences in the tendency to lend aid and ask for aid; and differences in the logistics of social contacts (Coleman 1988:102). The second form of social capital Coleman proposed was "informational channels" (Coleman 1988:104). In this case, the resource is an access to valuable

[2] Coleman acknowledged his debt for social capital to Loury (1977, 1987) and referred to Bourdieu (1980) as cited in Coleman (1990). Bourdieu and Coleman edited a book together (Bourdieu and Coleman 1991). In its epilogue, Bourdieu explained this undertaking as a successful combination of scientists coming from different philosophical and methodological backgrounds (p. 373).

information—thanks to membership in a given structure, a person can gain important information that facilitates action. The third form is "norms and effective sanctions." This form implies the existence of appropriate norms that facilitate cooperation, actions for common good, and effective rewards, such as prestige.

Later, Coleman proposed three another forms of social capital (Coleman 1990). "Authority relations" is a form of social capital that is focused in the hands of a single actor, through other actors giving him or her this power to control certain actions. "Appropriable social organization" refers to a situation in which social structures established to attain one goal can also work effectively for a different cause. It also applies to situations in which the original goal of a given organization has disappeared. Its significant resources of social capital can be transferred to activities concentrated on other aims. "Intentional organization" is a form of social capital that results when actors invest with the aim of receiving a return on their investment. Coleman gave the example of a business organization, which, apart from investments in tools or human capital, has to plan its structure to enable effective work.

Coleman also provided three factors that allow for the creation and sustainability of social capital. The first is "structure closure", which facilitates the norms of reciprocity and especially the norm of executing sanctions. Closed structures help create norms and, in the longer term, trust. Norms, in this way, are sources of trust. In other words, for Coleman, trust was rather a product of a social environment in which sanctions are effective rather than a product of personal relations. The second factor is the "stability of social structure". Each form of social capital is dependent on the stability of social structures. One of the risks for this stability is the mobility of people, because it disrupts the structure (Coleman 1990:320). The third feature is "ideology", which "can create social capital by imposing on an individual who holds it the demand that he acts in the interests of something or someone other than himself" (Coleman 1990:320). One example is religious ideology, which encourages people to act in the interests of others. There are also ideologies that can be harmful to social capital because they encourage individuals to be more independent from each other.

The second most prominent social capital researcher was Robert Putnam. He proposed the so-called 'communitarian approach' to social capital in the book "Making Democracy Work", in which he raised the issues of democracy and economic performance. In his work, Putnam studied differences in economic performance between Northern and Southern Italy (Putnam 1993) and later applied his ideas again in his research concerning civic life in United States of America (Putnam 1995a, 1995b, 2000). Rather than treating social capital as a resource that works to assist individuals, Putnam saw it as a property of collectivities, such as groups

and regions. His book "Bowling Alone" popularized 'social capital' beyond academia, making it part of a public discourse (Song 2013). Having conducted over 20 years of research on the institutional performance of Italian regional governments, Putnam noticed that the apparent north/south division was present both in the economic and public spheres. Putnam introduced social capital as a notion that could explain these differences: social capital, in the form of horizontal associations within civil society, facilitates spontaneous cooperation, and consequently, civic organization and the development of institutions. These, in turn, both influence the government's performance, and hence the economy. In Putnam's approach, social capital refers to:

> *Features of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions.* (Putnam 1993: 167)

There are two processes that explain the association between civil society, economic and political performance. The first process is an internal one: members of associations formed for one common purpose create trust among each other, which has positive spill-over effects into other areas of activity. The second process is an external one: social capital causes a milieu of trust, so that effects are not limited to the members of an association. Conditions for such generalized trust have been built as long-duration processes. Later Putnam argued that "voluntary cooperation is easier in a community which has inherited social capital in the form of norms of reciprocity and networks of civic engagement (…) spontaneous cooperation is easier thanks to social capital" (Putnam 1993:167). Putnam's work was inspired to a great extent by the works of Alexis de Tocqueville, who did not use the language of social capital directly, but spoke about certain sociocultural factors and their connections to political practices. As Putnam noted, de Tocqueville observed that "civic associations, for example, reinforce the *habits of the heart* that are essential to stable and effective democratic institutions" (Putnam 1993:11).

In his later work, Putnam (2000) was explaining how he developed his later definition of social capital: "By analogy with notions of physical capital and human capital—tools and training that enhance individual productivity—the core idea of social capital theory is that social networks have value. Just as a screwdriver (physical capital) or a college education (human capital) can increase productivity (both individual and collective), so too social contacts affect the productivity of individuals and groups" (Putnam 2000:16). Using this comparison with other forms of capital, Putnam defined social capital thus:

> *Whereas physical capital refers to physical objects and human capital refers to properties of individuals, social capital refers to connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them.* (Putnam 2000:16)

The above conceptualization assumes that social capital is very close to 'civic virtue', which implies that social capital is inherently positive. However, civic virtues are not equivalent to social capital: they become more powerful when "embedded in reciprocal network of social relations" (Putnam 2000:16). Putnam underlined that social capital has two sides: public and private, because people who invest in social capital with an official aim of creating public good can also obtain individual benefits. For example, members of service clubs "mobilize local energies to raise scholarships or fight disease" (Putnam 2000:18), but at the same time the members gain connections that can be useful for individual purposes. Further, social connections are crucial because they involve mutual obligations. Putnam emphasized that frequent interactions among a diverse set of people tend to produce a norm of generalized reciprocity (Putnam 2000: 18). This norm of reciprocity is an asset to the community, because it increases institutional efficiency and creates social trust[3] (i.e. in other people). Despite the fact that Putnam initially defined social capital only in positive terms, it was later acknowledged that it can have negative, external consequences. He also distinguished two subtypes of social capital: bonding and bridging social capital (Putnam 2000).

Bridging social capital is inclusive and is directed externally. It is ascribed to intergroup relations, where interactions take place among the representatives of different groups. Bonding social capital is exclusive and directed within the group. This kind of capital contributes to the sustainability of reciprocity within the group and is the basis for solidarity within it: "bonding social capital, by creating strong in-group loyalty, may also create strong out-group antagonism" (Putnam 2000:21). Moreover, many groups can bond along some dimensions and bridge across other social connections, such as the black church, which brings together people of the same race, but of different classes. Putnam noted that "bonding and bridging are not 'either-or' categories in which social networks can be neatly divided, but 'more or less' dimensions along which we can compare different forms of social capital" (Putnam 2000:22).

Putnam assumed that people living in areas with high social capital can benefit from it. However, he remained silent on equality of access to social capital and the "common goods"

[3] It should be noted that there are different types of social trust. Firstly, particularized trust is informal and occurs among like-minded people within a social network (family, friends, neighbours). Generalized trust helps connect people who are different and may increase the likelihood of volunteering and civic activity (Putnam 2000). Sometimes generalized trust resembles trust towards institutions. In general, social networks characterized by trust are more likely to have reciprocal relations and strong ties.

related to it. He somehow assumed that even people with poorer social connections can benefit from living in a high social capital area through the spill-over of benefits coming from the area itself, an argument which has been criticized for being far too optimistic. Also, in Putnam's thought, individuals are positioned as over-socialised—social capital is an external factor that shapes people into adopters of collaborative actions for the public good. Individual agency is considered only to a limited extent, and primacy is given to collective units of analysis, like communities[4].

Criticisms of Coleman's and Putnam's approaches

Coleman's and Putnam's approaches share key features that have been subject to criticism. Firstly, both approaches lack a clear-cut definition of social capital. In Coleman's work, there is no clear indication of whether social capital refers to the networks in which people participate, or the benefits derived from these networks, such as information (Foley and Edwards 1999; Portes 1998, 2000). Moreover, its individualistic base means that any system of relations can be regarded as capital as long as it provided some value to a given action. Therefore, due to this lack of definitional clarity, the operationalization of Coleman's conception of social capital is very much context-dependent in terms of location, actions, and actors' utility functions. In Putnam's case, it has been argued that his understandings of reciprocity norms, trust, and networks of civic engagement are so close to each other that the boundaries between them are blurred and these terms are used exchangeably (Portes 1998; Foley and Edwards 1999). Moreover, the Coleman's conceptualization has been regarded as contradictory (Portes 1998). For example, Coleman included the mechanisms that generate social capital (such as reciprocity expectations and group enforcement of norms) in his definition of the term, just as he included the results of its possession (such as privileged access to information), and the appropriable social organization that provides the context for realizing both sources and effects (Portes 1998). The realization that Coleman and Putnam's approaches mix the consequences and sources of social capital heralded the emergence of postulates to separate them (Portes 1998; Woolcock 2001), as equating social capital with the resources acquired through it can easily lead to tautological statements (Portes 1998). The lack of clear-cut definitions also led to another issue: ambiguity with regards to levels and units of analysis. Putnam's early work concentrated on regions of Italy, but also on neighbourhoods and towns. Coleman's work acknowledged

[4] There is a difficulty in shifting from the individual to the group level: "A community cannot possess anything... communities are products of complicated sets of social, political, cultural, and economic relationships... Communities are outcomes, not actors... Communities unquestionably matter, but they are not actors that exhibit any form of agency" (DeFilippis 2001:789)

that social capital is a part of groups or individuals. As a consequence, depending on the context, these scholars provided different definitions and operationalized social capital on the basis of different units, which make comparisons difficult.

The second issue is that social capital was initially presented as an inherently desirable feature. Under Coleman's approach, social capital focused on benefits for individuals, rather than on what it could prevent them from doing. As a result, undesirable aspects of, for example, network closure (e.g. social exclusion) were less often analysed (Portes 1998). A similar problem was present under Putnam, who was basically focused on the argument that social capital is a community property whose defining characteristic is to facilitate action and cooperation for mutual benefit (Putnam 1993:35). As a result, some have argued that social capital as a concept can be potentially useful, but it is normative and assessing (Foley and Edwards 1999; Kass 1999). There has been concern that the popularity of the concept has allowed social policy to ignore structural inequalities (Muntaner et al. 2001; Fassin 2003). Coleman's approach based on rational choice theory and Putnam's communitarian approach have failed to address power and conflict issues (Schuller, Baron, and Field 2001).

The third criticism has concerned the fact that this notion is analytically fixed (Fine 2001:65; Fine 2010) and ahistorical (Morrow 1999). According to this argument, especially Coleman's approach remained decontextualized from a historical context and, therefore, has offered much more appeal for economics because of its methodological individualism and simplicity in application (Fine 2001).

Other approaches to social capital

The multidimensionality of the concept of social capital, variety of empirical referents and unclear level of analysis, coupled with its rapid popularization, has favoured the emergence of a wide spectrum of interpretations and modifications. Michael Woolcock explored the importance of social relations for economic development, especially in developing countries (Woolcock 1998). He distinguished two forms of social capital that are complementary to each other: embeddedness and autonomy, which can operate at micro and macro levels. Embeddedness was based on Granovetter's work (1983), which posited economic actions as embedded in social relations and argued that development causes a change in type, not degree, of embeddedness. At the micro level, embeddedness has referred to *intra-community ties* and, at the macro-level, to *state-society relations* also called *synergy*. Autonomy, at the micro level, refers to *extra-community ties* (linkage or bridging social capital) and, at the macro level, to *organizational capacity and credibility* (organizational integrity). The combination of these four

dimensions can produce different developmental outcomes, and therefore, they constitute different policy and theoretical dilemmas. Table 1 below presents outcomes at the micro level, and Table 2 at the macro level.

Table 1. Micro Level: Extra Community Networks and Intra-Community Ties and Development Outcomes

		Intra-community ties	
		Low	High
Extra-community networks	Low	Amoral individualizm	Amoral familism
	High	Anomie	Social opportunity

Source: Woolcock 1998:172

The first outcome concerns a situation in which both the level of embeddedness and the level of autonomy are low at the micro level. This is called "amoral individualizm", a situation in which there is "neither familial nor generalized trust, where narrow self-interest literally permeates all social and economic activity" (Woolcock 1998:172). The second outcome, "amoral familism", is characterized by the presence of strong intra-community ties but low extra-community linkages. The third outcome, "anomie", is characterized by high extra-community ties (linkages) and low integration. The best opportunity for development is when both linkage and integration are high.

Table 2. Macro Level: Organizational Integrity and Synergy in Top-down Dilemmas of Development

		Organizational integrity	
		Low	High
State-society relations (synergy)	Low	Anarchy (Collapsed states)	Inefficiency, ineffectiveness (Weak states)
	High	Predation, corruption (Rogue states)	Cooperation, accountability, flexibility (Developmental states)

Source: Woolcock 1998:177.

At the macro level, low organizational integrity and synergy results in "anarchy". High organizational integrity and low synergy results in "weak states"; low organizational integrity and high synergy results in "predation". High levels of both form of social capital produce cooperation, accountability, and flexibility, which are named under developmental states. It is important to note that Woolcock underscored the importance of sources of social capital, rather than consequences. The main argument was that there are both costs and benefits associated with a given source of social capital. Benefits, if they occur, are the result of these complementary forms of social capital, and these results are likely to change (Woolcock 1998).

The postulate of the separation of social capital sources and consequences was also put forward by Alejandro Portes, who defined social capital at the micro level as "the ability of actors to secure benefits by the virtue of memberships in social networks or other social structures" (Portes 1998:6). Such a definition implies that social capital can both have negative and positive outcomes, depending on the presence of certain structures, such as norms of obligation to other members. What is relevant is that Portes was critical of the tautological thinking in Putnam's approach, and therefore he postulated separating the sources of social capital from its consequences to avoid non-falsifiable conclusions. An important feature of Portes' work is the fact that he underlined negative aspects of social capital: excess claims on group members, restrictions on individual freedoms, and downward levelling of norms.

Then, Francis Fukuyama used social capital to explain different levels of economic development between different states. He presented a definition of social capital as a property of entire societies: "a capability that arises from the prevalence of trust in a society or in certain parts of it…usually created and transmitted through cultural mechanisms such as religion, tradition, or historical habit" (Fukuyama 1995:26). Fukuyama argued that acquisition of social capital does not happen through direct, rational decisions made by individuals, but it depends on "the moral norms of a community and, in its context, the acquisition of virtues like loyalty, honesty and dependability" (Fukuyama 1995:27). Fukuyama sees 'spontaneous organization' as the most desirable form of social capital: it is not created by family members, nor created by the state.

Trust is the most important moral virtue in Fukuyama's approach to social capital. He mainly discussed how trusting relationships can decrease transaction costs in the economy. When people working in one organization trust each other because they share the same norms, doing business is cheaper. Such organizations are also more able to innovate. One of the examples was the case of Americans, who "pioneered the development of the modern corporation in the late nineteenth and early twentieth centuries" (Fukuyama 1995:27). In societies in which people do not trust each other, the virtue of trust is replaced by the formal rules, which can be enforced even by coercion.

Classifications of social capital

The theoretical development of social capital concept has led to important distinctions between different forms of it (Eriksson 2010). Researchers have distinguished 'structural' and 'cognitive' dimensions of social capital (Stone 2001; Islam et al. 2006; Harpham 2008). These two elements are not exclusive but complementary to each other. Structural social capital refers to the composition, extent, and activities of local-level institutions and networks (Krishna and Shrader 2000; Eriksson 2010). Cognitive social capital refers to norms of trust and reciprocity, which work within structures. De Silva et al. (2007) stated that cognitive social capital concerns perceptions of the quality of social relationships such as trust, while structural social capital concerns the quantity of members in networks (De Silva et al. 2007). To put it a different way, structural social capital refers to what people do, while cognitive social capital refers to what people feel with regards to social relations (Harpham, Grant, and Thomas 2002).

As mentioned in the section above about Putnam's approach to social capital, a distinction has been drawn between 'bonding' and 'bridging' social capital. Bonding social capital refers to strong relations within a rather homogenous group, such as family, neighbours, close friends, and colleagues. By contrast, bridging social capital has weak ties. Links between those of different ethnic and occupational backgrounds constitute bridging social capital, both formal and informal. To these two notions, Michael Woolcock added the term 'linking' social capital (Woolcock 2001). Linking social capital consists of vertical ties between people in different formal or institutionalized power hierarchies. In this way, it can be said that this classification acknowledges different power positions among social actors, something that is not much present either in earlier Putnam's work (1993) nor in Coleman's work (1988, 1990).

Scholars have also proposed a distinction between individual and collective approaches to social capital. Bourdieu was the precursor of the individual-centered approach to social capital. Similarly, Coleman has been also regarded as proponent of individualistic approach to social capital, as he was focused on social capital as an asset for individual, even if he also stresses the role of social structure and collective actors (Eriksson 2010). In turn, Putnam has been regarded as proponent of collective approach to social capital.

Eriksson (2010) provided a distinction between structural and cognitive forms of collective and individual social capital (see Table 3).

Table 3. Distinction between structural and cognitive forms of collective and individual social capital

	Structural	Cognitive
Collective social capital Social cohesion approach	Aggregated bonding, bridging and linking social networks	Aggregated trust and reciprocity norms
Individual social capital Social network approach	Bonding Bridging Linking	Trust and reciprocity towards individuals

Source: Eriksson 2010.

An individual can be involved in different networks (structural social capital). Involvement in these networks can result in the creation of reciprocity norms and trust between people (cognitive social capital). At a collective level, different structural forms of social capital are often defined and measured as aggregated levels of involvement, i.e. as the share of people involved in various networks. Similarly, trust is defined and measured as aggregated levels of trust, such as the proportion of people declaring that they trust in a certain area (Eriksson 2010).

1.2. Debate about social capital and health

The different conceptualizations of social capital have led to different ways of applying this notion in the areas of public health, medical sociology, and anthropology. The social capital and health theme appeared for the first time in the late 1990s in the Kawachi study (Kawachi et al. 1997), which focused on links between social capital, mortality, and income inequality. The Kawachi study was followed by a body of other works that became increasingly nuanced as the general social capital literature progressed, with different definitions and research strategies.

The present literature review has found that there have been three broad categories of studies concerning social capital and health. The first category of studies includes studies in which social capital has been conceived of as social networks of individuals. The second category of studies has viewed social capital as the attribute of a 'collective'[5]. The third category has pointed out the relationship between social capital and the state. Applying the notion of social capital to health studies has also been challenging because health is determined by all aspects of life, including material conditions, education, and social relationships. This has resulted in a number of operationalizations of health measured using individual, community, society, and global scales (Łęcka 2018).

[5] It should be noted that 'collective' is a vague term. It is not always clear whether conceptualizations of social capital as relational and as a system use the same as the distinction between 'micro' and 'macro'.

1.2.1. Social capital at the individual level

In first category of health studies related to social capital, social capital has been conceived as an aspect of relationships among individuals, that is, as a property of individuals that can be found in the networks of individual participants. As mentioned in previous parts of this thesis, this individual approach was introduced by Bourdieu and later was taken up in the conceptualizations presented by Alejandro Portes (Portes 1998) and Nan Lin (Lin 2001). Under this conceptualization, actors can access different resources through their relationships (structural social capital), which are characterized by trust, reciprocity, and norms (cognitive social capital). Structural social capital can include notions like 'networks, social participation, civic participation, connections'[6]. In turn, cognitive social capital is equated with interpersonal, social trust and reciprocity (Hyyppa 2010).

In the research on links between social capital and health it is characteristic that scholars coming from the public health domain tend to problematize mechanisms or links between social capital and health as resources[7]. These resources are denoted as psycho-social or behavioural processes (see next paragraph) that take place at the micro level and are caused by the participation of an individual in social networks, which are regarded as the meso level. In this regard, social network structure is characterized by indicators such as size, range, density, proximity, or reachability and network ties are characterized by frequency of face-to-face contact, reciprocity of ties, duration, or intimacy (Berkman et al. 2000:847). What is important is that many of these studies have stopped at the meso level (networks or groups), and usually have not considered the broader socio-political context in which networks form and are maintained (i.e. the role of the state). Due to the often applied character of these studies, different mechanisms linking social capital and health have been taken into account based on the levels of analysis in which various features are assumed to operate. This has led to a debate over the mechanisms that link social capital and health, which mostly remain unclear (Abbott and Freeth 2008; Harris et al. 2010; Eriksson 2011) and context-dependent.

There have been different propositions for the mechanisms that link social capital and health. Berkman et al. (2000) emphasized *social support* (emotional, instrumental, and appraisal support) as one of the mechanisms. Examples are an individual borrowing money when he or she encounters a health shock, or people wanting to get health advice but being unable

[6] We can see that structural social capital at the individual level can be mixed with a communitarian approach. In many studies, even if the researchers have talked about individual social networks, definitions have included terms like 'social and civic participation.' Presumably this includes an individual's participation in a particular social or civic association.

[7] In this respect, I use the notion of resources available thanks to access to social capital, which is equivalent to the mechanisms linking social capital and health.

to do so because of a limited availability of doctors, such as is the case in rural areas (Cohen and Lemay 2007; Kim, Kreps, and Shin 2015). Social support deepens trust and also reciprocity.

Another mechanism that has been proposed is *social influence*. For example, the influence of peers on health behavior such as smoking is well established in health promotion research. Merzel and D'Afflitti (2003) found that changing norms was critical for the success of a health promotion programme, and role modelling by trusted peers was an effective way to influence norms. Further, Berkman et al. (2000) raised the role of *social participation* through involvement in social networks as an influence on health. Social participation gives a sense of belonging to a community and the opportunity to learn new skills. Finally, networks provide *material resources* for their members. Group membership can provide access to resources and services with a direct bearing on health, such as job opportunities and higher health care services. Although social networks can have a positive influence on someone's health, they can also have some negative one, such as a lack of support for those who do not conform to the existing norms within the network (Berkman and Kawachi 2000). Another example is related to social influence, which, depending on norms, can be enhancing or damaging to health. It is worth underlining that available studies about social capital and maternal health in developing countries are limited and indicate that social capital and maternal health is associated with higher levels of self-rated health (Lamarca et al. 2013) and better health-related behaviours (Elsenbruch et al. 2007).

While the above-mentioned studies utilized quantitative approaches to the measurement of social capital, there have also been attempts to explore this issue qualitatively. The first group of qualitative studies of social capital related to health tended to look at social capital in a way similar to that proposed by Bourdieu (Bourdieu and Wacquant 1992) and Portes (1998), namely that social capital refers to resources embedded in social networks. In this kind of study, social networks enable individuals to access different forms of social support, such as scarce material resources, as well as emotional support. An illustration is a study that explored discourses on health-related informal support to first-time parents after childbirth in poor suburbs of Dar-es-Salaam in Tanzania (Mbekenga et al. 2011). The study showed that parents relied on material and emotional social support from extended and close family, but when they did not adhere to social norms, they tended to receive less support from others. Another study investigating social capital and resilience among people living on antiretroviral therapy in Uganda showed that HIV patients were able to overcome a wide range of risks thanks to social networks as they could access material resources and also were encouraged to continue treatment and avert the risk of non-adherence (Nanfuka et al. 2018). Ware et al. (2009) examined the relationship between social capital and adherence to antiretroviral therapy in three public HIV-treatment

settings in Nigeria, Tanzania, and Uganda. An individual's social relationships were critical resources for adherence to antiretroviral therapy and managing economic hardship as well as overcoming stigma related to HIV (Ware et al. 2009).

Studies taking individual approaches to social capital, apart from the structural dimension, have also taken on the lens of the cognitive aspects of social capital. How structural and cognitive forms of social capital (e.g. not only group membership, but also trust and social norms) may have influenced the progression of the HIV epidemic in three villages of Tanzania was the main topic of a study conducted by Frumence et al. (2011). Using the categories of cognitive and structural social capital, the study found that both forms of social capital protected against HIV infection by expanding access to networks and empowering vulnerable groups to practice safer sexual behaviours (Frumence et al. 2011). Moreover, in an earlier study using the same categories of cognitive and structural social capital, Frumence et al. (2010) investigated the relationship between social capital and HIV prevalence in the same localities in Tanzania. They discovered that both cognitive and structural social capital were more pronounced in villages with high and medium HIV prevalence rates when compared to a village with low HIV prevalence rates (Frumence et al. 2010). In turn, a study from Ethiopia (Hussen et al. 2014) showed that bonding social capital provided a first line of support for people with HIV in a situation of societal stigma. Drawing from the linking social capital framework, Musinguzi et al. (2017) examined the claim that village health teams in rural Uganda, as an example of community health workers, linked and connected communities with formal health care services. The study touched upon a broader problem recognized in the literature, that, in some cases, the introduction of community health workers is interpreted as a government's attempt to control people and even hide its inability to provide health services. The study defined social capital as a "social resource accessed through a person's networks and participation in community events". Musinguzi et al.'s study found that linking social capital involved the accumulation of ties with individuals in power and institutions of influence outside the community. The study also acknowledged the power relations between patients and health care providers.

One of the most important charges against Putnam's and Coleman's approaches to social capital has been that sources and consequences are not separated clearly (Portes 1998). Indeed, few health-related studies have investigated the sources of social capital. A study by Larsen (2010) examined how the cultural norm of labia elongation was a mechanism through which social capital was produced in Rwanda. The study showed that the cultural practice of labia elongation enforced social norms, thus increasing trust (cognitive social capital) and strengthening social ties within the community (bonding capital). This type of social capital had the potential to lead

to negative consequences as well, such as socially isolating females who refused to or were unable to take part in labia elongation (Larsen 2010).

One element of social capital, namely trust, has emerged as especially important in the context of relations between patients and health care providers. Trust is essential for individual health because particularised trust towards a provider who has knowledge of prescriptions and medical knowledge is critical to ensure patients' collaboration in treatment and acceptance of health care interventions. This is especially important in a medical context in which sensitive information is revealed (Østergaard 2015). Gilson (2003), in a study on trust between patients and health care providers, paid attention to different mechanisms that built trust. These turned out to be managerial and organizational practices (such as a caring attitude, engagement, and open dialogue), as well as political processes that led to such managerial and organizational practices (Gilson 2003). Another study by Gilson (2005) looked at reasons that people feel trustful of providers. It showed that respectful treatment for patients, understood as positive attitudes, thoroughness, and technical competences for patients, was critical for building trust between patients and health care providers. On the contrary, a study from Mali about maternal health risk perceptions revealed that dissonance between biomedical health care providers and local sociocultural values caused a lack of trust in modern health care (Arborio 2007). This lack of trust was also caused by a lack of respect: for example, women tended to be treated roughly by midwifes, including being slapped and left alone for periods after being accused of practicing traditional medicine behind the back of the health personnel. Personal trust in midwives compared to traditional birth attendants influenced where women wanted to give birth. Moreover, patients tended to assign treatment of different risks/symptoms to different sectors: while physical risks were controllable by the health professionals, social risks were managed outside of the modern health sector. In turn, Olsen (2010) investigated the impact of global health initiatives on trust in health care provision in resource-poor settings. This study was one of other studies showing how 'expert knowledge' has been imposed in developing countries without considering the needs of local communities (Birungi 1998; Gilson 2005; Olsen 2010). This lack of consideration has pushed people away from horizontal health care and its quality, and has also undermined trust between patients and providers.

1.2.2. Social capital at the community level

Another type of study has concerned the possible links between collective social capital and health. As mentioned at the beginning of this section, the term 'collective' is vague. Under Putnam's concept, it can denote an association or a voluntary organization,

or a neighbourhood in which people trust each other. In the health literature, studies have looked at how these collectives can be beneficial for health, i.e., how they contribute to the general health in the community. In general, these studies have framed social capital as social cohesion within communities and have examined how social cohesion, income inequality, and health are related to each other (Berkman and Kawachi 2000; Muntaner et al. 2001). This kind of framing has also been present in WHO documents under the framework of 'social cohesion' (Wilkinson and Marmot 2003). It should be born in mind that, although public health studies have attempted to show different mechanisms linking social capital and health, they have also acknowledged that potential links between collective social capital and health are still debated and have a less solid empirical and theoretical grounding (Kawachi et al. 1997, 2008). One of the basic problems of relations between social capital and health is a dilemma: is health a precondition of a community with high social capital, or it is social capital that causes people to be healthy? Another challenge related to this approach to social capital is that moving to a macro level happens through simple aggregation of information from the micro level. This is the case for survey/pooling methods.

Despite these methodological difficulties, the literature on these links has continued to grow. At the collective level, one of the potential mechanisms that has been revealed is that social capital can have a mediating role between economic inequality and health (Wilkinson 1996, 1999; Kawachi et al. 1997; Kawachi and Kennedy 1997, 1999, Wilkinson and Marmot 2003; Marmot 2005; Islam et al. 2006). For example, Kawachi et.al. (Kawachi et al. 1997) wrote an influential paper about social capital understood in a Putnamian way: social capital or the lack of it was measured by responses to the United States General Social Survey showing the degree of mistrust (the percentage of survey respondents in each state answering that "most people can't be trusted"), levels of perceived reciprocity (the percentage of respondents replying that "most people look out for themselves"), and the per capita membership in voluntary associations of all kinds. Each of these indicators was correlated with lower mortality rates. The paper concluded that "disinvestment in social capital appears to be one of the pathways through which growing income inequality exerts its effects on population-level mortality" (p. 1495). What is important is that the authors claimed that one of the aspects of social capital is its inclusiveness, which automatically assumes that "benefits are available to all living within a particular community, and access to it cannot be restricted" (p. 1496). This assumes that social capital creates certain 'environment' which is conducive for general health.

Another study which shown that social capital can have a mediating role between economic inequality and health is Wilkinson's study (Wilkinson 1996). The study suggested

a number of such mediating mechanisms, such as emotions, helplessness, motivation, and self-perceptions, which are, surprisingly, psychological rather than social (Muntaner et al. 2001). Kawachi, Kennedy, and Glass (1999) discussed that cohesive neighbourhoods are more successful than others at uniting for the good of their neighbourhoods. High levels of social capital in local communities can also influence health-related behaviours through the spread of healthy norms by social control over deviant behaviours in the community (Kawachi, Kennedy, and Glass 1999). Further, collective social capital is believed to facilitate faster and wider diffusion of (health) information and knowledge, which can thereby have an effect on health (Kawachi et al. 2008). Finally, collective social capital is said to enable 'empowering processes' in communities that facilitate health behavioural change (Campbell 2000).

1.2.3. Social capital and the state

Relationships between social capital and health have surfaced in studies concerning the capacity of the state to solve the problems of collective action for the public goods, such as the delivery of health care services. In the context of health, there has been a set of studies that have problematized the relationships between state health providers and patients in the context of building trust in the state during doctor-patient interactions. These studies have also examined the concept of service delivery by health bureaucrats (Rothstein and Stolle 2008). These works have indicated that patients build their knowledge on the basis of their contact with health care providers, the reputation of health facilities, and the level of risk they might be exposed to at health facilities. Because health care systems are based on the idea that health is a public good for which the state has special responsibility towards citizens, failure to secure a minimum level of medical safety appears to foster mistrust in the public sector. Moreover, trust is relevant to the public health care system, which is in some countries dominated by the state, as it not only produces health but also imaginaries of state-provided social protection. This, in turn, reflects broader issues of trust in the state, as those who receive professional services are more likely to express greater trust in the state. This has implications for equity as poor people in poor countries tend to express lower levels of trust in the public sector (Østergaard 2015). Such a conceptualization of trust—firstly, from the point of view of health and secondly, from the point of view of state-society relations—presents social capital as linked to the features of political systems that enable norms to develop and shape social structures, such as the rule of law and recognized civil and political regimes (Woolcock and Narayan 2000; Szreter and Woolcock 2004).

Secondly, there has been another approach to state-society relations. It has reversed Putnam's thinking, that social capital builds efficient institutions, to quite the opposite—that social capital is not able to exist independent of the state or political processes (Foley and Edwards 1999; Tarrow 2005). The role of the state in building different kinds of social capital has been raised in other contexts (Fox 1996; Bebbington 2008), as well as in the health area (Szreter and Woolcock 2004).

1.3. Summary

This chapter reviewed the existing literature on social capital and health. Numerous works have been written about the theoretical and methodological issues of social capital as well as about the associations between social capital and health in empirical research. Probably many more pages of this thesis could have been devoted to all the nuances in this topic; however, this was not the main goal of the chapter. The main goal of this chapter was to present the major theoretical debates about the concept of social capital in order to make the clear current state of the art of the theoretical debates in this field, keeping in mind also the aim of this thesis.

In doing so, the chapter was divided into several parts. Firstly, I presented the most seminal definitions of social capital. I provided an overview of definitions by the proponent of the individual approach to social capital, Pierre Bourdieu and the two American scholars who have been credited with making social capital a popular term in academic and policy circles. It has been established that these scholars represent different epistemological stances and therefore their approaches to social capital differ. The chapter also offered an overview of the limitations of Putnam and Coleman's approaches and other approaches that have proliferated on the basis of their work.

The next step was a discussion of the empirical studies that have employed different approaches to social capital and applied this notion in empirical research at the intersection of social capital and health. The literature review seemed to indicate that studies concerning social capital and health can be divided into three categories: studies that have looked at social capital at the individual level; studies that have looked at social capital at the community/collective level; studies that have looked at social capital and the role of the state.

Several careful thoughts emerge from the review of the above-mentioned studies. Firstly, vague conceptualizations have led to a proliferation of measurements of social capital and aspects of allegedly the same phenomenon. It turns out that employing the concept of social capital can imply different research questions and can be an entry point to discuss other issues,

such as social support and trust, which can create areas of research on their own right. Secondly, an important feature of micro-level conceptualization of social capital literature is the examination of trust, which has been considered in terms of building relationships between patients and doctors and is likely to increase effectiveness of treatment. Thirdly, there is a profound problem with the mechanisms that link collective social capital and health—it seems that they are context-dependent, and it is difficult to find agreement on a finite list of these mechanisms. Fourthly, there has been a limited number of health studies that have looked at the structural and institutional factors that create social capital.

2. Social capital within Pierre Bourdieu's theory of practice

Having reviewed the major theoretical contributions in the social capital debate and having shown how these definitions have been applied in the literature about social capital and health, in this chapter I would like to propose a theoretical approach for this study.

In doing so, firstly I will present the conceptual system used by Bourdieu in his analysis of social practices. It should be emphasized that this thesis does not aim to deal with the theory of practice in great detail and does not claim to be making an original contribution to Bourdieusian scholarship. I am making an argument about the role of social capital in maternal health practices using relevant tools borrowed from Bourdieu's scholarship[8]. Secondly, the specific features of my borrowing, interpretation, and application of the concepts from Bourdieu's toolkit to the purposes of this research will be reemphasised here.

2.1. Bourdieu's approach

As was explained in Section 1.1, *Definition of social capital*, although the term social capital was popularized by James Coleman and Robert Putnam, one of the first modern conceptualizations originates from the work of Pierre Bourdieu, who wrote about social capital in the 1970s and 1980s. However, he considered social capital within the theory of practice – which employs notions of field, habitus, and forms of capital – which he used to theorize the interaction between structure and agency, as well as the creation and reproduction of social order, which were central to Bourdieu's sociological work (Jacyno 1997). Practices are agents' actions and the interactions among them in various life spheres in a defined time and place (Sztandar-Sztanderska 2010).

Bourdieu connected structuralist approaches, which gave priority to the power of social structures but dismissesd the power of individual agency, with individualistic approaches, which reduced social structures to "the conjunctural space of interactions, that is, a discontinuous succession of abstract situations" (Bourdieu 1984a:244). The relational thinking built into his conceptual system allows us to see that any 'choice of practice', including health practices, can be analyzed in relation to embodied dispositions (*habitus*) and structures of positions

[8] It should be noted that I deliberately structure this section to describe, in order, field, habitus, and social capital in particular among the types of capitals mentioned by Bourdieu. I highlight the issue of exchange between social, economic, and cultural capital to a lesser extent. This is casued by the fact that those who usually use Bourdieu's approach transform social capital or reduce it to the other capitals, thereby eliminating most of the social capital literature (Fine 2002). My aim is to avoid this tendency. For broader discussion about exchange between the three types of capital and health, please see Veenstra and Abel (2019).

or of capitals distributed unequally within social fields. Bourdieu's approach was aptly summarized by Williams: "Bourdieu attempts to capture the 'intentionality without intention', 'knowledge without cognitive intent', that 'pre-reflective, infraconscious mastery' which agents acquire in their social world by virtue of their 'durable immersion' within it" (Williams 1995:682). Therefore, Williams continued, "much of daily life (including health-related behaviour[9]) is simply taken for granted and organized according to a practical, largely unthinking, logic of which actors are only dimly aware" (Williams 1995:585). Bourdieu did not study the medical field directly, but his theoretical approach has been used to examine different issues of health and illness (Williams 1995; Shim 2010; Meinert 2010; Strand 2011; Collyer et al. 2015; Veenstra and Burnett 2014; Collyer 2017; Dobylte 2019, to name a few examples).

2.1.1. On field

The issue of field is a central tool in Bourdieu's scholarship. The field is a kind of 'microcosm' inside the social universe that has its own historically and culturally determined logic and produces its own type of practices and relations between its participants (Szacki 2002). It includes the social and symbolic spaces that are constituted around a specific activity and a specific stake, such as education, health, economy, art, or religion. Bourdieu, in his work with Wacquant, defined field in the following way:

> *In analytic terms, a field may be defined as a network, or configuration of objective regulations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation in the distribution of species of power (or capital), whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.).* (Bourdieu and Wacquant 1992:97)

There are several features of the field that are featured in its definition (Sztandar-Sztanderska 2010:49). A field consists of differentiated positions of social actors, defined in each case by the particular kind of capital they possess, which is also called their resources or power. Bourdieu noted that a field can be compared to a game (Bourdieu and Wacquant 1992). A field is defined by so-called 'rules of the game' and 'stakes' in that game, which are not explicitly codified. Although agents who are in the field have unequal positions, they take part in the game

[9] The formulation of 'health-related behavior' is the notion that is mostly associated with rational choice theory – for broader discussion please see Williams's article (1995).

because they share an interest (*illusio*) in the very existence of the field and the continuity of the game. This interest is a driving force of action (Bourdieu and Wacquant 1992).

In this context, the health care field can be conceptualized as a social space occupied by agents such as doctors, midwifes, nurses, traditional birth attendants, and patients. Their positions are defined by the amount of capital[10] that they possess. Each field is a space in which agents struggle to take the best position, i.e. achieve an advantage over other agents and appropriate the large capital that is valued in a given field (Szacki 2002). In the health care field, this can be cultural health capital,[11] which refers to the "particular repertoire of cultural skills, verbal and nonverbal competencies, and interactional styles that can influence health care interaction" (Shim 2010:1). Those who are in a dominant position can define the criteria for health and illness, normality and deviance. In other words, they introduce certain principles of classification of social reality. These principles become embodied in the internalized structures of classification (*habitus*) and institutionalized in the form of rules governing organizations. This possibility to embrace the most important position, which gives the power to define norms of classification, is the main stake in the game. Moreover, even if agents occupy opposing and conflicting positions, they are interested in the existence of a given field and agree that the game is worth playing, as shown by the very fact that they take part in it.

The concept of the field presupposes a degree of autonomy (Dubois 2015:207) that, in the context of the health care field, means the independence of a medical activity (Dobylte 2019). Although each of the fields has specific rules of the game, which make it distinct from other fields, in practice, the rules of different fields are intertwined. There are fields that are more or less autonomous; however, ideal autonomy is not possible to achieve (Sztandar-Sztanderska 2010). Field autonomy "varies considerably from one period and one national tradition to another" (Bourdieu 1993:40). This issue was illustrated by Strand's (2011) analysis of the field of mental health, in which Strand argued that the structure of positions is dependent on the economic and political field. Consequently, the role of the state and the market should be taken into account when defining the logic of the mental health care field (Strand 2011).

The bureaucratic (or state) field has a special status in relation to other fields, including the health care field. The state concentrates all types of capital (economic, cultural, and symbolic). In terms of economic power, the state has the capacity to define the scope of health services, the financing of facilities, and the distribution of medicines. It can promote particular types of financing – general taxation, or privatized user fees. Moreover, the state is able to shape

[10] Please see the next sections on capital.

[11] Cultural health capital can include, for example, a patient's proactive attitude towards accumulating knowledge or style of communication. These skills can be used by patients and may result in more attentive engagement with health professionals (Shim 2010).

cultural capital through the schooling system and the framework for the medical training of health professionals (Bourdieu 1994). In mentioning the issue of concentration of different forms of capital by the state, Bourdieu referred to many historical processes, such as: the introduction of taxes and the recognition of the state as an institution legitimized to its collection; the unification of economic space; the unification of laws and languages; and the homogenization of communication in bureaucracy and education. Control over resources created advantage over other agents, groups, or institutions. Concentration of capital gave the power to control other types of capital and the rate of exchange between them. Therefore, state capital was regarded as meta capital by Bourdieu (Sztandar-Sztanderska 2010).

The fact that the state has the power to define certain systems of classification takes us to the notion of symbolic violence. The nature of such violence is not obvious; that is, it encourages particular behaviours in citizens in such a way that they are not aware of coercion. The state does not have a need to give orders, or conduct open coercion to create an ordered social world: it aims to embody cognitive structures that are adjusted to objective structures and provide a faith, a kind of *doxic* subordination to the existing order (Sztandar-Sztanderska 2010).

The main tool that gives power to the state is education, which produces certain cognitive categories that are deemed to be 'natural' or 'taken for granted'. These categories are used by people to perceive and assess the order of the world. Schools equip the state with the power of forming people, and its main power is that it is not perceived as powerful. In Bourdieu's understanding, education has political dimensions, which are fulfilled by perception schemas. These schemas are never neutral, but always work for the advantage of certain groups. Therefore, the ability to impose certain classifications becomes a stake in the struggle for power. Schools do not make this ability visible, but rather allow for such socialization that supports keeping a balance between external structures and individual dispositions.

The field of health care can be interpreted as a site of symbolic power – a subtle form of domination towards agents and with agents' complicity that reproduces social order (Bourdieu and Wacquant 1992; Dobylte 2019). The dominated groups not only accept forms of symbolic power as legitimate, misrecognizing their reproduction of inequalities, but also see the dominant groups (for example, health care providers) as the rightful agents to use that power (Dobylte 2019). Bourdieu noted that "the clinical act implies a form of symbolic violence"[12] (Bourdieu

[12] Having the power of naming, a doctor can categorize certain symptoms based on indices or information given by a patient. This categorization can act as a kind of social control over the patient's view of the illness. In the process of doctor-patient interaction, there is a problem of power relations involved in "the translation of the spontaneous clinical discourse of the patient into the codified clinical discourse of the doctor" (Bourdieu 1984b: 64)

1984b:64). This symbolic act of imposition has on its side all the strength of common sense, because it is performed by a delegated agent of the state (that is, the holder of the monopoly on legitimate symbolic violence). The central argument is that it is possible to control human life through the control of knowledge. Usually patients do not perceive diagnoses and treatments as a form of social control (Waitzkin 1989). Moreover, doctors are "agents entrusted with the operation of classification" (Bourdieu 1984b: 207) who perform their function the guise of the treating people. In other words, "they successfully perform what they (objectively) have to do only because they believe that they are doing something different from what they are actually doing" (Bourdieu 1984b: 207).

2.1.2. Habitus

Field structures *habitus*, which can be defined as the product of history and experience (Bourdieu 1977; Veenstra and Burnett 2014). *Habitus* reflects the shared systems of historical and cultural classifications and also the individual history of an agent (Dobylte 2019). In the context of health practices, *habitus* can be understood as incorporated systems of perceptions of health and illness as well as classifications of treatment methods that influence the medical choices of a patient.

Bourdieu underlined that *habitus* is adjusted to the conditions where it is acquired: the position of one's family, one's material circumstances, or the social conditions of one's neighbourhood. These objective structures generate dispositions adjusted to these conditions (Bourdieu 1990). *Habitus* is durable, in the sense it functions below the level of consciousness. To describe the implicit adherence between the field and *habitus*, Bourdieu talked about *doxa*, which is the taken-for-granted understanding of categories that people have about their social worlds (Veenstra and Burnett 2014). These categories of perceptions are generated by dominant agents but incorporated within *habitus* of the dominated too and, therefore, generally remain undiscussed. One example of a *doxic* attitude could be a perception about the role of health care providers as authorizing withdrawal from regular social roles and responsibilities due to mental health problems (Dobylte 2019). *Doxa* can be questioned in situations when the fit between subjective and objective structures is destroyed, such as scientific crises when medical knowledge is questioned.

Questioning the dominant classifications implies agency (Dobylte 2019). However, in Bourdieu's understanding, questioning existing norms is very much dependent on the objective conditions and the position an agent occupies in the field. Bourdieu's understanding of *habitus* was subjected to many criticisms and was accused of being deterministic (Sewell 1992; Williams

1995) and oriented towards the past, in spite of "new experience being continuously incorporated in the *habitus"* (Bourdieu and Wacquant 1992:133). Abel and Frohlich (2012) noted that *habitus* does not attempt to explain how structure can be changed and how individual agency is increased.

However, Bourdieu's theory of practice has features that do make it flexible and adaptive to different situations. Veenstra and Burnett (2014) stated, "Bourdieu's theory of practice may be more impervious to the critique of determinism than current evaluations of it in health promotion and public health would suggest" (p.188). Firstly, although *habitus* has an enduring effect on those who hold it, it only provides the characteristic repertoire from which individuals can creatively build their action (Swidler 1986). Secondly, *habitus* is adaptive, which means that, when schemas are applied in a new field with which they are not aligned, they can trigger innovative actions to achieve balance between *habitus* and the field (Veenstra and Burnett 2014). Bourdieu defined *habitus* at one point as "a system of lasting transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions and makes possible the achievement of infinitely diversified tasks" (Bourdieu 1977:83). *Habitus* also enables us to see agents as future-looking, because "it possesses a practical sense" in the field that Bourdieu referred to as the ability to anticipate events (Bourdieu 1990:66).

Thus, the structural conditioning of culture or social conditions and what a person does in practice never simply overlap (Mjaaland 2015), and social change can be present in Bourdieu's conceptual system (see Sewell 1992). Bourdieu's approach can help us to understand women's health practices as health choices constrained within the limits of the field and structured by their own capital resources, with social capital being one of them. In other words, the forces of the field structure the capacities of agents, giving shape to the type of choices that they can make (Collyer et al. 2015). From such a perspective, it is possible to better understand why and how people conform to disadvantageous structures and make choices that strengthen their subordinated position. For example, in the health care field, women might accept dominant moral codes that condemn contraceptive use even if these services are legally available (see Mjaaland 2015). This approach seems also to resonate with approaches to agency that explain compliance with existing structures of inequality. An essential advantage of this approach is that it combines both the material and symbolic factors that condition the social context in which choices are made.

2.1.3. C*apital*

The position of different agents in the health care field – midwifes, doctors, and traditional birth attendants – is defined by their stocks of capital. By capital, Bourdieu meant resources that are "efficacious in a given field, both as weapons and as stakes in a struggle that allows their possessors to wield a power, an influence, and thus to exist, in the field under consideration" (Bourdieu and Wacquant 1992:98). Each field has a different form of capital that is especially valued. However, across all fields, social, economic, cultural, and symbolic forms of capital exist.

At this point, it is worth recalling the definition of social capital as per Bourdieu:

> *The totality of resources (financial capital and also information, etc.) activated through a more or less extended, more or less mobilisable, network of relations which procures a competitive advantage by providing higher returns on investment.* (Bourdieu 2005:194–95)

Bourdieu's conceptualisation of social capital as the interaction between agents' networks of relations and the social resources mobilizable within them as a part of the order of the field has several implications.

Firstly, social capital is not equivalent to the possession of different forms of linkages: bonding, bridging or linking. Such classification neither indicate that these connections indeed grant access to resources, nor allow one to identify the particular conditions upon which those resources are granted. By saying that "relationships are constantly practiced, kept up and cultivated" (Bourdieu 1977:37) and that they "are product of the history of economic and symbolic exchanges" (p. 207), Bourdieu's approach enables us to understand them in a dynamic way, and not as simply number of friends or memberships. It cannot be denied that social capital is built on agents' networks, but Bourdieu's definition within theory of practice puts emphasis on the transformation of such connections into useful relationships.

Secondly, the existence of social networks cannot be taken for granted (Bourdieu 1986). Social networks must be constantly created and recreated. In other words, social networks are the products of investment strategies, individual or collective, conscious or unconscious, aimed at establishing or reproducing social relationships that are directly usable in the short or long term. In this way, social relations are different from the logic of economic exchange. As Bourdieu noted, "there are some goods and services to which economic capital gives immediate access, without secondary costs; others can be obtained only by virtue of a social capital of relationships which cannot act instantaneously, at the appropriate moment, unless they have been established and maintained for a long time, as if for its own sake, and therefore outside the period of their

use (…) the cost of investment in sociability which is necessarily long term because time lag is one of the factors of the transmutation of a pure and simple debt into that recognition of nonspecific indebtedness which is called gratitude" (p. 252). To recapitulate: social capital requires investments in the form of time, cultural knowledge, or material resources (gifts).

Thirdly, the ability of social agents to invest time, cultural knowledge, or material resources into social networks depends on their initial positions, which are in turn shaped by access to valuable social resources. This means that, for example, possessing more economic capital at the outset allows people to invest more in social relations (e.g., to conduct a richer social life). Also, having more economic capital affects actors' positions from which they develop relations with other actors in more dominant or more subordinated positions. In this way, access to social resources corresponds with actors' relations around a particular class-based position. Actors tend to develop relationships with similar people in terms of material conditions of existence and similar sets of practices and dispositions (Bourdieu and Wacquant 1992).

To summarize the argument so far, explaining social practices of an actor under Bourdieu's theory of practice requires consideration of a number of elements. First, one should examine the fields in which agents undertake actions and structures of "differentiated positions, defined in each case by the place they occupy in the distribution of a particular kind of capital" (Bourdieu 1998:15). Field denotes a structure of objective power relations "whose necessity is imposed on agents" (Bourdieu 1998:32). Power is equal to the possession of different forms of capital, which are particularly important in a given field. An unequal distribution of field-specific forms of capital (power), which vary across places and moments (Bourdieu 1998), results in some agents taking the dominant positions while others – the dominated ones (Bourdieu 1998:34). The *habitus* of the agent – a system of classifications and perceptions shaped by taking different positions within a field – should be taken into account as well. *Habitus* works in combination with the position of social agents, resulting in different practices. Although these strategies are subject to change and to the human imagination that is characteristic of *habitus*, Bourdieu defined two of them. The first is aimed at keeping the current stage of power, and the second one aims at changing this situation. Usually the first strategy is used by agents with the best position within the field – the dominant agents. The second one is applied by agents with worse situations – the dominated ones.

2.2. Bourdieu's approach and current social capital debates

Having outlined the main tools in Bourdieu's conceptual system, in this section I would like to (1) indicate limitations of Coleman's and Putnam's approaches to social capital, which has been described as mainstream conceptions of social capital (Cleaver 2005); (2) show how tools from Bourdieu's conceptual system offer a remedy to these limitations. It should be re-emphasized that, although Bourdieu's sociological work was concentrated on how reproduction happens in society, my interest in this toolbox is especially on Bourdieusian understanding of social capital. Below I indicate three basic problems with the Coleman's and Putnam's understandings of social capital, which are:

1. Limited consideration of the role of the state in the creation of social capital;
2. Limited consideration of individual agency in the appropriation of social capital;
3. Limited consideration of how people with different positions access social capital resources, especially those living in one social space.

One of the main limitations of Putnam's approach is the fact that it has been "disassociated from the broader context in which it is supposed to be created and have effect. Most notably absent is the role of the central state"[13] (Fine 2001:87). In this respect, Bourdieu offered historically and socially situated analysis of social capital thanks to the notion of *field*. Under Bourdieu's approach, health care is a field in which a certain structure of positions or objective power relations prevails. This structure is "imposed on all those who enter this field", and therefore, the "field is not reducible to the intentions of individuals or even to direct interactions between agents" (Bourdieu 1991:230). In other words, it is not that a group of individuals interact and act by their own logic, but rather that there is a historically determined structure that defines a shared principle of vision and division between what is normal and not normal. The concept of field gives importance to what is acceptable in health care and what is not by setting rules of the game. These rules create complex classifications and boundaries that mark inequality between social actors (Tilly 1998) and tell them what is right and what is wrong. Moreover, attention to structural factors (discussed in a greater detail below) and the role of politics allows us to pay attention to sources of social capital within the accessible resources that can lead to better health. This is in line with Portes's postulate

[13] Tarrow comments Putnam's model outlined in his book about Italy in the following way: "the lack of state agency in the book is one of the major flaws of his explanatory model" (Tarrow, 1996:395). Putnam paints an unsatisfactory picture of political life, and its determinants, by focusing on social capital (Fine, 2001; Tarrow, 1996). This line of criticism is a recurring theme across different critics of Putnam's approach to social capital (Fine, 2001; Jackman and Miller, 1998). Tarrow's critique ends with reversing the logic of Putnam's approach: that civic indicators (such as civic activity) are result of "politics, state-building, and social structure". He continues to argue that while "indicators of (the malaise) may be civic, the causes are structural" (p. 369).

(1998) that, especially in the case of Putnam, we do not have a clear-cut definition of what are the sources and consequences of social capital.

Another limitation of mainstream approaches to social capital is the fact that these approaches are based on an inadequate model of human agency and the ability of actors tostrategically invest in social capital (Cleaver 2005). Mainstream conceptions of social capital are underpinned by a modified version of rational action theory in which people are seen as social entrepreneurs, consciously investing in relationships (Ostrom and Ahn 2003). Such a rationalist view of an individual can result in victim-blaming approach, and a neglect of structural factors that limit the disadvantaged's ability to exercise their agency (Cleaver 2005). If social capital is built through institutional engagement, there is a need to understanding how everyday relations between people produce social and cultural norms that shape patterns of institutional inclusion and exclusion (Cleaver 2002, 2005). As noted by Bourdieu, it is important to both determine the presence of a social institution and also to examine its contents and practices. Especially for the poor people, institutional inclusion can be constraining (Cleaver 2005). Institutions as embodiments of social processes ensure that things are done in the right way in symbolic terms (Bourdieu 1977). The 'right ways' of socializing and participating in public are those that are in line with dominant views, which reinforce existing relations of authority and which channel everyday actions to reproduce existing social structures (Cleaver 2005).

Mainstream approaches to social capital present some limitations concerning how people with different position, social status, gender, or ethnic origin access resources. In Coleman's approach, social capital is regarded as individual economic functions, and it rarely enters into dialogue with other forms of capital (Portes, 1998; Portes and Landolt, 2000; Fine, 2001). The imperative in public health models is that, by some processes that are not discussed, income is distributed unevenly, and this has consequences for health. Putnam described community as if people had equal access to all the benefits of social capital. This assumption has been imported into the public health literature. Kawachi noted that all people in a community have equal access to the benefits that social capital brings, regardless of their individual situation (Kawachi et al. 1997). In general, social epidemiological studies have lacked systemic analysis in going from the individual to the social, as they have assumed that social capital is "a token panacea" (Fine 2001:107), following the same ambiguous path that Putnam embraced (Portes and Landolt 2000). In this way, social capital is another ecological factor, an external factor that can hamper or facilitate access to different resources relevant to health. Such an approach could lead to the situation in which social capital is a part of what can be described as another 'thing' that unsuccessful individuals, communities or neighbourhoods lack (Fine 2001).

Bourdieu's approach showed that social capital is a relational good, which means that it is possible to frame inequality as an intersectional issue of wealth, gender, age, ethnicity, etc. People with different endowments of economic, cultural, or social capital can invest differently in social relations. Under this reasoning, people with different stocks of capitals, including social capital, are likely to access different stock of resources. It is necessary to acknowledge how capitals are exchanged and see how this relates to a particular field.

The positions of different actors are not static, but subjected to change. Access to capitals also means access to power. This allows the deconstruction of community as a cohesive entity and shows who the 'dominating' and 'dominated' actors are. Bourdieu's approach, incorporating interaction between different power positions in the field and habitus, acknowledges class, power, and the conflicts attached to them and shows how these generate different practices. It should be noted that conflict does not have to be literal, but rather can be reflected in different types of dispositions, or *habituses*, of dominating and dominated social actors in a field.

2.3. Summary

This chapter was aimed at summarizing Pierre Bourdieu's theory of practice, discussing the notions of field, habitus, and forms of capital that are important tools within this theory. This chapter only touched the tip of the iceberg when it comes to Bourdieu's theory of practice. The existing literature discussing Bourdieu's theory of practice is vast and rich, and the constraints of this thesis have left a great number of theoretical debates out of this chapter.

The chapter had two basic parts. Firstly, it discussed the above-mentioned terms. Secondly, it provided an overview of the major limitations of mainstream approaches to social capital and indicated how tools from Bourdieu's conceptual system can offer a remedy to these limitations. In this light, it can be said that any 'choice of action' and the role of social capital in it can be analyzed in relation to (1) structures of unequal positions of the dominant and the dominated in a given field, and (2) the embodied system of dispositions (*habitus*) that agents acquire in a given material and social environment over time. Bourdieu acknowledged the role of the agent, whose *habitus* is acquired in practice and is constantly aimed at practical functions (Bourdieu and Wacquant 1992). The value of different forms of capital is determined by the field: the setting in which agents and their social positions are located.

3. Maternal health in global policies and health care in Ethiopia

In the previous chapters I outlined social capital theories and how they have been adopted in various studies, and explained the theoretical approach applied in this study. Before I present and discuss empirical results of the study, it is important to explore how health policies directed at reducing maternal mortality have been developed at the global level as well as in Ethiopia. The chapter consists of two parts. Firstly, I present how maternal and health policies have been developed over time to tackle maternal mortality, which still is an important public health problem in developing countries. Secondly, I show how the Ethiopian health care system was developing over three regimes – the imperial regime of Haile Selassie, the socialist regime of the Dergue, and the developmental state – in the particular institutional and political context of the country.

3.1. Global maternal health debate

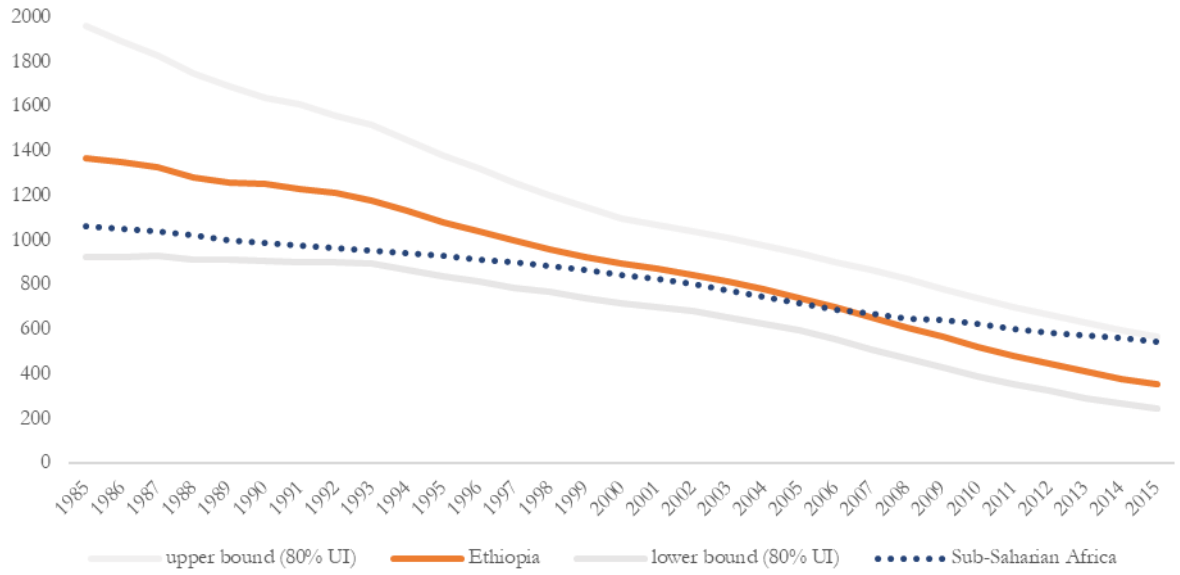
The term 'maternal health' is contested and debatable (Johnson 2016). In the global health discourse, maternal health has been framed as a narrow period of life experience in women's lives—pregnancy, childbirth, and six weeks of postpartum (Knaul et al. 2016). Within global health studies, much of the literature about maternal health has focused on maternal mortality, especially on the scale of the problem and the main strategies to combat maternal deaths. Such a conceptualization of maternal health equated with the number of women giving birth in health facilities and separating it from the broader reproductive health and rights agenda was sometimes seen as too narrow (Melberg et al. 2016; Storeng and Béhague, 2017).

The array of main institutional actors dealing with maternal health has been changing since the twentieth century. In the first half of the previous century, these stakeholders were colonizing countries, Christian missions, and NGOs such as the Rockefeller Foundation (Campbell 2001). Over time, these actors were replaced, or joined by, the World Health Organization (WHO), USAID, the United Nations Population Fund (UNFPA), UNICEF, and international NGOs such as the Bill & Melinda Gates Foundation and the Population Council.

Assessment of the magnitude of maternal mortality is a difficult task. The phenomenon has a complex set of causes, including both direct medical complications during pregnancy, childbirth, and postpartum, as well as indirect reasons such as gender inequality, racism, health systems governance, and patterns of colonialism (Say et al. 2014). While the technical

interventions addressing maternal mortality have been well understood for a long time (Campbell 2001), how to create appropriate conditions to implement them is less clear (Koblinsky, Campbell, and Heichelheim 1999). The seriousness of the problem was acknowledged at the beginning of the twenty-first century by including the problem of maternal mortality in the United Nations' Millennium Development Goals (MDG). Within the MDG agenda, Goal 5 was aimed at reducing maternal mortality by three quarters between 1990 and 2015. The indicators used to measure progress against the target were maternal mortality ratio (MMR) and the proportion of births attended by skilled health personnel (Freedman 2003). WHO indicated that the estimated global MMR was 211 in 2017, which represented a 38% reduction since 2000, when it was at 342 (WHO 2019:97). In sub-Saharan Africa, the MMR was 542, which was a 38% reduction since 2000 (Figure 1) and was the highest MMR when compared to other regions[14] (WHO 2019:97).

Figure 1. Maternal Mortality Ratio (MMR) in Ethiopia and sub-Saharan Africa between 1985 and 2015



Source: own elaboration on the basis of: WHO. 2015. Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

Maternal mortality has shown the biggest discrepancy between developing and developed countries (Johnson 2016), and deaths of mothers in developing countries have continued to account for 99% of all maternal deaths. The situation has been most serious for women in sub-Saharan Africa, where one in every 160 women dies of pregnancy-related causes during her lifetime, compared with only 1 in 3,700 women in developed regions. Only nine countries

[14] Other regions are: Northern Africa and Western Asia, East and South-East Asia, Latin America and the Caribbean, Australia and New Zealand, Europe and Nothern America.

of the 73 that declared a commitment to reducing the maternal mortality ratio by 75% by 2015 as a part of the MDG achieved this aim: Bhutan, Cabo Verde, Cambodia, Iran, the Lao People's Democratic Republic, the Maldives, Mongolia, Rwanda, and Timor-Leste (WHO 2015a). The problem of maternal death stagnance is by no means limited to the recent period covered by the MDG. By the mid to late 1980s, epidemiological data from low-income countries showed virtually no decline in the MMR, despite the significant investments that had been made in various strategies aimed at MMR reduction, be they horizonal or vertical public health programmes. Researchers asked why child mortality rates have steadily declined, while maternal mortality rates have stayed unchanged, or why is such difference between rich and poor countries (Freedman 2003).

Although maternal mortality is now mostly associated with developing countries, in the past, high mortality rates were also a common phenomenon in the West. At the end of the nineteenth century, maternal mortality ratios in most of today's developed world were above 600 per 100,000 live births (De Brouwere, Tonglet, and Van Lerberghe 1998). In countries of the West where data was available, estimates of maternal mortality rates ranged from 235 in Denmark to even 689 in the United States in the 1920s. In view of the high mortality rates in developing countries, in the mid 1980s maternal health received the label of 'neglected tragedy' (Rosenfield and Maine 1985). It was argued that causes of maternal death in developing countries were identical to those in developed countries at the beginning of the twentieth century (such as haemorrhage, infection, and obstructed labour). Therefore, researchers asked which strategies that had worked in the West could be applied to developing countries.

In the article addressing this question, Vincent de Brouwere analyzed case studies of three countries (Sweden, the United Kingdom, and the United States) that had managed to decrease maternal mortality, proposing several factors that contributed to such success in the West. Firstly, the scale of maternal mortality revealed by the statistics that became available in the late nineteenth century increased decision makers' awareness, which was critical to establishing maternal care as a priority area (De Brouwere et al. 1998). Another factor that contributed to the decrease in maternal deaths in West was the professionalization of midwifery (Johanson, Newburn, and Macfarlane 2002), further accompanied by obstetric care improvement and the development of scientific biomedical technologies. They increased the chances of children's and women's survival during pregnancy (De Brouwere et al. 1998). The speed of the professionalization and development of biomedical health care was conditioned by the willingness of decision makers to enforce such policies, their strategies to make obstetric care available to communities and the extent to which professionals were held accountable

for providing quality care. The authors outlined an 'evidence-informed' model of effective delivery care that postulated a series of technical and interrelated political elements that a country should employ to reduce maternal mortality.

De Brouwere's study built its conclusions on an earlier work conducted by Irvine Loudon, whose study has been described by many maternal health practitioners as groundbreaking in its perception of maternal health (Behague and Storeng 2013). Rather than attributing declines in maternal mortality exclusively to technological changes, Loudon attributed maternal mortality decline to a mix of factors, notable among which were more intensely skilled and accountable midwives and coordinated health system action to improve the therapeutic management of childbirth, including the limitation of unnecessary medical interventions and the more effective control of sepsis (Loudon 1992). These two historical and case-based studies proved that not only medical and technological solutions are important for maternal death decreases, but also political will and health systems governance.

Nearly 30 years on, the results Loudon presented about the importance of both medical interventions and the health system approach still resonate within some circles of maternal health practitioners (see, for example, Behague and Storeng 2013). Addressing maternal mortality is a complex issue that requires the improvement of health system governance, effective care during obstetric emergencies, and political will.

Since the establishment of the WHO, strategies to combat maternal mortality have involved the transfer of biomedical technologies that had been instrumental in reducing maternal mortality in Western countries (De Brouwere et al. 1998:771) to low-income states. Often, the strategies have been described as 'magic bullets' that have taken the shape of discrete interventions to combat maternal deaths. In sociological language, these strategies can be described as 'travelling models' of interventions: standardized institutional interventions, whatever the scale or field (a public policy, a programme, a reform, a project, a protocol), with a view to producing any social change through modification of the behaviour of one or more categories of actors, and based on a 'mechanism' and 'devices' (Olivier de Sardan, Diarra, and Moha 2017). However, it cannot be said that these interventions have been implemented in the atmosphere of unanimous agreement in the global health community about their efficacy. It was rather a subject of constant negotiation in the international maternal health community (see Behague and Storeng 2013; Storeng and Behague 2016). This shows that the prioritization of a given strategy aimed at reducing maternal mortality is a political issue.

Before moving on to describing these different interventions to combat maternal deaths, it is important to note that the approach to studying maternal mortality in health policy literature

is different from medical anthropology point of view. Studies more affiliated with policy analysis were meant to support policy action and were more or less driven by the normative desire to improve population health. Within medical anthropology and the history of medicine, scholars have provided a critique of this increasing medicalization of childbirth and pregnancy. It has been argued that the process of pregnancy in all societies is touched by a cultural context and customary practices and that women can be alienated during hospitalized birth with authority over baby delivery placed in the hands of a medical doctor (Lock and Kaufert 1998; Martin 1987). Especially in developing countries, where birthing practices were subject to change by colonial powers, how to handle birth and where to give birth takes on symbolic meaning. Pregnancy and childbirth, both in the West and in Africa, have also been seen as expressions of social status and modernity, rather than exclusively as a physiological process (Johnson 2016; Weis 2017). The increasing use of biomedical technologies such as appliances to monitor different stages of pregnancy, procedures for inducing labour, separating women from their families, or birthing in a horizontal position have caused delivery and pregnancy to be seen as medical problems requiring interventions. Researchers have often posed the question of whether women get more or lose control over their reproduction (Ginsburg and Rapp 1991:314–16). Deborah Lupton noted this paradox, that: "the medical system was the source of oppression against women, as well as contributed to their liberation" (Lupton 1994:129).

In the following section, I outline strategies, policies, and institutional arrangements that have been adopted to tackle maternal health in developing countries. The timeframe in my analysis encompasses the period since the establishment of the WHO up to 2018. The chronology in which the particular strategies and policies are presented attempts to capture the order in which they emerged. On the other hand, the decline of certain strategies (for example, antenatal clinics) did not happen all at once, but rather was a gradual process. Consequently, there were periods in which these strategies were applied simultaneously to different extents.

3.1.1. Antenatal clinics and education for mothers

In the early 1950s, one of the strategies used to reduce maternal mortality was antenatal clinics and education for mothers (De Brouwere et al. 1998). A report by the 1950 WHO Expert Committee on Maternity Care stated: "In the implementation of a programme of maternity care, expenditure for adequate training of personnel should take precedence over other expenditures if, in fact, a choice has to be made" (WHO 1958:353). The WHO assigned teaching staff to medical and midwifery schools and organized on-the-job training. Efforts were made to include

domiciliary training for midwives to raise the standards of home births (Campbell 2001). Dr. Cecily Williams, a British paediatrician from Jamaica, was appointed head of the Maternal and Child Health division of the WHO, and immediately wanted to standardize the WHO member states' approach to medical practices for mothers and children. When comparing maternal and child health to the other three priorities of the WHO's initial charter, Williams noted that the improvement of maternal health required a broader strategy, addressing various causes of the problem:

> *The method of attack on an international basis cannot be approached in the same manner as one of the 'disease' priorities. The existing conditions vary from country to country; diagnosis, pathology, therapy and prognosis do not depend on well-understood or on laboratory controlled factors. Defects exist not on account of a pathological organism that can be identified with an oil immersion or by a serological technique, but on account of social and economic and nutritional conditions, on account of age old prejudices, customs and resistances, that will not necessarily respond to injections of this or that, nor to the exhibition of any standardised procedure.* (Cecily Williams, quoted in Weis 2017:71)

While this approach addressed the biological causes of maternal disorders, Williams's basic strategy to decrease maternal mortality in developing nations largely rested on changing birthing cultures by using health auxiliaries (Weis 2017). This rhetoric of the WHO, which argued that one of the reasons for maternal mortality was the issue of 'old prejudices' that needed to be fixed, resembles in a way the rhetoric about changing birthing cultures used by colonial powers in Africa. Already the League of Nations Health Section noted concerns about maternal mortality in 1930, reflecting the desire of many colonial powers to transfer the benefits of medical progress to their colonies (AbouZahr 2003). Senior colonial officials believed that nurses and midwifes could have a positive role in changing indigenous cultural practices, such as excision. However, the broader response to this colonial push to medicalize delivery was a continued belief among women that childbirth does not require intervention (Thomas 2003).

The logic behind applying antenatal clinics relied on a so-called 'risk approach', which assumed that it was possible to identify at-risk pregnancies during antenatal visits and, in the longer term, anticipate complications during delivery (De Brouwere et al. 1998). This approach was complemented by family planning in the 1960s, when contraception became more widespread. Throughout the 1970s and 1980s, there were limited attempts to challenge assumptions about antenatal clinics and the education approach (Campbell 2001).

However, over time, studies started to indicate that the antenatal clinic approach had little impact on the detection of obstetric problems. In 1984, the so-called 'Kasongo study' shown that

the women found to be at risk by personnel at antenatal clinics were only of a small proportion of the women with obstructed labour (van Lerberghe and Pangu 1988). On the basis of this study, Maine (1990) argued that most complications threatening the mother's life could not be identified at an antenatal clinic because of low sensitivity and specificity. Moreover, even if antenatal clinics seemed to be cheaper solutions, they could not be effective if they were not complemented by emergency obstetric care (Maine 1990). The focus on antenatal clinics omitted a number of other contextual factors that could matter to maternal health, such as the treatment of existing problems (De Brouwere et al. 1998). As Weis (2017) noted, "…prevention of morbidity through sound antenatal care, better nutrition and child-rearing practices was insufficient to treat patients' actual needs: birth crises were spontaneous and could not always be prevented or predicted by antenatal consultation and material poverty" (p. 80). On the whole, the basic problem with the antenatal clinic approach was insufficient integration with other elements of the health system and distraction from other factors that could influence the outcome of a delivery, which by no means were restricted to the health sector.

3.1.2. Primary health care and traditional birth attendants

In the 1950s and 1960s, disease-specific mass campaigns against malaria, smallpox, tuberculosis, and yaws were implemented separately from general access to primary health care. Brown et al. (2006) interpreted the emergence of such vertical programmes as the application of American-style development theory to health, described by the promotion of technologies brought in from outside to eradicate disease, generate economic growth, and create markets for US expansion to help in the battle against communism (Brown et al. 2006). However, by the mid-1960s, the failure of these vertical programes to meet the needs of poor and rural populations led to the realization that a broader approach to the provision of medical care should be taken. This also coincided with the fall of colonialism and the spread of socialist movements that paid attention to long-term growth instead of short-term technological interventions (Cueto 2004).

In the 1970s and 1980s, attention started to shift to primary health care (PHC) in developing countries (AbouZahr 2003). There was a realization that the simple transfer of medical care models from industrialised countries to developing ones was not going to work. This was the main argument behind the Alma Ata Conference in 1978. Alma Ata Conference participants committed to health strategies that both provided services and addressed the social, economic, and political causes of illness. The greatest attention was given to PHC that focused on decentralizing health services to local communities and prevention. Finally, due to scarcity

in the health workforce, it assumed extensive community involvement and the use of available personnel, including auxiliary health workers, Traditional Birth Attendants (TBAs) as well as a small number of highly trained personnel for complicated tasks (Rosenfield and Maine 1985; De Brouwere et al. 1998; Lush and Campbell 2001; Łęcka 2012).

This decentralized model of primary health care started to be implemented at the time of the realization that most causes of maternal mortality, such as haemorrhage and obstructed labour, could not be avoided by prevention tools such as screening during antenatal visits (Rosenfield and Maine 1985). As mentioned in the section about antenatal clinics, a sizeable proportion of complications can occur for women with no recognisable risk factors that could be identified at an antenatal clinic. The management of these various complications is not possible without hospital facilities and highly trained personnel who can perform operations such as blood transfusion, C-sections, and screening. This meant, the justification went, that there was a need to set up a network of decentralized health care facilities, that women could reach at a reasonable cost and time (Rosenfield and Maine 1985). Such a solution was meant to address the problem of great distances, typical for developing countries. Therefore, the major investment needed involved the establishment of a comprehensive referral system of care. Solutions for how to establish such a system of decentralized health care were present even before the Alma Ata Conference in 1978. The example is a model developed by Taylor and Lapham (1974) in which health centers in rural areas would each serve a population of approximately 4,000 people with an estimated 160 births per year. Each health center would be staffed by a midwife and a village assistant responsible for ANC and education, family planning, the supervision of normal deliveries, and the management of early complications of pregnancy. For every 10,000 people, Taylor et al. recommended a 20-bed mother and child health center, staffed by a physician with obstetric experience and several nurse midwifes or other trained health professionals (Taylor and Lapham 1974).

Scholars documented that a shortage of professional health care personnel was a serious problem in developing countries. The Alma-Ata Declaration recommended the flexible mobilization of various types of health workers, depending on local needs (physicians, nurses, midwives, auxiliaries, community workers, and traditional practitioners) who were suitably trained socially and technically to work as a health team (WHO and UNICEF 1978). It was seen that the integration of TBAs could be possible and would help to fill this gap. The basic observation that justified the training of TBAs was that there were not enough professional health personnel to provide maternity care, not at present nor in the immediately foreseeable future. Moreover, there were not enough beds or staff at the hospital level to absorb

the workload that would be created if all women had access to a hospital for their confinement. The major advantages of TBAs were that they were accessible, culturally acceptable, and able to influence women's decisions to seek care. It was assumed that TBAs would not work outside of the health system, but would support biomedical primary health care. However, their skills were inadequate; therefore, there was an imperative to train them in delivery. Rosenfield and Maine assessed the involvement of TBAs in health care delivery in a move away from Western medical models as a great improvement in efforts to achieve universal health care access (Rosenfield and Maine 1985).

In the 1980s, some authors started to voice some doubt over the effectiveness of TBAs. Although initial reflections on the use of TBAs seemed to be positive, a number of elements had been underestimated. Firstly, the knowledge and the function of the TBAs were likely to differ across regions and countries. In one region, a TBA could be a well-trained woman, but, in another place, she would be a woman who was around at the time of delivery and could hold the mother's arms. Secondly, it was argued that there was no consistency in terms of what was done wrongly by TBAs and which actions should be limited. The training of traditional birth attendants does not seem to have an impact on maternal mortality unless it is combined with accessible hospital care where obstetric services are available (De Brouwere et al. 1998). Towards the end of the 1980s and at the beginning of 1990s, the promotion of TBA training began to be slowly abandoned.

3.1.3. Safe Motherhood Initiative

Not very long after the Alma-Ata Declaration was adopted, it started to be criticized for being too broad and idealistic. A common criticism was that the slogan "Health for All by 2000" was not feasible (Cueto 2004). In a paper issued in 1979, Walsh and Warren, representatives of the Rockefeller Foundation, recommended implementation of a number small-scale, cost-effective interventions, whose effects could be easily measured. This strategy promoted the selective primary health care discussed at a conference convened by the World Bank and the Rockefeller Foundation in Bellagio (Cueto 2004).

Selective primary health care heralded the establishment of a more technocratic approach to setting health priorities. Proponents of the approach suggested that specific diseases or conditions would be selected on the basis of their prevalence, morbidity and mortality, and the feasibility of their control, which would in turn be established through assessment of the effectiveness and cost of available interventions. The selective approach was swiftly adopted by UNICEF (Irwin and Scali 2007). Within selective primary health care, attention was

paid to maternal and child health. For the latter, the famous 'GOBI' (growth monitoring, oral rehydration therapy, breastfeeding, and immunization) initiative was established as a response that could reduce the premature death of children. GOBI was seen as easy to monitor and evaluate (Cueto 2004), in contrast to the long and expensive process of establishing comprehensive health care, which would tackle different diseases.

Rosenfield and Maine underscored the invisibility of the maternal health component in maternal and child health programmes in their famous article "Where is the M in MCH?" (Rosenfield and Maine 1985). The article focused on the technical limitations of selective primary health care. The key argument proposed to justify the call for action was that levels of maternal mortality in low-income countries were not natural but represented an avoidable loss of life. Such a framing of maternal health implied an ethical obligation to act. Moreover, the fact that women died of medical complications that had been eradicated in the West was a clear evidence that international development cooperation was failing in this regard. Maternal health started to be described as 'neglected tragedy' and as a matter of social justice. As the then Director General of the WHO pointed out, "those who suffer are neglected people, with the least power and influence over how national resources should be spent" (Mahler 1987:668). Mahler also noted that the West had managed to deal with this challenge thanks to dedication and the reallocation of priorities.

The maternal mortality issue received attention from the international community at the Safe Motherhood Conference in Nairobi in 1987. The conference was organized by the World Bank, the UN Population Fund, and the WHO. Held at the time of the United Nations Decade for Women 1976–1985, the Safe Motherhood Initiative called for broad goals such the improvement of the status and autonomy of women. The conference issued a call to reduce maternal mortality in developing countries by 50% by 2000 (Mahler 1987). The rhetorical style of the Initiative implied that maternal mortality required the active participation of all parties, ranging from international agencies, national and district governments to women themselves, as well as the strengthening of health care systems. More attention was paid to women's education, legal status and family planning (Weil and Fernandez 1999). Proposing such a broad set of goals and strategies, Safe Motherhood took a comprehensive approach to maternal health.

The Safe Motherhood Initiative was implemented at a time when improving gender equality and women's rights were issues central to the arguments of women's health activists. Women activists both in Western and developing countries in the 1980s were concerned with the relationship between poverty, gender status, and health (Kabeer 1994).

However, the relationship between the Safe Motherhood Initiative stakeholders and those women's health activists remained rather tense. Some Safe Motherhood Initiative advocates distanced themselves from the "feminist agenda" (Campbell 2001:10). On the other hand, some women's health activists stated that the whole Safe Motherhood movement did not truly reflected women's rights and health, as its emphasis was on motherhood and disregarded other areas of women's lives (Rance 1997). The focus was on the result (pregnancy) rather than on women's choices (AbouZahr 2003).

3.1.4. Emergency obstetrics and skilled delivery

Ten years after the announcement of the Safe Motherhood Initiative, in 1997, WHO statistics showed that maternal mortality ratios had not improved (WHO and UNICEF 1996). While there had been a little progress in some parts of America and Asia, the situation in sub-Saharan Africa was still poor (AbouZahr and Wardlaw 2001). In this context, the Safe Motherhood Initiative Inter-Agency Group organized technical consultation in Colombo, Sri Lanka, in 1997. The conference recommended specific strategies for averting mothers' deaths: emergency obstetric care to treat delivery and pregnancy complications, and skilled delivery. Emergency obstetric care means those interventions that target women with complications during pregnancy, childbirth, and the post-partum period, such as haemorrhage, obstructed labour, infection, eclampsia, and complications from unsafe abortion. Secondly, skilled birth attendance referred to attendance at deliveries by people with midwifery skills (doctors, midwives, and nurses) who had been trained to manage normal deliveries and diagnose, manage, and refer complications. The definition excluded TBAs and community health workers. Thus, from 1997 onwards, the comprehensive policy vision was replaced with a more focused set of recommendations designed to avert deaths from obstetric complications. These strategies were adopted in the growing awareness that the goal of halving maternal mortality by 2000 was not being reached: global MMR fell 11% from 385 to 341 maternal deaths per 100,000 live births between 1990 and 2000 (WHO 2015b).

Such a shift was not welcomed by all the experts in maternal health (Behague and Storeng 2013). However, "there was a growing sense that it would damaging to the field's reputation to demonstrate a lack of programmic consensus by not endorsing a more selective emergency obstetric care approach" (Behague and Storeng 2013:74). The two strategies of emergency obstetric care and skilled delivery were regarded as a proxy for how a health care system could deal with maternal mortality. There was an assumption that the more women were attended, the greater was their likelihood of survival. Therefore, the process indicator of deliveries

attended by skilled personnel was adopted within the Millennium Development Goal (MDG) subtarget, when the UN in 2000 declared improving maternal health one of the eight MDGs (Buttiëns, Marchal, and de Brouwere 2004).

3.1.5. Continuum of care and the Partnership for Maternal, Newborn and Child Health

The first decade of the new millennium witnessed a growing fragmentation of global health initiatives. The most important were: the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Alliance for Vaccines and Immunization; the World Bank Multi-Country AIDS Programme; and the US President's Emergency Plan for AIDS Relief (PEPFAR). These vertical global health initiatives were disease-oriented and established by bilateral and multilateral donors (Brugha 2010). In particular, the introduction of the Bill and Melinda Gates Foundation (with support for child health) and the GAVI Alliance (for immunization) marginalized maternal health in the context of other initiatives (Storeng and Béhague 2016). This marginalization expressed itself in decreasing overall development assistance allocated to maternal health. Funds for maternal health in 2005 achieved one of the lowest levels since the 1990s, especially when compared to HIV, tuberculosis, and malaria (Buffardi 2018).

During the first decade of the twenty-first century, there was also a growing debate about the poor effectiveness of international development assistance. This led to a proliferation of more cost-effective approaches that promoted the values of ownership, alignment, and managing results. To make these efforts more 'coordinated', the Safe Motherhood Initiative was transformed into a partnership with advocates for child health (Storeng and Béhague 2016).

Announced at the UN General Assembly in September 2005, the Partnership for Maternal, Newborn and Child Health (PMNCH) was established as a network of organizations linked by a secretariat hosted by the World Health Organization (Fassil et al. 2017). This meant that the Safe Motherhood Initative was dismantled. The common mission of the new Partnership was achieving Millennium Development Goals (MDGs) 4 (reduce child mortality) and 5 (improve maternal health). There were hopes that the PMNCH would unify fragmented maternal, newborn, and child health stakeholders (Bustreo et al. 2012).

The PMNCH adopted another strategy for averting maternal deaths and also improving children health, which was a continuum of care framework. This approach had two dimensions. Firstly, it referred to the physical continuum between the home, health center, and district hospital. The other dimension was the link between maternal, newborn, and child health. The approach was also attentive to health system strengthening in order to make interventions possible (PMNCH 2011; Yeji et al. 2015). In 2015, the PMNHC adopted a broader framework

of sexual and reproductive health, which was founded on a life-course approach (Langer et al. 2015). The new approach revealed a return to a more holistic understanding of health problems and the broader factors that influence maternal health.

Having outlined how strategies to tackle maternal mortality have been developed over the years, I would like to focus on Ethiopia and present how health care services were established in the particular institutional and political context of the country.

3.2. Context of the health sector in modern Ethiopia

This subchapter reflects on health sector development under three regimes in Ethiopia—Haile Selassie (1930–1974), the Dergue (1974–1991), and the EPRDF's period (1991–2018). The reason behind such an approach is that it is difficult to understand contemporary Ethiopia and its policies without examining its long story of modern state formation. In this case, the formation of health care was also a part of broader modernization projects that were undertaken over the three regimes in Ethiopia. This review focuses on key institutional and political developments since the beginning of the twentieth century. The intention is to paint a broad picture of the genesis of the current shape of Ethiopia's health care policies and how they unfolded in the country's institutional and political contexts.

3.2.1. Imperial period under Haile Sellasie (1930–1974)

While most of the modern African states were set up following colonialism, modern Ethiopia was built from an indigenous state. Emperors Tewodros II (1855–1868), Yohannes IV (1871–1889), and Menelik II (1889–1913) worked towards the consolidation of Ethiopia into one state from the core areas in the Abyssinian highlands. Contemporary Ethiopia emerged in the process of the unification of several regions with different cultures into one empire (Mulugeta 2020). The reign of Menelik II in the late nineteenth and early twentieth century, in particular, was exceptional. Menelik II replied to direct attack by Italians seeking colonization of the country during the Battle of Adwa in 1896 (Rubinkowska-Anioł 2013) and then succeeded in reuniting Ethiopia.

The very first efforts to modernize health care were attributed to Menelik II (Berhan 2008). As Ethiopia lacked medical infrastructure and most of the population relied on traditional medicine, the first efforts in modern health care started with the construction of hospitals in the capital city. The first modern hospital was established in Addis Ababa following the battle of Adwa in 1896, when Menelik II requested help from the Russian Red Cross to treat about

3,000 wounded soldiers (Berhan 2008). Later, these efforts were invigorated during the rule of Haile Sellasie. These two emperors were responsible for various modernization efforts in the country (Bartnicki and Mantel-Niećko 1987).

Haile Sellasie's rule was characterized by the implementation of a set of reforms that he personally called "foreign-inspired civilization" (Weis 2017:62). In his autobiography, "My Life and Ethiopia's Progress", Haile Sellasie described the historic beginnings of medical care in Ethiopia as his own initiative[15]:

> *As there was only one hospital, called the Menelik II Hospital, in existence at Addis Ababa, it was not sufficient to protect the health of the entire population. But from 1922 onwards, We had many hospitals established at Addis Ababa and the other major cities; We gave permission and financial aid to various missions and as hospitals were being built, the health of many people began to be safe-guarded. Furthermore, We had arranged to have the Swedish physician, M. Hanner, appointed to the hospital which We had named Bet Saida and which We had established at Addis Ababa with our private money*. (Haile Sellasie 1999:207)

Haile Sellasie described how the hospital used a machine called X-ray, which had been never known before in Ethiopia, and as a consequence, "the medical work of Bet Saida Hospital became progressively more extensive and successful" (Haile Sellasie 1999:207). By the time of the second Italian invasion (1935–1941), there were 11 national, state-owned hospitals, including six in Addis Ababa, and 35 clinics in the country (Berhan 2008). Early efforts to build hospitals were focused in Addis Ababa and the main cities, largely ignoring the rural areas of Ethiopia. Misrecognition of the rural provinces' needs was only one examples of the favouring of the urban elite (Marcus 1979).

The fact that health facilities were located in urban areas was even more problematic given the nature of health problems in Ethiopia, which were strongly related to overwhelming poverty. For example, in the health facilities opened by the Italians in Jimma, visitors suffered from chronic malnourishment, syphilis, and typhoid. In facilities in Addis Ababa, patients suffered from cardiovascular and blood diseases, syphilis, respiratory problems, digestive problems, infections, and skin diseases. Eye problems were also prevalent. As Marcus noted, "obviously venereal diseases were a nationwide problem; tuberculosis was rife; eye problems were general; blood disorders were endemic; and Ethiopians seemed to break a lot of bones" (Marcus 1979:23). In the case of maternal mortality, Julius Prince, who was the chief of the public health division of USAID in Ethiopia between 1958 to 1969, claimed that maternal mortality was said

[15] See Weis (2017).

to be related to the low level of health care, and children's deaths were caused by diarrhea and malnutrition; intestinal parasites were presumed to be widespread; malaria, typhus, and yellow fever, relapsing fever, yaws, leprosy, and tuberculosis were assessed to have a high prevalence. These problems were attributed to poor living conditions and especially sanitation, which left a lot to be desired, especially in rural areas (Prince 1962).

The low health outcomes of the population were exacerbated by a constant insufficiency of medical staff. In 1947, there were 80 physicians in Ethiopia, only foreigners, working mostly in urban areas. Fifteen years later, in 1962, there were 200 foreign and only 20 Ethiopian physicians in the whole country. Among them, around 50% to 60% were deployed in urban areas (Prince 1962). Early efforts to fill in the gaps in personnel included the training of dressers and nurses (Yayehyirad, Gebre, and Hailu 2013).

A major step in local medical training was the launching of the Public Health College and Training Center in Gondar in 1954. The Gondar College was funded by the United States government, the World Health Organization, and the United Nations' International Children Emergency Fund. Establishing this college was a part of medical programmes supported by the United States that aimed at the popularization of a new governance model in the South, involving the employment of generalists rather than specialists (Turshen 1985). Gondar College was established 700 km northwest from Addis Ababa, which Turshen attributed to political games among the provincial governors, with the result determined in the end by Haile Sellassie. The school was strongly influenced by foreign advisors, similar as the Ethiopian Ministry of Health established in 1947.

Gondar College trained three types of rural health auxiliaries: health officers, community nurses, and sanitarians. This kind of staff was supposed to work in a health center—a basic clinic that served a catchment of 1,000 people[16]. The main task of a health center was to address common health problems in Ethiopia and educate the rural population about 'modern' ways of life (Weis 2017). The training curriculum for workers at Gondar emphasized prevention rather than treatment. Despite the recognition that the preventive and curative aspects of medical care could not be divorced from each other, the emphasis was on prevention, as it was argued that "80%–90% of the illness that plagues the population is preventable" (Prince, 1962:80).

Among the three types of workers, health officers and sanitarians were meant to be men, while community nurses were meant to be women. The function of community nurses was to work with families and to handle nursing and midwifery needs (Rosa 1962). The community nurses were mostly trained in the prevention of health problems, such as antenatal care

[16] This auxiliary model of care was considered to fit Ethiopian conditions better, given the fact that around 95% of population lived in rural areas (Barry 1964).

and nutrition, which involved a lot of educational aspects. According to the rhetoric of the service-training programme curriculum for the Public Health Training Center in Gondar, this nursery course included 14 weekly Maternal and Child Health Clinic sessions in seven different locations outside the town. This resonated with the global WHO recommendation to use antenatal clinics to detect at-risk pregnancies. In discussing some aspects of care and work with mothers in antenatal clinics, Franz Rosa, the director of Gondar College, underlined several performative aspects of the interaction between personnel and mothers, which somehow set the hierarchy between health workers and their women clients. Firstly, he stressed the importance of health promotion and the type of conversation that should be conducted with women. It should start with questions about feeding, about whether a child was able to sit, and about immunization, rather than directly questioning, "What is the problem?". The health worker should sit next to the mother and child, not across the desk, so that they could be in more direct and close contact. Mothers who were waiting should sit within 'earshot' of the mother being interviewed so that they could avoid boredom and could learn by overhearing. At that time, health education was also aimed at altering various habits including those of nutrition and food preparation, taking care of children, and sanitation practices (Rosa 1964:115).

Scholars have variously interpreted the auxiliary training at Gondar. Community nurses had little involvement in curative medicine and instead focused on cultural reformation and preventative health. Childbirth and maternal health were used as a space for reforming backward traditions and thus were seen as an entry point to greater social change in the country (Weis 2017). As Turshen (1985) suggested, the adoption of the auxiliary model, as well as other public health solutions, was conditioned by medical foreign aid transfer, especially aid from the United States via the Rockefeller Foundation. The impact of the United States was even more strengthened by the fact that it had influence on the WHO. The auxiliary model was seen as an example of a new policy tool transferred to developing countries regardless of their need and development level. Moreover, even if this model was used because of Ethiopia's low level of development, the Gondar school was considered to be elitist: "by 1962 more health officers (84) than nurses (58) or sanitarians (76) had been trained, an indication that Ethiopians were using the highest available level of medical training in the country as stepping stone for other careers" (Turshen 1985:53). Moreover, the idea that health care services must be decentralized and graduates of Gondar should be deployed in the countryside was also not fully realized: "when the course was stopped in 1977, only 28 of the health officer were posted in health center and clinics" (Turshen 1985:53).

Educating women about modern care was compromised by a number of factors. Firstly, the measures undertaken at health clinics were insufficient to fulfil the needs of rural women, who were frequently disappointed with the care quality. Weis (2017) argued that "with the arrival of the health center and Gondar team, communities were eager to receive the curative treatments promised by the 'hospital' and the 'doctor' who worked there, but many were left disappointed by the poorly equipped centers that were designed to prevent, not cure disease" (Weis 2017:80). Secondly, modern ideals about proper care remained in opposition to local assumptions about care. For example, there was a push to stop birthing in the customary upright position and adopt a supine posture (Weis 2017). Thirdly, the system of decentralized health care and also the referral system used in the case of a difficult delivery was compromised by the quality of the transportation infrastructure. Indeed, the decentralization of health care services was seen as a reasonable choice for organizing health care in rural areas, given the large size of a country like Ethiopia (Prince 1962:80). However, the network of clinics was not accessible to many people, as many still lived too far from them.

The period of Haile Selassie's rule in regards to medical care was characterized by the imperative of the modernization of the country. The Emperor used such an approach to present himself as modern, even as the country was underdeveloped (McVety 2012; Weis 2017). Many scholars have described in detail the contradictory nature of the Emperor's educational reforms and the ways in which such actions constituted the performance of a Euro-centric modernity (Bahru 2001; Markakis 2011; Paulos 2006). In the case of health care, despite these efforts to bring services closer to rural populations, just before the revolution of 1974, most of the medical care expenditures went to urban hospitals (Kloos 1998), and the estimated health care coverage was around 20% (Getachew 1990).

3.2.2. Dergue period (1974–1991)

Regardless of Haile Sellasie's efforts to modernize the country, there were social groups that remained unimpressed with the reform effort that was going at a snail's pace. Young elites and university students in particular argued that the empire was politically hegemonic (Mohammed 2012). The growing frustration in the 1960s led to a revolution in 1974 that toppled the 82-year-old Emperor.

The socialist Dergue government took power. Mengistu Haile Mariam emerged as a leader of the Party of the Workers of Ethiopia. Despite the rhetoric of abandoning the feudal and centralist approach of the previous regime, the Dergue maintained a centralist way of rule. The country adopted a socialist economic system. Banks, businesses, and factories

were nationalized. In the land programme of 1974, the government declared all rural land the common property of the people, held by the government. New structures of governance at the local level—Peasants Associations (also called kebeles) and weredas—were established. They acted as a primary mechanism of party control and were used for communicating development plans at the local level (Vaughan and Tronvoll 2003). As per the National Democratic Revolution Programme, the state launched various 'mass campaigns' (called *zemecha*—'development through cooperation' in Amharic). These campaigns, frequently led by students, were aimed at building health stations, wells, and latrines and at the provision of education classes for the general population, including health education (Kloos 1998).

The period when the Dergue took power coincided with a global paradigm shift in thinking about access to health care, which was marked by the Alma Ata Declaration of 1978. The health policy of the socialist government committed to the Alma Ata Declaration on primary health care (Getachew 1990). In line with the new approach, the focus was shifted even more from urban to rural areas and to the expansion of basic health care. This shift was emphasized by the Minister of Health, Teferra Wonde, during the opening address of the Ethiopian Medical Association:

> *Health for all by the year 2000 with the participation of the broad masses is based on the concept of primary health care integrating all related activities in the spirit of self-reliance. The increasing practical help in health care delivery in clinics and health centers and kebeles (local urban and rural community centers) is contributing to the goal and the broad masses have built and are maintaining health institutions.* (Teferra 1979:99)

The government developed a 10-year prospective health plan covering the years 1984/85 to 1993/94. The ambitious goals of the health plan included strengthening and expanding mother and child services, especially immunization of all pregnant women and children under two years, an increase in per capita visits to modern health care services from 0.5 to 2.5 per year, and a decrease in infant and child mortality. The plan developed a six-tier health system and emphasized community participation, intersectoral collaboration, and the gradual integration of vertical programmes and specialised health institutions. Scholars have argued that the new government shifted attention from building hospitals in urban areas to ensuring the development of primary health care (Kloos 1998).

Community health services started to be organized around kebele health posts, which were staffed with Community Health Agents and trained Traditional Birth Attendants (Yayehyirad et al. 2013). This approach was in line with the global trend of deployment of TBAs. Training

for TBAs covered health education, sanitation, curative care, and maternal and child health. However, the kebele health care system was not linked to the national health care system, as the kebele administration was totally responsible for management, resource mobilization, and physical facilities (Yayehyirad et al. 2013).

The socialist government also raised the issue of maternal and child care. During the 1979 Annual Conference of the Ethiopian Medical Association, the Minister of Health acknowledged the importance of the mother and child health programme, developed by a combined team of Ethiopians and three foreign experts, in guiding and directing all maternal and child services (Teferra 1979). Additionally, there was a plan to develop a national maternal and child health center to conduct research projects, provide training, and advise the Ministry of Health. It was planned that by 1984 around 54% of mothers and children would be covered by the PHC programme (Teferra 1979).

Similarly to the situation under Haile Selassie' regime, policy on contraception lagged behind. Helen Pankhurst's study showed that the state under the Dergue did not do much to be involved in contraceptive use (Pankhurst 1992). In her study in the Amhara region, conducted at the end of the Dergue's time, Pankhurst depicted how limited was the role of the central state in the promotion of contraception. The Family Guidance Association, an organization promoting family planning services, established clinics in which contraception was available, initially only to married women whose husbands agreed with it. Later, the removal of spousal authorization requirements in 1982 softened this law and allowed women to take contraception without their husbands' approval[17] (Cook and Maine 1987). There are various explanations for why the Dergue did not attempt a grand population control policy. Clapham's suggestion was fear of opposition: "there has been no sustained government attempt to control the rate of population increase…the government is increasingly aware …any attempt to reduce the birth rate would require a large scale campaign which would tax its resources and possibility bring it into the long confrontation with peasants attitudes and religious beliefs" (cited in Pankhurst 1992:134). Pankhurst argued that sidelining the issue of reproduction was a matter of locating of birth in the private domain, not the public domain, and designating it as women's business in particular (Pankhurst 1992).

[17] According to Cook and Maine (1987), 16% of the women who requested contraceptives were turned away because of a lack of authorization. When the spousal authorization requirement was removed, clinic utilization increased by 26% within a few months. The authors suggest that this showed that, apart from women being turned away because of the lack of authorization, there were also women who had never come to the clinics because they were aware of this requirement.

Anti-Dergue insurgency groups had sprung up in various parts of the country (Pausewang and Abebe 1994), and years of struggle ensued (Veale 2003). In the north, where the movement was the strongest, three dominant armed groups became active: the Ethiopian Democratic Union (EDU), the Ethiopian People's Revolutionary Party (EPRP), and the Tigray Peoples Liberation Front[18] (TPLF). Towards the end of the 1970s, the TPLF managed to oust rival parties and concentrate itself on the struggle against the Dergue (Vaughan and Tronvoll 2003).

In the areas it controlled, the TPLF established a basic health care system using newly-formed state-like structures at the village level called *baitos*. The representatives of the *baito*, usually up to fifteen, were elected from among the local mass organizations. The role of these structures of local government was to serve as the lowest level organ of authority with written bylaws, as well as being the prime organization for resisting the military government and providing social services, including health care and education. Given that Tigray was supported by the international non-governmental organizations during the 1980s, *baitos* were responsible for the coordination of support from abroad (Vaughan and Tronvoll 2003). By 1990, *baitos* had built around 88 clinics adjacent to rivers to avoid air raids. In terms of financing, the *baitos* mobilized their communities to establish revolving funds for drugs and equipment (Gebreab and Zwi 1997). The TPLF also opened a school for health workers recruited from the local population. The criteria included willingness to volunteer, commitment to struggle against the Dergue, and a background of grade four or five. These initial ideas about the health system were discussed during several conferences (see Gebreab and Zwi 1997), during which commitments to a 'democratic and revolutionary health system' were mentioned. The democratization of the health care system meant that communities should have the right to decide about health priorities and resources allocation. Being revolutionary meant that the new health system would foster "new ideas, allow innovations and replace old and harmful practices with new ones" (Gebreab and Zwi 1997:44).

It should be also noted that, similarly to under Haile Sellasie's regime, the country remained profoundly poor. The 1980s were a time of crisis for Ethiopia. Since the late 1970s, the rural economy had been largely ignored and heavily taxed. The Dergue government imposed direct taxes and levies on peasants, and forced them to work on community development projects or other state-led activities. Internal and external grain trade restrictions were the equivalent of implicit taxation. In the mid-1980s, famine and war caused a major humanitarian disaster and a suffering economy.

[18] For an elaborated history of the TPLF please see John Young's "Peasant Revolution in Ethiopia: The Tigray People's Liberation Front", 1975–1991; Sarah Vaughan's PhD, "Ethnicity and Power in Ethiopia" and Mulugeta Gebrehiwot Berhe's "Laying the Past to Rest. The EPRDF and the Challenges of Ethiopian State-Building".

3.2.3. Ethiopian's People Revolutionary Democratic Front (1991–2018)

The TPLF in coalition with other parties[19] expanded beyond Tigray in 1989 and seized power in Addis Ababa. In May 1991, Mengistu fled from the country and the Transitional Charter created the multiparty Transitional Government of Ethiopia (TGE), which started an ambitious effort to transform a highly centralized single-party arrangement into a radically deconcentrated federation, drawn along the lines of major language groups, which has been described as an "experiment" (Abbink 2009; Kloos 1998; Vaughan and Tronvoll 2003). The economic policy of the TGE endorsed a free market economy with an emphasis on privatization and subsistence agriculture.

The TPLF-dominated EPRDF employed the notion of 'revolutionary democracy' as an ideological tool that guided its project of state building since 1991 (Vaughan and Tronvoll 2003, Vaughan 2011). Despite adopting the nominal name of democracy, its application of this concept differed from the understanding of liberal democracy in the West (Lefort 2010). Firstly, it was not about a plurality of views and plural representation, but "communal collective participation, and representation based on consensus" (Vaughan and Tronvoll 2003:117). As it derived its meaning from the grassroots Ethiopian experience of ethnical diversity, it aimed at securing the collective rights of the 'nations, nationalities and peoples of Ethiopia', while pushing individual rights into the background (Lefort 2010). Secondly, the revolutionary democracy assumed that the social forces of the citizens were consciously and incessantly engaged in the decision-making process. Revolutionary democracy gave weight to by far the largest social group: the subsistence farmers (Lefort 2010). Scholars have argued that the ideological position of the then-EPRDF was a fusion of Marxist ideology and ethnicity[20], which gave Ethiopia its own model of governance[21].

After the first years of liberalization and democratic opening (Abbink 2009), revolutionary democracy started to be discussed in the context of the 'developmental state'. The idea

[19] In 1989, the TPLF formed the Ethiopian Revolutionary Democratic Front, together with the Ethiopian People's Democratic Movement. Later these two parties were joined by the Oromo People's Democratic Organization (OPDO) and the Southern Ethiopian People's Democratic Front (SEPDF) (Agerawi 2009; Vaughan and Tronvoll 2003). These four parties were the main members of the EPRDF coalition until its end in December 2019.

[20] For a broader discussion of revolutionary democracy please see Agerawi Berhe (2009), Vaughan (2003, 2011), Vaughan and Tronvoll (2003), de Waal (2012), and Abbink (2009, 2011).

[21] This case of governance is constantly attracting the interest of scholars as, despite the country's low performance on social and political indicators and negative reputation among human rights organizations, it is still a major recipient of Western aid and is a focus of Chinese investment. The political model of Ethiopia is considered a risky novelty, which is seen as having some theoretical significance (Turton as quoted in Abbink 2009).

of the developmental state was raised by the Ethiopian PM and the political and ideological leader of the EPRDF—Meles Zenawi—in his various writings (Lefort 2013; de Waal 2012). In the draft manuscript of his unfinished master's thesis, "African Development: Dead Ends and New Beginnings," he provided the justification for a 'democratic developmental state' (de Waal 2012).

The PM's thesis opened a window into the EPRDF's thinking[22] about the concepts of democracy and market, and the role of the state and social capital in the development process, and by means of superimposition, democracy. This is a place where the political economy of Ethiopia meets the concept of social capital, which is crucial to the assumptions of this thesis.

Meles' view on social capital derived from the works of Robert Putnam. His thesis comprised an overview of the main assumptions of Putnam's study of Northern Italy and proposed how the Italian experiences could be implemented in Ethiopia. Meles wrote about social capital and development in the following way: "even if a developmental state was to be solely concerned about accelerating growth, it would have to build the high social capital that is vital for its endeavours. It would have to stamp out patronage and rent seeking. These are the very same things that create the basis for democratic politics that is relatively free from patronage" (Meles Zenawi, no date:10). For Meles, creating a "proper blend of norms, values and rules" could reduce uncertainty and transactions costs. The creation of such social values and norms was called "social development" or "social capital accumulation" (Meles Zenawi, no date 4). Social development happens through social activity by civic engagement in horizontal networks. Norms are inculcated and sustained through modelling, socialization, and sanctions (Meles Zenawi, no date:4). Therefore, in this interpretation, social capital is an instrument used to reduce transactional costs and also to create proper norms in the Gramscian sense (de Waal 2012:153). This could resonate with the assumption of revolutionary democracy according to which people participate in development through consensus. This consensus is achieved when people have common values and norms governing their behavior. While it is possible to disagree with Meles's assumptions in his work, some scholars put forward an argument that thesis "represents a serious attempt to develop, and apply, an authentically African philosophy of the goals and strategies of development (de Waal 2012:152).

[22] There are also other writings which I did not accessed and which could give insight into Meles's thinking – some of them are mentioned in "Laying the Past to Rest. The EPRDF and the Challenges of Ethiopian State-Building" by Mulugeta Gebrehiwot Berhe (2020). However, looking for such documents is difficult, even more for researchers without direct lingakes, and there is no single repository of EPRDF documents.

Decentralization and health care policies

Political changes after 1991 and the ideological underpinnings developed by the new government are crucial for understanding the technical reforms that later unfolded in the country. In order to study the role of social capital in the health practices of mothers at a local level, it is especially important to understand the decentralization process. This process was meant to break with the centralist legacy of previous regimes, bringing social services closer to rural populations. Table 4 below summarises the three stages of decentralization after 1991.

Table 4. Three stages of decentralization

Decentralization stage	Period	Main changes
1st stage – devolution of power to the regions	1991–1995	Central government devolved state powers to geographically-defined nine ethno-linguistic National Regional States (*kililś*).
2nd stage – building the wereda	2001	Wereda governments took on the bulk of service delivery responsibilities and began receiving block grants from their respective regional governments.
3rd stage – empowerment of kebele	2005–2008	Establishment of kebele manager Local councils members increased from several tens to 300 More systematic deployment of 1-5 groups

Source: own elaboration on the basis of Emmenegger, Keno, and Hagmann (2011).

First stage of decentralization

The first stage started in 1991 and involved the creation of a four-trier governance structure: the center, the nine regions roughly based on majority ethnicity plus the cities of Addis Ababa and Dire Dawa, the zones, and weredas. It concluded with the adoption of the new Federal Constitution in 1994 that was considered to have a strong democratic character and to reflect Ethiopia as a party to all major international treaties on human and public rights (Abbink 2009). Scholars have argued that the 1994 Constitution was nicely worded, but at the same time "it vests sovereignty in the 'nations, nationalities and peoples' of Ethiopia, a shady and ambiguous clause, innovative but much criticized, notably in relation to Article 39 on their right to secession from the federation – a very unrepublican notion" (Abbink 2009:13). The Constitution also gave a strong position to the Executive, i.e. to the ruling party.

The 1990s were also formative years for political organizations in those regions where the EPRDF had not operated before (Vaughan 2011). Although the whole process of the establishment of party cells goes beyond the scope of this chapter, it is important to note that, just after 1991, the EPRDF did not have party structures all over Ethiopia.

Therefore, the party dispatched local speakers who had undergone political training to introduce communities to their cadres. This process created a space for the organization of so-called Local Peace and Stability Committees, which "formed the nucleus both of the reconstituted local state, and the party's expanding political structure" (Vaughan 2011:627). During this expansion across major regions (i.e. Tigray, Amhara, SNNPR and Oromia), ethnic People's Democratic Organizations were established to run in the 1995 national elections (Vaughan 2011). It took some time before the effects of establishing this political and state structure at the local level became visible nationally.

A commitment to democracy and the acknowledgement of Ethiopia's pluralism was also expressed in the first Health Policy in 1993: it was rural-oriented, with a decentralised political system set up in place based on primary health care (Kloos 1998:100). It expressed "the commitment to democracy and the rights and powers of the people that derive from it and to decentralization as the most appropriate system of government for the full exercise of these right and powers in our pluralistic society" (TGE 1993:3). Democratization within the health system meant "establishing health councils with strong community representation at all levels and health committees at grassroot levels to participate in identifying major health problems, budget planning, implementation, monitoring and evaluation health activities" (TGE 1993:5). It conceptualized health through physical, mental, and social well-being, which were regarded as necessary for "the enjoyment of life and for optimal productivity" (TGE 1993:5).

It concluded with a description of policy priorities, stating that information, education, and the communication of health should be given appropriate prominence to enhance health awareness and to propagate important concepts and practices of self-responsibility for health. The policy also acknowledged the need for the integration alternative medicine into modern health care. The major groups targeted by the policy were children and women, those at the forefront of productivity, the rural population, pastoralists, the urban poor, and national minorities, as well as those hit by natural disasters.

In line with this policy, the government enacted national policies on women, social affairs, education and training, and disaster prevention and management. These policies were enacted in a climate of scant health statistics in the country.[23]

[23] Maternal mortality ratio estimates were to be obtained from vital registration, longitudinal studies of pregnant women, or repeated household surveys. As noted by the World Bank in 2005, Ethiopia had no vital registration system, nor had it carried out a national household survey. The first population-based national survey was the Demographic and Health Survey 2000, which incorporated questions on maternal mortality (World Bank 2005). The major causes of this mortality were related to emergency obstetric care and complications from safe abortions. There was a lack of a sufficient level of antenatal care (only 26% nationwide), a lack of skilled delivery (around 6%), and female genital mutilation (FGM) was also widely practiced, as nearly 80% of women between the ages 15 and 49

Second stage of decentralization

In the late 1990s and early 2000s, the broader political landscape in Ethiopia was marked by conflict with Eritrea and an ideological crisis within the EPRDF[24]. This was followed by a split within the party, the emergence of Meles Zenawi as the undisputable leader, and the articulation of the developmental state as an alternative model of socio-economic development within the wider framework of revolutionary democracy (Medhane and Young 2003:392).

The second phase of decentralization started with the District Level Decentralization Programme of 2001. Weredas (districts) were empowered administratively by block grants that were directly transferred from regions, bypassing the zones (see Table 4). Since that time on, they have been responsible for "setting priorities, delivering services, and determining allocation at the local level within the framework of national policies" (World Bank 2005:84). In practice, wereda-level administration has been responsible for health center and health post construction as well as the provision of drugs and equipment. Formally, the second stage of decentralization was aimed to increase "local participation and strengthen ownership, as well as improve service management, efficiency in resource allocation, and to improve accountability" (World Bank 2005:84).

Technical decentralization at the wereda level took place within a broader project of capacity-building starting at the federal level and moving through the regional and zonal levels to the wereda. The EPRDF aimed at integrating the functions of the party leadership more clearly within the purview of the state (Vaughan 2011). At the federal level, roles and activities previously undertaken by informal political party advisers were replaced by new ministries for rural development, federal affairs, and capacity building. At each level of government—federal, regional, and wereda—this new capacity-building structure was established, replacing the party cadre system. At the wereda level, the head of this capacity-building department was usually the oldest and most powerful person in the local administration.

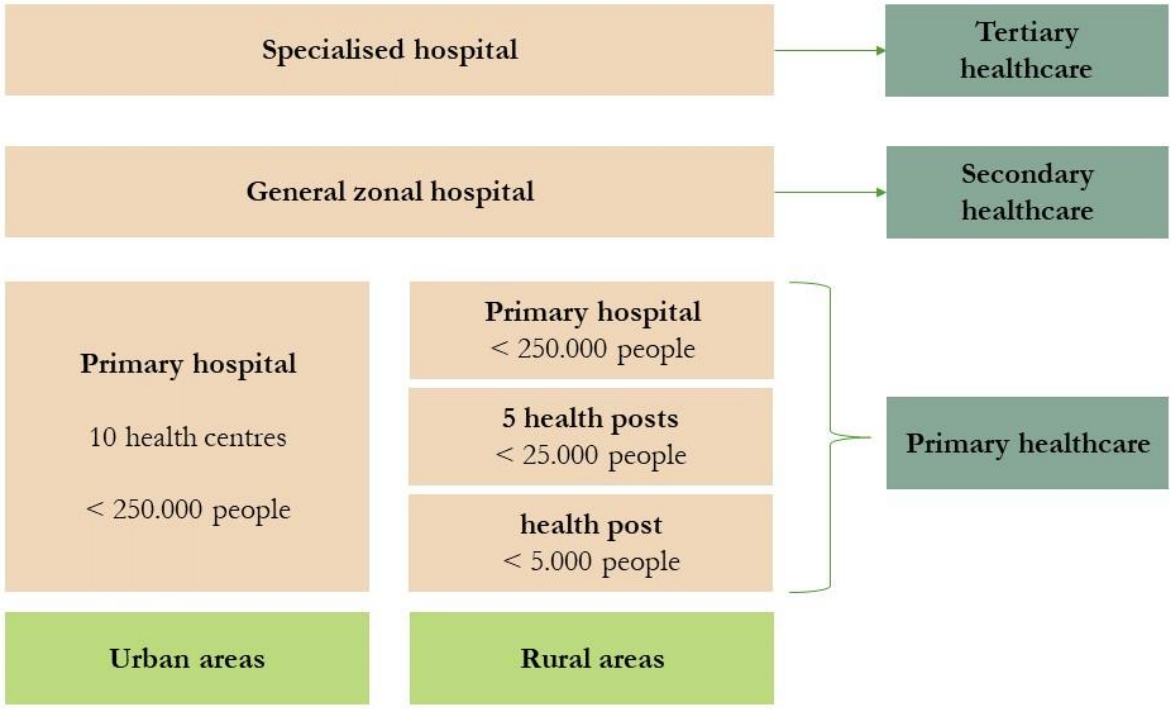
These changes started to happen in the midst of the establishment of the Health Sector Development Programme, which covered the years from 1997 to 2015. The Programme consisted of four five-year Plans which fed into the planning of the development process in the country. The first Health Sector Development Plan (HSDP I) covered the years from 1998 to 2003 and was oriented towards the expansion of infrastructure. The main aim was to increase access to health care from 40% to 50% (World Bank 2005:86) by delivering PHC services throughout the country. Another reform involved change from a six-level public health system

had been circumcised. Others factor that influenced health were fertility, nutrition, HIV/AIDS, and a lack of health knowledge.

[24] It goes beyond the scope of this chapter to go into the details of the crisis. For more details, please see Vaughan and Tronvoll (2003); Mulugeta Gebrehiwot Berhe (2020).

to a four-level system. In this new set-up, five health posts would belong to the catchment of one health center, which would serve up to 25,000 people. The next tier was the district hospital, acting as a referral center for ten health centers, serving in total 250,000 people. Zonal hospitals provided services for one million people (Figure 2).

Figure 2. Health care system in Ethiopia



Source: own elaboration on the basis of World Bank (2005).

The HSDP II covered the years from 2002 to 2005 and was a prelude to the HSDP III. In light of the lack of health workers in the country, in 2003 the government introduced the Health Extension Programme (HEP), which was a programme of community health workers inspired by the ideals of the Alma Ata Conference (Yibeltal et al. 2019). The aim of the HEP was to provide "quality promotive, preventive, and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children. The policy places particular emphasis on establishing an effective and responsive health delivery system for those who live in rural areas" (Pathfinder International 2008:1). The HEP assumed the training of Health Extension Workers, who would be recruited from among high school graduates and undergo one-year training concerning disease prevention and control, family health services, hygiene, and health education. Each health post was to be staffed by two Health Extension Workers who were meant to liaise with health care

facilities for referrals, particularly for high risk pregnancies and emergency obstetric care. Seventy-five percent of the work of the HEWs would consist of outreach activities. The remaining 25% would be spent at a health post, providing services such as immunizations. HEWs would train families in Health Extension Packages (Table 5). Although the HEP was initiated and led by the Ethiopian government, it was based on the challenges and experiences of the earlier health worker initiatives, such as TBAs. Moreover, the team from the Ministry of Health derived its inspiration from India (Netsanet and Ramana 2013), where it was sent for a study visit.

Table 5. Components of the Health Extension Package to be implemented in rural areas

Disease Prevention and Control	Hygiene and Environmental Sanitation
HIV/AIDS, sexually transmitted infections and tuberculosis prevention & control	Solid and liquid waste disposal
Malaria prevention & control	Water supply and safety measures
First aid emergency measures	Food hygiene and safety measures
Family health	Healthy home environment
Maternal and child health	Health education and communication
Family planning	
Immunization	
Nutrition	
Adolescent reproductive health	

Souce: Author's own elaboration on the basis of Ethiopia's Health Extension Program: Pathfinder International's Support 2003–2007 (Pathfinder 2008).

The Health Extension Programme is still considered the bedrock of Ethiopian's efforts to expand primary health care in rural areas and was seen as instrumental in improving population health and achieving Millennium Development Goals. The programme received endorsement from Dr. Teodros Adhanom, the state minister of health and later the chief of WHO (Byass 2017). Dr. Teodros connected the HEP with the Alma Ata Declaration and PHC:

> *Our focus is primary health care... At Alma Ata, with the 'Health for All' declaration more than 30 years ago, the whole world said the focus should be on primary health care. But, in practice, that is the most neglected area today* (Teodros Adhanom, quoted in Donnelly 2011:1908).

In 2005, the "Health Sector Country Status Report" by the World Bank illuminated issues related to the expansion of health care services. Ethiopia was particularly celebrated for its decline in infant and child mortality rates and also its adoption of standardized interventions such as polio immunizations, vitamin A distribution, and creating awareness about HIV and AIDS. The maternal mortality ratio was not the subject of this report *per se*, but rather discussed within the context of childcare. The report identified major problems with accessing health care facilities, which were distance and the lack of perceived need for using health care services. The conclusion was that education of the population was needed to created demand and behaviours conducive to health. In order to address malnutrition, the report proposed "informing mothers about appropriate feeding practices", not mentioning where the food should be obtained. Information campaigns were also directed towards other vertical interventions, such as using bed nets, and the need to use latrines and wash hands. Moreover, the report concluded that there was not enough personnel able to perform skilled deliveries and more complex clinical functions. This meant that a main intervention used to reduce maternal mortality—skilled delivery—was available up to a limited extent (World Bank 2005).

Third stage of decentralization

The beginning of HSDP III coincided with the 2005 national elections. Unlike the elections of 1995 and 2000, in which the opposition was absent or marginal, the governing EPRDF for the first time permitted its real democratic opening (Lefort 2010). After a small and controversial win for the ruling party, protests erupted in Addis Ababa (Aalen and Tronvoll 2009; Di Nunzio 2014). The opposition leaders were arrested, around 200 protesters were shot, and journalists were also detained (Aalen and Tronvoll 2009).

The 2005 elections were followed by third level decentralization with a set of administrative and political reforms[25]. The ruling party realized that there was a need to build 'national consensus' through mass mobilization of the people. The reforms involved increasing the capacities of the lowest administrative unit (the kebele) by: establishing cabinets that resembled ministerial structures (Di Nunzio 2014); increasing the number of members of kebele councils (local parliaments, from whom the cabinets are elected) from several tens to even 300 (Vaughan 2011); establishing more systematic sub-kebele structures: 1-5 networks and 1-30 development teams; re-establishing mass associations such as women's and youth associations (Di Nunzio 2014).

Although some of the structures were not totally new to the local governance landscape (like 1-5 networks), it was the intensity of their establishment that was surprising. The EPRDF

[25] These are described in greater detail in the Results chapter; here I outline only the main points.

tied these administrative reforms to the political expansion of party membership. Between 2005 and 2008, the number of the EPRDF party members increased from 760,000 to four million in 2008 and more than five million in 2010 (Vaughan 2011).

These bureaucratic reforms were assisted by shifts in sectoral development policies[26]. These reforms were often called 'behavioural changes' that were supposed to drive broader social change[27]. This basically meant that the rural population was constantly called upon to act in various development campaigns. In the area of health, the HSDP III also employed a 'mass mobilization' approach to improve maternal health, decrease child mortality, and combat HIV/AIDS, malaria, TB and other diseases, with the ultimate aim of improving the health of Ethiopian people and achieving Millennium Development Goals (FMOH 2005:12). Health education was aimed to convince the rural population to adopt 'healthy behaviours' such as breast feeding, using bed nets, and maintaining hygiene. HEWs were the main brokers of health education, and they were supported by volunteers: community promoters and TBAs (literate members of the community, often former healers), who would work under the supervision of HEWs. In general the HSDP III assumed strong "community mobilization and sensitization in order to ensure genuine community participation and develop democratic decision making process" (FMOH 2005:73).

The HSTP III reiterated a commitment to the provision of Safe Motherhood services—skilled attendance and referral for obstetric care in health centers and hospitals. Births could take place at home or at a health center, but should be assisted by a skilled attendant. Other services for maternal health included basic antenatal care, immunizations, postnatal care, the promotion of vitamin A and iron supplementation, treatment of childhood illnesses, and provision of family planning services.

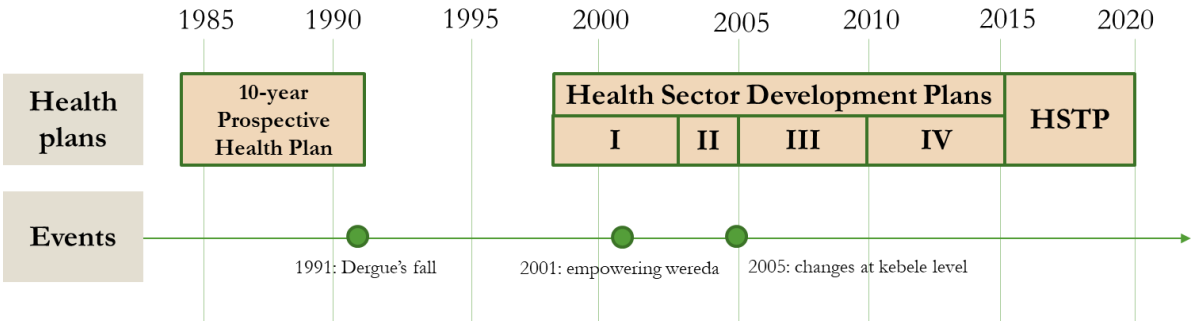
The HSDP IV covering the period from 2010 to 2015 remained committed to similar objectives as the HSDP III. However, one of the major changes was that the programme aimed to use the capacity of HEWs even more and to "broaden and deepen the engagement of local communities and particularly women in the management of their own health" (FMOH 2010:6). To this end, the government proposed the creation of the Health Development Army, which relied on the assumption that the Army would consist of networks of five households and one model family. In each network, a model family would influence other households to adopt healthy lifestyles. In practice, this meant the Health Development Army was another name for 1-5 groups, dedicated to women only. Studies indicate that Army is an important social

[26] These changes have been documented for youth programmes in Addis Ababa (Di Nunzio 2014), peasants (Lefort 2010), and road construction (Emmenegger 2016).
[27] See, for example, "The Act of Living: Street Life, Marginality and Development in Urban Ethiopia" (Di Nunzio 2019).

network when it comes to most health information provision and communication (Shifera et al. 2019; Abebe et al. 2019; Kok et al. 2015). The network advocated the benefits of institutional delivery to women and notified the HEWs if a woman's labor started at home (Jackson 2016).

In 2015, Health Sector Development Plans were replaced by the Health Sector Transformation Plan (HSTP) 2015/16–2019/20 (Figure 3). The HSTP used the rhetoric of moving from the 'rehabilitation and expansion of basic health services' to 'improving the quality of health service delivery and respectful care'. The aims of the HSTP by 2020 were to reduce MMR to 199 and the under-five mortality rate to 30. The strategies used to achieve these aims involved a move from skilled delivery that could take place at home to institutional delivery that could take place only at health center. Moreover, a continuum of care was also adopted to tackle the life-course health problems of women. The focus on the Health Development Army as a tool of community mobilization to 'manage their health' remained strong.

Figure 3. Health Sector Plans in Ethiopia between 1985 and 2020



Source: own elaboration.

In general, health sector development over the years has been evaluated in different ways. This was done especially in the context of HEP effectiveness. In terms of technical performance, success of HEP is well documented (see Donnelly 2011; Hailay and Awash 2013; Olson and Piller 2013; Yaliso et al. 2014; Tesfaye et al. 2015; Yibeltal et al. 2019). This excellent performance has been linked to the country's pro-poor policy stance, which has seen 70% of government expenditure going to the five pro-poor sectors of agriculture, education, health, roads, and water, and the allocation of funds to effective primary health care interventions that have been said to contribute to the decreasing maternal mortality. Also the Demographic and Health Survey 2015 noted significant improvements in basic indicators for maternal mortality, family planning, or under-five mortality (CSA and ICF 2016). Progress has been noted in terms of basic health indicators such as antenatal care and skilled delivery (see Figure 4 and Figure 5 below). In the "Bulletin of the World Health Organization", Ethiopia, along with

Rwanda and Malawi, are referred to as pioneering countries in community health worker investment. The country has been admired by the Bill and Melinda Gates Foundation, the UK prime minister Tony Blair, and many others in policy and academic circles, especially those dealing with the more technical aspects of the health system in Ethiopia (Prata and Summer 2015; Hailay and Awash 2013).

Figure 4. Women receiving prenatal care (%)

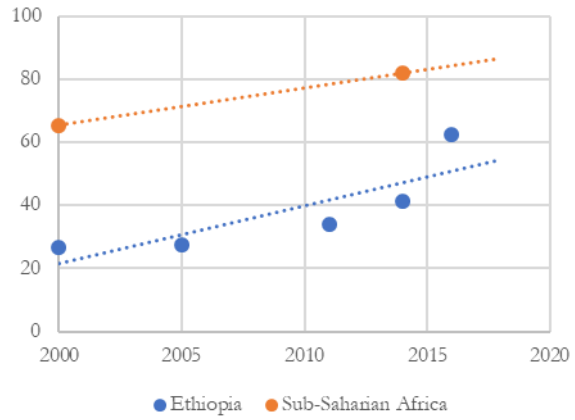
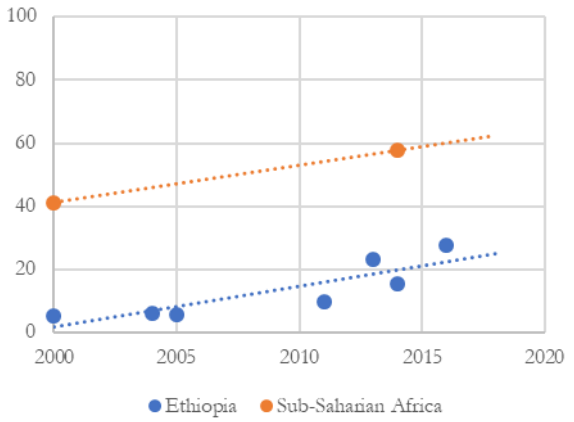


Figure 5. Births attended by skilled health staff (%)



Source: own elaboration on the basis of World Bank, UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys (World Bank Data, https://data.worldbank.org, access: 17-05-2020).

However, while the HEP has been praised for achieving changes in maternal and child outcomes, these big conclusions can be based on very poor data (Easterly 2014:125), a concern that has been frequently repeated with regards to maternal health measurement (Melberg et al. 2019). This seemed to be confirmed by the National Health Accounts[28], which explicitly acknowledged that data about the in-kind contributions of communities participating in the Health Development Army and malaria control initiatives as a part of the Health Extension Programme could not be estimated. Activities such as building waiting centers near health facilities for expectant mothers and making ambulance services available are difficult to measure, as the methodology generally has defined health expenditure in terms of financial transactions. This has posed serious questions about the way that numbers and measurement shape the reality in which health sector programmes are implemented. Moreover, the Ethiopian health sector has increasingly relied on external funding, which poses serious questions about the sustainability of the solutions.

[28] Health Accounts tracks total health expenditure flows of a health system from financing sources to purposes of spending and end users, for a given time period. Ethiopia's sixth round of Health Accounts covered the fiscal year 2013/14.

There are a number of challenges related to the implementation of maternal health services. Individual-level factors (perceived need for visiting health care facilities, economic situation and social networks of a woman) play a role in accessing health facilities. Although a big emphasis in the government interventions was placed on health education, studies suggest that the perceived need for medical interventions during delivery remained low. For example, women still preferred to give birth at home as it was considered as a 'natural event', especially in the emerging regions: Afar, Benishangul-Gumuz, Gambella, and Somali[29] (Mohammed et al. 2018). Studies pointed out perceptions about a 'normal' delivery, which should be short (i.e. around 4 hours), take place at home and with the presence of both male and female relatives and neighbours (Bedford et al. 2013). Delivery was continued to be perceived as "an ordinary event that has been managed at home for generations" (Tesfaye et al. 2012:14). Besides, there was misconception of services provided at health facility and strong beliefs in efficacy of TBAs (Meselech et al. 2014). There is an evidence that individual perceptions and beliefs related to health and health services influenced decision about whether to use maternal health services (Bergen et al. 2019; Datiko et al. 2019, Gezahegn et al. 2020; Abebe et al. 2019; Mohammed et al. 2018; Jackson et al. 2016; Mirgissa et al. 2016, King et al. 2015; Sipsma et al. 2013). On the other hand, the picture emerging from studies is not uniform, as there are studies arguing that women recognized that both home and institutional deliveries had beneficial aspects and limitations (Tesfaye et al. 2012).

Studies also indicated economic problems that prevent women from accessing health care (King et al. 2015; Meselech et al. 2014; Mirgissa et al. 2015; Jackson 2016, Mohammed et al. 2018; Gezahegn et al. 2020). Work burden at home and the necessity of taking care of children prevented especially poorer women from accessing health facilities (Bergen et al. 2019). While a lot of women generally attended the first antenatal care visit, they failed to attend recommended four visits before giving birth, and refused to go for delivery earlier.[30]

Structural factors (quality of care at health facilities, transportation, distance) influenced women's ability to visit health facilities for pregnancy issues and delivery. The quality of care provided at health facilities left a lot to be desired (Pitchforth et al. 2010; Sipsma et al. 2013; Mirgissa et al. 2015; Burrowes et al. 2017; King et al. 2015). Other factors included inaccessible transportation by ambulances and long distances (Kebede et al. 2010; King et al 2015; Bedford et al. 2013; Meselech et al. 2014; Jackson 2016, Mohammed et al. 2018). Although women are transported to the health facility, there may be no transport to return home from the facility after the birth (Jackson et al. 2017; Gezahegn et al. 2020).

[29] Interview, Federal Ministry of Health, Maternal Health Division, 8 November 2018.
[30] Interview, Federal Ministry of Health, Maternal Health Division, 8 November 2018.

Social networking is also a factor for accessing facility-based health care (Gezahegn et al. 2020). Family and neighbours played an important role in this process, for example by organizing traditional stretchers (Jackson 2016). Health Extension Workers together with Health Development Amy contributed to an increasing awareness of institutional delivery (Kok et al. 2015; Jackson 2016) and also they called an ambulance for a laboring woman (Dusabe-Richards et al. 2016). However, these studies rather omitted the role of bottom-up organizations in helping women to access health care facilities.

Studies acknowledged that there has been a significant lack of accompanying political analysis of the health sector (Østebø et al. 2018), especially at local level. Supporters of Ethiopia's health reforms have seemed to ignore the political nature of autocracy in the country. For example, a well-known supporter of the health sector in Ethiopia, the Bill and Melinda Gates Foundation, did not note that the Ethiopian government was an autocracy, which, among other things, denied food aid to its political opponents (Easterly 2014:125). In general, the political dimension of health sector analysis in Ethiopia have been absent. This, in turn, can lead to a skewed or incomplete picture of how health policies have been translated at the local level and how effective they have been (Østebø et al. 2018).

3.3. Summary

This chapter was aimed at exploring how health policies directed at reducing maternal mortality have worked at the global level and in Ethiopia. In doing so, it consisted of two parts.

The first part was dedicated to the efforts in the international maternal health community that were aimed at reducing the extent of maternal deaths since the establishment of the WHO in 1948 to the most recent policy imperatives. Strategies to combat maternal mortality have involved the transfer of biomedical technologies that had been instrumental in reducing maternal mortality in industrialized countries to low-income states. These strategies involved education of mothers at antenatal clinics, training of trafitional birth attendants, promotion of primary health care, emergency obstetric care and skilled delivery, up to the recent trend of promotion of so called 'continuum of care' which promotes utilization of broad range of reproductive services over the life course. These interventions changed their priority in the global maternal health community and there is no consensus which one is the most suitable to decrease the number of maternal deaths. However, there is an agreement that maternal health depends on a mix of political, social and economic factors.

The second part was dedicated to presenting how maternal health policies developed in Ethiopia over the three regimes: Haile Selassie (1930–1974), the Dergue (1974–1991),

and the EPRDF's period (1991–2018). In the case of Haile Sellasie's period, regime generally associated the health care as a mean of modernization of the country. Maternal health care services were not target *per se*, because the country totally lacked the health care infrastructure. At that time, efforts remained focused on urban areas and generally the needs of rural population were not met. Moreover, where services were available, many women could not utilize health care because of the livelihood constrains which were common on rural areas. The focus on the clinic gave primacy to education, but it was not related to the livelihood aspect of women living in Ethiopia.

The Dergue era was marked by the commitment to the Alma Ata Declaration. This period was marked by the roll-out of different mass campaigns and drought periods. Mass campaigns demonstrated repressive nature of the Soviet-style government: along with villagization and resettlement programmes, they were political tools used to validate and legitimate its quest for control. Similarly as its precedessor, the Dergue tried to expand health care infrastructure to local level, and maternal health was integrated into this effort.

The EPRDF period which is defined by the party's commitment to the ideals of 'revolutionary democracy' and 'developmental state' marked the period of great expansion of biomedical health care to rural areas. These changes were introduced as a part of broader plan of socio-economic development of the country. One of the most important projects is the launch of Health Extension Programme, which is aimed at training local health staff, responsible for delivering curative and preventive health services at local level.

4. Methodology

The aim of this chapter is to discuss the methods used in this study for information gathering and the techniques devised for data analysis and interpretation. The chapter is structured as follows. Firstly, I review the research questions that guided the study. Secondly, I elaborate on the worldview in which my study is immersed and justify the selection of the research design. Thirdly, I describe the fieldwork site selection process and data sources. Then, I explain the data analysis procedures and reflect on the validity and reliability of the research. The chapter ends with a reflection on research ethics, my position as a researcher, and the limitations of the study.

4.1. Research objective and questions

The current study aimed to explain the role of social capital for health practices of mothers based on the example of a rural community in Southern Ethiopia. To this end, the study used a definition of social capital as resources embedded in social networks (see Chapter 2 about social capital with Bourdieu's theory of practice) and was guided by three research questions:

1. What are the main forms of women's networks, and what are the factors influencing their formation?

Rural life in Ethiopia is characterized by multiple forms of associations, both bottom-up and inspired by the state. As this study was mainly aimed at exploring the process through which social capital influences health practices, it is firstly needed to investigate the kinds of relationships women established. These different empirical expressions of social capital were defined considering the historical period, location, and material reality of the study's participants (Bourdieu and Wacquant 1992). Besides, I wanted to demonstrate how women established their networks in relation to their objective conditions (gender, wealth) and associated practices. Such an approach could help us to understand the presence of different organizations in the community, explore how people become members of these organizations, and understand how they accessed the different resources available in them. This question prepared the ground for the exploration of the ways through which social capital affected the health practices of mothers.

2. How does social capital affect health practices?

Social capital consists of two interacting factors: social relations and the resources embedded in them. This duality is critical, as having social relations is not an asset *per se*, but depends also on the quality of the resources accessible through them (Bourdieu 2005). In Bourdieu's approach, the ability of relations to improve a social actor's position in the field is not obvious. The actor's position can be enhanced by relations only if they are relevant to the forms of capital exchange operating in a field. This question was aimed at investigating the different resources that were available to the mothers involved in the social networks in this study.

3. What factors affect mothers' decisions to seek care and the situation of health care workers?

This question was aimed at understanding the factors that determined the use of health care services by women and influenced the work of the civil servants in the health system, especially the Health Extension Workers. The question raises the issue of the factors that limit or facilitate the agentive capacities of social actors under the structures of opportunity and constraint (Bourdieu and Wacquant 1992). As such, agency is understood as implementing strategies within particular structures, and not as the application of the free, autonomous will of an individual. Understanding these factors is crucial to the effectiveness of health policies aimed at the empowerment of women and improvement of their health, because these factors can potentially strengthen, promote, deflect, or inhibit policy goals.

4.2. Research paradigm and the qualitative case study approach

Social scientists should recognize and acknowledge their own ontological and epistemological positions because they influence their theoretical and methodological approaches (Marsh and Furlong 2002). Responding to this postulate, this study was explicitly guided by a constructionist perspective that assumes that there are multiple realities based upon people's perceptions, and that knowledge is constructed, not discovered. Berger and Luckmann ([1966]1991) pointed out that people construct social reality based on intersubjective realities that are shared in the world with others. As they state: "The reality of everyday life presents itself to me as an intersubjective world, a world that I share with others… there is an on-going correspondence between my meanings and their meanings in this world" (Berger and Luckmann, [1966]1991:37).

Selecting constructionism as the epistemological position for this study had an impact on my perception of the research problem. It meant that I saw the role of social capital in health practices as a socially and historically constituted phenomenon. I assumed that each participant in the study could experience the same situations very differently, depending on their social, cultural, and political conditions. Moreover, I bore in mind that the process of knowledge production is influenced by researchers who enter into this context and whose analyses are influenced by their own experience and backgrounds. The generation of meanings is always interactional and thus fluid in character, as it takes place during constant interaction among social actors (Crotty 1998). In the same time, the study acknowledges that "thesis that social reality is not given, but is created by people, should not be taken literally" and that "social reality does not exist only in the sphere of imagination" (Szacki 2002:79). To put it differently, the study acknowledges that social reality exists but is mediated through the meanings created by its participants.

Qualitative case study approach

Guided by the constructionist perspective, I argue that a qualitative strategy was the most appropriate research strategy for this study. Qualitative research can be broadly defined as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Corbin and Strauss 1990:17). The rationale behind the selection of a qualitative approach arose from the prevailing quantitative, indicator-based perspective within maternal health research and social capital studies[31], which have tended to disregard unequal power relations in society.

I selected a case study approach because of the nature of the problem and the dominance of explanatory questions. The role of social capital in maternal health practices is a contemporary phenomenon within a real-life context, in which boundaries between the context and phenomenon are not clearly evident (Yin 2009; Creswell 2018). Moreover, my research required the collection of accounts and histories of a wide range of individuals, which also favoured the case study approach. Case studies, being embedded in a small but closed scope, offer explanatory power and powerful histories, and are better understood among non-academic audiences (Flyvbjerg 2006). As I was interested in a holistic approach to the studied phenomena, a case study was the most relevant approach. Case studies can be categorized into single-case studies or multiple-case studies (Yin 2009). As this research looked at one community, it adopted a single-case study approach.

[31] Please see Appendix 5 for evidence.

Site selection criteria and timeline of the research

I selected the maternal health practices of mothers in the community of Aze Debo as a subject of my single case study. In other words, I viewed the study of these maternal health practices as the study of a social phenomenon within one social system – the community of Aze Debo. Aze Debo is a community in the Kambata Tembaro Zone in the Southern Nations, Nationalities and People's Region of Ethiopia (7°14'12.3"N, 37°51'44.5"E). Several criteria were used to select this community as a case study site.

Firstly, I had identified the four main regions in Ethiopia (Amhara, Oromia, SNNPR and Tigray) as potential sites for the research based on their political stability and the safety of conducting research in these areas in comparison to the emerging regions (Afar, Benishangul-Gumuz, Gambella, and Somali), which were less politically stable and safe. In order to select a region, I compared statistical data on maternal health in terms of the number of skilled antenatal care visits[32], place of delivery, assistance during delivery, and timing of first postnatal check-up for the mother. The results showed that the SNNPR had the lowest outcomes for all the indicators, apart from the percentage of women with a postnatal checkup, on which SNNPR had comparable results with the Amhara and the Oromia Regions (Central Statistical Agency [Ethiopia] and ICF International 2012). SNNPR provided therefore a space for exploring the reasons behind such low progress on maternal health indicators.

Secondly, according to the WIDE study, Aze Debo is considered to be an exemplar of one of the major types of agricultural-ecological systems found in the major regions in Ethiopia. It should be noted that WIDE communities were chosen as illustrations of different types of rural communities, featuring wide variations in a range of parameters relevant in the Ethiopian context such as livelihood systems, ease of access, culture and identity-related factors, and religious affiliation (Dom and Pankhurst 2019). Therefore, there is a likelihood that patterns found for selected types of communities can also be transferable to other communities of the same type.

Thirdly, logistical and practical issues were also taken into consideration. Aze Debo is located 220 km from Addis Ababa in a south-west direction. It was possible to get to Aze Debo by a relatively well-maintained road from Hawassa, which is a regional capital, as well as directly from Addis Ababa. These routes were neither easy, nor extremely difficult. However, the travel from Addis Ababa to the case study area could take one full day or half a day from Hawassa, which is located 130 km away. In a more local context, the community has an asphalted road to Durame, which is the zonal capital, and seems to be quite well-integrated

[32] Skilled providers included doctors, nurses, midwives, health officers, and health extension workers.

with this city. Finally, the village was selected due to practical issues: there was WIDE qualitative data available about Aze Debo which covered the period from 1995 up to today. Therefore, I could have immediate access to a rich set of information about the contemporary history of the community.

It should be noted that selection of the above-mentioned research site did not happen at once, but took place over a longer period between 2015 and 2018. It could be divided into two phases: the first phase when I was considering another community as a potential site, and the second phase in which I joined the Ethiopia WIDE project. The subsequent stages of the research are presented in Table 6.

Table 6. Timeline of the research

RESEARCH STEP	2015	2016	2017	2018	2019
1st stage: CONCEPTUALIZATION					
Review of secondary sources and literature					
Development of theoretical approach					
2nd stage: IMPLEMENTATION					
First visit in Wassera (September 2015)					
Second visit in Wassera (September-October 2017)					
First fieldwork round in Aze Debo (March 2018)					
Second fieldwork round in Aze Debo (July 2018)					
3st stage: DATA ANALYSIS AND WRITE-UP					

Source: own elaboration.

When it comes to the first phase, I was considering another community, Wassera (7°22'35.67"N, 37°49'14.95"E), which is one of the kebeles in Doyogenna wereda, a neighbouring wereda to the Kedida Gamela in which Aze Debo is located. In 2015, I visited Wassera for only short period, but nevertheless, thanks to this visit, I had an impression of what a rural community in Ethiopia might look like and how health care services there might be organized.

When I went back to Ethiopia in 2017, I spent time in Wassera for a period between September and October. Having also visited a health center in the neighbouring wereda capital, Doyogenna, I was impressed that the Franciscan Sisters who were running the health center in Wassera were able to maintain this facility. It lacked some equipment, and it suffered from a lack of ambulances, but the quality of the buildings and medical devices was exceptionally good. Sister Hanna, who was a health officer at the health center at that time, introduced me to the health center and also to four health posts that were in the catchment area. This provided

a striking contrast between the health center, which was maintained by the church, and the government-funded health posts, which were much less taken care of. I left Wassera feeling sure that I would be back soon.

My third, longest visit in Ethiopia took place when I had already joined the WIDE team in early 2018. This stay in Ethiopia marked the second phase of my research site selection process. I visited two communities in two regions in 2018: in February, I visited Harrasaw, the community in Eastern Tigray, and Aze Debo in March 2018. At that time, I decided to switch my study site to Aze Debo because it allowed me to continue my research based on my initial assumption of doing research in the SNNPR, but it offered the opportunity to use longitudinal data from WIDE. I used the time I spent in Aze Debo to conduct a first line of interviews, which allowed me to narrow my topic of interest. In the period March to June I was in Addis Ababa designing the second part of the research, and I also worked as a research fellow for WIDE. In July 2018, a research officer did a second round of fieldwork for me in the community. The details of what that fieldwork included are described in the next section.

4.3. Techniques and data sources

While there is a repertoire of research instruments for conducting case study research (Yin 2009), this research used both secondary and primary sources such as in-depth interviews with observation components.

4.3.1. Secondary sources

I undertook a comprehensive review of various secondary sources: policy documents concerning the health system and maternal health care provision in Ethiopia, issues of the Ethiopian Medical Journal available at the University of Warsaw, the literature concerning health and the health care system in Ethiopia, and the Ethiopia WIDE research database. The use of these documents took place both before and after the fieldwork (Table 7).

It is worth noting that the use of documents can differ depending on the social science discipline. For example, in policy analysis, documents such as Health Sector Transformation Plan are treated as straightforward sources of information about a particular policy field. Often, they describe a given policy using categories such as its aims or functions, showing set of hypotheses that explain how the given intervention is meant to produce desired effects (Lacouture et al. 2015). In more critical approaches, which are characteristic of a more anthropological approach, policy documents can be seen as cultural texts that use certain

narratives to justify actions and to highlight some aspects of policy and silence others (Shore and Wright 1997). In this study, I applied an in-between approach, because documents helped me to reconstruct historical events relevant to health policy developments. On the other hand, I was looking for patterns about how debates about maternal health were narrated and represented in documents.

Table 7. Secondary sources used in thesis

Type of source	Repositories
Policy documents	Website of the Ethiopian Ministry of Health (www.moh.gov.et)
Papers and academic publications	Google Scholar
Ethiopian Medical Journal query (1962–1995)	Library of the University of Warsaw
WIDE qualitative database	Ethiopia WIDE (www.ethiopiawide.net)

Source: own elaboration.

With this approach, policy documents helped me to reconstruct how issues around health, and especially maternal health, had been shaped over the past years: their discourses, related resources, and the rules of the game that governed the behavior of different actors in the field of health care. Of great importance were: the Health Care Strategy issued in 1993; the Ethiopian Health Sector Development Plans I (1997/8–2001/2), II (2002/3–2004/5), III (2005/6–2009/10), and IV (2010/11–2014/15); and the Ethiopian Health Transformation Plan 2016–2020, which I used especially in Chapter 4.

Next, I used the issues of the Ethiopian Medical Journal available at the University of Warsaw. This helped me to explore long-term developments in the area of health care in Ethiopia since the beginning of the twentieth century (see Chapter 3). Although it was not the main purpose of the study, I found it useful to see the changes and continuities in health policies especially for the periods of the rule of Haile Sellasie and the Dergue, which have generally been less described and analysed in the secondary literature.

The literature about health and the health care system in Ethiopia proliferated particularly after the launch of what has been called an innovative and groundbreaking solution to the national public health challenges: the Health Extension Programme in 2003 (see Chapter 3). Maternal health, which is one of the main topic areas of this programme, has been studied mostly within the context of this particular programme. On the whole, research that has followed the implementation of this programme has relied mostly on quantitative results and has not made any reference to political context (Østebø et al. 2018), which I found an important shortcoming.

However, there have been studies that have explicitly addressed the political context of health care in Ethiopia and that have influenced my perception of the research problem, especially the most in-depth ethnographic studies of the Health Development Army (Maes et al. 2015a, 2015b) and Community Health Workers (Maes 2015, 2016). Studies concerned with the political context of state-society relations were also important in problematizing the research (Vaughan 2003; Vaughan and Tronvoll 2003; Lefort 2007, 2010, 2013; Emmenegger, Keno, and Hagmann 2011; Jones 2014; Østebø et al. 2018). Of great importance were also discussion briefs prepared by the Ethiopia WIDE team between 2017–2019 (Jones 2014; Bevan 2017; Loveday 2017; Pankhurst 2017; Vaughan 2017, 2019), which documented the development progress in the areas of service delivery, provision of health services, young people's transition experiences, and women's economic participation.

The Ethiopia WIDE database enabled me to access longitudinal information about Aze Debo as well as other information about other WIDE communities. The data from two rounds of WIDE1, WIDE3, and WIDE Bridging Phase were available on the project website[33]. The first two editions of the research provided data for all twenty communities, while the latter only had data for four communities (Yetmen, Sirba, Harrasaw and Aze Debo). As I wrote the Community Report for Aze Debo in 2018, in my thesis I have reused data that I already knew earlier with adequate references. Nevertheless, my own interviews conducted in March 2018 and the semi-structured interviews conducted by the female research officer in July 2018 remained my primary and unique data sources.

4.3.2. Interviews and observation

For the fieldwork stage of research, the main method used was individual in-depth interviews. I treated the narrations of the interviews not as objective truths, but as perspectives and meanings given by my respondents. Morevoer, I was particularly interested in the manner in which people make sense of their experience by describing it in their narratives. My approach to interviews with women was informed by Williams (2000), who noted that "narratives of illness are often marvellous stories which weave together a picture of the life of the narrator, combining detailed descriptions of symptoms and critical assessments of clinical care, with dramatic accounts of everyday events and circumstances" (Williams 2000:135). Interviews basically contained beliefs that women held about their health or accounts about their participation in social networks, but the most interesting thing was how they constructed their causal accounts

[33] WIDE website: www. ethiopiawide.net.

in the way they did. Williams summarizes this lay knowledge in the following way: "in contrast to the educated timidity in crossing disciplinary boundaries so characteristic of academic life, this lay knowledge was comfortable in its synthesis of epidemiology, history, geography, political science, anthropology, theology" (Williams 2000:137). To put it in a different way, this knowledge can be conceptualized as "a narrative which not only frames the individual's past, present and future, but also provides a framework of understanding for individuals' relationships to the places or 'relational settings' in which they live, and the histories of those places" (Popay et al., 1998:639).

In total, 50 interviews were conducted with three groups: (1) ordinary women of different ages and wealth status (2) key informants – representatives of bottom-up and state-led organizations in Aze Debo as well as (3) policymakers in Addis Ababa. Among them, I conducted 18 by myself, and 32 were carried out by my female research officer exclusively for the purpose of this study. Below I describe the three main groups of respondents and also describe the timing of these interviews.

Ordinary women

In March 2018, my fieldwork aim was to orient myself within the community and identify relevant topics. My starting point was the Ethiopia WIDE database comprising qualitative reports about the community. This source equipped me with information about what had been happening in Aze Debo since 2011. Thanks to this, I saved a lot of time because I did not have to collect data about the community from the very beginning, but rather I could focus on the topics relevant to my study aims. In doing so, I focused on researching basic health problems in the community, going beyond the pure aspects of maternal health care services. I also was interested in the links between different community members and the organizations that were considered the most relevant by research participants. I adopted such an approach because I wanted to explore the study site and only after some time to formulate more precise questions, "keeping an open eye to unexpected aspects of the process, by abstaining from pre-arranged procedures and operationalizations" (Denzin and Lincoln 2018:603).

Contacts with research participants in Aze Debo were made in various ways. In general, when I came to Aze Debo, I was officially introduced to the kebele administration, as entering the community without such an introduction would cause suspicion and probably would not be very effective. Even if this created bias, as local government officials could direct me to respondents, doing the research without the officials' consent would have caused mistrust.

Then, interviews were conducted by snowball sampling and the aim was to get a variety of perspectives from women of different age, wealth and social status.

In the fieldwork in July 2018, ordinary women (i.e. those without any official position in the community) were selected on the basis of a combination of two criteria: wealth and age. All my respondents were mothers of children of different ages, who had given birth at least within the past 5 years. While determining the age of the respondents was relatively easy[34], determining their wealth status in a rural context was not so self-apparent. In my study, wealth status in Aze Debo was assessed on the basis of three factors: amount of land, assets such as livestock, and type of livelihood activity. These factors were assessed relative to other people in the community. Such an approach is chosen because of several factors.

Wealth assessment in rural Ethiopia is inevitably related to the ownership of land and consequent involvement in agriculture. In 2011, arable land represented 75% of the Aze Debo kebele area. Landholdings were very small: more than 40% of the households had less than 0.4 ha (Aze Debo Community Report 2011). Given that land distribution is mediated through the state and the number of people increased between 2012 and 2018, the average size of land plot per household was likely to decrease. There were accounts in the WIDE study that those who wanted to establish new households faced a serious problem with access to land: frequently they simply had to live with parents or share crop land with others. Therefore, land was a precious asset that determined wealth and poverty in Aze Debo and beyond.

Another element used in wealth assessment was type of livelihood. Moreover, given the fact that main the livelihood—farming—was dominated by men, and my respondents were mostly married mothers, their wealth was defined through the prism of their husbands' livelihood activities. These, in turn, were likely to be more profitable if the household had more land to diversify crops. Moreover, households having migrants in the family also tended to be richer. Women's involvement was mainly in care and domestic chores, as well as other smaller livelihood activities. Another expression of wealth was also house type (see Section 5.1.2 about household material conditions in Aze Debo). Summing up, the assessment of wealth was based on observations of how much land a household possessed, the major livelihood of the household members, and also the house's appearance.

[34] Throughout the course of the fieldwork, it emerged that some of the participants were, in fact, older than they had indicated, or they were not fully sure of their age. For example, a woman indicated that she was 25 years old during the main data collection stage, but she had 15-year-old daughter.

Table 8. Women participating in the study – March and July 2018

No.	Wealth status	Age	No. of children	Interview month
Respondent 1	middle	25	4	July 2018
Respondent 2	middle	25	2	July 2018
Respondent 3	poor	23	1	July 2018
Respondent 4	rich	18-30	1	July 2018
Respondent 5	rich	20	3	July 2018
Respondent 6	poor	20	3	July 2018
Respondent 7	middle	39	6	July 2018
Respondent 8	middle	32	3	July 2018
Respondent 9	poor	31	3	July 2018
Respondent 10	poor	32	5	July 2018
Respondent 11	rich	40	4	July 2018
Respondent 12	rich	38	3	July 2018
Respondent 13	middle	43	3	July 2018
Respondent 14	poor	40	6	July 2018
Respondent 15	poor	45	8	July 2018
Respondent 16	rich	41	4	July 2018
Respondent 17	rich	42	5	July 2018
Respondent 18	middle	41	3	July 2018
Respondent 19	middle	22	1	July 2018
Respondent 20	poor	33	3	July 2018
Respondent 21	poor	34	4	July 2018
Respondent 22	poor	25	3	July 2018
Respondent 23	middle	30	3	March 2018
Respondent 24	poor	44	4	March 2018
Respondent 25	poor	35	4	March 2018
Respondent 26	poor	30	4	March 2018

Source: own elaboration.

It should be also mentioned that a person who is relatively rich within a community does not have to be rich in relation to other rural communities or nearby towns. In other words, rich people from Aze Debo could be regarded as 'poor' in another type of community. This also means that the total wealth in the community was determined by its wider circumstances, such as accessibility or its location in a drought-prone area.

With these caveats about wealth assessment, Table 8 shows the basic characteristics of the women who took part in my study, both the women whom I interviewed during my first visit in March 2018 and the women interviewed in July 2018.

Key Informants

In addition to ordinary women, interviews were conducted with key informants who held important positions in the community. Those included representatives of state and local government and community organizations. It should be noted that many of the respondents could combine different positions, for example, a person holding a position in local government was also a preacher at a Protestant church. In this regard, we must bear in mind that this makes a clear-cut delineation of their roles impossible. Similar to the case of the interviews with ordinary women, my interviews in March 2018 concerned the main health problems in the community, organizations that were important from the point of view of both mothers and all women, and the local health care system. It also happened that some of the key informants, such as the Health Extension Worker and the Kebele Manager, were interviewed more than once.

Table 9. Key informants participating in the study

No.	Profession	Organization	Interview month
1	Kebele manager (2nd time)	State-led	July 2018
2	Iddir leader	Bottom up	July 2018
3	Former Traditional Birth Attendant	NA	July 2018
4	1-5 network leader	State-led	July 2018
5	Former kebele manager	State-led	July 2018
6	Gender Officer/Leader of church praying group	State-led	July 2018
7	Development Agent (female)	State-led	July 2018
8	Leader of church prayer group	Bottom-up	July 2018
9	Leader of Women League/women's prayer group	State-led	July 2018
10	Wereda health bureau officer	State-led	July 2018
11	A kebele official working at the Natural Resources Management office	State-led	March 2018
12	Health center officer from Bezena Benara	State-led	March 2018
13	Female cabinet member	State-led	March 2018
14	The richest man in Aze Debo	NA	March 2018
15	The richest's man wife	NA	March 2018
16	2nd iddir leader	Bottom-up	March 2018
17	Influential woman—a teacher's wife	NGO	March 2018
18	Kebele manager (1st time)	State-led	March 2018
19	Health Extension Worker	State-led	March 2018

Source: own elaboration.

I applied interview guides in the fieldwork in July 2018 for both ordinary women and key informants. Various topics emerged from the analysis of the information obtained through the interviews conducted in March 2018 and through personal observation, and were also inspired by the theories of social capital (for more detailed explanation please see Appendix 2). Having interview guides allowed me to ensure comparison between informants. The interviews were open-ended, but assumed certain topics would be covered and also contained certain sub-topic questions that were flexibly introduced depending on the flow of the interviews.

Table 9 presents the key informants who took part in my study, both those whom I interviewed during my first visit in March 2018 and those interviewed in July 2018.

There were two kinds of interview guides. Firstly, the interviews guides for ordinary women contained questions about the people and organizations in the village who were most important to them, what kind of support was provided through these networks, which networks were important from the point of view of health and for women in general, what kind of support could be obtained from these networks, and what was the perception of trust in the community. Women were also asked in detail about their experiences of delivery.

Secondly, interview guides for the key informants contained questions about maternal health status in the community: how had it changed through the past decades, what were the most important networks for mothers, and what kind of benefits were derived from them. Moreover, these informants were asked about social trust perceptions.

Observation

When I was in Aze Debo in March 2018, I applied observation as a method aimed at obtaining descriptive data that placed emphasis more on variety than on detail. Interviews provided a great opportunity to combine conversations with observing. Interviews took place in the front of women's houses, often with small children being present. This enabled me to observe the everyday practices of the women: throughout the course of the stay, I felt more confident about the routine of the daily lives of women. I also noticed that people started to recognize me and get used to my presence in the community. Throughout my stay in Aze Debo, I was spending as much time as possible in the community to learn how people responded to situations and how they organized their lives (Liamputtong and Ezzy 2005; Liamputtong 2008). Interviews appeared to be more elaborate with women who held positions within the community than with those whose main activity was household chores.

This informal observation continued throughout the research done by myself and the research officer. I tried to capture these insights as much as possible in a research diary

and reflect on how these informal observations shaped my thoughts and understandings. I took fieldwork notes regularly. However, this method played a secondary role in the present study and helped contextualise and interpret information obtained through interviews and from the WIDE database.

Interviewees in Addis Ababa

Interviews with national and international experts were utilized to situate women's narrative accounts within institutionalised strategies and policy discourse as well as conxtualize information in the policy documents. In interviews with institutional respondents I applied a flexible mode of conversation, depending on a person's background and the flow of the interview. Interviews were conducted with representatives of the Ethiopian Public Health Institute and employees at the Federal Ministry of Health (Table 10). These included representatives of Maternal and Child Health Department, the Child Health Department, Family Planning, and the Health Extension Programme.

Table 10. National and international experts taking part in the study

No.	Position	Organization
1	International health consultant	Freelancer working for various international organizations
2	Specialist in maternal health	Ethiopian Public Health Institute
3	Specialist in maternal health	Federal Ministry of Health
4	Specialist in child health	Federal Ministry of Health
5	Specialist – Health Extension Programme	Federal Ministry of Health

Source: own elaboration.

It should be noted, however, that these respondents were not directing me to the site or linked to the selection of other interviewees at the local level. These interviews with experts at government bureaus rather were instrumental in understanding the rationale behind how government policies related to women's health were implemented and how they were understood at the federal level. This contextualization was a key element in giving me confidence in my understanding and interpretation of the research results.

Language and interpretation

The importance of language is central to the data collection process, especially in Ethiopia, which is home to more than 70 languages. Although, thanks to my studies in the Department of African Languages and Cultures at the University of Warsaw, I can read and write in Amharic, my speaking skills are not adequate for spontaneous communication. Besides, the usefulness

of Amharic in Aze Debo was limited in any case as most of the participants spoke Kambaatigna, both the ordinary women and people in official positions. Even though some of the respondents holding positions in the kebele administration spoke English (for example, the kebele manager), they preferred communication in Kambaatigna.

Therefore, in the first and second phase of the research, I conducted conversations using translators who both spoke English and Kambaatigna. In the third phase of the research, the follow-up interviews were conducted by a female research officer whom I had known from the WIDE research and who had over 10 years of experience in conducting qualitative research in Ethiopia. Doing research through another person during this phase was dictated by several factors. Firstly, the research officer whom I selected was involved in the fieldwork in WIDE. Given the training necessary to conduct the research and the difficulty of hiring high-quality researchers, this was more suitable solution. Secondly, I believed that employing Ethiopian researchers would be more appropriate for exploring sensitive issues around maternal health. Thirdly, the issue of language was also taken into account. The main language in Aze Debo was Kambaatigna, and my research officer spoke Amahric; therefore, she selected her own interpreter. I believe this was a good decision, as it would have been difficult to find a researcher who both was a social scientist and spoke Kambaatigna. The translator for my research officer was a speaker of Amharic and Kambaatigna; therefore, my research officer and her translator had the possibility of discussing in their native language.

The interview transcripts were written down in English. In the case of interviews conducted by me, this process gave me an opportunity to reflect on what was said and choose suitable meanings in English. In case of interviews conducted by the research officer, I asked for a debriefing to make sure that everything was clear and understandable. Interviews in Addis Ababa were held in English and extensive notes were also taken.

4.4. Data analysis

The data analysis was divided into four steps (see Table 11). As a first step, notes from interviews were saved in separate Word files with a short categorization of the respondent in their names for the ease of reference. All identities of individuals were anonymized for confidentiality purposes.

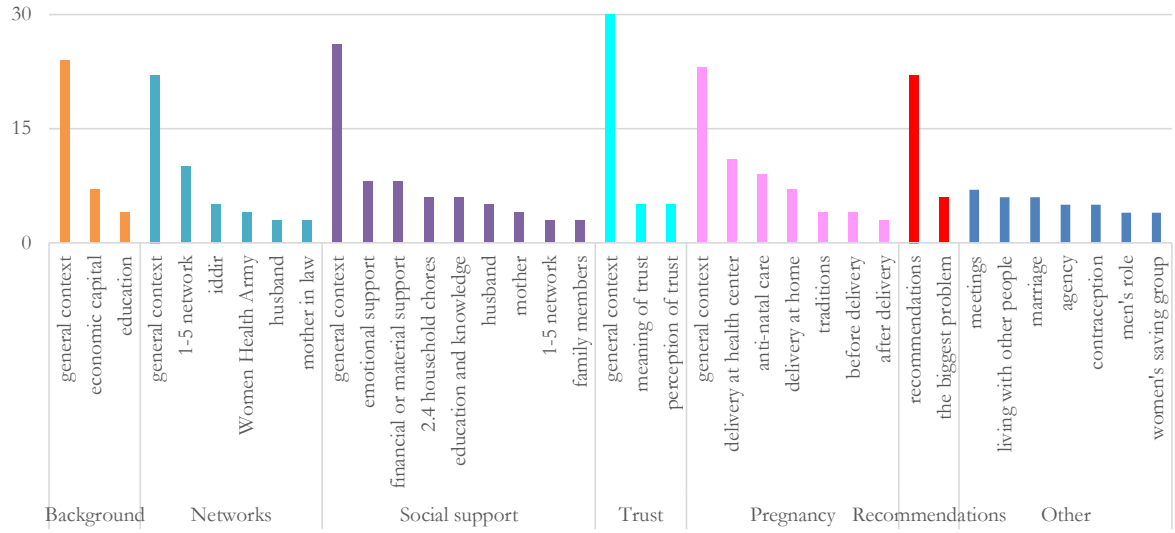
Table 11. Data analysis steps

	Step 1	Step 2	Step 3	Step 4
Task	**Data organization** (Transcription and organizing data)	**Data categorization** (Reading, reflecting, coding)	**Focused interpretation** (Identifying patterns, themes)	**Linking, synthesis and generalizations** (Validating and concluding)
Aim of the task	Preparing data for analysis, getting to know the data	Condensing to make meaning to raw texts	Categorizing data into subthemes	Comparing findings with the literature and relating them to research questions

Source: own elaboration.

As a second step, I categorized the data using MAXQDA programme and coded emerging themes. Using MAXQDA enabled me to move swiftly across different themes and facilitated thematic analysis. Ordering the data in the programme was an inductive and iterative process during which I repetitively read the text of interviews and created codes. Figure 6 below presents codes used for the study.

Figure 6. Codes in the qualitative analysis



Source: own elaboration. Above these are codes used 3 times or more.

The third step involved more focused categorization and simultaneous interpretation. Despite the fact that MAXQDA performed basic analysis through counting the occurrence of codes or words, it could not fully perform the analysis, but rather it served as a tool for ordering the data and having control over it. Over time, after an initial focused interpretation, the analysis evolved towards deeper interpretation, which involved the identification of relationships between emerging themes. The third and second step were linked to each other and conducted as an iterative process.

As a fourth step, I compared the findings with the literature and research questions. While the data analysis began as quite an inductive process, as it progressed a more iterative process was followed, whereby the analysis involved the interplay between existing theoretical understandings, the literature about maternal health in Ethiopia, and the empirical data. Contrasting my findings with different kinds of literature helped to increase my confidence in the findings. Also, it presented an opportunity to be more creative by proving deeper insight into the emergent interpretations. Similar literature allowed me to tie together underlying similarities in phenomena that have not usually been associated with each other.

4.5. Validity and reliability of the research

Assessing the quality criteria for qualitative research is contentious (Flick 2006). In particular, the criteria of reliability and validity are crucial to establishing the quality of any research[35] (Denzin and Lincoln 2018). Although these two criteria have been applied to quantitative research, the core ideas of these two concepts are the ones most often used in all kinds of research (Golafshani 2003). There is a consensus that reliability and validity are not simply declarations by the authors of the study, but rather they are built into the process of inquiry (Morse 2015).

Creswell (2018) argued that there are many strategies that can bring validity of the research, including: triangulation, member checking, detailed description, researcher's bias, discrepancy in information, prolonged presence in the field, debriefing, and external audit. In my study, I triangulated data through using interviews with respondents of different wealth and age, as well as different functions within the community. Moreover, the findings were discussed against the broader literature of social capital and health, which provided wider lessons from the research. This allowed me to build a detailed description of the case study and present a panorama of actors' discourses and rules within this area. I discussed the results with my research officer to better understand the message of the interviews. I also revealed all biases that might have occurred during the research process, not only those concerning my own positionality as a researcher. In describing my results, I also presented discrepancies in the information received from different respondents.

[35] Sometimes authors have suggested different criteria for quality evaluation, depending on the research paradigm. For example, in the constructionist paradigm, Lincoln and Guba (1985) reformulated the classical criteria of reliability and validity under the the auspices of 'trustworthiness'. Techniques to ensure trustworthiness include credibility, transferability, dependability, and confirmability. I applied notions of validity and reliability because any research should be characterized by the appropriateness of its research tools, processes, and data, and should enable up to some extent generalizibility and the drawing of broader conclusions.

In terms of reliability, in qualitative research this refers to consistency and care in the application of procedures, analysis, and conclusions, which is reflected in an open account that remains mindful of the partiality and limitations of the findings caused by the researcher's position (Cypress 2017). To meet this criterion, I provided a detailed overview of the whole methodology I used. This study could be replicated, if one wished to do so, using the interview guidelines and list of respondents. As the study adopted a constructionist perspective, it is important to acknowledge my own personal bias, motivations, or interests, which are described in the Section 4.7 *Reflexivity*.

4.6. Ethical issues

Qualitative research raises a number of ethical responsibilities for research participants, professional and academic colleagues, research sponsors, and the wider public (Green and Thorogood 2004). The ethical responsibility of a research project goes beyond the conventional focus on the conditions of field research to the constitution of an intellectual project (Mosse 2015). Research ethics involve a number of elements, such as formal ethical review, informed consent, confidentiality, and the responsibilities of the research participants.

In the case of this study, ethical clearance was sought from and approved by the Academic Director of the Graduate School for Social Research at the Polish Academy of Sciences. When I decided to move my study site from Wassera to Aze Debo, I gained a supporting letter from Hawassa University. Relevant documentation is attached in Appendix 4.

Besides formal ethical clearance guidelines, the research involved informed consent. When I was conducting interviews, I spent some time explaining the aim of my research and how the data would be used. Emphasizing the voluntary nature of interviews, confidentiality, and the right to withdraw at any time are also crucial for ethical research. Consent was obtained verbally from all participants when I was working with an interpreter, which was especially important for illiterate women. During all discussions, I gave primacy to the interviewees and their obligations: sometimes interviews were disrupted when a woman had to do something in the house.

Social research ethics also stress confidentiality as a key criterion for ethical practice. This first means not disclosing information gained from the research in other settings, such as informal conversation. In this case, ensuring total confidentiality between research participants and other members of the community proved to be difficult, because the community easily noticed a foreigner's presence in the village. Thus, many people noticed whom I had interviewed. However, the data obtained during conversations were written down and not

disclosed to other people. Names and other identifiers were changed to protect privacy. Moreover, despite the fact that discussion of all issues related to the implementation of state policies can be risky (i.e. expressing criticism), this research did not cause such issues, as the women generally expressed criticisms more towards operational issues related to the health system, rather than criticism towards the government.

Ethical research requires researchers to consider their obligations towards participants as well as other stakeholders. My participants' life was frequently characterized by poverty and a lack of power. Thus, the question of how I can use what I have learnt and what is its usefulness have arisen. In all my encounters, I tried to adopt a position of non-judgment and empathy to others' experiences, coming from the perspective of a person from a different culture. The issue of reciprocity is also delicate. I provided compensation to the women and tried to limit the interviews to a reasonable amount of time so as not to disturb the participants' plans. At the outset of the main data collection, I decided that the participants should receive financial compensation for taking part in the research. While there are no clear guidelines on financial compensation, it has been suggested by other researchers (e.g. Morrow 2012) that the decision to use compensation should take into account local realities and contexts.

In terms of obligations towards the funders of this research, I acknowledge that this study would not have been possible without financial support from the Graduate School for Social Research at the Polish Academy of Sciences. Moreover, the invaluable support from WIDE allowed me to conduct this study. Without the combination of support from these two sources, I would not been able to conduct the research.

4.7. Reflexivity

As noted in the section about reliability, one of the techniques to ensure it is an explanation of a researcher's position. From the beginning of this study, I was convinced that the researcher is never an isolated or autonomous person within the research process.

During my stay in Ethiopia, two issues became apparent. Firstly, there was the issue of me being an outsider to the country and to the community I was studying. The issue of a researcher's membership (insider/outsider) in the group or area being studied is relevant to all qualitative methods, as the researcher plays a role both in data making and analysis (Ingram, Rosser, and Jackson 2005; Tinker and Armstrong 2008; Dwyer and Buckle 2009; Hamid 2010). As I have mentioned earlier, I conducted part of my fieldwork myself, and partly it was conducted by a research officer. As argued by Dwyer and Buckle (2009) rather than considering the issue of insider or outsider as a dichotomy while conducting a research, it is possible

to consider this issue as a continuum. In this regard, I clearly was located far much farther away from my research participants than my research officer was. However, even though my research officer was much closer to the community, at least because of speaking the Amharic language, still she was living in Addis Ababa, was educated, and did not speak Kambaatigna. We were both at quite distant from our respondents.

Secondly, reflecting on my position caused me to acknowledge also that there is no such thing as scientific objectivity. In this regard, I follow researchers who have been destabilizing and challenging the natural science assumptions (Harding 1986; Reinharz 1992; Jaggar 2007). I agree that all knowledge is 'situated' and can reproduce maps of perceptions reflecting various categories of the gender, class, race, and nationality of the researcher. The different positions in the space between myself, the research officer, and the research participants had impacts on issues of representation in the interviews and data analysis. I treated interviews as situated encounters that generated partial knowledge: in these situations, a researcher is a partial producer of knowledge, rather than a person who uncovers a reality and truth that is out there (Reinharz 1992). Throughout the fieldwork and the subsequent research stages, I asked myself how I could represent women's experiences and positions and how I filtered this information through my own experience. Moreover, to diminish the inequal power relationships that resulted at the very least from the fact it was me who was preparing the research, I attempted to make conversations more natural and less official. They took place in venues that were less intimidating for the interviewees. Moreover, I respected the daily routines of the women, which sometimes interrupted our interviews, and throughout my stay in Aze Debo, I always was respectful of local ways and norms concerning behavior or clothing.

4.8. Research limitations

After going through the research process, I would like now to indicate the limitations of the study and possible ways of improvement in the future.

Firstly, given that the topic concerned a deeply private issue in women's lives, significantly more time could have been devoted to investigating the meaning of pregnancy and motherhood and how it has mattered to women of different generations: this would have given me more insights into the realities of the lives of women functioning under different conditions and historical periods. As a result, this would have helped me to understand better women's responses of accommodation or resistance to certain aspects of medical norms that I investigated in this study. In the same spirit, I would like to have also included men in this study, responding

to the postulate that reproduction should be perceived as a concern of both men and women, not only of women.

Secondly, occasionally some research participants seemed to share the official story about maternal health services and the number of deliveries at home (which was 'always zero') and at the health center (which means that all women delivered at a health center). This could be related to the pressure with which government officials were forced to meet targets related to development interventions. Although research officers and I made clear that the research was not affiliated with the government, it was difficult sometimes to encourage women to share more information. This could lead to the criticism that the interviewees were not indeed telling us the 'truth' about their social lives and behaviour. One of the characteristics of the constructionist perspective is that studies can allow space for contradictions and differences in people's discourses, or within social networks, rather than focus on gathering social facts (Price and Hawkins 2002).

The problem of telling official stories has seemed to be present also in studies in which other reseachers have applied qualitative methods in Ethiopia: Jackson noted the same issue in her study "Health Extension Workers' and Mothers' Attitudes to Maternal Health Services in Tigray" (Jackson et al. 2016). Also, a recent study about maternal death reporting showed that civil servants wanted to present the best sides of their work (Melberg et al. 2019). In the WIDE project, the issue of telling the official story was also present up to extent and it was filtered by the social standing of a participant and an individual's life trajectory. Also, in other contexts where there has been some kind of coercion from the government, such as Cuba, studies have found that women may have structured their answers so that their preferences were aligned with the governmental agenda, which explained divergence from those imperatives of systemic poverty-related barriers (Johnson 2016). The lesson that might be drawn from these studies and from my own is that accounts of study participants have value not only because of their content, but also because they reflect certain positions and relations with those in power. In these cases, telling official stories was related to being aware of the potential consequences of criticism.

The third challenge related to the project was that finding an outgoing female respondent was a difficult task, compared to male respondents. During the WIDE research, I found that male respondents were more forthcoming when it came to revealing their opinions on various matters. Women in Aze Debo were not very open about revealing their personal stories, and there seemed to be a lack of sentimentality concerning childbirth. This likely could reflect a lack of analysis in the community concerning these experiences. Telling one's story and analysis

of the story require reflectivity and empowerment, which seemed to be in a short supply. There was also little evidence that women perceived maternity and maternal health as a matter of choice.

4.9. Summary

In this section, I outlined the research approach taken to understanding role of social capital for health practices of mothers based on the example of a rural community in Southern Ethiopia. I presented the rationale for selecting a qualitative case study approach, followed by site selection criteria and data sources. In the case of the latter, I presented the complexity of sources and also my approach to using them in this study. Later, data analysis and ethical issues were discussed. At the end, I presented my own positionality in relation to the researched and the research topic as well as discussed the research's limitations. In the next sections, I will present the empirical findings that emerged during the fieldwork conducted in Aze Debo.

5. Results

The main goal of this chapter is to present the results of the fieldwork that I conducted in Aze Debo in 2018. My own data are complemented by data gathered during Ethiopia WIDE research in 1995, 2011–13, and 2018 to give a broader perspective on processes in the study area. In doing so, the first Section, 5.1, *Background of Aze Debo,* presents the material conditions of the community inhabitants and the main sources of income that prevail in households' livelihood portfolios, as well as the biomedical health care system in the community. The reason behind such an approach is the need to explain in what environment women live and how their position can be defined within it. This will serve to contextualize the data presented in sections 5.2 to 5.4, where I structured data in line with the sequence of three research questions. In Section 5.2, *Forms and factors of women's social networks* I describe how women in Aze Debo established connections through conscious and unconscious practices and how the establishment of relationships was determined by social agents' objective conditions. Section 5.3, *Links between social capital and health,* discusses various health-relevant resources accessed through social networks by women. The last Section of the chapter, 5.4, *Factors affecting care seeking and health workers' situation,* discusses factors that affect women's decisions to seek care at biomedical health care facilities and the HEW's institutional situation in health care.

5.1. Background of Aze Debo

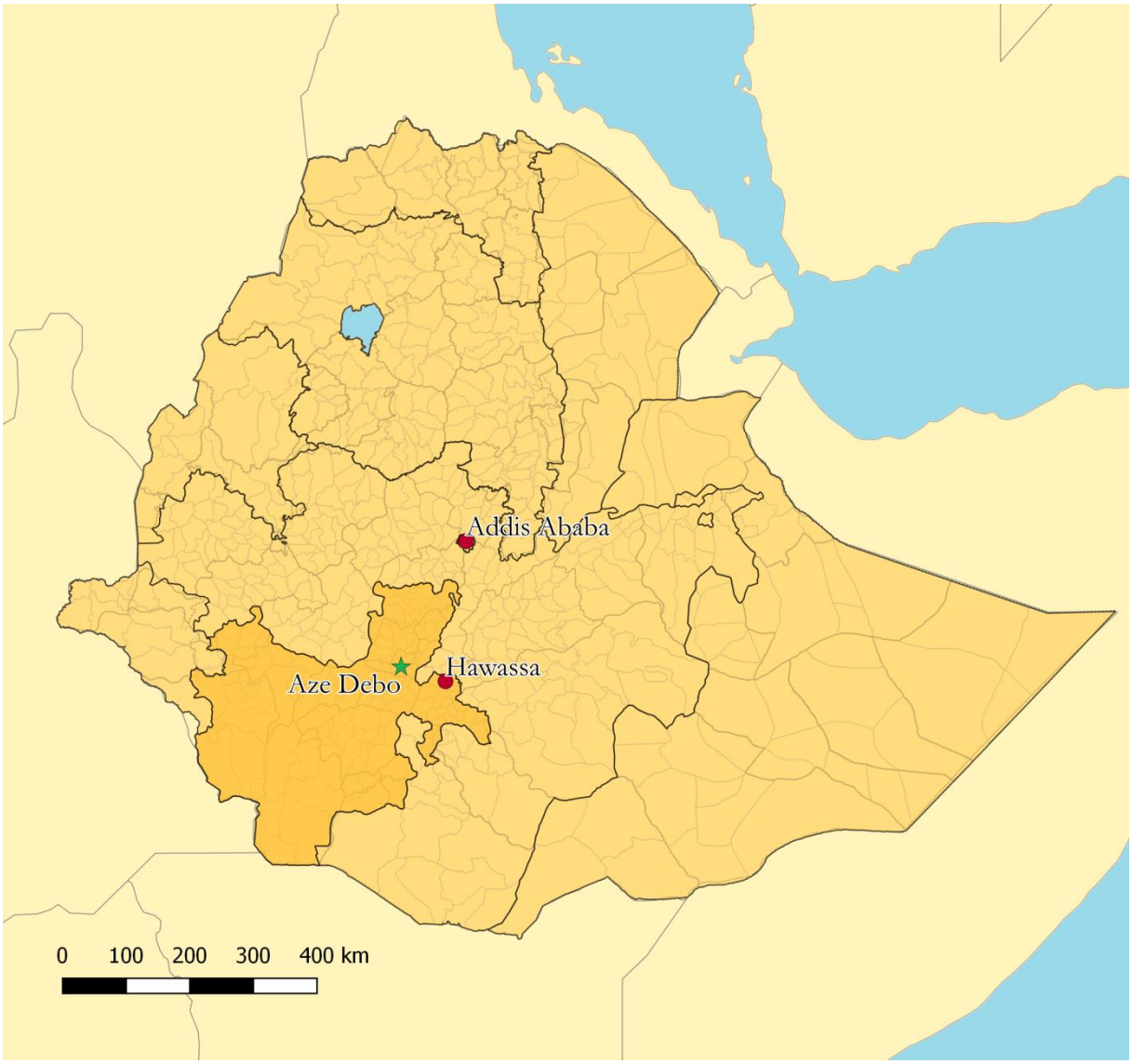
5.1.1. Location and history

Aze Debo[36] is a kebele located in Kedida-Gamela wereda in the Kambata-Tembaro zone of the Southern Nations, Nationalities and Peoples' Region (SNNPR). The kebele is situated 5 km from the wereda zonal capital, Durame, at a distance of 290 km from Addis Ababa along the Hossanna[37] road in a south-west direction, and 130 km away from Hawassa, a regional capital of SNNPR. The maps below present the location of the wereda and kebele within Ethiopia and within the zone (Map 1), as well as a topographical sketch of the village (Map 2).

[36] This section is based on WIDE data: Ethiopian Village Studies: Aze Debo (1995), Aze Debo Community Report 2011, and Aze Debo Community Report 2018, Ethiopian Rural Household Survey (2009) as well as my own observations. Besides, Aze Debo is sometimes called Aze Debo'a.

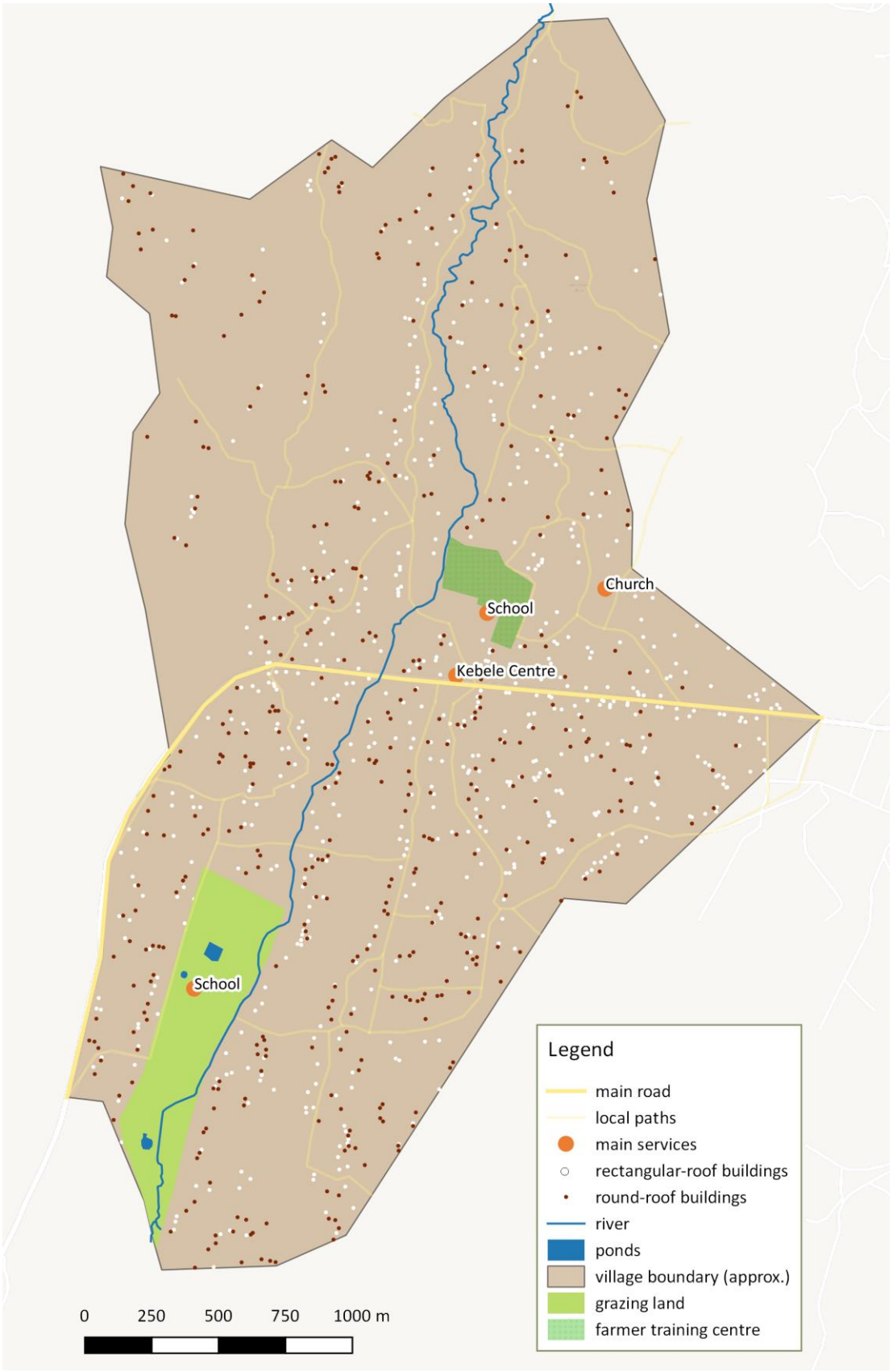
[37] Hossanna is a town and a separate wereda in SNNPR and the administrative capital of the Hadiya Zone. An older name for this town is Wachamo.

Map 1. Location of Aze Debo within SNNPR and Ethiopia



Source: own elaboration on the basis of OpenStreetMap layout.

Map 2. Settlement sketch of Aze Debo



Source: own elaboration based on Google Maps.

In terms of climate, much of the kebele area is *weyna dega* (midland and moderately warm) flat land[38]. The average temperature has been reported to vary from 12°C to 26°C over the year. The rainy season occurs twice a year, firstly from June to September (heavy season), and secondly, between mid-February and April. In recent years, however, these patterns have been changing: the weather has become more unpredictable and temperatures have been more extreme than in the past. The community is vulnerable due to recurring drought periods which hit the community in 2008 as well as in 2015.

The history of Aze Debo is set within the broader modernization that has unfolded in Ethiopia since the nineteenth century. The SNNPR, in which Kambata is located, was culturally different in comparison to 'highland Ethiopia', associated with the Amhara and Tigray regions. Historically the Kambata province, which was part of Ethiopia from the beginning of the early fifteenth to the mid-seventeeenth century, was governed by local kings. Amhara rule was imposed in 1892; however, because the political structure was characterized by centralized rule, this did not change Kambata deeply. A number of distinct features of the Kambata community structure remained, one of them being clans, which maintained their identity and survived even through the centralization tendencies of the nineteenth century.

In the first half of the twentieth century, Kambata remained a part of Ethiopia under the imperial regime of Haile Sellassie. Among the major events that affected the site under the Dergue regime (1975–1991) were land reform, resettlement, a literacy campaign, and military service. As a result of the land reform, many people who were tenants, and some who owned disproportionately little land, were allotted land. At the same time, some lost all or part of their land. This affected the social relationships among people in such a way that there has been reciprocal hostility between the people who lost land and those who received it. The literacy campaign in particular, and education policy in general, are some of the Dergue's most appreciated activities in the area. In the 1990s, numerous people believed that the Dergue did its best in this respect, 'liberating' many people from illiteracy and laying strong foundations for education. This tradition of high educational scores was also present in contemporary Aze Debo[39]. On the other hand, in 1975, the Dergue started national military service. They took the children who ordinarily would assist their elders on farms to the internal war front, as well as

[38] Ethiopia has most of its agricultural production in zones named *weyna dega* (highland areas from 1500–2300 meters above sea level) and *dega* (2300–3200 meters above sea level). In these two types of zones, land productivity overlaps with the densest rural populations. In addition, these agricultural zones are characterized by various moisture and temperature regimes. This, in turn, determines which crops can be produced in a given area. Crops that grow in *dega* and *weyna dega* are the most commonly produced crops in Ethiopia and dominate the portfolios of smallholder farmers, whose average land size per household is less than one hectare (Dorosh and Rashid 2012; Lowder, Skoet, and Singh 2014). The most popular crops in Ethiopia are cereals (teff, wheat, maize, sorghum, and barley), followed by pulses, oilseeds, and coffee as a major cash crop.

[39] See Community Report Aze Debo 2013, p. 108–115.

adults who were forced to fight unwillingly, leaving their farms behind. In general, the Dergue regime has been remembered as very painful and harsh for people in Aze Debo.

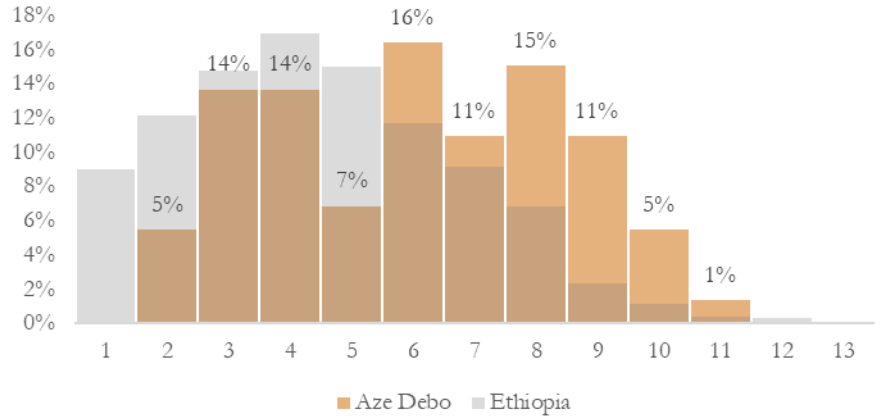
Natural hardships have hit Aze Debo several times. One of them was the 1985 famine, when people had to sell their cattle to purchase food, and some were sentenced to beg and even died of hunger, though nobody can estimate the exact number. Famine was followed by heavy rain and floods in 1988 and 1993. In 1994, famine once again seriously affected the area, and many people died of hunger and famine-related problems. A drought hit the community also in 2008 when nearly 30 people died because of a lack of nourishment, and around half the community sold all their cattle to buy food. The drought reoccurred in 2015, as it did in other parts of Ethiopia. Even though the contemporary situation in case of food security is better, Aze Debo remains vulnerable, especially to climate change and its consequences.

5.1.2. Household material conditions

There were around 1,038 households in Aze Debo in 2018 with total number of 7,105 people (3,455 women and 3,650 men). On average, there were six members in a household in Aze Debo in 2009 (Figure 7), as per the Ethiopian Rural Household Survey 2009 (ERHS 2009), but eight years later this number was said to increase to eight, as noted by the wereda officials during fieldwork in March 2018. However, it should be noted that the community has faced significant migrations, especially among its youth, as confirmed by many respondents from the community: within the past five years, around 150 men and 100 women have migrated to Addis Ababa or Hawassa, and there were around 50 to 60 international migrants, mainly to South Africa. Around 430 young people who had completed grade 10[40] remained dependent on their families and stayed at home with them, mainly because of the lack of job opportunities.

[40] The educational system in Ethiopia is divided into primary, secondary, and higher education. Elementary (primary) education is divided into the Elementary First Cycle (grades 1–4, ages 7–10) and the Elementary Second Cycle (grades 5–8, ages 11–15). After completing grade 8, students take the Elementary School Leaving Certificate Examination. Secondary education consists of the First Cycle (grades 9 and 10, ages 15–16) and Secondary Preparatory (grade 11–12, age 17–18). After the First Cycle (grade 10), students take the General Secondary Education Certificate Examination. After this, they can proceed to Secondary Preparatory (grades 11 and 12), or technical and vocational education and training (TVET). After both cycles, students can apply to university (FMOE 2015).

Figure 7. Number of people in households of Aze Debo comparing to Ethiopia



Source: own elaboration on the basis of ERHS (2009).

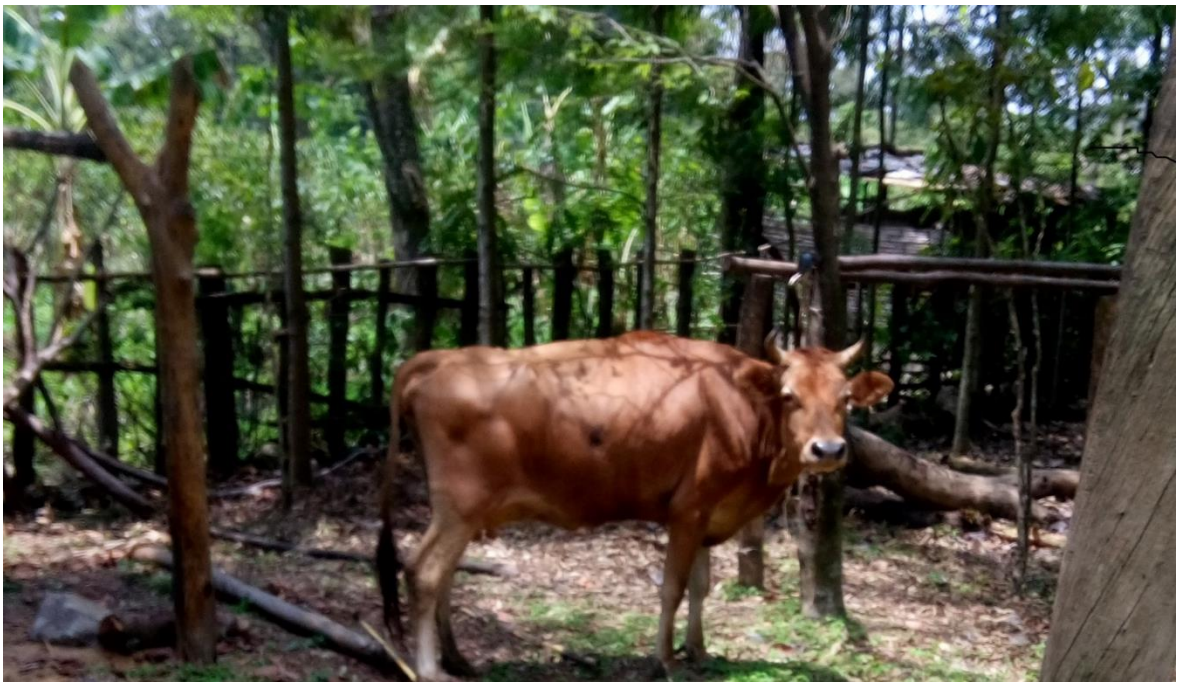
Most residences in Aze Debo were structured according to wealth status. The houses of rich farmers had brick walls, roofs made of corrugated steel sheets, verandas, and permanent access to electricity and appliances such as TVs, radios, and mobile phones. The living room was usually next to the entrance, the bedroom was in the back, and there was a separate kitchen; the latrine was on the side, or behind, the house. Households with medium wealth also tended to have a modern house (with a separate room for livestock, a kitchen, a sofa, and wooden furniture). Poor households had a traditional house: a hut or a corrugated iron-roofed house without a separate kitchen. Very poor households had a small hut shared by numerous family members.

Information about the most valuable forms of physical capital in an agricultural economy—land and livestock—indicated that most households were not in a very favourable condition. The majority of households in the community were smallholders having one or two timad of land. In terms of livestock, one of the most popular types was cattle (hybrid cows and bulls), followed by poultry and bees. The ownership of cows in particular has expanded, contributing to increasing dairy production. Around 80% of the community had at least one hybrid cow, and almost every household had chickens. Beekeeping has been a traditional farming practice in Aze Debo, but it seems that it has been small scale, as there was only one cooperative, some small-scale honey farmers, and five larger honey producers.

Photograph 1. Houses of poor and wealth people

Source: WIDE fieldwork. The photo on the right shows returee migrant's house with the modern roof below.

Photograph 2. Hybrid cow in Aze Debo ('Jersey')



Source: WIDE fieldwork materials.

A review of local household ownership of farm equipment showed that farmers used traditional methods for farming. There were no tractors, threshers, or harvesters in the entire kebele, and farmers mostly relied on traditional ways of cultivating their land. Moreover, although irrigation has a lot of potential, extremely rudimentary technologies mean that this potential was far from being fully exploited. Only modern inputs—chemical fertilizer and improved seeds—were widely distributed through government officials to the farmers.

To assess the overall material conditions of the residents, I used estimates for households' monthly food and non-food expenditures from the ERHS 2009 and complemented this information with evidence obtained through interviews and observation. The basic limitation of the ERHS dataset was the fact that estimates were based on the 2009 edition of the Ethiopian Rural Household Survey, in which Aze Debo was one of the communities investigated. The questionnaire enquired about household expenses in the following consumption categories: food expenditures, non-food expenditures, and household expenditures.

This evidence showed that monthly food expenditures were 60 birr per household (around 5 USD in 2009), two times less than in the other 19 WIDE villages. This result could be caused by the fact that many households were self-sufficient in terms of food provision. In case of Aze Debo, the more popular foods bought were coffee, avocados, kocho[41], tella[42], and fruits. There was definitely less consumption of vegetables such as onions, tomatoes, and cabbage, as well as sugar and salt, than in other Ethiopian regions. The most significant difference between Aze Debo and other regions was found in the purchase of stimulants such as strong alcohol or tobacco, which could be a reaction to the presence of Protestant churches that did not allow such substances.

In terms of non-food items, ceremonial expenditures, iddir dues, and donations to the mosque were smaller than in other WIDE communities. However, the total scale of non-food expenditures was quite similar. In Aze Debo, people paid more for drugs, traditional medicine[43], school items. Definitely less money was spent on construction materials, children's shoes, and school fees.

In general, these data support the claim that Aze Debo was a poor community in 2009. This conclusion seems to be confirmed by interviews conducted in 2018, which contained questions about perceptions of inequality in the community and changes in the past seven years.

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[41] Kocho is a bread-like fermented food, made from enset plant.

[42] Tella is a local beer.

[43] The term 'traditional medicine', when translated from English to Amharic to Kambaata, seemed to have a negative association among respondents. The government has initiated many policies that aimed at the elimination of 'harmful traditional practices' such as female genital mutilation or yearly marriage. The negative connotations could be responses to these initiatives.

According to local informants, rich people accounted for about 10% of all households in the community. Usually they were involved in both farming and trading activities, had more land[44] (i.e. one hectare or more), and family members in the United States or South Africa. Rich farmers were those who produced various crops and also reared livestock (poultry, bulls). Thanks to having cattle, their wives could work in dairy production and bring in additional income. Moreover, rich farmers were more resistant to prices fluctuations and fluctuations in productivity caused by climate change.

Middle wealth households constituted around 20% of the community members, and generated income from their farms products and small-scale trade. They had smaller plots of land than the rich people, i.e. on average one or two timad of land. Middle wealth farmers had limited chances to diversify their livelihood activities; however, some of them tried to sell eucalyptus trees, timber, or coffee on a small scale, and their wives mostly engaged in petty trade like selling butter, coffee, fruits, vegetables, and retail crops at the market. According to female farmers, they grew mainly teff, maize, coffee, vegetables (cabbages, tomatoes, potatoes, carrots, peppers), and fruits (avocados, mangos, bananas). Some of them had enset[45] plants. Those who migrated to Sudan, Djibouti, and Arab countries were mostly from middle wealth families.

Poor people were those without land, or those who had only a small amount of it (a maximum of 1 timad). They possessed traditional house without separate kitchens, generally had no migrants in the family, and often relied on cash transfers from the PSNP[46], a social protection programme funded by the government targeting food-insecure households (Frankowska 2019). In the local context, poverty was understood in relation to the residents' limited capacity to secure stable income. Poor households depended on state support and, due to a lack of resources, their ability to lift themselves out of poverty was constrained.

[44] Information about average land sizes is based on interviews conducted as part of Ethiopia WIDE and my own interviews. Data about land sizes in the country overall is available from the 2001/02 Ethiopian Agricultural Sample Enumeration, which is based on the World Census of Agriculture, the only survey programme that describes the entire farming sector for countries throughout the world in an internationally comparable manner (Lowder et al. 2014) every 10 years. The latest data for Ethiopia are from the 2001/2002 Census.

[45] Enset is large non-woody plant—a gigantic herb, up to 6m tall. It is also called the 'false banana' and is a staple food, especially in the Southern Nations, Nationalities, and People's Region.

[46] The PSNP is the second-largest social protection programme in Ethiopia and was established in 2005. The main goal of the progamme is to prevent households from the depletion of assets and to enable them to create new assets after a drought. To this end, the programme provides cash or food transfers in exchange for public works. Poor and vulnerable households with limited labour capacity receive unconditional (direct support) payments. Moreover, eligible households with pregnant or lactating women or infant children receive temporary direct support. The PSNP operates in chronically food insecure weredas in six Ethiopian regions: Afar, Amhara, Oromia, Somali, SNNPR, and Tigray.

5.1.3. Household livelihood activities

Rural households were involved first of all in agriculture, complemented by non-farming activities as well as migration. Around 10% of all households depended also on the above-mentioned Productive Safety Net Programme (Aze Debo Community Report 2018).

As mentioned in the previous sections, the farming activities in rural areas of Ethiopia are determined to a great extent by its agroecological zone, which determines temperature and moisture. Therefore, local agriculture in the study area was based mainly on enset (Photograph 3) and coffee production. Most farmers were producing crops such as maize, wheat, teff, potatoes, vegetables, root crops, pulses, and fruits (mango, avocados, apples). The major cash crop was coffee, which in recent years was attacked by a coffee disease that reduced the likelihood that coffee could remain a major cash crop.

Photograph 3. Enset – traditional staple food in Aze Debo

Source: WIDE fieldwork materials.

A household's arable land determines its farming strategies, and in the longer term, is often the major factor that influences the household's wealth. Given that the current government land policy is based on state ownership, rental markets pursued through sharecropping and cash rental are becoming increasingly important determinants of access to land. In Aze Debo, rich farmers who had larger plots of land did not have to share their land with others; they could afford

to rent the land and, in this way, could produce more. One rich farmer, who was also a big trader, had four hectares of land, but he also rented half a hectare of land from the school and another hectare from an individual farmer for sharecropping. A middle income farmer, in turn, had one quarter of a hectare of land, in addition to a garden and the land where he built his house. He had never rented it out. He did not trade much, but rather concentrated on farming exclusively.

Apart from crop production, livestock was also traditionally an important component of the livelihoods in Aze Debo. In recent years, its importance has been expanding compared to crop production. There is a clear gendered pattern in relation to cattle, with women dealing with dairy and men with fattening. Male farmers explained that there therefore was some competition between men and women within households. For example, when a man wants to give more feed to the bull he is fattening, his wife may argue to feed the cow instead; or when there is a need and animals have to be sold, the woman may say the bulls should be sold even though they are ploughing at that moment, whereas the man might want to sell the cow instead. One of the farmers said that mostly it is men that finance the purchase of hybrid cows by spending a big amount of money; however, due to the culture, women manage and control the income from milk and dairy products.

Photograph 4. Modern and traditional beehives in Aze Debo

Source: WIDE fieldwork materials.

As mentioned above, farming in Aze Debo was not mechanised at all, and farmers tended to use family members' and neighbours' labour. There were different farm labour mechanisms,

such as labour sharing (or reciprocal work), hiring farm day labourers, or giving work out for contract. Farmers helped each other during harvest, but the rest of time, most of them worked individually. It is possible to assert that, regardless of economic status, farmers relied on the work of family members or neighbours, but the use of other options depended on their wealth[47].

Wives, in addition to typical household activities like cooking and taking care of children, were involved in some farming activities. One of the typical activities of wives, irrespective of wealth status, was dairy production. For the past several years, dairy production has started to play a very important role in households' livelihood portfolios. Wives also helped their husbands sow crops and work on irrigated vegetables. They tended to sell and manage the income from vegetables, though their husbands were also involved in money management. According to information provided by a middle-income farmer, wives and children were also involved in irrigation.

Photograph 5. Road from Aze Debo to Durame – zonal capital

Source: WIDE fieldwork materials.

Apart from agriculture, households were involved in non-farming activities that included livestock and wood trade, petty trade, transport services to Durame (using bajajs, motorbikes, or minibuses), running shops in the kebele including small-scale tea and coffee shops,

[47] In the case of rich farmers, they can afford to hire farm employees from Aze Debo and Durame. One of the rich farmers mentioned that he helped four widows and their children by providing them with food/crops, and in return they assisted him on his farm. Middle wealth farmers use family labour, and support among them ('debo') during harvest was common. A middle wealth farmer relied on neighbours and family, and sometimes neighbours also worked together with them in rotation, mainly during harvesting. Poor households relied on the support of other households or the church. For example, a church leader ploughed the land of a poor female farmer.

and operating small businesses like bakeries or wood workshops. There was an increasing number of girls who had completed grade 8 or 10: usually they got married and were involved in household work. Men, in turn, have become increasingly interested in non-farm work. There was perception in the community that the trading of farming products (livestock and crops) and wood or running transport businesses were some of the options for the men.

The lack of job opportunities was a large problem for the younger generation. Unemployment combined with rising aspirations and a lack of land for establishing independent household pushed many to migrate from Aze Debo both locally and internationally. The main destination for work was South Africa and Arab countries, especially for young men from 17 to 40 years old. In the case of such destinations, relatives or friends were facilitating the travel, covering the substantial cost and asking them to work in their business. Migration to South Africa was associated with wealth and success. Migration to Sudan was also popular, especially among women. Migration to Sudan started when people from Aze Debo went to Humera (on the Ethio-Sudan border) in search of farm labour, mainly to harvest sesame.

Other people from Aze Debo have migrated to urban and industrial destinations within Ethiopia. This kind of migration was less important economically than international migration, but involved a larger number of people. Urban destinations included Addis Ababa, Hawassa, Dukem, Metahara (Oromia), and Tendaho (Afar), where people went to work in industrial sites or sugar processing factories. Working in industrial sites was said to be harsh and even dangerous; therefore, some people came back. Migration did not imply the breaking bonds with family left behind. On the contrary, many respondents mentioned that, thanks to migrants, they were able to invest in agricultural outputs, build a better house, etc. In general, migration influenced the status of a household a lot.

For some households, the PSNP was also an important source of livelihood. Since Aze Debo has been hit by drought, the village has been included in the programme since its onset in 2005. Recently the proportion of household under the programme decreased according to some respondents from 30% in 2013 to 10% in 2018. Support was provided in cash, transferred once per month. Those who were able to work had to contribute to public works such as the construction of internal roads, watershed structures, and ponds, environmental sanitation activities, work on the Farming Training Center farmland, livestock fattening, or cleaning the kebele compound and office. There were also exemptions for those who were not able to work, or for pregnant women.

The PSNP was regarded as a crucial support for very poor households, which were not able to withstand problems related to the drought, preventing them from falling into even deeper

poverty. One of the beneficiaries said that he "prayed for the programme to continue". However, opinions were rather mixed and mostly negative about the potential of the PSNP to change people's economic situation in a sustainable way. People mentioned factors such as dependency syndrome, PSNP beneficiaries abandoning work on their own farmland, and their inability or unwillingness/lack of interest to improve their livelihoods (Aze Debo Community Report 2018).

5.1.4. Health care services

Mapping of the healthcare field begins with the identification of relevant individuals, organizations or institutions present in the setting (Collyer 2017). The logics of the field structure the capacities of agents and gives shape to the choices that can be made. In 2018, health care field was dominated by state-led providers. Local health care system consisted of a health post, located in the kebele center next to the main road to Durame, and a health center in Bezena Benara, a neighbouring kebele in the same wereda, located around 5 km from the center of Aze Debo.

Photograph 6. Health post in Aze Debo

Source: WIDE fieldwork materials.

The health post located in the kebele center was supposed to have two Health Extension Workers[48]. The health post was built in 2007 together with other kebele buildings, such as the Farming Training Center, Development Agents' offices, and additional rooms for the kebele administration. It was well maintained in comparison to other health posts that I had visited in weredas close by. It had electricity and a latrine outside, but no running water. The health post had two rooms: one was bigger with wooden shelves, a desk, and chairs. On the walls there were many hand-written posters with charts in Amharic, showing the priorities for the health care sector and monthly progress. There were also many documents on the shelves: family folders and other types of medical documentation of patients coming to the health post. When it comes to drugs, health posts should have Coartem[49], oral rehydration salts, folic acid, and pills for family planning, but there were problems in getting a reliable supply. Community respondents noted a lack of drugs for some diseases, and also the high costs associated with them (Aze Debo Community Report 2011).

The basic point of contact for all those coming to the health post was the Health Extension Worker. HEWs are full-time, paid civil servants who are generally responsible for the implementation of Health Extension Packages, which encompass a wide range of areas: antenatal care, postnatal care, safe delivery, family planning, vaccination services, malaria diagnosis, and education against harmful traditional practices, as well as health treatment to some extent.

The health post was a relatively new innovation in Aze Debo since 1995. Data from 1995 indicated that Aze Debo's health care was dominated by traditional modes of treatment: people used to treat themselves at home, unless the disease got serious. Among the treatments were different plant-based therapies and practice of local healers. A health center was not in the community at that time; people used to get service from a government health center and a private health clinic in Durame. However, this health center did not have any doctor, and had only an irregular supply of drugs and vaccines. There was also a pharmacy in Durame. The nearest hospital was located in Hossanna, around 70 km from Aze Debo. Data from 1995 indicated that there was one traditional health attendant who helped with deliveries at home. However, in the 2000s, this person's role had decreased and relations with HEWs were unexplained. In 2011, a working traditional birth attendant explained that, before the deployment of the HEWs, great attention was given to training traditional birth attendants and many were able to provide effective delivery services. However, after some time, their work started to be 'ignored' by the HEWs. She had totally stopped working with them, but prior to this she would had taken women to the HEWs and assisted in various ways. She would push down

[48] During my visit one of them was outside of Aze Debo as she was attending education in another city.
[49] Coartem is a drug that treats malaria.

on the abdomen of the mother and massage immediately after the baby came out; she would dress the baby with clean cloth; she would tie the umbilical cord with a thread and cut it with a boiled and cooled razorblade. In the past, she used to assist two women per day. Nowadays, she explained, she was not attending even one birth in a month because many women were going to the health center for delivery. In 2018, officially there was no active traditional birth attendant in the community, and consulting private health providers was a rare practice.

Women could access the health center that is the neighbouring kebele, Bezena Benara. They were expected to get a referral from the health post, although this was not mandatory. Having a referral from a health center was mandatory for getting treatment at a hospital.

Maternal health services encompassed antenatal care (ANC), delivery at the health center, and post-natal care (PNC). In principle, as a part of ANC, mothers could get vaccinations, pregnancy supplements, and education on how to take care for themselves and react to potential problems. Women were supposed to attend four ANC visits, during which a delivery plan could be prepared and women who were assessed to be at risk could be referred for appropriate interventions. Delivery was supposed to take place at the health center, especially since the onset of the Health Sector Transformation Plan IV in 2011, when delivery at home was banned. Delivery at a health center required therefore travelling to a health center or, in difficult cases, to a hospital. The PNC was directed towards monitoring mothers and newborns in the first days after delivery, including educating mothers about danger signs (Bevan 2017).

5.2. Forms and factors of women's social networks

The analysis in this section is focused on the first research question: What are the main forms of women's networks, and what are the factors influencing their formation? In doing so, it consists of two parts. In the first part (5.2.1), I present parallel systems of community management in Aze Debo that regulated the everyday lives of inhabitants. In the second part (5.2.2), I present the distributions of actors' access to connections of potential health relevance within the village and with local authorities, according to their levels of economic wealth. This analysis examines Bourdieu's understanding of sociability as shaped by the actors' material resources, which condition investments in relationships, and dispositions, which bring together those of a similar social position (Bourdieu 1977). Besides, following Portes's argument (1998), I separate the sources of social capital from its consequences, and I look at the ways social capital was formed. This helps avoid a fundamental problem with Putnam's argument, namely its logical circularity: residing both in communities and individuals, social capital is a cause and an effect.

The present chapter relies on Ethiopia WIDE data from fieldwork rounds in 2011 and 2018 and my own fieldwork interviews conducted in 2018.

5.2.1. Local systems of community management

In Ethiopia, local communities like Aze Debo are characterized by the parallel existence of state-led and bottom-up governance systems. On the one hand, the existence of the system of kebele/wereda administration was inherited from the Dergue, who devised it as a means of communicating development plans and ideology, and of gathering information about anti-revolutionary activities (Vaughan and Tronvoll 2003). On the other hand, local associations are run by the community members themselves and are instrumental in organizing different social, economic, and religious matters. They could be conceptualized as state-led and bottom up fields of community managements, whose functionings intertwines with health care field.

These different organizations exert different kinds of power in communities. To understand power relations between bottom-up, state-led organizations and the community in rural areas, there is a need to consider traditional authority, religious position, gender, and age (Vaughan and Tronvoll 2003). Traditional authority in Aze Debo belonged to clans and iddirs—funeral organizations. There had been a view in the community that Kambata was stratified according to clan status. According to this view, members of higher clans were the most numerous and powerful, but the information on this topic was somewhat contradictory. Some male farmers stated that members from lower clans were sometimes excluded from access to different services, as the kebele "gives them less than they should". The community trusted clans rather than iddirs, which were said to be "used by the government". There were also strong views that any nomination to a wereda, regional, or national administrative position was based on clan membership. In contrast, young people admitted that their friendships could be based on school, church, or even kinship, but said that they were not based on clan membership.

Religious authority in Aze Debo belonged to Protestant churches, which were able to control some behaviors in the community, such as khat chewing or strong alcohol consumption. In the past, around eight to ten years ago, people coming from lower clans and poorer households were not allowed to take part in church services or take leading roles, but nowadays this pattern was changing. Women's role as evangelists had been also increasing in recent years. Age also played a role in establishing authority. The elders mediated conflicts (for example, about land, fighting, arguments, and threatening) and divorces. The elders were not representative of the entire community, and in Aze Debo there were no women among them. It should be noted that the women whom I interviewed belonged primarly to iddirs

and churches—this might be caused by the fact that I was interested in people who were involved in some issues important to women and health.

This community based-management structure, which was aimed at religious and social affairs, existed alongside the state-led management structure that took the form of the kebele and wereda administration. As mentioned in the Chapter 3, beginning in 1991, the government implemented a decentralization process, which affected the provision of public services at the lowest level. The process took place in three stages. The first phase involved a shift from a centralized system to a federation comprising nine states with borders drawn along ethno-linguistic lines, proclaimed in the 1994 Constitution. With the second phase of decentralization around 2001, the wereda was given responsibility for setting priorities, delivering services at the lowest level in rural areas, and determining budget allocation in line with national policies. The third and the most recent stage of decentralization took part after the 2005 elections, as a part of a 'good governance package'. This stage involved reform of the lowest administrative unit in Ethiopia: the kebele and its structures.

The kebele has an extremely important role for those living in rural areas, as it is the first point of contact for the rural population with the central state (Emmenegger, Keno, and Hagmann 2011; Lefort 2007, 2010). Various studies within Ethiopia have shown how the new institutional arrangement has altered the face of public administration and how it has affected state-peasants relations (Emmenegger, Keno, and Hagmann 2011; Lefort 2007, 2010; Vaughan 2017, 2019). The kebele is responsible for preparing an annual community development plan, collecting land and agricultural income taxes, 'mobilizing communities' to contribute to development projects (such as road construction or irrigation), and conflict resolution. It also covers issues related to identity cards, registers marriages, and is responsible for the distribution of various services and entitlements, such as cash transfers in the areas affected by drought. Therefore, it channels a number of resources that matter to the everyday life of the rural population.

The kebele consists of three entities: a legislative kebele council comprising people elected from the community and acting as the highest representative organ, the executive kebele cabinet whose members are elected by council members, and the judicative social court[50]. This administrative structure is prevalent to a similar extent in four major Ethiopian regions. However, it should be noted that this nomenclature of local administration is subject to considerable terminological confusion. This can be caused by the unclear division of work

[50] Justice consists of the social court and is strongly influenced by customary institutions. I omitted these organs as they were not relevant to the aims of this study. For more elaborated information, please see Aze Debo Community Report 2011 and Aze Debo Community Report 2018.

between the kebele council (which is the highest body and is meant to be a representation of the community, because it is elected from among citizens, but has a rather ceremonial role) and the kebele cabinet (which formally implements development interventions decided upon by the council, but in fact, does so as instructed by the wereda). Therefore, the kebele cabinet is sometimes called the kebele administration, or 'kebele administrative council'. The kebele chairman is sometimes called the 'kebele administrator' (Emmenegger, Keno, and Hagmann 2011).

One of the first reforms of the third stage of decentralization concerned increasing the number of kebele council members elected from among the community members. In 2011 in Aze Debo the number of kebele council members increased from 51 up to 200, which supposedly indicated that the representation of community was stronger. The council was tasked with evaluating progress on various development interventions (i.e. in education, land management, and health) which were set as a priority by the wereda. The mechanism of evaluation was called *gemgema* (criticism or self-criticism) and involved regular meetings during which kebele officials were evaluated for their performance in attaining development goals in the front of members of the council. In addition, the role of the kebele council was to provide advice to the kebele cabinet and 'to represent the community' (Aze Debo Community Report 2011).

Regular community members did not mention a lot about the kebele council in either 2011 or 2018. For example, in 2018 male farmers mentioned that kebele council members were living in the community and they interacted with them in day-to-day life. However, farmers had no issue to discuss with them individually in their role as kebele council members (Aze Debo Community Report 2018). This can be explained by the fact that it was kebele cabinet representatives with whom the ordinary people in the village had contact on a daily basis.

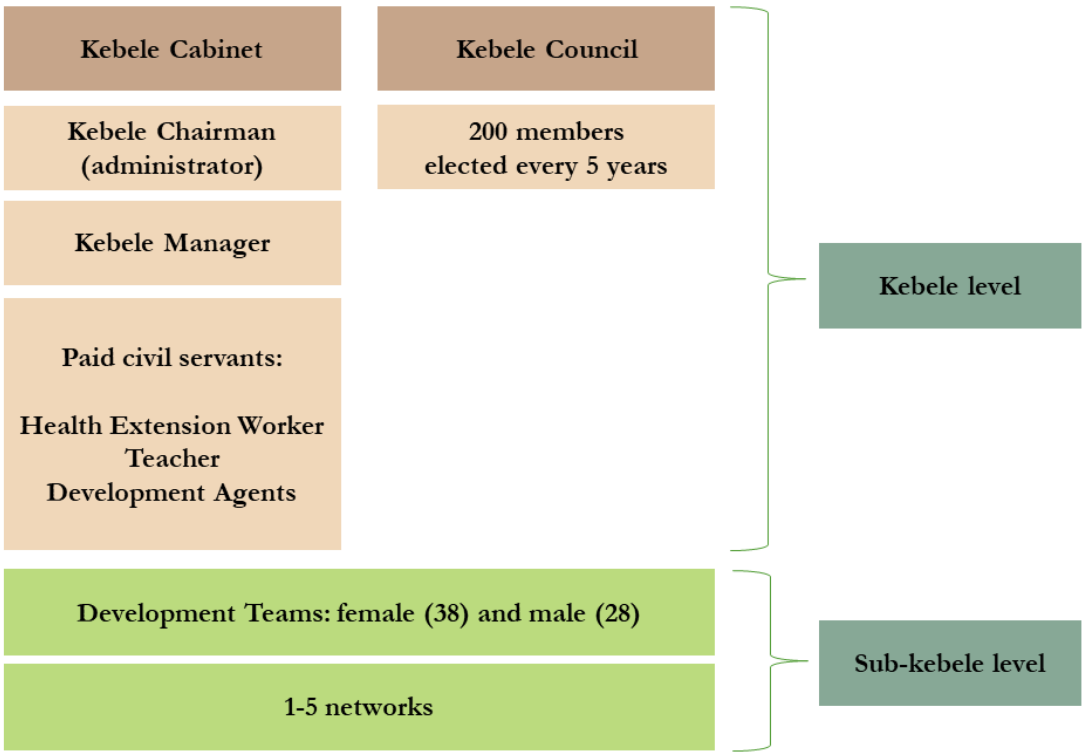
The kebele cabinet is an executive body that usually is led by the chairman. In Aze Debo, the kebele cabinet consisted of a chairman, his deputy (the kebele vice-chairman), the kebele manager, one Health Extension Worker, three Development Agents, and teachers. The kebele manager was meant to support the kebele chairman and to implement all development activities with the support of sectoral civil servants. In 2011, the then chairman was probably also the leader of the kebele's local branch of the ruling party. This overlap between party and state structures has caused difficulty in delineating boundaries between the state and the ruling party.

[51] Before the April 2008 local elections, kebele councils consisted of a maximum of 15 members including the chairman, vice-chairman, and secretary (Aalen and Tronvoll 2009).

Apart from strengthening the kebele's bureaucracy, the next element of the decentralization was the creation of Development Teams and 1-5 networks. In Aze Debo, there are 28 male Development Teams, which work within a sub-kebele structure called *gots* (Aze Debo Community Report 2018). Development Teams (consisting of 30 households) are led by leaders who organize the work of their respective team members, such as clearing and expanding internal roads and fencing springs, and the adoption of farming technologies for different types of crops (row planting, application of fertilizer and weed killer). There are also 38 female Development Teams, which are focused on health issues.

Development Teams consist of smaller groups: '1-5 networks', also called '1-5 groups'. Networks consist of five households living close to each other in one neighbourhood. Among them, one household is a leader. These are small structures, so that the households belonging to one network can easily communicate and discuss issues like debt payment, contributions, etc., and check each other's achievements in various fields (agricultural production and use of inputs, health packages, etc.). In 2011, there were reportedly 171 1-5 networks in Aze Debo. Figure 8 below presents the local government structure in the community.

Figure 8. State-led community structure in Aze Debo



Source: own elaboration.

Apart from the state structures, Aze Debo had the ruling party mobilization structures. Those directed at women were the Women's Association (200 members), the Women's League (having different numbers of members from 67 to 200, depending on the respondent), the Women's Federation (an umbrella organization for the Women's Association and Women's League, with around 800 members). However, despite the fact that these organizations existed, their roles and significance were rather limited. Among these three organizations, the Women's Association seemed to be most functional (Aze Debo Community Report 2018).

All members of the kebele council and the cabinet were members of the ruling party. The basic party structure in a kebele consists of smaller cells. In each village, there are three cells and in each cell there are 20 to 25 members. In 2011, the local party leader explained that there were 547 heads of household and all were members of the EPRDF party. Members of the community pointedly hinted that there was pressure to become a party member. One person explained that the government practice of directly and indirectly enforcing that everyone should be a member of its party was one of two things they resented. Another person mentioned that community members "are not comfortable with the pretentious policy of government towards democracy and the measures it has been taking against opposition party members" (Aze Debo Community Report 2011:121).

Photograph 7. Kebele administration compound

Source: WIDE fieldwork materials. Left: kebele manager's office; right: information tables.

The state-led government management structure was differently assessed by the local population. During informal conversations, community members mentioned that access to services could be conditional upon good relations with kebele officials, membership in clans, church attendance, or party membership. For example, an ex-soldier and model farmer complained that the chairman and other kebele officials favoured their families in the distribution of resources and that space for consultation with the community was limited. A person who used

to hold a position in the kebele was strongly convinced that nominations in the kebele administration were based on family and clan relationships. Moreover, perceptions of the decline of the government were strong, and were based on examples of corruption and defrauding of government funds (Aze Debo Community Report 2018).

Photograph 8. Meeting at the center of kebele

Source: WIDE fieldwork materials.

5.2.2. Formation of social capital

In the rich and dense environment of local management structures, women participated in a variety of organizations and networks beyond their family. Interviews with women revealed that the first group of connections consisted of state-inspired groups, which included female 1-5 networks and relations with a Health Extension Worker. A distinctive group enumerated by women were women's saving groups that were somehow integrated into the structures of 1-5 networks. It was said that teaching about the importance of savings is an additional duty of female 1-5 networks.

The second group of connections consisted of semi-formal organizations: iddir, women's prayer groups affiliated with the Protestant church and equbs[52]. Tables 12 and 13 below present respectively the main types of organizations to which my respondents in Aze Debo belonged and the mapping of their connections.

Table 12. Types of women's connections within Aze Debo

No	Type	Connection with health	Connection with government
1	Health Extension Worker and other civil servants	Responsible for state-led interventions	State-led
2	1-5 network	Responsible for state-led interventions	State-led
3	Women's saving groups	Overlapping with 1-5 networks	State-led
4	Women's prayer groups	Psychological support	Bottom-up
5	Iddir	Cooperating with 1-5 networks	Bottom-up

Source: own elaboration.

The comparison of women's access to different organizations shows that the connections were not entirely equally distributed. It appears that, firstly, all women of different wealth categories tended to belong to the same networks. Among the 12 poor women, 10 belonged to 1-5 networks, four to a women's saving group, and two to iddir, and no women participated in the women's prayer group. Only one woman did not have any contact with the HEW. Among eight women of middle wealth, four were members of a 1-5 network (including two leaders of 1-5 networks), three were members of a women's saving group, three were members of an iddir, and three belonged to a women's prayer group. Again, only three women did not mention contact with the HEW. In the case of the six rich women, there were two members of 1-5 networks (including one leader), three women were members of women's savings groups, two were members of an iddir, and one was a member of a women's prayer group.

While this distribution obviously does not have statistical significance, it shows certain patterns of connections. Firstly, it seems that 1-5 networks predominated when it came to declaration of participation, and followed by the women's saving group, iddir, and women's prayer group. Secondly, it can be seen that leaders of 1-5 networks tended to be richer women.

[52] Only one woman interviewed belonged to an equb – a community-based revolving savings and credit association. Equbs were not included in the table as only one woman belonged to one, which could be caused by two factors: equbs are not so popular in Kambata as compared to other parts of Ethiopia and secondly, equbs require contributions from members, and usually it is men within a household who control money.

Thirdly, membership in iddirs and women prayer groups tended to be higher among middle-wealth and rich women.

Table 13. Networks of respondents

No.	Age	Income Status	Contact with HEW	1-5 network	Women's saving group	Iddir	Women's praying group
1	25	middle	x				x
2	25	middle					
3	23	poor	x				
4	18-30	rich	x				
5	20	rich	x		x	x	
6	20	poor	x	x	x	x	
7	39	middle	x	x	x	x	x
8	32	middle	x	Leader	x	x	Leader
9	31	poor	x	x			x
10	32	poor	x	x			
11	40	rich	x	x			x
12	38	rich	x	Leader		x	
13	43	middle	x	Leader		x	
14	40	poor	x	x		x	
15	45	poor	x	x	x		
16	41	rich	x		x		
17	42	rich	x		x		
18	41	middle	x	x	x		
19	22	middle					
20	33	poor	x	x	x		
21	34	poor	x	x			
22	25	poor	x	x			
23	30	middle					
24	44	poor		x	x		
25	35	poor	x	x			
26	30	poor	x				

Source: Author's elaboration.

The question arises as to how these associations are formed and how they are taken care of. Within the social capital literature, there have been several propositions regarding potential factors that affect the development of extended networks of relationships in a given community or society. Putnam paid attention to diverse forms of civic engagement or actors' common culture (Putnam 1993, 2000). Other approaches centered on individual networks underlined

indicators related to network structure such as actors' socio-demographic characteristics such as age, gender, or education (see Hooghe and Stolle 2003). In the face of a variety of potential explanations, the qualitative examination below does not provide a full understanding of these factors, but rather attempts to explain the most salient factors that contribute to the understanding of the distribution connections presented in Table 13. This is in line with Bourdieu approach that postulated context-specific exploration of social capital (see Fine 2002).

Wealth level

One of the forms in which actors' material conditions determine their access to an extensive network of relationships refers to their capacity to afford the costs of preserving and strengthening a relationship (Bourdieu 1986). If we look across income groups, there is evidence that indicates the poorest households in this study faced material restrictions to developing more extended relationships in the community. Wealth status expressed through ownership of land and assets often went hand in hand with the respondent's location. People living in more remote areas, such as the hilly parts of Aze Debo, tended have worse access to various services, such as school, electricity, or water. Women from these areas frequently faced many problems when they needed to get to the health center for delivery, as the ambulance was not able to pass through the internal roads, which get muddy during the rainy season. Those who lived in the center of the kebele had better access to transport to Durame and various services such as shops; they were also more likely to have access to electricity, which could allow them to start business.

Women are responsible for housework and tend to have more tasks if they are poorer. In such a situation, they have to support their husbands with physical work and have less time to invest in relationships. Several women mentioned that their participation in networks (in general) was low due to economic constraints and the consequent work burden. For example, Respondent 9, who was a member of a church prayer group, said, "I attend a church prayer group and it gives me spiritual support. But I do not actively take part in any other networks since, whenever I have time, I assist my husband in casual work".

Another woman (Respondent 14), who participated in an iddir and an equb, and wanted to join a women's savings group, confirmed that, due to workload and the fact that husband needed support, she could not have been more involved in 1-5 network activities. Respondent 15 said that although she was formally part of a 1-5 network, she could not participate more as she had to work with her husband in casual work. However, she belonged to a women's savings group, in which they also "discuss health issues after prayers, which take place in rounds

in different members' homes". Respondent 1 did not participate in 1-5 networks, and she did not belong to a savings group; she had to assist her husband in trading avocados, so her social interaction in the community was less.

Work burden at home and taking care of children were barriers to activity in associations, along with the problem of contributing money to initiatives like savings groups. Respondent 9 said that she "resigned from this savings group as she lacked money to save on weekly basis". Respondent 20 joined a 1-5 network only recently, but did not participate in its life very intensively due to care of her children. Moreover, Respondent 24, despite the fact that she was a member of a women's savings group in which she saved 20 birr per week, had to stop participating as she did not have enough money to save. Respondent 22 was a member of a 1-5 network, but it was her mother-in law who actually participated more intensively; as she had two smaller children at home, she said her participation in networks and groups was minimal. She used to be a member of a savings group, but she terminated her membership due to a lack of money to save.

The above-mentioned respondents were all Productive Safety Net Programme beneficiaries. Their husbands found jobs in wage labour[53] (Respondents 9, 15, and 22). In the case of Respondent 15, her husband broke his leg around 2014 while he was cutting trees. As a result, he was not able to work well; rather, he was involved in some simple activities. In the case of Respondent 14, her husband "buys eucalyptus trees from people, cuts them, and breaks them to make them ready for use of house building". These activities were precarious, depending on the physical ability to perform them, what made these households more vulnerable. In general, the situation of the households of these women was characterized by a lack of assets such as limited or no land and a lack of cattle. This had another consequence, namely that these households could not access new agricultural inputs, notably improved seeds and breeds. Women from these households could not afford either to invest in relationships because of low wealth status, or to change their economic standing very much, as their hand-to-mouth low-return activities did not help them to start new, more profitable.

Of course, there were also other factors that determined what women did and how successful their efforts could be. These were both community-level economic factors and social norms concerning the division of labour, as well as individual characteristics, such as status within a household and age[54]. Aze Debo was located near a zonal town (Durame), but still was relatively remote and separated from bigger markets. Although there was a coffee processing plant inside the kebele, the work was poorly paid. Moreover, the drought, which

[53] Examples of wage labour include daily work on road construction, water development, and factory construction.
[54] This division into community- and individual-level factors was derived from Loveday (2017).

hit the community in 2015, was the most painful for the poorest households. They received cash transfers as a part of the PSNP, but the amount was too small to help them with more than survival. The problem of access to land seemed to be less painful for women and more problematic for men. However, it still mattered, as the lack of land and the lack of possibilities to establish an independent livelihood for men delayed marriage also for women. Status within a household mattered in terms of the type of activities available to a person, but this was again strongly influenced also by the wealth of a household. Running one's own business (such as a hairdressing place) was reported more rarely among poorer women who had not had access to initial capital (Aze Debo Community Report 2018). Also the possibility of migration, either within Ethiopia or abroad, was limited for these households, because of the initial capital needed for investment in the trip.

Among my respondents, there were, however, some women who were capable of becoming involved in income-generating activities on their own. Prevailing types of activities were the trade of dairy products (Respondents 8, 11, 12, 13, 18, 26) and fruits (Respondents 1,8, 12, 26). Often these households had a cow, which enabled dairy production and trade in Durame. However, the income from this activity was still helpful for meeting everyday needs rather than transforming these families' lives rapidly. Among my respondents, there were not women who had control over the household income, but in the whole of Aze Debo there were cases of women who were becoming more independent from their husbands thanks to the trade of dairy products. Only one respondent (Respondent 3), who was a certified female hairdresser, had managed to open a hairdressing shop. However, at the time of the research, she lacked capital to continue her business. In addition, the demand for hairdressing was less since Aze Debo was not an urban center. Due to this, she believed that she would not be successful; she felt that, to make success happen, she would need to move with her business to Durame. Another woman (1-5 network leader), who was also a female head of household, seemed to be quite successful despite being alone. She had a daughter who had migrated for work to Addis Ababa; when her husband died while working at a Metahara sugar factory, she came to Aze Debo, which was her husband's birthplace, and his brother gave her a plot of land, where she built a house. She did not have another plot for farming, but nevertheless, she was a butter trader. Because of a lack of land, she could not expand her activity.

There was also one economic activity in which only some types of women were involved; it was looked down upon by the community and seemed to be not appropriate for married women. This activity was the production of an alcoholic drink locally known as *areke*. Some of the respondents declared that there was only one areke house, which was opened

by a returnee migrant from Metahara in 2015, but in fact there were seven of them inside the kebele.

On the whole, it can be said that household poverty limited the possibilities for interaction with others. Poorer households relied on ad-hoc activities and cash transfers from the PSNP, but while these sources of income were sufficient for meeting everyday needs, they could not permanently change lives. Overall, there were various factors that influenced their household's ability to improve situation. On the one hand, there were community-level factors, like the fact that Aze Debo was a drought-vulnerable community and such shocks were painful mostly for the poorest households. Secondly, the wealth of a household determined the amount of time and assets that women had at their disposal. It seems that once a household was poor, there were not many possibilities to get out of the poverty.

Rules of customary organizations

As presented earlier in the chapter (5.2.1), Aze Debo has a number of local organizations. Although organizational participation has been seen as strengthening local civic culture (Putnam 1993), organizations display different features when it comes to access to their inclusiveness, rules of operation and internal dynamics.

From the point of view of the mothers whom I interviewed, the most important bottom-up organization was the iddir. In 2018, there were a number of iddirs such as the bigger and smaller iddir of mothers, and the main men's iddir for married heads of households. All of these iddirs contributed certain amounts of money monthly (ranging from 5 to even 30 birr per person), and made coffee and food for a person who had lost a family member. Although iddirs were considered as bottom-up organizations, it is difficult to say that they were totally informal due to the fact that they had an administrative structure. For example, the biggest iddir had administrative positions such as the leader, the vice leader (*sebsabi*), the treasurer (*hisab shum*), the secretary (*tsehafi*), and the store keeper (*gimjabet*) (Aze Debo Community Report 2011).

Iddirs are very important institutions when it comes to community-based social protection. Their primary role is protecting members in the case of family members' deaths. Death of a close family member can be very painful, especially for poorer households. Several households reported significant problems arising from huge mourning expenses in 2011. A poor elderly widow who lost her husband around 2007 after a three-month illness explained that, since then, the household had not been able to have any improvement because they had spent a lot of money on the husband's medication and were exposed to additional expenses during his funeral ceremony. Another 28-year-old man who had recently lost his wife during childbirth said that

he had spent 4,500 birr for her medication and funeral, which he had borrowed from neighbours. He had not yet finished repaying this debt even though a significant portion of the expenses (2600 birrs) had been covered by the iddir. He too said that this situation meant that he could not bring any change in his life (Aze Debo Community Report 2011).

Iddirs were involved in other activities beyond the organization of events around funerals. For example, in 2016 the mothers' bigger iddir had started to collect some savings and since then they had managed to accumulate some capital. They even had plans to start providing loan access to members to set up various businesses. The importance of iddirs was mentioned by several respondents in the context of development activities, as illustrated and more elaborated in the Section 5.3.

The information regarding the inclusiveness of iddirs indicated that there was an agreement that iddirs should include everyone, even the poorest. However, despite this opinion, there seemed to be differences between iddirs in terms of how people could participate. For example, in 2011, there were different kinds of iddirs for different types of members: iddirs for richer and for poorer people, smaller iddirs and at last one larger iddir (having even more than 400 people), and also women's iddirs. In the latter, the women's contributions were smaller than the men's (Aze Debo Community Report 2011). Therefore, it can be said that norms that regulate the work of iddirs are not aimed at exclusion, but unintentionally can strengthen division between iddirs and their members.

Moreover, changes in mourning practices in recent years have caused fewer people to participate in funerals, and these ceremonies have started to become more expensive for poor households. As noted in 2011, previously mourning could last a long time and many people from the community would be there, but it would not cost a lot as there was no tradition of preparing huge quantities of food and drink. However, nowadays rich people have started to prepare extravagant feasts for funerals and this recent trend of "wasting money on wedding and funeral ceremonies" has increased. One poor man explained that, in the past, boiled or parched grain with a cup of coffee was all that was prepared for attendants at funerals. However, since around 2007, attendants at funerals had been invited to eat injera and wot[55]. This 'extravagance' was especially the case for rich people—and in addition, their funerals are attended by many participants, so a large amount of food is needed. Some rich individuals have started to provide soft drinks and packed water for funeral attendants, which "costs a huge amount of financial resources and is beyond the capacity of the majority" (Aze Debo Community Report 2011:141).

[55] Injera is a fermented flatbread, traditionally made out of teff flour and served with a stew called wot.

There was also another type of community-based organization that was said to matter in the community—namely, clans and elders. These two were not mentioned during interviews by women. With regards to clans, in Aze Debo there were 37 clans. The three largest and most powerful clans represented more than 65% of the population: they were the Galla (descendants from Oromo), the Dubbo, and the Nurto. Political power has somewhat rotated between these three clans. There has usually been no conflict about this. The Galla are in fact politically dominant (even though, compared to the others, they are somewhat latecomers, and there still are some Oromo links e.g. with the names of some villages, etc.), just because they have largest number of people. The Dubbo are the most powerful economically, and the most educated. They were the first to convert to Protestantism and so had the first schools built on their land (Aze Debo Communiy Report 2013).

Clan leaders fulfilled important role in handling issues such as land border conflict, family disputes, and violence, together with the elders. There was some overlap in that most clan leaders were elders, but not all elders were clan leaders. People from the community spoke respectfully of elders, as noted by a middle wealth household head:

> *Elders are highly respected and play a great role in resolving the disputes in the community. They do not charge anything for their service and make peace between the conflicting groups. They also provide advice that is very essential in shaping individuals… they bless, advise.* (Aze Debo Community Report 2011:143)

It is important to note that there was a great likelihood that those who were clan leaders or elders were rich farmers or religious leaders who were also labelled as local elites. They had several common features. Firstly, they had economic capital in the form of land, livestock, and assets like bigger houses. Secondly, they had higher cultural capital—they were renowned for their speaking skills and also their ability to mediate in conflicts, as well as for their involvement in church life. Finally, they often had extended social networks, both with migrants beyond Aze Debo, as well as with officials within the kebele and wereda.

Among them, there were no women. If community respondents referred to 'an influential woman', her 'eliteness' was defined through the prism of her father: he was a well-known teacher in the kebele at the time of Haile Selassie, or was 'a well-known advisor' to the community and fought with Orthodox Church leaders, for which he was sent to prison.

Rules of state-led organizations

As noted in previous section, social capital analyses rarely take a perspective on the role of the state in building a particular type of network in a given community (Fine 2001). The case of Aze Debo shows that the role of the state is fundamental in creating formal associations.

In Aze Debo, Health Development Army networks were established around 2011 to 2012 and were directly driven by government effort. As can be seen from excerpts from official documents, the main focus of these networks was on values such as 'community ownership', 'mobilizing the community', creating 'responsible citizens' and so on. On paper, Health Development Army leaders were described as coming from 'model households' which were selected because of active involvement in other development work and acceptance by the community. It could be said that being a 1-5 leader implies a kind of distinction from being an ordinary woman. If someone becomes such a leader, she has to be a model woman in terms of adopting 'healthy lifestyles', meaning that she internalized certain rules of behavior that are in line with those in a dominant position (i.e. state-supported biomedical health care). The Army's aim was to strengthen and improve the Health Extension Programme and extend it deeper into communities and families (Maes et al. 2015a).

A woman who was a Women's League Leader and church prayer group leader described the structure and activities of the Health Development Army in the following way:

> *There are 38 women leaders who are leading 38 women's development teams. All these 38 leaders first get education about maternal health from a HEW. Then they educate their respective development team members. Then, in 1-5 development teams of women, also the leader further educates their respective members in detail. So, these networks or structures are most important because they are vital for transferring information, education, and messages sooner. They are mechanisms for faster messaging or educating since the HEW cannot reach and educate each and every woman in the community*.

The type of work promoted by the Health Development Army was strictly related to the issues around the health and reproductive aspects of families' lives; therefore, it strengthened, rather than challenged, the existing role of women as attached to the reproductive side of life. This was especially evident if one looked at male development teams, which were focused on farming. The rationale behind such a division and separation of men from women was to give women the space to speak freely and to express their opinions.

In the case of other networking opportunities promoted by the state, it is worth looking at livelihood cooperatives. In this case, the kebele promoted participation mostly in farming cooperatives, which necessitated that this encouragement was directed more to men rather than

to women. In 2018, there were several types of cooperatives, focused on bull-fattening, irrigation, bee-keeping, poultry, and dairy production. Among these, women mainly worked in poultry and dairy production cooperatives; these groups were considered quite successful, although cooperatives on the whole were assessed by many community members as ineffective. However, it should be noted that these cooperatives met the needs and possibilities of married women, i.e., the category of women to which my respondents belonged. It seems that younger, unmarried women were those who tended to benefit neither from economic interventions addressing the needs of youth nor from those targeting women. For example, in 2018, a young woman said that the government offerred possibilities only for men and not for women (Aze Debo Community Report 2018).

Religion

Protestant churches in Aze Debo were highly valued and respected institutions in the community. This was because a number of changes were assigned to them, especially in terms of the provision of health and educational services in the past. Key community informants explained that Protestant leaders (mainly Kalehiwot and Mekaneyesus) and their missionaries were influential and highly regarded by the community for several reasons:

> *Firstly, the community is aware of their role in converting them from traditional religions to Protestant Christianity. Secondly, they were the first to have opened schools and built health institutions on Kambata soil, since the 1920s; in this way, they have highly contributed to the success of many individuals from the area.* (Aze Debo Community Report 2011:28)

What is important, there were also strong ties among members of the same Protestant denomination in different kebeles. For instance, Protestant followers in Aze Debo raised money and assisted co-religionists in other areas. They also organized spiritual conferences together (Aze Debo Community Report 2011). Different community members noted that not attending a church programme was equivalent to exclusion from the community. Moreover, many respondents indicated that their church and co-religionists were their main support in life – spiritually and otherwise. Those living in South Africa were sending money not only to their families, but also to mother churches as offerings. As a result, some churches had constructed huge buildings for their congregations.

Photograph 9. Protestant churches in Aze Debo

Source: WIDE fieldwork materials.

It seems that Protestant churches promoted more horizontal relations among people, which enabled accommodation of difference among people much more than in the Ethiopian Orthodox Church present in highland Ethiopia, in which society has been deeply hierarchical (Mohammed 2018). Of course, within Protestant churches there was no discrimination based on economic standing. These churches had a role in shaping greater acceptance towards potters, who come from the Fuga clans[56], which have been despised and marginalised in the past. Giving more space for individual freedom and acceptance of difference was also visible in gender relations in the Church. Some women whom I interviewed were church prayer group leaders. This was assessed by respondents as a change in terms of gender relations, because in the past women were not allowed to be leaders.

It is also likely that the Protestant philosophy may have contributed to changing patterns of achieving power in the community. The achievement of higher status is based on merits, for example, in the area of education. This new script of acquiring leadership skills both in religious and social settings could change the social structure (Mohammed 2018). This meant that it was not only the traditional elders or clan leaders who were taking power, but also other people who were not so obviously renowned. The script for good conduct in life went beyond education, and also concerned 'performing well' in other areas of life. This view seemed to be confirmed by wereda officials, who underscored the influence of the Protestant doctrine on people's lives. For instance, polygyny was very rare and widow inheritance had virtually

[56] The older literature has mentioned that, in Kambata, there were two groups of marginalized minorities: the Tumaano (smiths) and the Fuga (tanner-potters). The Fuga were marginalized to a far greater extent that the Tumaano. Fuga often were isolated from the rest of the population, and frequently considered impure because they eat the meat of animals that have not been ritually slaughtered (Wolde-Selassie 2003). In recent years, the distinction between ordinary community members and Fuga has started to decrease, even if up to some extent it still exists.

disappeared. Local traditional drinks like *selo* and *gesho,* which used to be sold at all markets and along the roads, had been replaced with a barley-based non-alcoholic beverage called *shaimeta.* Also, the consumption of *khat* was condemned.

In some areas, churches have also provided space for presenting state-led interventions. These areas concerned raising awareness about HIV/AIDS (the wife of a middle-wealth man said that "it happens after Sunday mass"). In other cases, churches have reinforced a government message that would have been a church message even if government was not paying attention, like in the case of combating discrimination against groups like craft workers. In other cases, they have carried out service delivery activities that have strengthened the implementation of a government policy, because it was a priority for their congregation (like in the cases of the construction of drinking water points). Finally, the churches organized their members to support the most vulnerable individuals in the community either financially or, more often, in the form of labour.

An important feature of both customary, state-led and religious organizations was that those residents who were leaders in one association usually had a comparable position in other local organizations, both bottom-up and state-led. To name a few examples of 'multiple roles' among my respondents: the church prayer group leader was also the leader of the Women's League group; another woman (Respondent 8) was the leader of another church prayer group and the leader of a 1-30 Development Team. Respondent 12 was a leader of a 1-5 network and automatically a member of the 1-30 Development Team, and also belonged to an iddir.

However, sometimes competing priorities forced the women to choose one among their multiple roles. In the case of Respondent 8 (the leader of a church prayer group, the leader of a 1-30 Development Team, and the leader of a goods-producing group), she had to choose the role she wanted to perform:

> *As for the cultural goods-producing group/women's self-help group, this association was organized by a Siqqee women's development organization. Initially it had 17 members, but two members have left the group. In this group, we are saving money. Some of the members wanted to get a share of their money, but I gave them advice to strengthen our group by increasing our capital so that it will be a well-known self-help group even at the zonal level. Formerly I was a chair for this group but as I had more of a role in other development teams, I informed the group to select another chair and accordingly they selected another one.*

Moreover, it happened that if people participated in a meeting of one group, they also discussed matters that were important to another one. For example, women belonging to the same church prayer group got together, prayed, and later discussed issues related to collecting

money as part of their 1-5 group's saving activity. Therefore, the convenience of having several meetings at once meant that often the same people participated and sometimes meant that the same people were leaders.

This pattern was illustrated by a woman who was the leader of a church prayer group and the Women's League. She said that after praying at homes they talked about maternal health:

> *I have four children. Between these deliveries, there was some time interval. I advise other women to use a family planning service so as to have some gaps between deliveries so that they and their children will be healthy. The women's prayer group I lead has a weekly prayer programme on every Friday afternoon. It is held in a member's house turn by turn. In this prayer program, after we finish the praying, I teach the members about maternal health. Sometimes also the HEW goes and teaches them about health.*

The fact that these roles are concentrated in a few hands could be caused by several factors. Firstly, the responsibilities of these local leaders indeed meant that having such positions required time and resources that not everyone could afford. For example, the leader of an iddir has to organize meetings, mobilize their people, and also interact with the kebele administration. This can be very time consuming, not only from the point of view of the substantive content of the tasks themselves, but also because of issues like distance in the community and the possibility of informing people. Secondly, assuming roles in a hierarchy of state-led and bottom-up organizations requires a certain level of education (for example, for the position of treasurer). This was the case for Respondent 5, who became a secretary for a savings group because other members could not write, or a Women's League leader who was appreciated by the community because of her speaking skills. Although education levels have increased in the past years in Aze Debo, going to university is not an obvious decision, as it is also related to the wealth of a student's household. Therefore, it is likely that a woman who goes to the university must be richer than other girls, who usually finish their education at grade 10.

Among the mothers that I interviewed, one rich woman in her 40s was exceptional in terms of her education. In this regard, her life story seemed to be distinctive in the way she did not comply with the perceived injustices in her life. This woman was not from Aze Debo, but she came to the village when she got divorced from her first husband and got married to a man from Aze Debo. She was educated up to grade 10; despite her wish to continue her education, she did not have the money to cover the fees, so she had to stop. She got married and gave birth to four children. After she gave birth to her third child, she joined Ethiopian College in the town of Shone and started learning accounting through a distance programme in classes over the weekends. She had studied for two years, and she was to graduate the next year. At that time,

her husband was also studying in high school. Even though they were married, both were studying. Her education enabled her to assume positions within the kebele—as a volunteer, but also as a secretary for the World Vision programme aimed at improving women's livelihoods. When her husband married another wife, she knew that having two wives was a crime, because as she said, "I am educated". She took the case to the court, which basically shared equally the assets of their households, but in the end it was her husband who prevented her from benefiting from this ruling. The story of this woman shows that having education can enable assuming community roles, but also emancipates women in the sense of giving them conviction about their own rights. In general, however, these cases of women who were able to openly voice their opinions, or be involved in local political, administrative, and development leadership were very limited: in practice, they were exceptional individuals.

Gender

Women in Aze Debo tended to mobilize a different set of networks than men. It was possible to notice that interaction among women was conditioned by the common practices and routines associated with their traditional domestic responsibilities as wives and mothers. Domestic responsibilities implied rather similar daily schedules, which created greater opportunities for interactions among women. For example, a woman tended to move into her husband's home after marriage and live in her mother-in-law's compound. Such a situation might limit possibilities for interactions with social networks in the woman's previous community. As most of the time husbands were working on the farm, women tended to spend most of their time together: this was the case for six of my respondents in Aze Debo (Respondents 2, 4, 5, 7, 9, 14). Moreover, they had lived on their mothers in-law's compounds. Consequently, they had a lot of interactions with their mothers-in-law and with their neighbours. In the case of Respondent 4, her mother-in-law assisted her with household chores and when she was busy during pregnancy, she took her to the health center when she needed to deliver. Respondent 14, whenever she lacked food when her husband did not earn anything from wood sales, asked her husband's mother, who usually gave her some grain.

Photograph 10. Women in Aze Debo in the front of health post

Source: WIDE fieldwork materials.

Moreover, due to the nature of their work around care for children, women's mobility was also more restricted than men's was. They stayed at home for housework or, if they worked beyond home, it was in a location close to their home, like a coffee processing plant in the kebele.

Thus, in this manner, women's objective conditions affected their chances for interaction. Daily routines made women attached to their home area, and they were not used to public speaking. This limited exposure to community life, especially in the case of poorer women, affected their overall ability to be involved in the community management structures. Sometimes young married women were not confident enough and deferred to their husbands' interactions with the kebele. In Aze Debo, a woman in her 20s from a middle-wealth household said: "Since I am a woman and newly married, I do not have any role in any cooperative or government intervention" (Pankhurst 2017:202).

Photograph 11. Women's participation in watershed project

Source: WIDE fieldwork materials.

On the other hand, it cannot be said that women's situation and gender position within the community has not been changing. Data from 1995 presented quite a rigid picture of 'ideal women':

> *Desirable qualities for women are neatness, being able to make good crafts, being a good cook […]. Undesirable traits in woman include not obeying their parents, not obeying the husband and parents, committing adultery, etc. On the other hand, 'Qualities desirable in men (according to men respondents) are intelligence, cleverness at administration, being a hard worker, generally being educated and natural cleverness even without going to school.* (Bevan and Pankhurst 1995:14)

As we can see, the qualities 'desirable' for women were those associated with the house. However, over time, the possibilities for women have started to change: women in 2018 were much more courageous when it came to outfits, they migrated a lot to improve their quality of life, and they also wanted to be educated. Some of them even worked within community structures, like the kebele manager who had completed a bachelor's degree at the university

or the women associated with the milking cooperative, where they were able to challenge existing gender norms. On the one hand, this was welcomed by the women themselves, but men found it as challenging, because women were more outgoing than in the past.

Remoteness

Spatial contiguity is assumed to facilitate the interactions between agents, potentially promote community cohesion, particularly if people have been living in the same area for a long time (Halpern 2005). In this study, it was possible to observe that spatial proximity was first of all related to the creation of 1-5 networks, but also to other forms of mutual support like livestock sharing, especially when it was embedded in kinship-based relations. Spatial contiguity was associated with the division of land between relatives as a part of inheritance. In the past, it was a part of Kambata culture that men owned the land and females did not farm alone. It was a male head of household who decided who inherited land—in the most cases, it was sons who inherited land. Daughters in principle did not have any right to land, since they did not live with their family, but moved to their husband's house after marriage (Ethiopian Village Studies: Aze Debo, 1995). On the other hand, there were some women in the 1990s who owned land: either because the male head of household had died and the children were too young to inherit; or the women were divorced and lived on their fathers' land by getting some share of it; or their fathers did not have sons. This rigid system of inheritance started to change in recent years. Women started to be aware of the new government law that they could claim inheritance. Women's Affairs offices have been very active in the promotion women's rights to land. Within the past decade, no woman has been removed from the land when her husband died. Besides, a Women Association leader in Aze Debo explained that "in the course of the last year, the association reported the case of a widow whose plot of land was taken away by the brother of her deceased husband. With the support of the wereda women's association and the kebele administration, they were able to return the land to the woman" (Aze Debo Community Report 2018:151). It seems, therefore, that women did not access land in great numbers, and still mostly moved to their husbands' land. Changing one's place of living was not so easy, regardless of the location in the kebele.

It seems that those who were living on the outskirts of Aze Debo did not have much space for changing their situation. This location was not promising when it came to interaction with one another regularly. Locality also determined access to medical services. Some of the households living in the hills were cut off from the kebele center and from the main road to Durame, especially during rainy season. One of the major problems related to living in this

area was getting to the health center for delivery. A Health Extension Worker mentioned that "it happens that women living on the mountains decide very late to deliver at health center and therefore they give birth on their way." In 2011, a widow mentioned that her house was far from all health facilities, including the health post. As a consequence, her household and their entire village had no access to electricity; roads were inaccessible by vehicles even in the dry season, let alone in the rainy season (Aze Debo Community Report 2018). The problem with access to services was also noted by 1-5 network leader:

> *There is a drinking water problem in the mountainous area. It would be good if the government would improve the water infrastructure in the community. Also, there is no electricity for most households in the kebele. So, to enhance people's lives, I would also like it if the government would install electrification in the future.*

Similarly, fetching water from its sources is not an easy task, and it takes more time in the hills than in the lowland villages. Furthermore, the location is highly exposed to flooding and massive soil erosion during the rainy season; on some occasions, households in the village had lost some of their crops. The 1-5 network leader underlined that significant improvements had been made in minimizing the magnitude of these problems by constructing terraces, planting trees, and rehabilitating gullies, especially in communal holdings. However, no soil and water conservation activities had been carried out in her holdings as she did not want this. Additionally, she explained that she did not use any extension advice or packages like improved seeds, fertilizer, and other inputs, which was a consequence of being far from the kebele center.

5.2.3. Summary

This section started by presenting the system of community management at work in Aze Debo. This system consisted of a state-led community management structure and, at the same time, a bottom-up system of community management aimed at regulating social, economic, and religious affairs. Then, I provided an overview of the type of organizations that mothers participated in. These were bottom-up organizations, such as iddirs and Protestant church prayer groups, as well as state-led organizations such as 1-5 networks overlapping with the activity of women's saving groups.

The structure of women's network shows that they were primarily focused on organizations concerning religious affairs (like church prayer groups), or on networks that

were obligatory for them, such as 1-5 groups which were directed towards women's reproductive role.

The accounts about network formation led to the following thoughts. Firstly, there were a variety of factors that appeared to condition the process of network formation in the area of the study. These factors included: material restrictions, norms of inclusion for customary and state-led organizations, the role of Protestant churches in promoting horizontal relationships, gender, and remoteness. These factors worked in combination, producing different results. For example, my respondents were grouped in 1-5 network because there was a state-led effort. However, they were also socializing with each other because they were living close to each other and had gender-specific lifestyles (such as the fact that they had to stay mostly at home to take care of their children). There were also social norms which still limited their mobility. These women (who were mothers) therefore were more likely to socialize among themselves rather than reach out to people who were not directly in their closest neighbourhood. In Bourdieu's language, the process of formation of these women's networks was the result of the gender- and material-based position that the women occupied in their social space, rather than clear-cut conscious, calculated strategy. Establishing networks was rather immersed in everyday practices.

Secondly, because relationships were established in the course of everyday practices, it often happened that meetings of one organization were an occasion to discuss also issues related to another one. Sometimes it happened that the leader within this first organization assumed also the second leading position. This could lead to a situation in which people who had extended networks and interacted with others on an everyday basis could establish more of these connections and could concentrate many positions in one hand. It was not only the issue of everyday interactions but also the fact that these people could have more time to interact with each other, because they were richer, or they had higher education that was a requirement on a given position (definitely a requirement within the kebele cabinet, but also necessary to become someone like the treasurer of an iddir). In Bourdieu's terms, these people had higher economic and cultural capital. This could lead to a situation in which poorer people, who did not have such forms of capital (for example they did not have economic capital, so they had to work more at home), could not access these relationships and were less likely to develop networks. On the other hand, those who that assumed those positions, in turn, were in a better position to extend their networks as part of their respective responsibilities.

Thirdly, it could be argued that women did not establish networks only within the home space—they also participated in numerous associations: 1-5 networks, iddirs, prayer groups,

and savings groups. In this regard, the power of the central state was significant in defining the type of network women were involved in. While women participated in health-oriented 1-5 networks, which were associated with their reproductive role, men were grouped into cooperatives that addressed their productive role, or were more involved in the kebele's public issues.

5.3. Links between social capital and health

The present section aims to respond to the second research question: it explores different consequences of social capital for women's health practices in the area of study. As networks by themselves have limited value if they are not able to facilitate access to capitals relevant to a given field, there is a need to study simultaneously both networks and the social resources that are embedded in them. This is in line with the definition of social capital as per Bourdieu within the theory of practice. The literature about social capital and health has mentioned several mechanisms influencing health practices, such as social support, social influence, material support (Berkman and Kawachi 2000), and social control (Portes 1998), to name a few examples. In this section, I look at mechanisms that occurred in the field rather than trying to apply notions from the theoretical literature.

5.3.1. Health education

The first mechanism through which social networks affected women's health practices was health education. In the Ethiopian policy documents, the logic linking education and health outcomes has assumed that the "status of individuals or groups with regards to their wealth, education and access to basic utilities such as water, electricity and road determines their access to health care and ultimately, their health outcomes" (FMOH 2015:55). Not only is general school education important for health, but also direct health education. Health education has been one of the major areas of the Health Extension Programme, along with promotion of hygiene and environmental sanitation; prevention and control of major communicable diseases; and promoting and providing family health services (FMOH 2015). Education has been said to create awareness and demand for health care services, as well as ensure "community participation in planning, implementation, monitoring and evaluation of health activities" (FMOH 2015:92), which in the longer term will empower the community to manage their own health and contribute to the community's development (Meseret and Yihenew 2004). Such an approach to education has assumed the removal of the top-down approach in which

experts have told ordinary community members what they should do, but instead, has assumed that women incorporate certain behaviours so that they become their own dispositions. The new model of care during pregnancy has assumed that women go for antenatal care, deliver at a health center, and make use of post-natal care. In a policy view, demand for these services needs to be created and education conditions maternal outcomes as much as the material circumstances of the community and the availability of biomedical infrastructure.

Nevertheless, the policy concept of care in pregnancy and approach to birth have remained in opposition to traditional birthing culture. In rural Ethiopia, childbirth used to take place in the home. Generally, local communities in Ethiopia perceived that the resources and knowledge necessary for a healthy pregnancy were available within the community: women should not travel long distances or expose themselves to the sun. Pregnant women did not want to tell people about their condition, so the pregnancy was often camouflaged for as long as possible. Studies indicated that women did not want to be exposed to others during pregnancy, did not want to show their genitalia, and did not want to be exposed to the cold that is characteristic of health facilities (Pankhurst 1992). Moreover, the kneeling position was seen as a proper way of giving birth, instead of lying on the bed. Many women appreciated the fact that they were assisted by others who did not intervene very much in the labor, but instead only assisted and provided care during delivery.

This 'traditional' birthing culture' and perceptions of proper care during pregnancy and childbirth were meant to be changed with the use of certain brokers: Health Extension Workers, the Health Development Army (i.e. 1-5 networks), and iddirs. The change strategies included: provision of health education during house-to-house visits (e.g. by helping mothers care for newborns, cook nutritious meals, and construct of latrines and disposal pits) as well as conferences; identifying and training model families who were meant to set a good example in the area of health, and also HEWs setting a good example for others.

Health education through door-to-door visits was one of the major activities on the Health Extension Worker's agenda. They made up around 70%–75% of her work. The Health Extension Worker said that "in the past, when women were not yet convinced of the benefits of delivery at health center, people were sending dogs to her, but now it is better". Door-to-door-visits are a chance to follow up on women who basically stay at home and therefore ensure that they go for ANC in a timely way, as well as an opportunity to check other things, for example whether a household has built a latrine.

Another health education strategy was community conferences for pregnant women. Conferences were led by the health officer from the health center, who taught women about how to take care of themselves during pregnancy, what and how they should eat, and that they should immediately go to the health center if they felt some pain. The pregnant women were also reminded about the need for the first and fourth visit of ANC to be done at the health center so as to get laboratory service for HIV and to check the status of the fetus; the rest of the visits can be done at the health post. It seems that this conference was different from conferences held in 1-30 Development Teams and 1-5 groups, which took place once per month and every two weeks respectively. One of the women said that "during these meetings, women discuss and consult about health and agriculture, they advise each other to deliver at Health Center, to vaccinate their children, the need to educate their children. Most of the 1-30 women members attend the meeting unless they face urgent things and in such a situation they can be absent through permission".

The topics of conferences concerned priorities which seemed to be imposed from the top down, rather than decided up through a bottom-up collaborative process between the community and administration. Such a situation occurred even if a participatory process of priorities planning should have been ensured by the inclusion of community members and leaders. Statements about community participation during interviews confirmed that both the HEW and local government members emphasized the importance of involving local communities, but on the other hand, the interview data showed that community participation was limited to going to the meetings and listening to communication from the kebele officials. The limited presence of a participatory approach in planning local priorities was not only the problem of the kebele level; it began at the zonal and wereda level and seemed to be rather hierarchical. On the one hand, the wereda official claimed that "development plans are designed bottom-up, i.e. kebeles are expected to submit their plans to be approved by the wereda, depending on feasibility" (Aze Debo Community Report 2018: 50). On the other hand, from the kebele chairman's point of view, the process involved several steps. Firstly, it was the zone that gave directions to the wereda regarding plans for development activities. Secondly, the wereda prepared a proposal for development activities and consulted about it with the kebele chairmen from all 18 kebeles. Thirdly, a kebele planning session was organized, during which each sector was given a chance to express concerns and views. The chairman said that, even though the plans were agreed on, the wereda tended to ignore the kebele's plan.

To illustrate this, he told the following story:

> *For example, in 2018, 30 hectares of land were planned to be cultivated in the kebele based on the availability of farmland. The fertilizer appropriate to this land size was agreed to be brought by the government; however they dumped double the volume of fertilizer, assuming that we have 60 hectares of farmland, which is not true. This forced farmers to take more fertilizer than needed. What is more, the repayment of the debt is also a trouble both for farmers and for the kebele administration*[57]. (Aze Debo Community Report 2018:51)

The community could express their 'concerns and views' mainly through 1-5 networks and 1-30 Development Teams[58], but in practice, little information could be obtained from 1-5 network members about concrete examples of how their needs were expressed and accommodated through these channels. If the topic of downward accountability from the kebele to the community was mentioned, it was done so in rather negative terms. For example, male farmers mentioned in connection to the performance meetings of the kebele cabinet: "these cabinet meetings should be open by inviting the general community which will facilitate transparency and enabling the evaluation to be more fruitful" (Aze Debo Community Report 2018:57). It seems that participation did not mean an inclusive process of consultation, but rather 'community mobilization' through 1-5 networks, which make sure that people gathered and contributed to different development goals, such as public works. This seemed to be reflected in the account of a woman kebele official who said that "if there are seasonal interventions, they [i.e. the kebele administration] work closely with 1-5 and 1-30 networks in mobilizing the community" (Aze Debo Community Report 2018: 50). Another concern was that women in general did not seem to be willing to express their views, but rather they adopted a strategy of being silent. Observation of two meetings with women (one inside the kebele, one on the health post veranda) showed that women were sitting quietly, and there

[57] Doubling the amount of fertilizer to be sold was caused by pressure from higher levels to use more fertilizer to achieve targets set at the higher level. This example shows a difficult relationship at times between the wereda and the kebele and also insufficient dialogue. Another example of the uneasy relationship between the wereda and the kebele was the issue of registration to the Community Based Health Insurance. People did not want to register to the scheme. Therefore, the justification of both wereda/kebele officials went, "There is a need to implement awareness raising on the importance of insurance, because farmers didn't accept it right away and they are doubting about its importance for their family" (Aze Debo Community Report 2018: 54).

[58] While 1-5 networks and 1-30 Development Teams served as mobilization for the people, there were different accountability mechanisms through which people could voice their opinions. These were first of all *gemgema*, but also appeals against wereda decisions, citizens report cards, suggestion boxes, budget consultations, and budget posting. For more detailed analysis of their application please see Aze Debo Community Report 2018.

was no conversation between the HEW and the participants. In interviews, women mainly talked about education and meetings in a pragmatic way, in the sense that these were things that needed to be done.

Women's lack of active participation in these meetings does not preclude the fact that the information they received during them was useful and helped to broaden the women's perspectives when it came to taking care of themselves and their families. All respondents underlined that these conferences were important events for their health because they allowed the women to access information; this information encouraged them to seek health care voluntarily so they could remain healthy. While women chose to agree with the new model of care for pregnancy and childbirth, there was some resistance when it came to another issue that mattered for women's health, namely female genital mutilation (FGM), which was a tradition in Kambata culture and as such it was practiced by most girls and families in the community. In the past, it used to be well celebrated, but this had stopped since the government with KMG (a local NGO active in the Kambata zone) introduced a ban and there was the threat that a person who was caught practicing such a thing would be imprisoned. However, whilst there was no longer a celebration for this practice, young girls asked to be circumcised. Boys would not get married to uncircumcised women because they believed that FGM had something to do with a woman's discipline—how well she would respect her husband and listen to his decisions once married. This example shows that even though a ban existed, women still found ways to practice FGM secretly, which could potentially make it more dangerous.

Examples set by the HEW were another strategy to educate women about new models of care during pregnancy and childbirth. In fact, in several conversations a question arose about "how the young HEW, who does not have children, can teach us?". The Development Agent underlined the importance of the HEW "setting a good example" in the area of health planning. She provided an example of another kebele where she worked in the past:

> *In Bechaka kebele, where I worked when the health extension package was initally introduced, the HEW gave birth every year for three consequative years. I asked her why she gave birth for three continuous years while she was educating women to use family planning services so as to delay pregnancy and to have certain gap between deliveries. Women were saying, 'The HEW is giving birth, but she prevents us from giving birth.' I argued with her that if she wanted to continue to work as a HEW, she should also use family planning. Otherwise, farmers would not trust her as a HEW, and they would not accept and apply what she teaches them. When I see [here in Aze Debo] different women like me, the HEW, the gender officer, the kebele manager, etc. who are educating woman about pregnancy and delivery, we give birth at some time*

intervals and the number of children we have is less. Therefore, the community in general and women in particular trust them and are eager to apply what are they taught to apply.

Setting good example is a basis for a HEW to establish trust relationships with women. However, not only does conduct in the area of health matter. The way a HEW handles resources that are subject to distribution can also undermine trust with the community. This can be illustrated by the case of supplementary food distribution. There appeared to be some kind of disappointment among women because they allegedly thought that the HEW did not distribute it fairly. This affected the women's willingness to participate in health education campaigns at the health post. A 1-5 network leader said that:

The distributor of supplementary food (flour for malnourished pregnant woman and plumpnate for malnourished children) does not provide this food for needy pregnant women; rather, with the cooperation of the HEW, they take it for their own purpose. This is a community concern. We raised this problem to the kebele for correction but still it is not solved. The distributor was selected by the community as she had completed grade 12, so she can list the supplementary food she gave to pregnant women. But she is the HEW's relative. When the HEW receives the supplementary food, she gives to the distributor who stores it in a separate room, but the distributor abuses this. Once she has given food to a few women, she says it is finished. So, most needy pregnant women do not get it. The community is disappointed about this corruption. We need to tell this to the head of the programme. As the HEW fears that we may raise this corruption issue, she does not gather the community for health education and she does not call the community for any meetings. Once the distributor was selected, still now she is serving but she should be replaced. However, there is no system whereby the community evaluates the quality of the service she has been providing. So, provision of this supplementary food should be improved. Due to this, some women do not want to go to the health post for maternal health services. Rather, they go to the nearby health center.

Trust in the health extension worker was also undermined as many women experienced problems when they started taking contraception, which was basically recommended by the HEW:

Most women are victims of the side effects of the respective kind of contraceptive they use. They experience various kinds of health issues. Some have continuous menstruation. For example, the implano can result in a continuous flow of menstruation for about three months, and during this time disagreements and fights can start between the husband and wife. There is one husband who removed the implano from his wife's arm three days after she did the implantation. There are some men who do not support the use of family planning at all. They see children as a gift from God and they think that they can grow with their luck; they say

that they can grow doing daily labor or using what they have. They do not worry about how they will grow. (Health Extension Worker)

Earlier, in 2011, the involvement of health promoters was another health education strategy. In 2011, the HEWs explained that there were 30 health promoters in the kebele. They mobilized people for vaccination and passed information to households when an epidemic arose in the kebele. The interviewed health promoter explained that he worked on health issues two hours a day, seven days a week. He followed upwith the 40 households in his neighbourhood. For instance, in one month he mobilized the households to take their children for vaccinations and the adults to go to the outreach programme of HIV testing in the kebele. He facilitated the house-to-house visits of the health extension workers in his village. He was a grade 12 graduate who had started work as a volunteer health promoter in 2010. He was selected and trained for six days at the wereda health office before taking his post. He also got training in the kebele from the health extension workers, and was trained by international NGOs in Durame. When he needed advice, he consulted the HEWs and collaborated with the health army members of his village (Aze Debo Community Report 2011).

It seems that the role of health promoters has disappeared over the years since 2011, and the Health Development Army was the only structure that was at work in 2018. The Health Development Army included almost all my respondents, regardless of their wealth status. Women narrated their participation in Army with regards to education in the following way:

I participate in a 1-5 network with my neighbour. I attend the weekly meeting and she gets lessons about keeping my environment and house clean, feeding, and ways of preparing food and taking care of children properly, including having balanced time as well as getting ANC and delivering at the health center. So, this team is important for me from the point of view of getting information on time and information related to health issues, including maternal health. (Respondent 10)

I am also a member of a women's development team of 1-5, and a 1-30 Development Team [the Health Development Army]. In this group, sometimes the leader shares the information she received from others, including the Health Extension Worker. So, in this case, these networks are important from the point of view of health issues. (Respondent 11)

The church prayer group leader (Respondent 8) said that, in the 1-30, they meet once every two weeks. In this meeting, they discuss and consult about health and agriculture issues, and they "advise among each other to deliver at health center, to vaccinate their children, the need

to educate their children". Most of the members of the 1-30 Development Teams attend these meeting unless they face urgent things whereby they can be absent through permission.

The third health education channel, after the HEW and Health Development Army, was the iddirs. For example, Respondent 5, a rich woman, said that, apart from the typical duties during funerals, iddir members also discussed and 'educated members' about the need to deliver at a health center. Respondent 12 stated that the iddirs were also playing a major role in eradicating polygamous marriage:

> *So, the iddir forced men not to marry another or a second wife because, if the iddir found out, these men would be punished. Formerly those who had a large size of farmland married more than one wife, but now this practice is no more exercised due to the punishment, as well as the fact that the awareness level of the community has improved. So, currently women's emotional state is not affected as a consequence of polygamous marriage. Similarly, iddirs are now encouraging women to deliver at a health center. To prevent home delivery, my iddir has set a rule to punish or cancel a woman's membership or that of her husband if she delivers at home. Therefore, iddirs have been playing a good role in enhancing women's wellbeing.*

A gender officer underlined the role of iddirs in polygamous marriage:

> *Iddirs are playing a major role to prevent practices that affect people's wellbeing. For instance, iddirs have been working to educate people not to marry another or a second wife because if a man is found to have married the iddir punishes him. Womens' affairs leaders also have been working and the community has become aware of the harmful effect of polygamous marriage. Due to these groups, there is no polygamous marriage. Due to this prevention, women are not physiologically affected like in the past. Iddirs are also important for women, as the iddirs have started to oblige them to deliver at a health center, which has been the mutual effort of the wereda health office, Bezena Benara's health center, and the health post.*

Even the kebele manager admitted the importance of iddirs to health education:

> *As iddirs are most influential in the community, they have become important for mothers and women because a new principle through iddirs was set to oblige women to delivering at a health center. Through the cooperation of the wereda health office, Bezena Benara's health center, and the health post, different iddirs have been given responsibility to create awareness and enable their members to deliver at a health center; otherwise, the iddir members who deliver at home would be punished and their iddir membership would be canceled. People have become aware of the importance of institutional delivery and fear punishment and cancelation of their iddir membership.*

The HEW said that nowadays iddirs are responsible for pregnant women:

> *Whenever a member of an iddir gets sick, people who do not carry the sick person are punished, and even their membership can be cancelled. So, the iddir's 'rule and regulation' is so serious in this area. Currently the transport access in the area has improved, so iddir committee members do not carry sick iddir members so often. Rather, they say that they can use either a bajaj, motor, or horse cart. However, in the case of a pregnant woman, they make strong effort to take her to a health facility for delivery. This is because if a mother got sick, the iddir would be held responsible. Even higher bodies would ask them, 'Why did the iddir not support this woman to access health care service?'*

When it comes to other sources of information about health, it is important to note that, in Aze Debo, access to TV or mobile phones is limited. This does not mean that their access to other sources of information was totally limited. For example, radio was still an important source of information for Respondent 16:

> *But most importantly, I listen to a radio, and I got important maternal health information from the radio […] I heard from the radio that if someone inserted a long-term contraceptive that serves for 3 or 5 years, and if they remove it after some months, they might not conceive until the service year, meaning until 3 or 5 years respectively. This means even though it is removed, still it has some effect to control pregnancy. So, it is not good to use a long-term contraceptive if a woman has a plan to get a child after some months. Rather, it is good to use short-term contraceptives. So, I hesitate about what has been said, that whenever someone wants to be pregnant they can remove the long-term contraceptive and can conceive immediately.*

Women generally underlined the causal link between the education provided by the HEW, Health Development Army, and iddir, and their practices during pregnancy (see Section 5.4). These accounts should be treated with caution. The fact that the women reported a causal link between education and health practices might have been caused by the more or less implicit pressure from the higher officials in the health or political hierarchy. The threat of legal litigation and consequences, such as being asked, 'Why did you not attend the meeting?' or 'Why did you deliver at home?' could be solid motivations to report 'desired responses'. Education therefore was implemented in a highly controlled environment.

5.3.2. Social control

A parallel system of community management (see Section 5.2.1) creates a space for practicing a lot of control over individuals. In the area of health, going door to door in order to check women and also the fact that one of the main purposes of the Health Development Army is 'to follow and mobilize women' can be regarded as quite intrusive practices. There was an obvious threat to those who did not adhere to the policy prescriptions concerning institutional delivery, with the most severe threat that of 'being taken to prison' which was open coercion. Less severe means of control included being called to attend meetings or conferences aimed at health education. Control was also exercised through the creation of documents, such as the Family Folder, which consisted of Health Cards and an Integrated Antenatal, Delivery, Postnatal and Newborn Card, which contained data about the population health of a given kebele.

The threat of the punishment of being taken to prison was brought up several times during my interviews. Firstly, during my talk with the HEW, she admitted the political nature of maternal care and health:

> *Currently, maternal health is a political thing. A person who knows about a home delivery and allows for it can go to prison. An iddir leader, if s/he knew and did not react, could go to prison. The wereda would ask the kebele chairman who had a delivery at home and who allowed for it… people who might know are the kebele chairman and the iddir chairman, and they could go to prison. Also, the women who delivered at home could also go to prison. We don't have such problems, and a 1-5 group can follow up on a pregnant woman and make sure she is going to deliver at a health center.*

Also, a kebele official working at the Natural Resources Management Office admitted that there was a punishment for not delivering at a health center:

> *If a woman gives birth at home, if there is a lot of bleeding, she may even die. People would be held accountable for that—firstly the health officer, there is a rule and regulation for that… and the kebele and wereda are going to ask about that. The person who delivered would be taken to prison. In this kebele, this is not going to happen... But I have heard that this kind of thing is happening in other kebeles. In which one? In Bezena Benara kebele […] I have heard about a woman who delivered at home and the health center officer tried to hide this information. I told her, 'You have to tell everyone, this is a very hot issue', but she hid this problem, because she was told to do so [by the health officer] and the wereda did not discover it. If wereda discovered it, she would be held accountable. Kebele people can also be held accountable: 'You did not give awareness'—this is how they would be asked.*

The kebele official also admitted that, if a woman delivered at home, the rule was to take her to prison, but they (i.e. the HEWs) usually did not do that, but took her to the health center instead and 'gave her awareness'—this was considered a kind of punishment, because instead of staying at home, the woman would be forced to go to the health center where she would be separated from family and friends. When asked if women were willing to deliver at the health center, a female cabinet member underscored the consequences of not delivering there:

> *There would be a lot of problems if she delivered at home, like bleeding… […] 1-5 group leaders and iddir leaders would go to the prison for that… People are afraid of iddirs, so they take delivery at a health center very seriously. Generally, delivery at home is taboo, because government policies do not allow for that to happen. There has been plenty of education about that.*

Many respondents underlined the status of Aze Debo as a 'home delivery-free kebele'. A health official at the wereda level explained how this started to happen when the HEWs stopped being allowed to assist deliveries at home:

> *Some years before, around 2013, HEWs were assisting women in delivery as at that time institutional delivery had not become familiar. After 2013, HEWs were also ordered not to assist women in delivery but rather to take them to a health center or hospital for delivery. Because of these efforts, nowadays there is no home delivery. In the last three years in Aze Debo, there has been no home delivery at all. Aze Debo is categorized as a Home Delivery Free kebele.*

This account reflected the opinions of many other respondents[59], who underlined that maternal deaths had been dramatically reduced and that they hardly happened anymore. When I conducted the interviews, this was the initial declaration, but after some time in conversation, both the Health Extension Worker and several respondents openly admitted that there were women who delivered on their way to the health center. In explaining the reason for this, they often used arguments that shifted responsibility to the women ("they left the house too late"), or to infrastructural problems (like the lack of ambulances) or structural issues—such as the lack of good roads and the rainy season[60].

[59] Also, the richest man in Aze Debo confirmed: "Wereda people say that people who delivered at home will be taken to the prison… but nothing like this is happening. There is no delivery at home. When women were delivering at home there was a lot of bleeding."

[60] While these factors can be read as excuses, it cannot be excluded that these factors prevent women from accessing health care facilities – this is explained in a greater detail in Section 5.4.

Meetings and conferences were strategies used by HEW and Health Development Army not only to educate (see Section 5.3.1), but also to control women. Meetings were said to be a method of ensuring community participation not only with regards to health, but also to agriculture. The perspective on meetings in Aze Debo was rather on negative in 2011, at least among farmers. They believed that meetings by and large did not have any useful implications. Other farmers said that meetings, which took place every month, could be reduced to one meeting annually, or suggested that it was better to spend time on the farm (Aze Debo Community Report 2011).

The organization of meetings and conferences was regulated by certain bureaucratic procedures that enabled exercising control at the local level. For example, the monthly conferences were obligatory for women, unless someone gave permission for them not to attend. The meetings were officially announced, i.e. notice of the meetings was posted on the health post veranda, and the names of attendees were also openly presented. These meetings were held by the health officer from the catchment health center, who was supported by the HEW and a nurse from the health center; they were people who had power over the distribution of various goods, such as supplementary food. Women learned about these meetings through 1-5 leaders. This was especially true for 1-5 leaders living in remoter parts of the kebele, who were held accountable for proper 'following up on women' and making sure that their network members were present at the meetings.

It was not only the HEW and health officer who were involved in checking up on the women, but also people from the kebele administration who were affiliated with the party. Even male 1-5 networks were used to 'discipline' women if they were disobedient, which was evidence of the unequal gender relations in the community:

> *The Health Development Army educates mothers on health issues. They identify pregnant women, encourage and advise them to use antenatal care. The leader of the Women's Development Team also educates their members about health. If their efforts do not bring change they inform the male development team as they are more powerful and the male team also creates fear and enables women to get education and access health services as well.* (Health Extension Worker)

Moreover, Health Development Army leaders themselves were working in an atmosphere of discipline. On paper, to become a leader, one has to meet certain requirements. Firstly, such a person usually comes from a model household that, according to a Health Extension Worker, had successfully implemented 16 Health Extension Packages. This adoption meant that the household and its members could be regarded as a model for others when it comes

to the adoption of 'healthy practices' such as having a latrine and going for ANC or vaccinations, which was also evidence that this household was able to manage their behaviours. When these practices were adopted, it meant that the given household had become 'modern' and abandoned 'traditional' lifestyle. Secondly, leaders were those who were active in various community matters and were able to express themselves better than other women. Being educated to a certain grade level was also considered an advantage as this meant the leaders could disseminate any written information they got. When they were granted their position, Health Development Army leaders had to work one day per week on the households they followed and had to report on a weekly basis to the Health Extension Worker about their status. While all this was done in the spirit of 'empowerment' of the leaders and women, it seems that because Health Development Army leaders had to 'report' to the HEW, their relationship was not equal to HEWs and kebele officials.

Another means of control was the formal requirement to prepare documents: a Family Folder, which consisted of a Health Card and Integrated Antenatal, Delivery, Postnatal, and Newborn Card. These documents were a part of Ethiopia's Community Health Information System[61] that began in 2010. The Family Folder was a document issued to every household in the kebele. It contained information about the household that was supposed to help the HEW to identify the health service needs of the family (in terms of preventive, promotive and environmental health). The front and back sides of the Family Folder were used for recording information on household characteristics—latrine, handwashing, waste disposal and drinking water facilities, and household HEP package training and implementation status. Health Cards and Integrated Antenatal, Delivery, Postnatal, and Newborn Cards were kept inside the Family Folder. Every member of a family who was older than five was issued a Health Card: for children below five, their documents were kept in their mother's health card. Health Cards were issued both for men and women. From the perspective of maternal care, the Antenatal, Delivery, Postnatal, and Newborn Card was important; it contained all the information about the status of a pregnant woman: her obstetric and medical history, current pregnancy, and birth preparedness (plan for delivery place and who would assist, and also the cost for delivery and transportation). It also indicated the result of this plan. It can be said that, through defining categories of services and proposing a certain agenda, this card gave a certain level of official legitimization.

[61] The Community Health Information System was aimed at data collection and documentation to meet the information needs necessary for providing family-focused promotive, preventive, and environmental health services at the community level.

Photograph 12. Health center in Aze Debo

Source: WIDE fieldwork materials. Left: delivery room. Right: post-delivery room.

The health documents were the data resource higher level officials used to calculate development policy targets and diagnosed the health situation of community members. These documents enabled health workers to exercise a certain level of discretion about what was reported, in what ways, and what kind of focus on which aspects of possible complications was presented. The documents served therefore as a mean of control: on the one hand, control on the part of the Health Extension Worker, because she noted everything about the households in the kebele; and on the other hand, control on the part of higher officials who assessed the HEW's work. It could be said that medical reports created belief, in the sense of *doxa*, that HEW's work makes sense, because it leads to achieving targets and involves implementing official rules, which are meant to improve health of mothers.

5.3.3. Social support

Apart from health education and social control, social support was the third resource accessed from social networks. Social support, present in of the form spiritual, emotional, financial, and material support, was frequently provided firstly by the family and the closest neighbours.

Spiritual support came from participation in the church prayer groups. As mentioned earlier (see Section 5.2), Aze Debo was dominated by the Protestant Church. Community and religion on a whole played a significant role in people's lives, and people spend a lot of time on religious practices.

Church prayer groups and choir meetings were the most important religious programmes in the kebele that were said to be a source of spiritual support for mothers. As was apparent

to the women, these programmes created an occasion for socialization and discussion not only of spiritual, but also other, issues. Among my respondents, five belonged to church prayer groups. Groups met in turn in members' homes, and this gave them spiritual power. After prayers, the members talked to each other and provided advice on various topics, including those related to pregnancy. Respondent 7 said that, in different phases of her pregnancy, a prayer group of mothers had been supporting her spiritually thanks to prayers as well as encouraging her to deliver at a health center. Therefore, she found the group to be important for her own health. Respondent 11 was also a member of women's religious group, in which they prayed together first and later discussed any issue members raised, usually if a member faced health problem or any other shock. In this case, the group members provided social and sometimes also financial support.

Apart from the provision of pure spiritual support, women's prayer groups created a platform for discussing the kebele's development goals (see Section 5.2.2 *Religion*). A woman who was a Women's League leader and the leader of church prayer group indicated how maternal health issues were included in the prayer group's meetings:

> *After we finish the praying […] sometimes also the HEW comes and teaches them about health. As this is a women's group, only women participate. They are free to raise/share what they have faced and discuss within the group for solutions. In this group, also we support each other in case of some event such as delivery or a wedding. We contribute in a material, financial manner (i.e. by contributing money) and emotionally. In addition, on Wednesday from 6 to 8 o'clock in the morning also there is a women's prayer programme at church. Men have a separate prayer program.*

This response was in contrast to what a local leader, the Protestant preacher and the richest man in the kebele, said about the linkage between the church and development interventions promoted by the kebele. He underlined that "we are teaching gospel, and teaching about contraception and delivery is the HEW's work." Women's responses indicated that church prayer group membership overlapped somewhat with 1-5 networks, so ultimately they had to collapse the meetings into one so that they did not have to meet twice.

The second type of social support accessed from social networks in this study was financial and material support. Both family and 1-5 networks were important for its provision. Given the fact that recently the 1-5 networks had been given a new task—starting savings in groups—they turned out to be a valuable source of funds. Women mentioned that they were organized in a savings group having around 25 members. They saved around 25-30 birr weekly and, thanks to this, they could take out loans of different values. For example, Respondent 6 took 700 birr

to buy one goat to rear. Respondent 7 took as much as 7,600 birr and gave this loan to her husband so that he could start to use the money for wood trading. These amounts were taken with interest. Both women admitted that, in addition to regular savings, they also contributed money to use to support members who faced some shocks such as the burning of their house, cattle getting sick. Respondent 8 shared the following story:

> *One woman was asking the team for support for medication when she was sick. So the team contributed money and supported her financially. In light of this, the team has proposed an idea to save money while they meet so that they can use the money for urgent members' need. Thus, we started saving with the team of 25 women. We decided to save, and enhanced the amount of money we are saving, and started to divide what we saved on an annual basis. Last week, for example, we divided our money and I got 3,000 birr. I will use it for trading: with this money now I am planning to buy butter to sell for the next big holiday, Meskel. Members also can borrow money for urgent needs such as for medication. With a loan of 1,000 birr there is interest of 50 birr per month.*

Material support took the shape of borrowing food and other things for everyday use. Relatives were crucial because of the need to carry women to a health center if the distance was large. This happened to respondents Respondents 22, 3, and 9. Respondent 22 told her story about how family carried her to a health center for delivery:

> *They carried me to the health center on a traditional stretcher and I came back by bajaj. I delivered my first child in the hospital, because the health center called an ambulance and took me to the hospital. I delivered the second one at the health center. When I was giving birth, I did not get any food service from the hospital or the health center. In getting this delivery service, the health worker's attitude towards my condition was very encouraging and they were caring for me properly. So, I am happy with the service they provided me. My second child is now four months old. While giving birth, when I left home, my husband's mother managed the domestic work. So, having her at home makes my life easier.*

Regarding her delivery experience, she also described that when she felt pain, her mother and husband tried to call an ambulance but they were not successful since the response they got was that the ambulance at that time was far away in the kebele and unable to serve them. She also heard from her mother that a second ambulance driver also said that the car did not have fuel and was unable to serve them.

Sometimes women realized that they needed to go to the health center, but it was too late to do it and they delivered at home or 'on their way'. Respondent 9, who was poor, said that she delivered her first child at home while she was on the way to go to the health center

in Durame as her labor was faster and she gave birth unknowingly. But immediately, when her neighbors, including her 1-5 group, got to know the fact they called the HEW and she treated her and advised to go to the health center in Durame for further needed diagnosis. Accordingly, she went and got treatment. The Health Extension Worker admitted that neighbours were important for birthing women to access the health center especially if they lived in remote and hilly areas of the kebele, such as Lay Debo and Azenesh Kida gots. In such cases, neighbours brought women through a traditional stretcher to the main road where they could access ambulance or bajaj.

Family, both husbands and mothers, were also supportive in terms of household chores. In the case of Respondent 2, her husband's sister assisted her with household chores, and their relative who was living with the household was also taking care of her children, going to market, and accomplishing domestic work properly. Her relatives who lived in the neighboring kebele were a source of emotional support for her. For others, mother-in-law was supportive for household work (Respondent 4 and 5).

Women implied that it was basically other women who helped them at home. Respondent 8, whose three children were all boys, lacked someone to assist her in domestic work. As sometimes she was involved in trading activities, and did not have the time to do household chores, she got help from a friend who was also her neighbour, who sometimes assisted her in domestic work. In addition, she mentioned that the daughter of her husband's sister was living close to her house. She was assisting her whenever she was away: she prepared food, boiled coffee and provided her husband and children with food and drink. She had siblings living in the kebele, and they supported her emotionally.

Mothers were equally important for the provision of support as husbands were. Respondent 3 described her situation in the following way:

> *When I had a health problem, I consult my mother and my husband, and they supported me by taking me to the health post or health center and buying any needed medicine. My social interaction is almost zero as there are no other people that I consult about this. I am living with my husband at my mother's house. She has often supported me in household chores, especially during my pregnancy and even in the first months after I delivered—my mother was the person who had been accomplishing all household chores. So, my mother is a good supporter for me in different aspects of my life, including providing shelter support for me and my husband.*

Mothers could be helpful when it came to emotional support, but also powerful when it came to their influence on their daughters' lives. This was the case when it came to FGM.

Although, at the beginning of 2010, the trend was decreasing thanks to a strong local campaign by a local NGO, the Protestant Churches, and the government, circumcision was on the rise again in 2018. In 2012, women of various ages indicated that there was no longer a ritual celebration of FGM as there used to be in the past. The decrease of FGM was attached to higher awareness: the woman head of a successful household said that her older daughters were circumcised, out of ignorance, but she did not circumcise her younger daughter because she "has awareness". The wife in the middle-wealth household also said that all their daughters were circumcised when her awareness was very low, but she would not circumcise her granddaughter living with her. The wife of a successful farmer too said that her daughters were circumcised, but she had a plan not to circumcise her granddaughters. The kebele chairman's wife explained too that her older daughters were circumcised when she was not aware of the adverse effects of FGM, but her younger daughters were not circumcised. A poor farmer's wife said that their daughters were very young still, but "they did not have a plan to circumcise them because she was aware of its negative effect" (Aze Debo Community Report 2011:20). As can be seen, daughters did not have much to say about being circumcised or not—it was mothers who decided.

5.3.4. Summary

The evidence presented in this section has shown that there were three basic resources that were available in social networks: health education, social control, and social support.

The two first resources were provided by the Health Extension Worker and 1-5 leaders, thus primarily by state-inspired actors. Nevertheless, these networks were imposed on family and neighbours connections of women. Health education was meant to changing the *habituses* of women in terms of their perceptions of proper care during pregnancy and what delivery should look like. In other words, it was aimed at changing a particular set of dispositions and norms concerning care in pregnancy and delivery. This was achieved thanks to a series of tools, such as meetings or home visits, involving iddirs, the local bottom-up organizations, and building trust in the health care system with the good example set by the HEW. Social control took the shape of (1) the direct threat of being taken to prison for failing to deliver at a health center, and (2) bureaucratic control, which took shape of meetings and also the creation of documents about the households and the work performance of the health extension worker.

Finally, the section provided evidence of what social support looked like in Aze Debo. There were two most important forms of social support provided by different channels. Spiritual

support was provided by Protestant churches, which had been playing an important social role in Kambata for a long time. Apart from churches, family and neighbours (who were also 1-5 networks) provided financial, material, and emotional support. Moreover, family and neighbours played a role in carrying a woman to a health center for delivery.

5.4. Factors affecting care seeking and health workers' situation

In this section, I would like to answer the third research question: What factors affect women's decisions to seek care and the health workers' institutional situation? This question is essential from the perspective of maternal health policies, which assume that women *should* give birth at a health facility. Put another way, these policies imply changing the 'old' practices to new ones, and its success depends on women's response and health workers' ability to perform their duties within health system. In Bourdieu's approach, individual choices and decisions are constrained by the structures in which actors operate. Agency is not totally understood as autonomous decision, but rather as the ability to apply schemas in a given context. In such an approach agents can act consciously in their own interest, but these actions are limited by various more or less obvious obstacles or barriers.

In this section, I ordered the results according to the factors that supported women's capacities to engage with formal health care and those that weaken them. In doing so, I look at distant factors that may affect health of women. Moreover, I discuss factors that hamper or facilitate health workers' ability to contribute to better maternal health outcomes. I separated women's voices from those of civil servants to make their positions in the context of the medical system clearer.

5.4.1. Women's perspective

Health education was framed as a major factor that increased women's ability to critically assess the state of their bodies in pregnancy. Door-to-door visits, conferences, and "education-raising activities" conducted by the HEW and 1-5 leaders did not find apparent opposition. Women generally appreciated the fact that health education was available and made them aware of various risks related to home delivery. None of the participants expressed any direct objection to the mandatory nature of institutional delivery, testing, education, or checkups. All seemed to accept that these were benefits of the health system and essential for ensuring health pregnancy and delivery. It could be said that women's agency was displayed through the persistent acceptance of the new model of care during pregnancy and delivery. This change

in the perceived need to deliver at a health center was attributed by women to education. For example, Respondent 11 said that, thanks to membership in 1-5 networks, women were more willing to deliver at a health center. Respondent 12 also underlined the role of education in influencing her decision to deliver at the health center:

> *I delivered my first and second child at home as at that time institutional delivery was not common and was not promoted yet. However, after I became very aware, I delivered my third child at a hospital. Initially, when I felt a kind of pain, I went to the health center but when I arrived there it was out of working hours and one health officer told me to wait until a midwife came. I got disappointed, and with my family I went to the hospital and I delivered there. I am happy for the service I got since they treated me well.*

This account revealed a change in women's behaviour during pregnancy, which was directly caused by education. As noted by a poor woman, before the Health Extension Programme was introduced:

> *…we did not know a lot about delivery at a health center. It was very difficult to deliver at home. Women who were assisting a young mother told her to remain silent. She could not scream. We could not express what we felt at that time. Women were sitting and waiting with a woman, and kept on telling her that 'time will come'... In my case, God was good for me, because I am alive now. In a health center, now it is different—they know what do to, tell women to drink a lot of liquids, and can refer a woman to the hospital, if there is a need.*

This also revealed that women felt encouraged by the fact that they could express their emotions. Knowledge of how to handle delivery was a critical aspect for women, which could play a role in deciding about delivery at a health center.

Women, particularly those of older age, underscored the huge impact of health education on women's health. They frequently compared the situation 'before' and 'now': periods were divided into the 'time when HEP was not so strong' and 'after'. For example, a poor woman, Respondent 14, was around 40 years old, had never attended school, lived with her mother-in-law in one compound, and had six children. She had delivered the oldest child at home—around 2005, when the Health Extension Programme was not so strong. Starting with her fourth child, she delivered at the health center because the HEW had given her advice about how to eat during pregnancy and take care of herself. Respondent 15 shared a similar story: she gave birth at home four times because "at that time, people were delivering at home". However, she also said that, thanks to education, people had started to come to the health center:

However, when the health extension programme took off, people were getting education from the HEW. Due to this, I delivered my fifth and sixth children in a health center in Durame. When I delivered my seventh and youngest child at the Bezena Benara health center because it was established close to the kebele.

The fact that education was conducted at meetings in which only women were present, seemed to provide them more freedom to express their opinions. Also the fact that they were neighbours who knew each other seemed to support free information exchange. Respondent 20 said that:

1-5 network members are neighbors and friends so they know one another well. Due to this, they discuss any health issue members face. As in these networks the members are only females, they do not fear to share the problem they face, in health or in relation with their husband. So, through these networks, women also get awareness about their rights and the need to fight to protect their rights.

While education was seen as a liberating factor that broadened the possibilities for critical reflection about their health status, women were sometimes resentful towards circumstances that affected their wellbeing and limited possibilities they have available to access health care.

One of crucial obstacles for women was household poverty, which generated a higher work burden. As mentioned in the beginning of this chapter, the main livelihood in the community was farming, with limited opportunities for women to be involved in other work, especially if they were mothers. Women were contributing to the household livelihood usually in the form of housework and childcare. A heavy work burden was mentioned as a major obstacle to women maintaining their health. Because they had other responsibilities at home, it was not possible to go the health center very early, and therefore some of them could deliver on their way. Respondent 5 narrated her pregnancy experience in the context of an increasing work burden and the hardships of everyday life:

Most women who are more than 25 or 30 years old, most of them who have a large household size have a domestic work burden that exposes them to kidney illness, and as they get up early in the morning they are exposed to catching it (…) To prevent these diseases, it would be good if other family members supported them in domestic work. Women also should get a balanced diet as pregnancy and lactation needs a good diet. Women should get more information and education on these topics.

In many households in Aze Debo, there are around six to eight people. As per my respondents, domestic chores, like cooking and processing food, fetching water, and washing

clothes were exclusively women's work. In cases where a woman lived with her mother-in-law and they did not have a lot of children, the work burden was smaller (as in the case of Respondent 3); it was similar when siblings or daughters supported the women. Women who did not have daughters but only sons lacked someone who could help in domestic work at home (Respondent 8) and sometimes relied on other female members of the household. There were also other changes in the community that affected women's amount of work. For example, in 2013, one woman commented that women's workload had increased because girls went to school, husbands and sons worked on the farm and did not get involved much in domestic work. She believed that there was a greater gender equality when it came to work duties at home: "These days both girls and boys assist their families when they return from school".

In 2013, the kebele officials explained also that there was a greater tendency to have the same duties among men and women:

> *At present, men take on some tasks like uprooting and transporting the roots and trunks of enset, which was a woman's domain in the past. In turn, women also got involved in many activities that were previously exclusively carried out by men like hoeing, weeding, and harvesting crops. Fetching water continued to be primarily the responsibility of female household members, although gradually male children and teenagers were involved in this too.* (Aze Debo Community Report 2011:41)

Women's household duties were also seen as the causes of various health problems. An illustration of 'the back problem' can be seen in the case of Respondent 7. Her narrative indicated that she did not face serious health problems during her pregnancies, but during her fourth pregnancy she got pain in her back. The reason behind this was, in her opinion, carrying heavy things such as fetching water. She got treatment from the health center and was finally cured. Then, after she stopped carrying heavy things while she was pregnant, she did not face any health problems. In her opinion, problems result from the fact that women are primarily responsible for handling household chores, while men are usually absent and busy with working on the farm or dealing with 'other things'. Respondent 16 noticed that heavy work might lead to miscarriage:

> *I do not have anyone who assists me in domestic work. My neighbour told me that I had a miscarriage maybe because of the domestic work burden since I am the only one who does every activity. But during my earlier pregnancy period I was fetching and carrying water, and I delivered safely.*

Respondent 20, who lost her fourth child, believed that also that heavy work and conflicts with others during pregnancy did not serve her health well:

> *When I was thinking about delivery at the health center, my labor came, and when my husband was on the way to take me to the health center by any means, either by carrying me through a traditional stretcher or trying to inform our neighbours, I gave birth at home. The child died after a couple of hours. I do not know the reason for the death. Then after some months, again I became pregnant but in the fourth month of that pregnancy I quarreled with someone and we beat each other. As a consequence of this, I faced miscarriage. I am disappointed because of facing these two cases. For the future, if I were pregnant, I would strictly attend antenatal care either at the health post or health center, and would avoid any labor-intensive heavy work such as carrying water from a far distance or exposing myself to physical fighting.*

The leader of Women League and women's prayer group acknowledged the gendered division of labour and its influence on women's health status:

> *This [the lower health status of pregnant women] is due to their domestic work burden—women's health status deteriorates when they carry water while they are pregnant. So, husbands should help their wives by fetching water, washing clothes, and even preparing food. The traditional gendered role needs to be changed though there are a few husbands who support their wives in fetching water and by doing some light domestic activities.*

A church prayer group leader also believed that women were overburdened by domestic activities, which had an effect on their health. This was especially true for women who were living with the family of their husbands and who had a large household size, because they performed many household chores since their husband's parents were older and could not help.

As is apparent, women underlined their work burden and linked it with risks to a healthy pregnancy. It was one of the reasons for their inability to access emergency obstetric care at the onset of labor. At the same time, they suggested that care at a health center helped them to avoid problems that might occur around pregnancy. Some women also emphasized that, if there had been no health post or the HEW's service, many of them would have died during their deliveries. In this way, risk had become a central discourse through which pregnancy was perceived. This is even more apparent if we notice that, in the landscape of health interventions related to reproduction, all surveillance and control measures were directed towards women, not men, and were aimed at saving women's live. Directing attention to possible risks that could pose a danger to a mother and a baby provided a rationale for normalizing 'health

enhancing' behaviours like antenatal care or skilled delivery through education. This was also strengthened by the legitimization of the health education from the state officials.

Another challenge was related to the insufficiency of food provided by local government. As mentioned in Section 5.1, Aze Debo was frequently hit by drought, with the last one taking place in 2015. It has been included in the PSNP since the onset of the programme in 2005. However, there were a number of challenges faced by the programme: insufficient quotas, selection criteria that were unclear both for community members and kebele officials, and insufficient communication between communities and the kebele. Over the past years, the proportion of households under the PSNP decreased from 30% in 2010 to 10% in 2018. As a part of the support, a maximum of five household members received cash transfers of 120 birr (around 4 USD) per person for half a year (six months), which was a decrease from previous years. Moreover, the transfer had been delayed, which could result in a greater insufficiency of food in households. These difficulties in terms of implementation, the low coverage of support, and the drought resulted in greater food insecurity for the community, resulting also in perceptions of unreliability and unpredictability (Frankowska 2019).

One of the methods used to overcome this problem was organizing food preparation sessions for women. As per the HEW, one of the trends affecting the health of women was the fact that "in the past, women gave priority for food to be given first to their husband and that he was given better quality food even if they were pregnant or lactating. Due to this prioritization, the meal they got would not be good. As a result of this, some of them were exposed to malnutrition". Again, the educational sessions were directed at women who, according to the HEW, should "become aware of getting a balanced diet; if they no longer gave priority to their husbands, their nutrition status would become better." Nutritious food was given to women who come for ANC as a kind of motivator to engage with health care system. As a result, "the ANC behavior of women has improved a lot", as noted by the HEW. The fact that women were coming to the HEW for ANC because of the possibility of getting food, also shows that the basic problem was poverty, which is a matter of public concern.

However, women noted that the amount of supplementary food provided was not sufficient to meet everyone's needs. Respondent 26 suggested that food should be delivered on time and in sufficient quantities; Respondent 11 said with resentment that there was some benefit coming from ANC sessions:

> *The HEW gives supplementary food to some women. But when it turns out that this food is only for malnourished women, if they feel quite well, they do not go for ANC. On the other hand, some women become malnourished and they do not get food because the supply is not sufficient.*

Unclear rules of distribution (also mentioned in Section 5.3) combined with an insufficient amount of food caused some resentment towards the formal health care system. A 1-5 network leader also critically pointed to the importance of food at the health center:

> *With regards to the treatment at Bezena Benara health center while giving delivery service I am extremely thankful to one male health officer, as he was very caring. While my daughter and neighbour were delivering, there was not any food supply provided though my daughter stayed there for three days. The health center only arranged for space where women and their accompanying people could stay. But I heard from others that they supplied the accompanying people with coffee to boil and drink but not any flour for porridge. So, the supply of coffee may sometimes be interrupted and sometimes there may be the provision of flour for porridge, which may be interrupted as well due to different reasons.*

The quality of service encountered at the health center was also mentioned as an obstacle. It encompassed the availability of drugs and the service provided by the health staff. A former kebele manager mentioned that sometimes women who went to the Bezena Benara health center could not get medicine, so they tried to buy medicine from Durame. She even said that she had heard complaints from some community members that sometimes they needed to buy medicine while they were members of Community Based Health Insurance[62]. Under that scheme, beneficiaries were entitled to receive free medicine from the health center for a given set of health problems. However, implementation challenges[63] led to the perceived unreliability of the scheme and decreased trust in the health system.

It was also interesting to see that richer women, who were more exposed to community life, were more critical towards the quality of health care services provided. This was the case for Respondent 5, who went to the health post immediately after she knew she was pregnant. The HEW advised and referred her to go to the hospital to get ultrasound screening. Following this, she went to the hospital and got ANC. After that, she continued getting ANC from the hospital because she wanted to get better service from there. She had five antenatal visits at the hospital. One day when she felt pain, she went to Bezena Benara health center as it was closer. At the health center they told her that she would give birth in two weeks and she prepared and hoped to give birth in the time they told her. However, it took her six weeks, which is far more. Because of that, she lost trust in giving birth at the health center and went to the hospital. At the hospital, they told her she would give birth in a week's time. Subsequently, she gave birth in this period. The richest man's wife was also choosy when it came to health services. She said

[62] Community Based Health Insurance was a formal insurance introduced in 2015 in Aze Debo.
[63] See Frankowska (2019).

that, because of the quality of services, she preferred to go to Durame. Apart from the fact that quality matters when it comes to such an important issue as health care, the cases of these two richer women showed that, even if the provision of health education seemed equally available to all women in the kebele, it was financial standing, and thus economic capital, that allowed a woman to get better care when she perceived that she needed it.

Sometimes a misunderstanding in terms of what was possible to receive at the health post could lead to higher expectations. The illustration of this came from Respondent 6, who was poor, and disappointed because she believed that the HEW did not informed her that she was expecting twins during her ANC at the health post. When she went to the health center for delivery, she was referred to the hospital due to prolonged labour. Due to former irrelavant diagnosis, she wanted to have her second birth in the hospital, but the health center did not find a medical justification to refer her there.

Another problem was the unkind behavior of health staff. The leader of Women's League and women's prayer group admitted that "female nurses' behaviour is sometimes a bit aggressive—but the male nurses are patient. I like the male nurses, but women who deliver prefer female nurses as they fear when male nurses see their internal body parts." This account showed that, although women could be aware of the benefits of medical care, nevertheless, quality and kindness during visits was still relevant for them.

Women were resentful because of the lack of transportation to the health center and the poor quality of the roads. In particular, those living in more remote areas did not have the means to get to the health center. In Aze Debo, wealthier households lived in the inner part of the kebele rather than in the hills. Again, even if women all had more or less an equal level of knowledge concerning the medical way of taking care of themselves during pregnancy, different levels of wealth combined with a structural factor—distance—could deter them from seeking care. A 1-5 network leader said:

> *While traveling to Bezena Benara health center, there is one river and bridge, which is very challenging to pass. Bajaj cannot travel through that river and bridge, and women are carried on a traditional stretcher. It is full of risks, and pregnant women can fall down into the river. Ambulances can go to this health center by another way. The government tried to build the bridge through public works PSNP beneficiaries. To do so, the government brought stone but, as there is no one who has followed up and supervised building the bridge properly, its construction remains incomplete.*

As an illustration of this problem, the same respondent gave an example of her neighbour*:*

> *My neighbor was on the way to deliver her third child. As the bridge is difficult to pass, when they took her the other way, a bit longer path, she delivered her baby while they were travelling. The lack of a good road to the Bezena Benara health center should be improved or an additional ambulance should be assigned since this is the closest health center that women can access a delivery service from, but when people need the ambulance the response that mostly is given is that the ambulance is working in another kebele or the ambulance is out of fuel.*

During conversations with women, the problem of ambulances and poor roads interacted with distances and additionally with weather conditions depending on the season. With regards to the ambulances, it happened that drivers could not come to take women to the health center because of a lack of fuel, or because they were busy with taking another women to the health center. This was additionally confirmed by a 1-5 network leader:

> *When my daughter felt pain, I was calling both ambulances repeatedly but the response I got was that one of the ambulances was in another far kebele and unable to serve us. The second ambulance driver also said the car did not have fuel and was unable to serve us (…) In the evening, people carried her and passed the bridge with a strong challenge, and God saved her life and she delivered safely. The kebele is vast and there are mountainous areas such as Azenesh Kida that are not accessible by car or motorcycle. If the ambulance is available it can go on another, longer path, but as mostly the ambulance is unavailable, people carry and bring women to the area that is accessible by bajaj. There are many women who have delivered their baby while traveling.*

These examples showed not only that the lack of a sufficient number of ambulances and poor road quality were problems, but also the fact that other people in the community were involved in laboring women's transition between home and health center. Therefore, having good relationships with others was critical for getting to the health center.

Photograph 13. Poor condition of roads in Aze Debo

Source: WIDE fieldwork materials.

5.4.2. State workers' perspective

My respondents who analyzed the factors that could hamper or facilitate their own work for better maternal health outcomes narrated them around three themes: the role of themselves and other civil servants in fostering 'better health practices', their own work constraints, and circumstances that hamper women's ability to make proper decisions.

For the Health Extension Worker, one of the biggest factors deciding her willingness to perform this job was satisfaction from observing health-related changes in the community. During her first years of work as a HEW in 2006, people did not want to cooperate with her and did not even allow her to approach their homes. It was challenging for her to do door-to-door awareness provision and observation of households' sanitary conditions. The common factor behind mothers' hesitation to use maternal health services, including delivering at home, was a lack of awareness. As the HEW noted, "to change this traditional thinking the government effort was strong". She was talking about her own satisfaction with increasing awareness in the community about maternal health services. Now she thanked God for the great change:

in comparing the health-seeking behaviour of woman, she said that in the past when she was going house to house for vaccinations, mothers hid their children as they did not like to inject them but now they were even calling her to ask about the vaccination day. Now people have changed and are more cooperative. HEW underlined that it was her commitment and endurance that had contributed to the new attitudes. One of the serious changes in recent years has been a change in awareness among women, which came about around 2014–2015. Before that period, there were different results in women's willingness to engage with formal health care, because there were no monthly conferences about the consequences of delivery at home.

Sometimes state workers' own experiences related to health problems during pregnancy served as their motivation to work for the improvement of women's health. A gender officer, who in 2017 faced miscarriage, assigned the reason for her miscarriage to the heavy work that she had performed: breaking wood that was used for fuel. She believed that breaking wood was a labor-intensive work that might have affected her unborn child. As she did not break much wood, she did not expect its effect. In light of this, she had been teaching women to take care while they were pregnant by avoiding carrying heavy materials such as fetching water from far areas and doing labor-intensive work. She also educated men about helping their wives in domestic work so that the health of their wives, especially if they are pregnant, would not be affected due to workload. She said it was only sometimes that she was serving the community since she did not work full-time like government employees. Due to this, she said it would be good if an employed gender officer worked continuously so as to achieve better results on women's wellbeing.

The strong political legitimization of the HEW's activities played a significant role in facilitating her work. People with various positions in the kebele administration were involved in maternal health interventions. For example, the Development Agent was involved in the change for health:

> *I teach women about the need for institutional delivery besides handling my own agricultural activities. Since I have started working in this kebele (since 2015) I have never heard of or come across a case of a woman who delivered at home.*

Even though Development Agent's main job was in agriculture, she was also responsible for following up on household sanitation and nutrition, and educating and encouraging women to use ANC and PNC. The wereda official responsible for the health sector also indicated that "health is the paramount issue next to the education sector, and among all the 23 sectors, health has the highest budget allocation".

Earlier than 2018, in 2011, there was a health committee with five members, led by the kebele chairman. It included one HEW and religious leaders[64]. The committee played a role in a close follow-up of implementation of health interventions. If there was a vaccination programme in the kebele, the health committee would instruct the health promoters and Health Development Army members, who then disseminated the information and mobilized the community. The committee was involved also in raising awareness against FGM along with the kebele administration and KMG. The kebele chairman linked the activity of health committee with the success of the kebele in the area of sanitation (Aze Debo Community Report 2011).

It can be seen, therefore, that legitimization from the state's side was very strong. This legitimization could be assessed as helpful in contributing to the successful implementation of maternal health interventions. The engagement of key actors—such as kebele chairman—and also pledging the highest budget allocation to health meant that the HEW had a certain extent of tools to fulfill her duties. Although this political commitment had the potential to create a promising space for policy implementation, there were some elements that influenced the HEW's work negatively.

Report writing and working in an environment with high pressure to achieve development targets were the main complaints of the HEW. This task was time-consuming and competed with the other tasks she had to undertake daily.

> *There are about 17 reports that I have to complete, some on a weekly basis and others monthly, for instance the Health Management Information System report, disease report, sanitation report, malaria report, food report, HIV carrier mothers report, list of mothers who delivered in a health facility report, tuberculosis report, AIDS report, and health care insurance members' report. Either I should have someone assigned to do the reporting work, or there should be paid incentives for the extra time that I spend on report writing. To improve mothers' health, I should focus on serving them rather than on preparing reports to be submitted to the health extension programme supervisor… Besides, sometimes we are called to submit a report sooner and in such situation we have to stop serving mothers and complete the report.* (Health Extension Worker)

The issue of report writing was also raised by the health officer at the health center, who argued that achieving and reporting targets, especially in the context of institutional delivery, was an important element of this job. Apart from encouraging women to deliver at the health

[64] This remains in contrast to the account presented by the preacher, who underlined that "we are teaching gospel, and teaching about contraception and delivery is the HEW's work".

center, sometimes his job was more paper-based than working with the real problems of women. Moreover, he mentioned that, due to the lack of achievement of assumed targets in terms of institutional deliveries, the previous health officer had been fired after an annual evaluation due to a lack of performance.

The submission of reports is needed because it serves as a basis for the evaluation of a given government employee as a part of *gemgema*. In this case, the Health Extension Worker was assessed at *gemgema* taking place at the kebele level, during which the kebele cabinet members were held accountable to the kebele council. The health center in which kebele officer served was held accountable to the wereda, and because of that he was evaluated at *gemgema* which took place at wereda offices in Durame. The result of *gemgema* is important for every kebele official, as it conditions further career development, or failure. In 2011, the officials explained that, through *gemgema,* several times in the past officials have been reshuffled or removed from their position. However, they added that some officials left their positions out of their own will whereas there were individuals who "want to stay many years in power" (Aze Debo Community Report 2011:126).

The account of the health officer concerning the danger of being fired for lack of performance was not unique. For example, another respondent said that if "a Development Agent has real but small figures in the report, they will be denied promotion, education, or will even be relocated to a distant rural place away from their family" (Aze Debo Community Report 2018:56). Fear of sending unsatisfactory reports had caused a trend of falsifying them. Although these issues are delicate and may seem difficult to verify, these accounts reflected a work atmosphere in which the pressure to report satisfactory targets was high and encouraged the sending 'good reports', which in the longer term prevents policy makers from improving health system. Under such circumstances, negative feedback on what worked and what did not was not very welcomed.

An overabundant work burden was another difficulty for the Health Extension Worker. In Aze Debo, there was only one HEW who served about 7,000 people in the kebele. This was because her co-worker had gone for education and she would be away for a year. Even if the HEW wanted to work more, her ability was constrained because of time limits and targets to be achieved. Although the workload had been eased thanks to the Health Development Army, it still posed a challenge.

Photograph 14. Everyday work at health post

Source: WIDE fieldwork materials. Upper left: women waiting for consultation with health worker; upper right: HEW; bottom left: reports and medical documentation; bottom-right: monitoring of health indicators in kebele.

There were also the ambulance problems faced by women that did not allow them to harness the possibility of using the formal health care system. The HEW and Health Officer agreed that there was a problem with ambulances. In particular, the HEW underlined that:

> *It would be good to enable women get service from the facility closest to their house. In the wereda, there are 18 kebeles. For these kebeles, there are only two ambulances. So, whenever a woman calls for an ambulance, the ambulance sometimes is in a far kebele and unable to arrive on time. In this case, the women take bajaj transport to go to the facility that is closest to their house. So, allowing women to get delivery service from the facility that they are close to is very important to improving their service delivery time.*

Finally, the last problem that the HEW mentioned was an issue that can be described as 'women's attitudes'[65]. The HEW said that, although women's attitudes towards health care had improved a lot, and they wanted to come to the health post and health center, there was

[65] The issue of 'attitudes' emerged also in the context of out-of-marriage pregnancy and abortion services, which were only available by referral from the HEW. Young women were afraid of talking about these issues with the HEW due to stigma related to out-of-marriage pregnancy.

a problem among some of the newly married women, mostly because many of them feared to come to the health post for ANC. Mostly they came after six months of pregnancy. Some of them came to the health post when they faced some pregnancy symptoms such as vomiting, but others who did not face this symptom did not come to seek ANC on time. Instead, they came when they were seven or eight months pregnant. The reason behind their fear was that people might blame them for becoming pregnant before improving their livelihoods. Due to this, they did not want to expose their pregnancy to other people. With regards to delivery, also some of the young women's mother-in-laws argued with these women about why they should go earlier to the health center as they did not want them to stay there for some days. This happened because some newly married couples lived with the husband's parents. To assist these young women, the HEW was giving them her phone number so they could call the HEW to ask about possible solutions. The HEWs and health officers highly encouraged women to deliver at the health center, but there were some women who feared that male health officers might see their internal body parts while providing delivery services and they had been debating this overtime in their minds. These were some of the factors that impeded women from seeking ANC on time and delivery services.

5.4.3. Summary

The evidence presented in this section has given insights into the factors affecting decision to seek care and the situation of health workers. From the women's accounts, a discursive divide between 'then' and 'now', 'traditional' and 'modern' approaches to one's health emerged, indicating a changing pattern of what was assessed as 'normal' and 'abnormal' in light of the dominating discourse about health care during pregnancy. The case of Aze Debo shows that women decided to follow a biomedical path because they realized that their fate was now better than it used to be in the past, when there was limited access to health care. Also, there was a growing consensus that birth is a risky event associated with bleeding, and a biomedical health care center can help women survive.

Among the factors that encouraged women to engage with the formal health care system was education, which enabled them to think more broadly about their health and critically assess their body's state. This, combined with the infrastructural availability of services, was a factor that encouraged to compliance with the formal health care system. However, there were constraints that women faced when deciding about care: general community poverty and related work burden, the perception of the quality and scope of health services, and distance to health centers. This suggests that problems related to the utilization of health services that were assessed

as ‘modern’ were more related to the general community poverty and service quality rather than insufficient knowledge about care. On the part of health care staff, there were also barriers and facilitators to performing their work. The fact that they had seen the effects of their own work was a motivator. A great role was played by the legitimization of their work by the whole local government. However, they also faced some constraints: report writing, work burden, and a lack of support from co-workers. It was also revealed, that despite significant progress in changing ‘old attitudes’, there were still women who treated health services with caution.

6. Discussion

In this chapter, I would like to discuss the results of the study. In the next pages, I will frame the discussion around the three research questions, referring to contemporary studies about health in Ethiopia and beyond as well as other studies concerning social capital in developing countries.

6.1. Reproduction of local social capital

As mentioned in the literature about social capital and health, the mobilization of social capital can be necessary for successful health interventions (Green and Kreuter 1999). While numerous studies have focused on the question of the consequences of social capital, it is relevant to ask about how social networks are created and what kinds of investments are associated with their establishment and maintenance.

The theoretical literature has provided various responses to the question of how social capital is established. The mainstream social capital literature has tended to portray social actors as social entrepreneurs, consciously investing in relationships as well as organizational arrangements in anticipation of concrete benefits (Coleman 1988). In Coleman's sense, people are rational actors who consciously invest in social relations to grasp benefits coming from involvement in these networks. As described in Chapter 1, Putnam's core claim is that deliberative activities and horizontal collaboration within voluntary associations promote trust, which cements the bonds of social life and provides the foundation for democratic governance and civil society (Putnam 2000). In Putnam's understanding, people are subjugated to collective norms in pursuit of 'collective good'.

The empirical findings reported in Section 5.2 regarding the processes of network formation and social organization reveal a more complex reality than the models in the mainstream of social capital literature. Firstly, the study has shown that there are basic bottom-up and state-led networks that often overlap with each other, and that the rules that govern these organizations can strongly influence each other. Secondly, the study showed several interrelated factors that shape actors' engagement in relationships. Women's capacity to engage in networks that could work for their health is conditioned by (1) their ability to incur costs related to socialization, so their material base; (2) lifestyles related to their gender (embodied dispositions, and thus gender-characteristic *habitus*, which is also shaped by the material

circumstances of their lives); (3) norms of inclusion (institutional criteria of inclusion that shape people's capabilities to be involved in social networks and shape similar modes of sociability).

Costs of sociability

The study found that women are generally in a dominated economic position that shapes their capacity to participate in certain associations, and not in others. In this regard, the evidence of this study coincides with other critical social capital studies that have explored the social capital of women in a developing countries context (Mayoux 2001; Molyneux 2002; Silvey and Elmhirst 2003). These studies have shown that women are very often central to the social capital forms that governments and development agencies are keen to mobilize in their community development policies. Evidence has shown that, in various locations all over the world, women are seen as those with the strongest community and kin ties, they are involved in supportive relationships, and they are those who support church activities and participate in local forms of associational life—basically in networks that are free of charge and are deemed to be 'feminine' domains. These domains include, for example, voluntary self-help groups in areas ranging from health to education and neighbourhood food programmes (Molyneux 2002). Such programmes are often governed by a tacit agreement that women are 'suitable' for emphatic care, associated with voluntary (i.e. unpaid) work, often in health projects. Such approaches assume that, because women are settled in their neighbourhoods anyway, they do not have to be paid for the tasks they perform for the common good. Therefore, they are likely to be a cheap project workforce.

Contrary to these views, this study has shown that there are various costs associated with forming and maintaining relationships. The costs of participation in social networks are both financial and non-financial. Some of these investments are available only to those of higher economic standing, such as contributions for gifts or preparations. Even more relevant are hidden costs of participation, such as the hard-to-quantify time needed to reach a meeting or the cost of the unpaid work of a 1-5 network leader. Often the ability to incur these non-financial costs is determined by a household's wealth. In this study, women who were less affluent lived in remoter parts of the kebele; therefore, the wealth of a household interacted with the remoteness of a household and affected the ability of household members to be involved in groups, both state-led and bottom-up. All these costs may seem not to be as relevant as they actually are in practice.

To show the importance of these costs of maintaining relationships, it is useful to look at a comparative analysis. The WIDE paper on service delivery in rural Ethiopia (Jones 2014) shed a light on the factors than prevent some people from benefitting from public services, channelled through state-led local government. The paper argued that harder-to-reach people lose out in two areas—the quality and delivery of services—because of everyday, seemingly trivial, experiences. People living in the remoter parts of a kebele have more difficulty accessing schools, health centers, electricity, and mobile phones. Roads, as in Aze Debo, are impassable or difficult in the rainy season. Poorer people struggle to access services that require them to input cash and, in some cases, time and physical effort: for example, it takes time and money for a pregnant woman to visit a health post for antenatal checks, or for an older person living with HIV to go to the health center to collect anti-retroviral treatment. The study also showed another side of the coin: these poor people contribute to the public good, providing labour for public works, income-generating activities, and social services that contribute to 'social cohesion', such as participation in self-help groups. If social capital is "the ability to secure benefits as a result of membership in social networks" (Portes and Landolt 2000:532), then the starting point is to consider the investment needed to establish networks.

Lifestyles

While the economic base of my respondents determined the extent to which they could take part in associations, there was another factor that mattered—gender. It could be said in Bourdieu's language that women's objective condition cause specific, gender-based lifestyles. It should be noted that my respondents were usually married women with children, which impacted a lot how and with whom they spent their free time. It is possible to state that the lives of women in my study had material-based and gender-based organization of space and time, similar to the case in other parts of Ethiopia (Pankhurst 1992; Jackson 2014).

Studies in Ethiopia have indicated that it is taken for granted that women are responsible for various household-related tasks. In 1992, Pankhurst noted that women in Ethiopia are responsible for everything related to food preparation, fetching water and firewood, grinding and pounding grain in the house, household sanitation, looking after children and the elderly, and taking care of the livestock around the house while they are pregnant (Pankhurst 1992). Despite the flow of time, 'home related work careers' were still mentioned almost 25 years later by Pankhurst (Pankhurst 2017). These kinds of 'careers' are often pursued by young women and girls in rural Ethiopia, and involve learning skills related to work inside and outside the house. Women are more depended on men as primary housekeepers, so they work mostly

inside households, while men go outside. Women's geographical mobility is restricted due to the character of their daily routines; if they perform economic activities, they do them in the local area, even if these patterns have changed slightly (Aze Debo Community Report 2011). The idea that women should not be mobile is also applied to the position of HEW, but to no other category of worker in the Ethiopian health system (Jackson and Kilsby 2015; Jackson, Kilsby, and Hailemariam 2019). However, there is another side to the coin. While mothers and pregnant women are still attached to the house, women's general freedom of mobility has increased immensely compared to the past (Bevan 2017). This can be attributed to a combination of factors including girls' access to education and various campaign initiatives to increase community awareness about women's rights, gender equity, and empowerment, as well as increased access to mobile phones, television and internet.

This study has shown that a gendered division of labour (i.e. women are mostly assigned the roles of housework and reproduction, with limited opportunities in the productive sphere) is relevant not only in the case of mothers. It is also the reality of everyday life for many young women and girls in other parts of Ethiopia. Despite ongoing changes in the lifestyles of the younger generation, young women are still not culturally able to form a household on their own, and opportunities for them to pursue an independent livelihood outside marriage are limited (Pankhurst 2017). Whether living in their natal or spousal household, most of their work ends up being in the domestic sphere. Only some of them have been able to obtain formal employment on the basis of their qualifications—and a few have been able to become HEWs, teachers, or Development Agents, vets, or micro-credit officers (Pankhurst 2017).

Marriage still continues to be the main 'method' to establish independent livelihoods for women in rural areas (Pankhurst 2017). Marriage, for many women, is an important transition to adulthood and marks the time when a woman can have a child in a culturally acceptable way (Jackson 2014). The importance of marriage can be better understood if one looks at the cases of women who did not follow this typical marriage path: unmarried mothers, widows, divorcées, and wives abandoned by polygynous husbands. As noted in the Aze Debo Community Report (2013) "there are few if any unmarried mothers [in Aze Debo] given the influence of the strict Protestant doctrine, and also no divorcee could be found (…) as divorce is frowned upon in the Protestant congregations. The ex-wife of the male divorcee had left the kebele" (p.32), while men divorcing do not leave the community. Further, "most of the widows interviewed are not rich and find it difficult especially when their children are at school" (Aze Debo Community Report 2011:32). However, while female-headed households in one of Pankhurst's

studies shared certain characteristics and constraints, it cannot be said that they were a uniform category and were certainly not all poor or destitute (Pankhurst 2017).

This study corresponds with other research describing the daily lives of women in rural areas in Southern Ethiopia. In her study about maternal mortality in the Kafa Zone (2010), Jackson underlined the common characteristics that structure how women can live their lives. She noted that it is natural that women work in and around the house, and that this is women's work, which differs from men's work. Some tasks, such as collecting water, preparing food and making coffee are daily routines. Even women who worked at the Women's Promotion Center in her study did not work in the fields but were expected to perform all the households tasks, including meal preparation and making coffee. This shows that women have a number of roles at a time—caregiver, mother, volunteer (Bevan 2017)—but it often happens that it is women who bear the disproportionate burden of the care responsibilities within the household. This resonates with a postulate arguing that "a more creative view would be to recognize that society's needs are better served by supporting both women and men to fulfil family care needs, and that working conditions can be restructured in ways that enable both women and men" (Jackson and Kilsby 2015:58).

The issue that emerges from the combination of all the studies above is the fact that work at home seems to be a natural predisposition of the women, and this becomes even more visible in the case of mothers. Connections that they establish through their domestic lifestyles are based on everyday interactions and involve a lot of connections like family and the closest neighbours. It seems that this durability of the existing social order, in which it is women who are responsible for domestic work, happens not as a result of deliberate action, but rather as a result of the conviction that 'this is how things have always worked'.

Norms of inclusion

Not only does the economic situation of women and their households or gender-based lifestyle determine women's participation in the networks, but also norms governing different organizations. In this study, the third trend that shaped women's capacity to reach out to others in different types of networks and activities were norms of inclusion—both for bottom-up and state-led organizations.

Among the bottom-up organizations, women in this study sometimes participated in networks that separated them from men. For example, gender segregation took place within iddirs and also in prayer groups. Although belonging to an iddir was not formally required by the kebele, iddir membership was culturally considered a must-have. Indeed, iddirs

in Ethiopia, beyond Tigray, are very popular. According to Hoddinott, Dercon and Krishnan (2009) iddirs were present in most of the WIDE communities. In their study, two-thirds of iddirs appeared to have no restrictions on membership beyond paying the necessary dues and fees, 14% were restricted to members of the same church or mosque, 6% were restricted to women, and 14% had some other restriction. Many of my respondents said that during iddir meeting they discussed different development activities, and that women like to attend these meetings because it kept them informed.

The last point about passing government messages indicates that division between 'formal' and 'informal' organizations can be misleading. A study by Hoddinott, Dercon and Krishnan (2009) confirmed that the misunderstanding of roles between state-led and bottom-up networks can lead to unintended policy consequences on the functioning of these networks, with potentially damaging effects on the capacity of the poor to mitigate and to cope with the effects of shocks. A better understanding of such networks can lead to the identification of components that complement existing networks that already serve the poor well, and to policies that can substitute for networks that are not reaching the poor (Hoddinott et al. 2009). As Tilly (1998) noted, the dichotomies of classifications like 'formal' and 'informal' organizations can miss the point that certain scripts of social relations intertwine, rather than work separately. As mentioned in the examples of women's prayer groups and iddirs (Section 5.2), a narrow focus on establishing a new function of institutional participation mechanism may obscure the fact that people are using their well-established networks and associations more than these new structures. Also, other studies like WIDE 2018 have indicated that these organizations remain important for community management even if new organizations are set up. In many WIDE communities in early 2018, people involved in community management as religious leaders and elders ensured more effective translation and implementation of government policies at the local level, mainly because of the trust that they enjoyed from the community members (Vaughan 2019). In the area of health, in early 2018, iddirs played a role that enjoyed a significant social trust among community members (Frankowska 2019).

Acknowledging these informal 'rules of the game' is relevant as it can impact the potential uptake of government campaigns in various policy areas. As noted by the Ethiopia WIDE "Equitable Service Delivery" brief (Jones 2014), despite the fact that various government policies have promoted rules for fair distribution of various resources, the local social norms of excluding certain groups of people have been very strong. For example, potters, a group that is deemed to have lower cultural status, reported that Development Agents would not believe that they were good at agriculture. In another WIDE community, a poor woman was forced to have

a contraceptive implant by wereda officials "telling her that she could remove it whenever she wanted". When she wanted to remove it because it gave her pain, she could not find the professionals, and the HEW who promised to help her "kept silent" (Jones 2014:6). These and other examples[66] show that some government officials' behaviours toward the disadvantaged groups indicate a lack of empathy towards these people and the factors that exclude them but not others. Therefore, in order to deliver changes to the lives of women, children, men, girls, and boys, any public policy requires not only the promotion of inclusion, but also the addressing of informal rules that can strengthen exclusion (Jones 2014).

Another important script of social life is provided by religion. It can be said that the rules of the game in the field of religion and systems of dispositions shaped by a religious field can also impact the different ways in which interventions are taken up. In Aze Debo, religion has supported a shift in perceptions about the activities in which women may participate. Over the years, women have started to be allowed to take on leadership roles. Protestantism has contributed to a greater acceptance of women's migration against the traditional assumption that women should remain at home. On the other hand, women cannot divorce, or be involved in the trade of *areke*, which can limit their possibilities for economic activity. It can be said that the value attached to churches in the community has created a type of collective identity, because, as Koster and Price (2008) argued, it has helped "identify with their cultural heritage, increase social integration and maintain social cohesion" (p.194).

Further, in this study, one of the preachers asked about Protestant churches' acceptance of government messages said that the church does not support circumcision and encourages women to deliver at a health center. On contraceptive use, it remains silent. This shows neither support nor opposition to contraceptive use—churches simply do not express their opinion openly. This distinction between the religious domain and the authority of the state represent the actualization of the field concept. The religious field structures religious *habitus*, which structures certain representations and approaches to issues like contraception, health care use, or women's rights. Bourdieu acknowledged contradictions between fields. These discrepancies result in a "destabilized *habitus* torn by contradictions and internal division, generating suffering" (as cited by in Van Holdt 2018:109). I did not ask directly about negotiations between government/religious activity in the area of maternal and reproductive health. However, it is apparent that there are certain areas of people's lives—such as those related to the condemnation of divorces, or the promotion of supporting the poorest of the poor—

[66] Examples can be found in *Equitable Service Delivery*, p. 6.

where religious scripts for proper conduct can prevent, or support, the results of the official campaigns.

Also among state-led organizations, women mostly occupied positions that were projections of traditional gender norms. Women held dominant positions in the health care field, where cultural capital—in terms of knowledge about 'proper care during pregnancy'—seemed to be explicitly appreciated by the health care providers and be directed to women only. This example shows that the state has power to set the rules of the game when it comes to patterns of association: it is not only about the right of citizens to organize themselves (Fox 1996), but also about the formalization of certain forms of capital conversion and distribution that favour the interests of dominant actors (in this case, representatives of biomedical health care). In other words, the official rules ensured that state-led networks in which women were involved basically favoured their involvement in 'feminine' areas of life, like health.

The question arises whether this gendered character of state-led social networks, transmitted from 'traditional social life', has the potential to improve women's lives (Molyneux 2002; Nussbaum 2000). By being concentrated on household life, women appreciate the fact that they can talk freely and can establish trusting relationships among themselves. On the other hand, how does this contribute to the improvement of their lives, and how does it reduce gender inequality, which is essential to achieving better health? Getting involved in social networks within the boundaries of inequal gender norms provides some space for women to create thick, safe relations, but, on the other hand, they are focused only on one field, which does not guarantee improvement of their general position. Involvement in feminine networks is not oppressive in itself, but the fact is that women have limited choice as to which networks they can become involved in.

The argument about the need to involve women in areas other than 'feminine' ones is important, as their ability to grasp the benefits of formal health care depends on the material condition of their households. This finding about the limited consideration for women in livelihood interventions resonates with the WIDE study, which showed that women's involvement in them leaves a lot to be desired (Loveday 2017). This is not to say that concentration on women's reproductive role totally prevails. Women's economic participation in Ethiopia is expanding and has become very diversified in the past 20 years, both in the farming and non-farming sector. The type of economic activities in which women are involved depends on the type of community in which they live, but at the individual level it has been wealth that matters the most, i.e. more than age or status within the household (Loveday

2017). The picture from WIDE has been mixed: in all communities, including Aze Debo, there have been a number of interventions not targeting women but to which, in principle, they have had access, but in reality their participation has been limited. Some of my respondents said that "there are no interventions for women, only for men." The recent change in perceptions of women capabilities and potential for economic growth has opened up some possibilities for women (Loveday 2017). In this way, it can be said that, although there has been official acknowledgement of the need for inclusion of women in economic life, the practical experiences at the micro level still show many constraints.

With regards to agency in establishing social relations, it is apparent that this process does not depend exclusively on rational calculations (Coleman 1988, 1990) or simply submissive agreement for the sake of the common good of the community (Putnam 1993, 2000). Relationships are established as a result of a combination of common, everyday practices that sometimes are not fully conscious. Moreover, women have to be a part of state-led networks in the thematic field determined by the state. In this way, it can be said that their capacity to freely reach out to others is somewhat limited. Women establish networks, but within the existing boundaries of their daily lives and official norms of inclusion. Perceptions about who can participate in which networks seemed to be regarded as 'a natural fact' by participants in this study. This was the case for both bottom-up and state-led organizations. When it comes to agency in participation in state-led networks, the study suggests that the agency of the women to freely invest in social relations was frustrated. For actors to decide whether to participate in a network means that they should have the right to refuse or to accept, and not be encouraged by formal sanctions to join. This does not mean that these women were not capable of exercising agency, nor that they had any less potential capacity to construct meaning for their social relationships. Following Cleaver (2005), the study suggests that these potential capacities were frustrated by the unequitable social and economic structures and institutions through which social norms were channeled.

To sum up, there are three takeaway messages. Firstly, it can be said that, although there may be a number of organizations in which one could potentially participate, the costs associated with them are serious obstacles which should not be underestimated. Therefore, even if participation in networks seems to be free, there is always some kind of investment, either financial or non-financial, that needs to be made in order to sustain relationships. The assumption that social capital is the starting point for moving out from a difficult situation (like any health problem), without consideration of broader issues of material standing, can lead to a situation in which individuals are deemed responsible for their deficit of social capital.

The analysis of social capital without taking account of the costs associated with its establishment can paint an overly rosy picture of the benefits that can be incurred from social networks. Moreover, my study has shown that women establish connections as a part of their everyday activities, which are a part of their lifestyle, by far determined by their role as caregivers and mothers.

Secondly, we have seen that the state presents agency in creating dedicated networks for women, participation in which is obligatory. When we consider participation in these networks as compared to the whole spectrum of organizations in Aze Debo, we can say that the existence of gender-based networks reproduces the existing social order in which women are attached to typical female spheres. It can be said that health-centered networks promoted by the state ensure that things are done the 'right way' in cultural and symbolic terms, i.e. traditional gender divisions are not much challenged and women are still attached to home, health, care, etc. Given the imbalance between economic and health activities as distributed between men and women, one can risk the assertion that women can participate in associations but on adverse terms, especially if one looks at the entire spectrum of community-based and state-inspired associations in Aze Debo[67]. This is not to say that being involved in health-related activities is detrimental for these women, but the overemphasis on health-related interventions meant for women only can limit the spectrum of life-changing activities that they can choose from.

Thirdly, the case shows that formal connections are established on the basis of informal ones and are mixed up with each other. This implies, therefore, that everyday practices and daily interactions present in the informal associations underpin the functioning official institutional arrangements. This is in line with other studies in a developing country context (Cleaver 2002; Mosse 2005). Also, other studies in Ethiopia have indicated that informal rules of the game are likely to impact the translation of government policies (Jones 2014).

6.2. Complementary character of mothers' relationships

In previous section, I discussed processes and factors that influence the establishment of social networks. In this section, I would like to add the second side to this picture: the resources that become available in networks, which have been also described as the consequences of social capital for health.

[67] See Section 5.2 on existing networks in Aze Debo.

The health literature related to social capital and health has proposed various propositions concerning the resources available in networks. Mainstream social capital scholars have tended to see consequences (also termed 'resources that are available in social networks') in two ways: as (1) resources that people can mobilize through purposive action, and (2) collective mobilization for the production of public goods. These approaches have neglected the objective conditions upon which networks are established and have portrayed benefits in rather limited connection with regards to their sources. It is not enough to investigate the existence of bonding, linking, or bridging connections; Bourdieu's approach sees the mobilization of different benefits by social actors as connected to their objective conditions (capital endowments) and subjective appropriation of objective reality (*habitus*).

This study has shown that the major types of resources available in social networks are (1) health education, (2) social control, and (3) social support. The study has shown that these resources are channelled to women through people in different power positions in the community. Those affiliated with the formal health care sector are in a 'dominant position', because they have the legitimization of the state, which is the major health care provider. Their role is mainly about creating awareness and controlling women's behaviours. Other people, who can be described as 'ordinary people' or those in a dominated position, are sources of social, spiritual, and material support. Thus, dominating and dominated networks were complementary in this study when it came to access to different types of resources.

Relations between mothers and health service

In this study, Health Extension Workers and 1-5 network leaders performed activities that were strongly legitimized by the state. They were responsible for educating women about proper care and also controlling their behaviours and exercising social control. Through these channels, HEWs and the 1-5 leaders defined the 'rules of the game'. Their dominant position decided the exchange value of various resources (i.e., knowledge about proper care during pregnancy meant that a woman had a chance to become a 'model woman'), and how these exchanges might occur (i.e. going to health education meetings meant that a woman could acquire awareness about proper care, or if a woman participated in 1-5 networks she had a chance to increase her medical knowledge legitimized in the health care field).

The study showed that health education is critical to the production of health and the production of compliant behaviours by mothers within a new model of care. However, compared to other discourses in the health sector (such as doctor-patient relationships), in health promotion, which includes health education, power issues are less often

made explicit (Abel 2007). Cultural resources for health are considered matters of free choice, individual taste, or consumer preference, which can be problematic, as they are also matters of conflict and power (Abel 2007). This may be particularly important in contexts where new norms concerning health are introduced which involve changing attitudes towards 'proper behaviour'. Even seemingly neutral practices are, according to Bourdieu, embedded in the system of social distinctions. This approach highlights the fact that setting norms, including those that are related to proper care, is a contested process of negotiation between actors of different positions around different interests.

I argue that health education in this study worked in two ways at the micro level. Firstly, for many respondents, health education was seen as a means for broadening women's awareness, leading to their empowerment. This empowerment discourse was an official one and it seemed to resonate very well within the Ethiopian government system (Maes et al. 2015a; Crivello, Boyden, and Pankhurst 2019). Secondly, education was meant to promote 'desired behaviour' or, as many of my respondents noted, a 'healthy lifestyle'. In a subtle way, such a reorganization of perceptions resulted in social control and worked as a means of discipline.

With regards to education as a means of empowerment, in policy documents[68] empowerment means a process through which people gain greater control over decisions and actions affecting their health. These decisions concern different areas such as taking contraception, delivery at a health center, and access to safe abortion. Gaining greater control can happen thanks to health education: empowered citizens are people who, based on the knowledge they have acquired, make informed decisions about how to care for their bodies. It is recognized that these decisions are said to depend on the community, but also on power dynamics within a household—for example, the extent to which a woman can decide the allocation of resources within the household and who is the main person who manages the household.

A central parameter in this empowerment framework in policy circles is 'choice', together with terms such as 'option', 'control', and 'power' (Malhorta, Schuler, and Boender 2002; Mjaaland 2015; Bardasi and Garcia 2017). As Kabeer argued, the issue of choice in empowerment frameworks in policy circles is based on a liberal, Western understanding of the person (Kabeer 1999; Kabeer 2002). The question arises how to move from the individualistic understandings of choice without ruling out the power and agency implicit in choosing (Kabeer 2002). This specification has often been lost when her most frequently quoted definition of empowerment is recycled in gender and development literature: "one way of thinking about

[68] See Health Sector Transformation Plan 2016–2020.

power is in terms of ability to make choices: to be disempowered, therefore, implies to be denied choice" (Kabeer 1999:2). Kabeer, in her empowerment framework, also distinguishes between "transformative agency" where women act against the grain of patriarchal values, and "passive agency" that might increase their efficiency but without challenging existing power relations (Kabeer 2005). This second point is relevant to different choices concerning women's health in Aze Debo and beyond, especially when it comes to FGM. In this study, women did not abandon FGM because this would limit their chances for marriage. Therefore, it can be said that they chose to comply with existing gender norms, even if they were harmful to the women's health.

In the local policy documents examined in this study, the concept of empowerment was related to the concept of participation[69]. Participation was understood in terms of membership in the Women's Health Development Army, similar to in other parts of Ethiopia. In Aze Debo, participation was understood as taking part in meetings on various topics (agriculture, health, etc.) to get knowledge about what was happening in the kebele. My study shown that participation was linked to the meetings and creating awareness. However, it seems that women were rather passive recipients of health care, rather than actively engaging in conversations about their health, or the functioning of the public health care system. Their participation in meetings was related to being informed rather than to speaking.[70]

Other studies about the utilization of health care at the local level in Ethiopia seem to have confirmed that participation has been associated with being a member of the Health Development Army and adhering to the norms of care it set. As Jackson noted in her study about changing the place of birth from home to health facilities in Kafa Zone, the Health Development Army played a role in following and mobilizing women in order to make sure that they followed official health advice. The Health Development Army was a tool for making sure that husbands did not oppose women going to the health center and that people were not engaging in traditional practices. Compliance was achieved thanks to the threat of being taken to court for opposition (Jackson 2016).

These findings seems to confirm studies arguing that participation in the Ethiopian context is related to coercion[71] (Vaughan and Tronvoll 2003; Vaughan 2017, 2019; Di Nunzio 2019). However, in 2018, there was evidence of wider resistance to participation (Vaughan 2019). The unwillingness of people—both kebele officials and the wider population—appeared as common themes. What is crucial, even 1-5 and 1-30 leaders reported that they had heard about

[69] See *Health Sector Transformation Plan 2016-2020*.
[70] It is well illustrated by Photograph 11.
[71] I did not ask directly about participation, nor did I ask about local understandings and language translation of the meaning of the word, which I admit are omissions from the perspective of the study.

meetings but not participated in them. As Vaughan noted, women leaders in Tigray sites had a new model of "mehiber[72]-combined with equb, which encouraged people to come to relatively short meetings, held close to home, with convenience and a practical focus" (Vaughan 2019:159). Moreover, attendance at meetings was less compulsory, but it still could have repercussions for the possibility of obtaining benefits (Vaughan 2019).

In the literature about social capital and health, social control has been enumerated as one of the major consequences of social capital in different contexts, including the context of health at the community level (Portes 1998; Kawachi et al. 1999; Lindström 2008). Kawachi et al. (1999) emphasized that social control can be particularly imposed on people in informal settings, where the community 'regulates deviant behaviour' among people, such as drug use or under-age smoking. This explanation can be connected to Coleman's (1988) reasoning about norms and effective sanctions, which influence not only the individual but also a whole community by encouraging certain behaviours while restricting others. In the case of maternal health, this social control in its strongest form has been exercised by the state.

Social control in this study worked through two mechanisms: education and direct formal sanctions. Health education incorporated a cultivation of the fragility of women's bodies, which worked as a form of social control through the constant threat of bodily harm to mother or fetus: the pregnant woman was encouraged to impose a wide range of restrictions on her own behaviour, but was also taught that none of these measures might be sufficient to sustain the pregnancy or guarantee the physical health of her child. In this way, the dominant cultural construal of pregnant embodiment created a *habitus* of vigilance, in Bourdieu's sense of the word: dispositions, behaviours, and ways of perceiving the world that are shaped by an ongoing fear of sudden loss or injury caused by unpredictable natural forces. As La Chance Adams and Lundquist argued, "this emphasis on biological factors covers over how anxiety is cultivated by our contemporary interpretation of reproduction, and how this interpretive framework shapes our perceptions and attitudes" (La Chance Adams and Lundquist 2013:36). These pedagogic rules have gradually become implicit and tacitly understood.

This study found that the incorporation of specific values — such as self-surveillance — through education was meant to serve as a distinction between the past and the present, and so represented the expression of modernization. The modernization of attitudes went hand in hand with the modernization of infrastructure. My respondents were subjected to different structural factors at different times: older women remember the naturalization of homebirth, but young women regarded delivery at a health center as something normal. Some studies about

[72] Mehiber is a religious association.

childbirth in Ethiopia have noted that sometimes older women preferred more traditional approaches to care (Jackson et al. 2016). This generational mismatch is acknowledged by Bourdieu's framework, because different material environments and organizations of the health care field in a historical sense generate differences in parents' and offspring's *habitus* (Bourdieu 1977). It is important to note that in the context of this study, Bourdieu's distinction did not work so much in the sense of distinction between women of different social classes, but rather between older and younger women. This distinction was marked by the different values, norms, and attitudes regarding health care in pregnancy present in different times.

This study found a medical system in which women are entitled to free health care, but which, at the same time, establishes certain requirements of social contract between the state and mothers, in which women deliver at a health center and regularly go for antenatal checks. If a woman deviates from these norms, she is labelled as backward and can be punished by the state. In this way, the state creates a disciplinary system governing women's behaviours. This study supports Maes' (2015) conclusion that there are some tacit normative assumptions that are the basis of practice for a decentralised state and citizens in the area of maternal health policy. These assumptions include the privatization of responsibility, in the sense that it is the woman who should be more aware of her own body and should take care of herself during pregnancy.

The issue of trust towards health care providers emerged in this study. The concept of trust is not explicitly mentioned in the Bourdieusian perspective on social capital. Contrary to Putnam's approach to social capital, in Bourdieu's perspective, trust as a potential component of symbolic capital can be exploited in the practice of symbolic power and symbolic exchange[73](Siisiäinen 2000).

The study showed that trust in the medical care is built through quality care provided by health care workers. Ostergaard in her study about health care systems in developing countries argued that quality of care, along with sensitive use of discretionary power, perceived empathy, and workplace collegially are the four major factors that seem to foster trust (Ostergaard 2015). These factors appear in different weight in different contexts. The power aspect is important in the public discussion about health care because of the inherent asymmetry in knowledge, control, and resources between professionals and lay people. This must be recognized by health workers in their sensitive and fair exercise of discretionary power (Gilson, 2005).

[73] As Siisiäinen noted, "with a slight exaggeration of the differences between Putnam's and Bourdieu's ideas we can formulate a Bourdieusian concept of trust: trust can be understood as a universalized value (virtue) posited as the basis of voluntary, disinterested action and exchange (or interaction). However, in the last analysis, the universal character of trust can be questioned and – as a rule – revealed as a euphemism concealing the hidden, but underlying specific interests of the powerful" (Siisiäinen 2000).

Indeed, in the case of Aze Debo, quality of care and empathy was something appreciated by women that therefore contributed to better attitudes towards the public health care.

Summing up, in this study the major type of relation between the women and the HEW and Health Development Army members can be broadly described as unequal: those people affiliated with the state had the power to determine systems of classification that they imposed on subordinated actors, who in this manner internalized, to different degrees, new values, rules, and attitudes related to medical care. In the same way, perception systems imposed by HEW and Health Development Army members caused women to accept that it was only them who were responsible for health; little reconsideration of men's role in this process was visible. Moreover, the internalized perceptions caused women to see significant distinctions between the past and the present. Health education had several functions: it helped to broaden women's knowledge about their own bodies and, in the opinion of many, helped them to better take care of themselves during pregnancy; it served as a symbolic marker of modernity in the views of women; and it worked also as a social control element by imposing certain systems of dispositions and moral obligations related to proper care on women.

It could be also said that health education had a double significance. There was a prevailing opinion that, thanks to health education, women were 'more aware' and took better care of their bodies. Women also appreciated the fact they interacted with other women and that HEWs were female, which could be related to the existing conditions of gender inequality (Jackson et al. 2019). However, as stated in the section about norms of inclusion, I found that because the state does not sufficiently support women's activity in other areas of life (such as those concerning livelihood improvement), it can reinforce existing gender inequalities through further (frequently unintended) limitation of contact with people dealing with issues other than health. Although an HEW represents the civil government, she is female and can be subject to the same local hierarchies that prevail in the wider society. Relying on female health workers may replicate gender norms in communities and within health systems, and leave power relations that require addressing male gendered behaviour unaddressed (Jackson 2019). Indeed, recent studies have indicated that even Health Development Army leaders experience similar problems to other women: insecure access to food and water, ownership of few assets, very low levels of schooling, heavy workloads combining work in several domains, and debt.

Relations with family and neighbours

While formal health care is provided by the state, the study showed that women had to rely on an informal system of support, which consisted mostly of neighbours and family, to access the biomedical health care.

The study showed that people were linked by multiple ties, and many of the inhabitants knew each other personally. A neighbour was also a relative and a member of the same iddir or church prayer group. It is important to note that 1-5 networks were superimposed on the connections women already had as family members and neighbours. In this way, women were able to get some kind of support from these people, especially when it came to transportation to a health center. The importance of relatives and neighbours for delivery is reflected in statistics: in the years 2011–2016, 28% of births were delivered by a skilled provider; most births were helped by family members, friends, or Traditional Birth Attendants (56%); 15% of women delivered their babies themselves (Central Statistical Agency and ICF 2016).

The study showed that, although there has been a change in the community in the approach to the model of care during pregnancy and delivery, the role of other family members and neighbours has remained important. Just as the companionship of others was crucial for women who delivered in the past at home, it has remained relevant for women who have moved to health centers. Although I did not record story about a woman who delivered at home, other recent works have described what such childbirth looks like, such as Jackson's research about maternal health and development in Ethiopia (2014). Jackson narrated how most of the women gave birth at home with the assistance of their neighbor, mother, mother in-law, husband, or sister. In addition to the support of close neighbors or family members, women called on God and St. Mary during their labor to help them deal with the pain. Jackson's study was conducted at a time when the Health Extension Programme had been just recently launched and the ban on delivery at home had not been introduced. Among her respondents, two of the four women who gave birth in a hospital or health center had planned to do so. In the accounts of the women, there was often a comparison of the functions that other women in the community performed: the birth assistant held the woman tightly by the shoulders from behind so the woman felt supported and massaged her abdomen with *kibbi* (butter). Almost all the women reported that someone had massaged their abdomen during labor, which is a common practice to deal with pain and speed up labor. Women wanted to keep their pregnancy secret for as long as possible; they did not want others to know, apart from relatives or neighbours whose role was to support the pregnant woman. For women without such people close by, there was a sense of being alone.

It would not be an exaggeration to say that women without familial and neighbour support would be likely to be deficient in the support required for their smooth transition to a health center (Reeves et al. 2014). This kind of support is often described as evidence for social cohesion or solidarity. However, it can be also a manifestation of poverty and a lack of state capability, as the formal health care system does not provide opportunities to get to a health center, and people have to rely on ad-hoc transport, which is not guaranteed and often is not available for all birthing women. Indeed, scholars have argued that weak social security systems may cause people to depend on their social networks for different kinds of material and economic support (Rostila 2013) and that patients' tight-knit relationships frequently fill the gaps in a weak health care system (Amoah, Koduah, and Gyasi 2018). Other studies of social capital in developing countries, not only in the context of health, have indicated that those with rural disadvantages usually depend on informal rather than formal systems of power to access resources (Mosse 2010), and that poor people, while lacking material assets, call on close relations with family, neighbours, and friends as a form of social security (Das 2004, Cleaver 2005).

The issue of building trust appeared in this study, but this time in the context of individual trust towards other people in the community. Women in Aze Debo argued that trust is conditioned by the ability to keep secrets. Other studies of social capital and pregnancy have indicated that, in the context of pregnancy, trust appears important (Agampodi et al. 2017; Jackson 2016). This becomes even more profound in the Ethiopian case. For example, Jackson reported that "birth should be kept secret, and others stated that it was best not to have too many people around as it might bring bad luck." For her respondents, it was not fine if people beyond intimate friends knew a woman was in labour, and it was not welcomed if others were around a labouring woman until she had delivered the child (Jackson 2016).

6.3. Compliance with modern care model and condition of health service

In Section 5.4, I asked a question about what factors affect women's decisions to seek care and the health workers' institutional situation. In this part, I would like to discuss the reasons behind women's compliance with the biomedical model of care and institutional situation of health workers.

Women's compliance with the biomedical model of care – a combination of material and symbolic factors

It is worth re-emphasizing that this study of Aze Debo delivered interesting cases of women's prevailing compliance with a new modern health care system. The picture that

emerged from the data was intriguingly uncomplicated. It seems that women did not oppose biomedical care, but they pragmatically pursued the logic of the dominant biomedical discourse, at least when it came to care for mothers and children. It seems that they wanted to deliver at a health center, and they wanted to go for antenatal care and use the benefits of biomedical care. In general, they followed practices that enabled them to 'save their lives'. Home birth was neither desired nor romanticized. The case of Aze Debo seems to confirm the hypothesis Johnson (2016) presented that "marginalized women[74] (…) tend to be least critical of medical intervention in pregnancy and childbirth" (Johnson 2016:181). The question arises: What were the reasons behind the prevailing declaration of compliance with the new model of care during pregnancy and childbirth, given the degree to which the government enforced medical authority? This concerned especially delivery at a health center, which was obligatory for all women, without exceptions. Despite the state medical control exercised over childbirth at the health center, women demonstrated little resistance. Below I discuss several factors that may have worked in combination to encourage women to seek care.

Firstly, it is right to emphasize that pregnant women in the study context received better treatment than they used to before the launch of the Health Extension Programme. Maternal health was free of charge at public health centers. Women were entitled to antenatal care, delivery at a health center, and postnatal care. Also, malnourished mothers were entitled to supplementary food available at a health post. Those who delivered confirmation that they were pregnant were exempted from PSNP public works. Women who remembered the 'old times' without such possibilities frequently appreciated these infrastructural and organizational improvements. At the health center, space for birthing mothers had been upgraded thanks to the presence of coffee and porridge. Women also noted an increased awareness about immunizations and ways of preparing food for themselves and their children. It was also true that many of these services were relatively new and had some shortcomings. The WIDE study (for example, see Bevan 2017) documented evidence of the low quality of these services for mothers. For example, women presented very ambiguous accounts about what was included in antenatal checks. Because of the pressure put on HEWs to meet targets, health providers' accounts did not always match the accounts of community members (Bevan 2017). In Aze Debo, according to the HEW, 93% of pregnant women received antenatal care, but little detail was derived from respondents' interviews. Also, other studies have indicated that indeed there are many shortcomings in the health care quality in Ethiopia (Jackson 2016; Jackson et al. 2016; Jackson

[74] Candace Johnson conducted research about preferences for care during pregancy and childbirth in four countries (Canada, the United States, Honduras, and Cuba) using the lens of intersectionality. She used the term 'marginalized women' to compare the lives of women from developing countries (Honduras, Cuba) in contrast to the lives of women from developed states (the United States, Canada).

and Kilsby 2015; King et al. 2015; Awash et al. 2007). However, despite these negative aspects, access to health care services can make a qualitative change of great importance in the area which did not have access to such services before.

Secondly, it seems that the prevailing experience of poverty and scarcity of resources like food and water, assisted by the scarcity of health care services, led to a situation in which women realized that their fate was better than in the past, when there was no access to health care. This was especially evident when women declared that it was structural factors, such as general poverty, or work burden at home, that prevented them from going to the health center. Education played a notable role in this realization that their fate was better now than in the past. In their account about the benefits of proper health care, women often noted that the current health care was a sign of progress. There was a growing recognition that birth is a high risk event associated with bleeding that requires the 'medical gaze' of a health practitioner. Women generally associated TBAs with risks and a lack of knowledge and technologies (medicines, etc.). The experience of the lack of biomedical care in the past, accompanied by the experiences of poverty, seemed to push women to biomedical care. Moreover, Aze Debo has only state-sponsored health care, and private health care has limited offerings outside the community, available only to better-off people. It could be said that women simply preferred what was available to them at a given moment.

However, the prevailing compliance strategy was not only a result of the experience of scarcity and the memory of a time when many mothers died. For many of my respondents, health was the 'basic functioning' in life. According to my informants, not only did being healthy mean a lack of disease, but also living in harmony with God and society, as well as being able to care and work. Childbirth, even if it was considered a normal event, could lead to a woman's death and therefore destroy all chances for better life in the future. Biomedical care minimizes the risk of health damage and health loss. This perception was reflected in the accounts of my respondents, who had seen many women dying because of lack of care. This change in perception can be potentially assigned to health education campaigns and the efforts of HEWs and the kebele administration.

Thirdly, the study can turn attention to the issue of the identity of women, which in the context of the study could be still defined by being a mother and being able to fulfil this social role. Despite the fact that I did not ask about ideals concerning proper womanhood and the meaning of motherhood, Ethiopia WIDE has shown that marriage and giving birth are important for women in Aze Debo:

Getting married has never been seen as a problem or disadvantage. It is seen as blessing and being lucky. Women who have got married feel the sense of security and completeness especially when they have children. No woman wishes to stay unmarried and called 'komo ker' [name given to a woman who has never got married. Establishing a family is seen as the main purpose of women, she has no other life other than that. And most girls who go to school prefer to get married and then proceed their education not to risk their chance of getting married – because men prefer young girls for marriage. (Aze Debo Community Report 2018:159)

Women lived under conditions of scarcity of resources and opportunities, and also under gender norms assigning women to their reproductive role. In this context, it seems that women preferred these actions and behaviours, which enabled them to strengthen their current position or at least keep it without challenging existing norms. Despite the fact that opportunities for women are broadening, as exemplified by the WIDE research, women still are thrown into a world where the default meaning of women is presented through their ability to become mothers. This corresponds with the concept of 'passive agency' as described by Kabeer (2005): women agree to behave and act within the existing constraints of their lives and can choose options that do not necessarily result in a greater gender equality or refusing the obligation to become a mother.

To recapitulate, the study suggests that compliance with biomedical maternal care results not only from the experience of poverty and scarcity, but also from the prevailing construction of women's identity as mothers (so internalized systems of perceptions). The realization that now their fate is better than in the past is combined with the visible expansion of health care infrastructure and also with education that has produced a new vision of individuals who have accepted new norms of biomedical care. Studies have indicated that women from the Global South usually do not romanticize events like natural birth, which is quite in contrast to women of the Global North, who often resist medical authority. Even if health care presents different shortcomings, "women of the Global South can make virtue out of necessity, rather than from 'desirable and authentic experience of mother'" (Johnson 2016:54). It could be stated that the prevailing strategy is strongly connected with both a material dimension (poverty) and a symbolic dimension (like the strong social position of being a mother and growing recognition in health policy of this status). At the same time, it should be noted that studies in the Global South have concentrated on depicting women as mainly impoverished and lacking agency (Johnson 2016). The study argues that, although their pursuit of better care for themselves is, to a great extent, a result of their experience of poverty, there is a need for greater attention

to their identities, as this can increase diversity and challenge the typical representations of these women.

It should be also emphasized that even the women who were compliant with the norms of medical care during pregnancy were not totally uncritical of such care. While the overarching objective of women's reasoning was not to resist the biomedical rationale, they noticed shortcomings in the medical system and, depending on their resources (both cultural and material), could adjust their responses. This was visible in the case of better-off women, who went to the city for delivery if they were not satisfied with the care provided at the rural health center.

Moreover, while in the area of maternal care women were mostly compliant, in other issues of reproductive health women (not only mothers) did not follow a clear pattern of compliance or resistance. This was particularly illustrated by some women's resistance towards contraceptives and return to FGM; in these cases, women made choices that could be seen as strengthening their gender inequality. Young girls in Aze Debo even asked for FGM, and boys would not get married to an uncircumcised woman because they believed that this had something to do with the woman's discipline—how well she would respect her husband and listen to his decisions in the marriage later. These decisions can be regarded as choices, but these decisions strengthened existing inequality. Such an approach resonates with Bourdieu's perspective on choice, which is mostly influenced by existing structures.

These examples of selective compliance and resistance to medical norms show that biomedical representation of what is deemed to be healthy is not always able to grasp women's experiences of their bodies and how they relate to their identities and desires. Other studies also have shown that medical norms can produce a range of resistant and compliant practices. The study by Root and Browner showed that result of negotiation between medical and 'haptic, subjugated' knowledges is always 'in flux and derived from numerous sources, biomedical, bodily and the interactions among them' (Root and Browner 2001:219). Many of these practices are also filtered by the experiences of women's mothers, sisters, friends, and health care providers, and also depend on each woman's perception and lifestyle. With regards to my study, it could be predicted, if not concluded, that, in certain aspects, biomedical maternal health services served women's interests – either this interest could be to be healthy and alive, or become a mother, or simply grasp the benefits of modern care that were not available in the past. Various examples, such as the one of contraception, seemed to confirm this claim. Some women claimed that they did not use contraception because

of the side effects, which could be termed silent resistance[75] and an unwillingness to limit the number of their children, which was against their husbands will. On the other hand, they sometimes wanted to use contraception because they realised that rearing children is difficult when one lacks a solid financial base.

Such a selective resistance and compliance seems to confirm the argument made by Root and Browner that women "negotiate diverse subjugated and diversified authoritative knowledges" to suit their needs and desires (Root and Browner 2001:196). It is fair to say, therefore, that the actions of women are always in flux and that very clear analytic divisions between compliant or resistant behaviours must be mapped very clearly.

Health sector providers – between targets and moral obligations to provide care

HEWs, along with other civil servants, have a unique intermediary position between the community and health sector (Haines et al. 2007). In Ethiopian context, such civil servants are a part of Ethiopia's local government system that has been an important driver of socio-economic change (Vaughan 2019). Along with other government programmes implemented at the local level, the capacity of the Health Extension Programme has been systematically built and reconfigured. The HEP evolution has been marked by a gradual movement towards a medicalised model of care for women during pregnancy: the emphasis has shifted from HEWs providing clean and safe delivery in a woman's home or at a health post to disseminating information about and creating demand for birth preparedness and complication readiness, the importance of ANC and skilled attendance at delivery, and referral to facility-based care.

Local experiences of the Health Extension Programme in Aze Debo showed many challenges in my study which are not exceptional in the Ethiopian context. In other parts of Ethiopia, HEWs have also experienced similar multiple difficulties in their daily lives and working conditions: poor infrastructure, lack of drugs, an unattractive salary scale. The living and working conditions of HEWs were not sufficient during the early phase of the implementation of the HEP (Yayehyirad et al. 2007). HEWs were deployed in remote areas where housing was very important in motivating and retaining them in the communities. The relationships between HEWs and other community health workers, such as TBAs, were not clearly established by 2008 (Awash et al. 2007). There was an unmet need for interventions to manage burnout or emotional difficulties (Jackson and Kilsby 2015). Despite the fact I focused in this study on ordinary women, Ethiopia WIDE has documented that, in general, local civil servants experience common issues, such as cumbersome reporting, upward accountability

[75] Personal communication, Addis Ababa, October 2018.

with local accountability variable and blurred, lack of inputs in all sectors, high workload, and little space for agency to stand up to top-down pressure. Moreover, health workers have little power in the kebele cabinet with bigger concentration on the livelihood field (Dom et al. 2011).

A HEW in Aze Debo expressed that she was satisfied because of the possibility of serving the community and also seeing the effects of her work. Other studies in Ethiopia have also indicated that fulfilment and the ability to serve the community were important motivations for health workers (Jackson et al. 2019; Maes 2016; Tesfaye 2017). Values like 'changing the community' and 'saving mothers' lives' have also been important elements in macro-narratives about the work of low-paid or unpaid health workers in urban context of Addis Ababa (Maes et al. 2015a). These motivations are important basis for building solidarity between health workers and with patients. While creating a motivated health workforce ready to serve patients is an important element of building effective health care systems, there is also another side of the coin.

Relying on the rhetoric of values and moral obligations such as self-sacrifice can lead to the situation where HEWs have less capacity and possibility to express their voice when it comes to their working conditions and payment. This can be exacerbated by the fact that it is mostly women who are health workers. Studies have suggested that there is a silent assumption in the HEP that women are naturally caring and self-sacrificing and willing to serve the community through poorly paid or unpaid community health roles (Maes 2015; Maes et al. 2015a, 2015b). To some degree, this same spirit is utilized to encourage women to join the Health Development Army; there may also be such a strong sense of obligation that women's participation in Army may be considered mandatory rather than voluntary (Jackson and Kilsby 2015). A body of research is looking not only at the fact of low salary at work, but also at the fact that women in these positions have the double burden of work at home and a professional job (Jackson 2015). In the situation when narratives of 'saving lives' and 'serving the community' appear, it can be difficult to assert one's rights related to the improvement of working conditions.

Health workers in an urban context in Ethiopia have also expressed the moral motivations that push them to accept unfavourable conditions of work. It seems that health workers enter "a moral economy involving powerful ideas about saving lives, sacrificing, and experiencing emotional and spiritual satisfaction, circulated by officials and supervisors as a way to socialise the Community Health Workers (CHW) – that is, to try to get CHWs to internalise and express the same moral sentiments or satisfaction, and thereby keep labour cheap" (Maes 2016:71). Maes (2016) suggested that "ideas of sacrificing as CHW and reaping rewards may be convenient and potentially effective for CHW employers", as these ideas give workers a weaker negotiation

position and weaken their capacity to be paid for their work. In my research, this could be the case for the Gender Officer who was accepting her volunteer work in the name of the good of the community.

Among the enabling factors, one HEW in my study underlined the political legitimization of her activity and the support from the wereda and kebele administrator. While there has been evidence that health is often dismissed at kebele meetings agenda, in the case of Aze Debo, health had been priority, receiving good support in funds, and also was well-performing in the whole wereda. What is important is that the strong political commitment and alignment of women with the 'directives' in the health sector was not related to strong political control, i.e., it was not related to election votes, as was the case for agricultural extension. It should be reemphasized that the Health Extension Programme has relied on a similar logic to agricultural extension. It has assumed dissemination of knowledge and a government development model through local 1-5 and 1-30 networks. Investment by the Ethiopian government in both agricultural and health extension has been driven by formal aims: stimulating broad-based agricultural growth and improving people's health. However, in the case of agriculture, studies have documented that extension also has a second objective: establishing control of the 'insecure' EPRDF government throughout the large and diverse country (Berhanu and Poulton 2014). HEWs share certain similarities with Development Agents, in that they visit every household, they follow women, and often they are party members. However, despite the fact that the HEWs work in a political environment, I never heard about HEWs exercising discrimination over access to health services for mothers, children, the aged, the poor, or the disabled due to party affiliation. As noted by Berhanu and Poulton, this would constitute a cultural taboo and be politically counterproductive (Berhanu and Poulton 2014).

Health workers also noted significant structural problems that made the utilization of health care difficult for women. One of them was the significant lack of ambulances that prevented women from having fast transit from their homes to the health center. While in Western countries it is assumed that women will be somehow transported to a health center by car, the problem in Aze Debo is a problem of access at all. During the rainy season, many roads are not passable, nor are there cars that can pass to the internal parts of the kebele. The Health Development Army seems to be instrumental in following up with women and organising transport for pregnant women. The problem, however, only starts with transport: the lack of drugs and some insufficiencies in equipment also pose challenges for the provision of care. This finding resonates with other studies in Ethiopia, which confirmed

that transportation is one of the major problems with accessing care (Bevan 2017; Jackson 2016; Jackson et al. 2016; King et al. 2015).

Health Extension Workers did notice some other socially constructed factors that deter women from using antenatal care and delivery care. Some women did not want to have their delivery or checks performed by a male health worker. This result was also present in Jackson's study, which stated that women often felt unable to talk about private matters or to be examined by people they did not know, especially male health workers, at the health center (Jackson 2016). This also strengthens the argument about the need for emphatic care and the issue of trust in medical settings.

The consequences of difficulties (heavy workload, poor working conditions, low salary, and lack of inputs) can be very serious both for ordinary women as well as for institution of the HEP. From the women's perspective, the lack of resources combined with the workload may cause Health Extension Workers to be unable to serve everyone in need. Moreover, there is a lack of sufficient time to provide fully emphatic care and meet everyone's demand. This can potentially lead to deterioration of trust in the public institution of care.

From the HEP's organizational perspective, the fact that HEWs' effectiveness is viewed through the prism of their ability to produce quantitative health outcomes may obscure their parallel capacity to act as advocates for a more empowering public health based on a non-numerical quality of service. This was presented in my study by the health officer who expressed the outrage that "if I am not delivering [results] I am fired". Studies have shown that work overload and excessive demands, combined with poor salary and working conditions, can lead to practices like data falsification, described by James Scott as 'acts of resistance'. (Scott 1998). The rationales behind such small resistances can vary. For example, Maes suggested that health workers may want to show that they are able to 'perform well' in order to give evidence for the significance of their work. This seems to resonate with the efforts civil servants in my study took to present their achievements in making positive changes happen. A study of reporting maternal deaths in Ethiopia also suggested that health workers underreported maternal deaths because of fear of blame (Melberg et al. 2019). In my study site, in the case of the PSNP, civil servants reported incorrect data because of pressure from wereda officials, i.e. they overestimated the positive impact of transfers on the rural community to satisfy expectations from a higher level (Frankowska 2019). False reporting is not the only problem, as data omissions are also an element of data inflation (Vaughan 2019). This may lead to situation in which a number of fundamental obstacles in the health care system may be not represented in reports.

7. Conclusions: The role of social capital in health practices

The main research objective of this thesis was to explain the role of social capital in the health practices of mothers based on the example of a rural community in Southern Ethiopia. In this concluding section, I provide responses to the three research questions and indicate my conclusions.

What are the main forms of women's networks, and what are the factors influencing their formation?

This study has shown that systems of social relations and the associations in which women participate are multiple and overlapping. There were several networks that were essential for women in this study: 1-5 networks together with the Health Extension Worker, iddirs, prayer and savings groups. Bottom-up organizations, such as iddirs or prayer groups, play an important role in community management and have their own scripts for functioning, often working as intermediaries or channels for government-led interventions. It is important to note that these networks – bottom-up and state-led – overlap with each other and are involved in local state-led politics. Therefore, in a situation where a bottom-up organization is involved in the policies of local government, it is difficult to point out which authority is more important for women and determines their compliance or lack thereof.

The research documented that networks are created along lines drawn by economic conditions, gender-specific lifestyles, and institutional norms that can influence who is included or excluded from particular networks. Firstly, establishing relationships requires investments in the form of time, energy, and money. Bourdieu noticed that social capital is a capital because it cannot be equally afforded by all people and, therefore, puts the poorest at a disadvantage. As was shown in this study, poorer women could not participate in some networks regularly, because they could not stop working at home and move to an activity that did not secure their everyday existence immediately. As for lifestyles, gender had an influence on the organization of time and space in the daily lives of women. They spent most of their time at and around their homes, socializing mostly with other women: neighbours, mothers, mothers-in-law, or children. There are also institutionalized norms that may shape the capacity of actors to reach out to others and to start useful relationships by establishing specific barriers to participation or conditions of inclusion. In this study's context, the gendered division of 1-5 networks could reinforce the assumption that it is mainly women who are naturally predisposed to take care of the domain of health, or even community health.

On the basis of these findings, it is possible to present conclusions about the processes that contribute to the formation of social networks. Firstly, there is a need to investigate the socio-institutional environment and material basis for being a part of an association before making any efforts that try to 'build social capital'. Establishing new networks or associations cannot conceal structural issues, notably inequities in the distribution of power and assets among different people living in one social space. The case of Aze Debo showed that ability to be involved in networks depended on women's material conditions and their ability to invest in relationships with others. Rather than concentrating on the beneficial effects of participation and association for the members of social networks, there is a need to pay far more attention to the effects of the lack of material assets on the poor, and to the socio-structural constraints that impede their exercise of agency in grasping the benefits of social capital. This conclusion supports the argument that it is impossible to separate social capital from material circumstances (Das 2004; Mohan and Mohan 2002; Cleaver 2005). In this study, even in the case of no-fee networks, the ability of women to participate was associated with their households' ability to incur non-financial costs. As networks must be constantly created and recreated, being involved in them is always related to some kind of investment.

Moreover, the state displays significant agency in proposing its own agenda for health care organization by creating networks and determining the norms that govern these relationships, as well as determining what kind of resources or benefits should be available within them. The state also shapes the institutional terms on which women can be involved in social arrangements and public space. The case in this study showed that the state can legitimize the default division of work between women and men, demarking the productive domain as belonging to men and the reproductive domain as belonging to women. Therefore, any policies designed to use social networks to enhance the health, education, or material status of participants, notably women, should take into account mechanisms that can challenge the systems of classification and appreciation that existing power relations impose over actors. This is because participants may internalize different levels of self-esteem and identities that strengthen their positions.

When it comes to the agency of social actors, the fact that participation in networks was almost obligatory frustrated the agency of the women in this study to 'freely' invest in social relations. A person should have the right to refuse or to accept such participation. This frustrated agency did not mean that women in this study were incapable of exercising agency, nor that they had less potential to construct meaning of their social relationships. Following Cleaver (2005),

the study argues that these potential capacities can be frustrated by inequitable social and economic structures and institutions through which social norms are channeled.

How does social capital affect health practices?

The evidence presented in the study showed that being involved in networks had three consequences for health: health education, social control, and access to social support. The notable position among these three was taken by health education, which at the local level worked in two ways.

Health education was a mean of broadening women's awareness, leading to a better assessment of their own health status to make informed choices about pregnancy and delivery. Education was meant also to reorganize perceptions around 'healthy lifestyles' that could have an indirect influence on health status, such as going for antenatal checks, food preparation, and hygiene and sanitation practices. Health education required women to participate in a series of meetings and conferences and involved door-to-door visits by health staff. This education was meant to empower women and enable them to take 'proper' decisions about the care they needed. Many women underscored that, thanks to education, they were able to take better care of their children and save their lives. Also, many women noted the significant difference from the circumstances in which women delivered in the past and their ability to recognize their own health status.

The imperative to increase women's awareness was intertwined with the second imperative – controlling women's behaviours. The educational process involved the infusion of certain 'valuable' practices related to modern care, such as consultations with biomedical health posts and health centers, monitoring health, and regular meetings with health staff. The adoption of these 'healthy lifestyles' created a distinction from the past, when women were 'uneducated' and 'backward'.

Women received health education from a Health Extension Worker and 1-5 leaders: people who possessed significant cultural capital relevant to the state-sponsored health care field. These people also had political capital, because their actions were legitimized by the state. The 1-5 networks were superimposed on the existing bonding networks of women's family and neighbours. Because their presence went down to the neighbourhood level, the 1-5 networks had a strong power to control how much women accepted care. This power was mainly exercised through education that reorganized perceptions about 'normal' care during childbirth and pregnancy. However, these networks also had more explicit power: direct sanction of those who did not adhere to the biomedical care model, i.e. the explicit treatment of women being

taken to prison because of home delivery. Education delivered by health professionals and 1-5 leaders was prescriptive rather than participatory: although women appreciated the knowledge gained through health education, there was little evidence that such meetings created a space for negotiating one of the most private spheres of women.

Finally, the study provided evidence on what social support looked like in Aze Debo. The two most important forms of support provided were spiritual and material support. The study shows that, although there was a change in the community in its approach to the desired model of care during pregnancy and delivery, the role of other family members and neighbours remained important. Just as the company of others was crucial for women who had delivered at home in the past, it was also relevant for women who moved to a health center. It would not be an exaggeration to say that, without familial and neighbour efforts, women would be likely to lack the support they required for a smooth transition to a health center.

This study has several conclusions on the links between social capital and health. Firstly, this study proves that social networks create 'common knowledge' about the new model of care during pregnancy. This common knowledge is not an aggregation of the preferences of community members who calculate their most profitable action. It is rather a process of influencing and shaping the preferences of groups of women, which denotes the symbolic power of health care workers in biomedical health field. The study nuances the literature about social capital and health (e.g. Kawachi et al. 1999) by including in its analysis the issue of power relations between dominant and dominated groups and showing that actions promoting effective diffusion of health information are not neutral undertakings. The question arises of how these dominant discourses of 'healthy lifestyles', which imply using modern health care services, are related to the previous attitudes and meanings attached to pregnancy and childbirth, and how the latter influences the uptake of health education campaigns.

Secondly, Ethiopia's aim of building a healthy population has been driven by the double imperative of women's empowerment through health education but also state control over their behaviours. This has been done in the name of social change and modernization. Such modernization is to be expressed through changing attitudes and creating a new model citizen through education delivered by state-sponsored networks, as well as bringing infrastructure closer to local communities. This study presents the complex interactions between these two imperatives: to be empowered means making independent choices, but it is difficult to make such choices in highly controlled circumstances. The question arises of how far the state move forward through controlling citizens in the name of delivering 'tangible effects

of development'? Moreover, even if women have access to certain resources from their networks, we need to ask not only what kind of social capital resources women require, but also what these resources allow women to do and to be.

Thirdly, the case shows that even an interventionist state can leave certain aspects of service delivery to be managed by the 'community'. The type of social support people got from their social networks in this study– namely, delivery to a health center – could indicate that the women in Aze Debo were rather poor and suggest that the state was not able to provide full-fledged care for these women. On the one hand, this support could be seen as the privatization of the responsibility for transporting a woman to a health center and the use of community resources – like help of other people – to fulfill this responsibility. Thus, bonding social capital plays a role in service delivery. On the other hand, such involvement of bonding social capital could be interpreted as in line with the EPRDF approach to democracy – democracy understood as participation in development efforts.

What factors affect decisions to seek health care and the situation of health care workers?

The study proved that the expansion of medical infrastructure and health education were factors that allowed women to engage with the formal health care system. This expansion enabled them to think more broadly about their health and critically assess their health status. These improvements also elevated the importance of being a mother. These factors were even more encouraging for women because the memory of many women dying during childbirth was still vivid. However, there were many constraints that women faced in deciding about their health. These factors included individual poverty, which was expressed in the women's work burden and the lack of food in their households. There were community-level factors, such as distance to health centers, and the lack of passable roads and reliable ambulance transportation. The results of this study suggest that problems associated with accessing health services that were labelled as 'modern' were more related to the general community and individual poverty, rather than to insufficient knowledge about care, or women's attachment to a view of childbirth as a natural event.

The Health Extension Worker's view on the factors influencing health care service utilization was congruent in some aspects with the views of women. Both the women in this study and the HEWs emphasized a lack of reliable ambulance service and a lack of equipment that would help refer women to the health center. However, an HEW noted that sometimes pregnant women had a perception that there was no need to go to the health center earlier than their baby was due.

The HEWs' institutional situation in the health care system was influenced by a number of factors. On the positive side, the HEWs were convinced that a change in attitudes and health-seeking behaviour had happened and indeed saw their agency in this process. A desire to help women and observation of behavioural changes in the community were significant motivational forces for the HEWs to continue their work in the health care sector. The legitimization of HEW work by the local government also helped the HEWs to perform their job. However, they also faced some constraints: an overload of report writing and excessive work burden.

There are two conclusions that can be made on the basis of these results. Firstly, the case of Aze Debo explains the circumstances under which women comply with the new model of care in Ethiopia. The study suggests that compliance is caused by the interactions of several factors: the experience of poverty, and therefore low material capital at the individual, household, and community levels; an increasing level of health knowledge, so that cultural capital is valued in the health care field; and the gendered, internalized norms that assign women's status according to their ability to become mothers and wives. It should be noted that it is not analytically sufficient to conclude that any one factors, be it lack of quality of care, 'social capital', or 'cultural attitudes', contributes significantly to compliance with the health care system. These factors act in combination, and the final reaction and resultant practice depends on the individual life trajectory of each woman. Moreover, women's compliance with the health care system does not necessarily mean that they are submissive to the 'modern' norms of biomedical care, which are in opposition with 'traditional' approaches to care during pregnancy and childbirth. Compliance with modern care can be rather interpreted as a result of a negotiation between tradition and modernity, in which women have the option of choosing which authority to follow based on their needs in maternal health matters.

Secondly, the case for Ethiopia's Health Extension Workers and Health Extension Programme fits into a broader trend among today's global health programmes that recognizes the importance of community health workers in disease-specific health campaigns as well as in efforts to strengthen entire health care systems and achieve universal health coverage. The narratives of the HEW in this study remind us that community worker programmes should seek out hardworking and committed people to take on roles in the health sector. Their ability to provide empathetic caregiving and quality care can provide a basis for building solidarity and trust with women. In the longer term, this trust in Health Extension Workers translates into women's willingness to use biomedical health services and builds their trust in state medical institutions.

Work burden, poor working conditions, and low salary pose real and serious challenges to the work of health staff. The persistence with which Health Extension Worker in this study tried to present her effectiveness and ability to perform her job well despite difficulties can be regarded as evidence that her sense of control over working conditions was rather limited. Health Extension Workers' bargaining power could be even hampered by the ethos of help and provision of care to mothers that dominated the moral economy. Internalized norms of helping others are not inherently problematic, but such sentiments can contribute to the difficulties that health staff face in asserting their desires and demands for better lives. As health workers are the 'face of the government' for many people in rural areas, it is important to ensure that the women who make up this workforce are not denied their rights to fair and equal working conditions and are not seen as a low-cost way to make up for the personnel shortfall in the health system.

Finally, the study has shown that legitimization from the state can be a powerful resource in the work of HEWs. The meaningful role of HEWs as decision-makers within the health system can give voice to women's concerns and issues in the community. However, the study also revealed that political legitimization was related to coercion and control in the name of development that was designed in a top-down manner through an insufficiently participatory process. The civil servants I interviewed said that they had been given targets, such as achieving a high number of deliveries at a health center, rather than being offered the chance to participate in a process that allowed them to report on their difficulties. The pressure to report the 'right numbers' shows that the health care system in Ethiopia is politicized and, therefore, any health programme, regardless of health area, should take into account the local dynamics of power structures.

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These were the major conclusion arising from this study. So what is the relation between mothers' social capital and their health? Social capital is the mothers' asset, but it is an asset that is incorporated in everyday practices and required investments. Having access to social networks translates into benefits like cultural capital, but also material support and social control. Mothers' incorporated systems of perceptions are changing in Ethiopia because of the changing conditions where they have been acquired. This change of *habituses* and attitudes to how a woman should properly behave during pregnancy is a part of the modernization effort envisaged by the Government of Ethiopia, in which not only is infrastructure updated, but also social norms are modernized. The major response of mothers to this strategy is compliance to the biomedical health care model. The final response can be interpreted as a result

of a combination of factors: the increasing level of maternal services compared to previous experiences of poverty, increasing levels of health knowledge, and the internalized norms that assign women's status according to their ability to become mothers and wives.

8. Appendices

Appendix 1. About Ethiopia WIDE

Information below comes directly from the book entitled: *Rural Ethiopia in Transition, Selected discussion briefs, 2018*, edited by Alula Pankhurst and Catherine Dom.

Ethiopia WIDE – Tracking rural change since 1994

Ethiopia WIDE is a rigorous independent longitudinal study of 20 rural communities in Ethiopia over 25 years. The 20 WIDE communities are examples of the major types of agricultural-ecological systems found in the four central regions of the country. They include 9 sites identified as surplus-producing or being in agricultural growth potential areas, 2 agro-pastoralist sites, and 9 locations considered more prone to drought.

A group of six sites in drought prone *weredas* were first studied by the Ethiopian Rural Household Survey (ERHS) in the 1980s. In the mid-1990s, WIDE1 produced village profiles of 15 communities, including these six. The 15 sites were selected by Addis Ababa University (AAU) Economics Department, the International Food Policy Research Institute (IFPRI), and the center for the Study of African Economies at the University of Oxford, to represent different agricultural-ecological types. Three cash crop communities were added in later years, and in 2003 WIDE2 added two pastoralist sites. WIDE3, conducted in three stages between 2010 and 2013, returned to the 20 communities. Most recently under the WIDE Bridge phase the team returned to four of the 20 communities in early 2018[76].

The WIDE communities are not "representative" in the way that a randomly selected and appropriately sized sample might be. However, they were chosen as exemplars of different types of rural community, featuring wide variations in a range of key parameters. These include livelihoods systems, remoteness or ease of access, cultural and identity-related factors, religious composition, and so on. The WIDE approach, premised on the use of well-accepted case-based methods to analyse the data on these exemplars, makes us confident that the patterns and trends of evidence and experiences found in the WIDE sites are likely to have been present in other communities of the same types and over the same or similar periods. As such, the conclusions

[76] Funding for the WIDE research changed over time. WIDE1 was funded by the UK government Overseas Development Assistance (ODA) department. WIDE2 was funded by the UK Economic and Social Research Council (ESRC) as part of a multi-country research programme. WIDE3 and subsequent phases were funded by development partners active in Ethiopia. WIDE3 was financed by British, Canadian and Dutch development funding through the World Bank-managed Joint Governance Assessment and Measurement (JGAM) Trust Fund. The WIDE Transition and Bridge phases were funded by the UK Department for International Development (DFID), Irish Aid, and the Swedish International Development Agency (SIDA) in Ethiopia.

reached in the research in general, and in these discussion briefs in particular, can be considered likely to hold more widely.

The WIDE Bridge phase (2018)

Following on from WIDE3 (2010-13), the WIDE Bridge research was conceived as a way of continuing to build an understanding of rural change over time; as well as a step towards a long-term vision whereby WIDE would be taken forward, as a country-wide Ethiopian-owned programme tracking qualitative rural change, by a network of Ethiopian universities continuing to produce WIDE-inspired research and policy-relevant outputs.

Substantively, in the Bridge research four communities were selected: Aze Debo in Kambata in the Southern Nations, Nationalities and People's Region; Harresaw in Eastern Tigray; Yetmen in East Gojjam, Amhara; and Sirba/Ude in East Shewa, Oromia. The research focused on trajectories since 2010/13 in relation to farming, non-farming, social protection, and local government/community management; the interactions between local contexts and policy developments in relation to land and urbanization, young people's economic experiences, and the 2015/6 drought (in Harresaw); and changes in inequality dynamics since 2010/13.

Institutionally, the Bridge phase allowed for initiating relationships paving the way for new institutional modalities to take WIDE forward. Strong links at researcher and senior leadership levels were established with four federal universities, Ambo in Oromia, Bahir Dar in Amhara, Hawassa in SNNP, and Mekelle in Tigray, and with the Addis-based research and policy-oriented Forum for Social Studies think tank. In the course of 2018 and following a range of meetings and joint activities (fieldwork, writing, dissemination etc.) these five institutions have formally expressed their keen interest in being involved as full partners in WIDE4, as a step towards the long-term vision outlined above. Together, the partners have reached a principled agreement on the WIDE4 partnership modalities.

Fundraising for WIDE4 is ongoing, and it is hoped that this three-year project can start in 2019 so as to be able to provide insights at the time of the transition between the second Growth and Transformation Plan (GTP II) and its successor.

Simultaneously, a series of awareness-raising and policy engagement activities will take place in the first half of 2019, including the publication of this book presenting the WIDE Bridge key findings and policy and practice suggestions The book is also available in Amharic, and both publications will be distributed to relevant stakeholders. Regional launches, meetings with federal agencies, radio, TV programmes and articles in newspapers are also planned.

The Ethiopia WIDE Bridge communities

The four communities selected for study in this Bridge Phase were: Aze Debo in Kambata in the Southern Nations, Nationalities and People's Region, Harresaw in Eastern Tigray, Yetmen in East Gojjam, Amhara, and Sirba/Ude[77] in East Shewa, Oromia. They represented a fair mix considering the focus of the research.

From a livelihood perspective Yetmen and Sirba, with good agricultural potential, contrast with Harresaw, cereal growing and drought-affected, and enset-based Aze Debo, vulnerable though not to the same extent as Harresaw. The research in 2018 found that three of the sites did well over the past five-seven years: in Ude/Sirba, the most 'connected' of the four, both the farming and non-farming sectors were flourishing, although pressure on land is high due to surrounding and internal urbanization and industrialization. In Yetmen, historically strongly connected to the national *teff* market, *teff* production continued to drive local economic growth although farming is also diversifying. In Aze Debo, farming is increasingly oriented towards a diversified production for local markets (eucalyptus, irrigated tomatoes, dairy, and poultry), a trend pulled by demand from the expanding nearby zonal capital Durame, and pushed by a coffee disease affecting production. In both Yetmen and Aze Debo nonfarm activities were also on the increase, notably trade. In contrast, in remote Harresaw, at the border with Afar, farming was strongly affected by recurrent poor rains and the disappearance of irrigation due to water scarcity over the past five years; this in turn affected non-farm activities although the sector was slowly expanding as an alternative to farming and pushed by increasing landlessness.

As we expected in selecting them, the four sites considerably differed in the extent and form of urbanization/industrialization affecting them: different patterns of urbanization were found to be present in all four (from within, encroachment from neighbouring urban areas, municipalization), with in addition, rapid industrialization surrounding Ude/Sirba, between Bishoftu and Mojo. In all four, there were commonalities and differences in a range of land dynamics including: a) the extent of urbanization/industrialization, with associated changes in land tenure; b) the stage of implementation of rural land certification; c) the value of both rural and urban land in these 'transitioning' communities; d) the extent of land expropriation

[77] The site used to be called Sirba na Godeti. It was renamed Sirba (by the name of one of the villages) in 2013, and later on renamed again as Ude Dhenkaka. Of the three rural villages, Ude, Sirba and Kumbursa, Ude had been almost completely included in a newly established municipality called Ude. Parts of the land of Sirba and Kumbursa have also been included in the municipality, more so in Sirba than in Kumbursa. In these briefs we have referred to Sirba/Ude or Ude/Sirba to maintain the continuity with the previous name.

and compensation; e) the extent of demographic pressure on land – with Aze Debo located in one of the most highly densely populated weredas of the country.

Also, the four sites represented a wide range of levels of connectedness: from Ude/ Sirba, strongly affected by changes in the Bishoftu-Mojo urban/industrial corridor, adjacent to the new Addis Ababa–Adama highway and bisected by the old road still much in use; to Harresaw, on an all-weather gravel road, 20 kms away from the small wereda town Atsbi and 45 kms away from Wukro and the Mekelle-Adigrat road, and at the border with the Afar Region. In between these two extremes, Yetmen is located on a recently asphalted road connecting the expanding towns of Bichena, the wereda center, and Dejen, to the zonal capital Debre Markos and the regional capital Bahir Dar, but quite far from both; and Aze Debo is adjacent to the Kambata zonal capital Durame, connected to the rest of the Region through a road asphalted since WIDE3 and expanding steadily, although clearly not to the extent seen Sirba/Ude with the Bishoftu-Mojo old road and the new expressway.

Finally, the four sites also differed in relation to the range of formal social protection programmes found in each. In Harresaw Emergency Food Aid (EFA) and the Productive Safety Net (PSNP) were active, and in Aze Debo the PSNP; these two programmes were not present in Yetmen and Sirba/Ude. The (newer) Community Based Health Insurance (CBHI) programme was implemented in all four communities. In Yetmen and Harresw there were also attempts to implement the Community Care Coalition (CCC) initiative.

Appendix 2. Questionnaires

Interviewed women

Please tell me about your background (questions about education, age, assessment of wealth/living standard on the basis of assets; how many people are living with that person? what are they doing? number of children?)

Networks and participation in the groups

1. Who are the 'notable' people in Aze Debo? Why do they have such status? Who are the notable people who live outside the site but whose actions affect the lives of residents? If they exist, why do they maintain their status?
2. Who are the most important people (or customary organizations) for you?

- Ask about: what does it mean to be important, and why are they important? (Please probe what kinds of resources are available from these individuals or in these groups: money, advice, emotional support, etc.)
- Ask about: kinds of interaction – is it for work, for entertainment, or other reasons?
- Get a sense of how formalized they are – both for individuals and customary institutions.
- Get a sense of how membership / non-membership creates inequalities among people.

3. Please tell a story about a time when you asked someone for advice from these networks. What prompted you to do so? Did you get what you wanted? Will you reach out to these people again?
4. Which networks in the community are important from the point of view of health issues*?*

- Do you participate in these networks? Why and how did you join?
- What kinds of relations and transactions take place between members of the network?
- What are the main rules governing the network?
- Are there organizations that are more important only for men or for women?
- Do members of this group benefit more than non-members? Please give examples.

5. Do you think you are advantaged or disadvantaged because of your position (status) in the community?

Social support for health problems and general wellbeing

6. Let's talk about health. Tell me whom you have consulted when you have had a health problem.

- ask about family members, extended family, friends, neighbours, other community networks

- ask about formal networks (HEW, doctor, people working at pharmacies)
- ask if the respondent thinks that the amount of support she received was enough for this particular problem. Why or why not?

7. (How) were these people supportive during your health problems?
8. What kind of health support did you receive from them?
9. Do you have someone to assist you with household chores and someone to turn to for emotional aid or to borrow money? (This question is about general help, not only about help for health issues).

Social trust perception

10. What do you understand by "trusting someone" ?
11. To what extent are people in the community:

- fair to each other? Why do you think so?
- helpful to each other? Why do you think so?
- trustworthy? Why do you think so?

12. Which people are the best help in any kind of problem for you?
13. When you have a health problem, whom would you ask for help? Why?

Pregnancy and experience of delivery

14. How should a woman behave when she is pregnant – according to the local culture? What traditional knowledge is related to women's and especially mothers' health?
15. Talk me through what your experience has been throughout the experience of being pregnant:

- what did the first months look like? Probe for interactions with different people/networks – why these networks, what kind of support did she receive, who initiated the contact with others, what kind of benefits did she receive?
- Have you ever been in a health center? If yes, for what reason?
    - Was it your own decision to go to the health center?
    - How did you get to the health center (eg. on foot, by bajaj, by ambulance)? Who helped you? Why did that person help you?
    - What duties did you have to leave at home?
    - How were you treated at the health centre?
    - Did you receive advice? Did you receive any medicines? If so, was it sufficient?

16. Think about the first few days after you leave health center and went home. Tell me what it looked like – what you did, and what you would have liked to have done.

17. Describe in as much detail as you can any expectations you had about transitioning back into your home environment. How was it in practice?
18. What barriers to or facilitators of recovery from delivery did you experience?
19. Did you ask for advice from other sources before and after delivery? Please probe for personal, institutional, and formal networks.

Other questions

20. What are common maternal health problems in Harrasaw/Aze Debo?
21. What are the common factors behind mothers' hesitation to use maternal health services?
22. Why do women deliver at home, and what are the potential sources of information pertaining to maternal health services?
23. What kind of support would you need to improve the health of mothers and women's health in general?

Key Informants

Please tell me about your background (questions about education, age, assessment of wealth/living standard on the basis of assets, how many people are living with that person? what are they doing? number of children?

Maternal health in the community

1. How should a woman behave when she is pregnant – according to the local culture? What is traditional knowledge related to women's and especially mothers' health?
2. What are common maternal health problems in Harrasaw/Aze Debo?
3. What are the major changes in terms of access to delivery at a health center within the last 5 to 10 years and women's attitudes to it? Why have these changes happened?
4. What are the common factors behind mothers' hesitation to use maternal health services? What is governmental response? How it is successful/not sucessful ?
5. Why do women deliver at home,and what are the potential sources of information pertaining to a maternal health services?
6. What kind of support would you need to improve health of mothers and women's health in general?

Social support and networks of mothers

7. Whom do mothers and women in the community consult for health problems? (Ask about formal and informal networks)?What kind of support can women receive from them (probe for financial, emotional, material support)? How has it changed since 2000-2010-currently?
8. What other people can provide help to mothers when they have health problems? How do they help? Can you provide examples?
9. What are the most imporant networks in general (formal and informal) for mothers and women in the community? Why are they important? Since when? How has it changed since 2000-2010-currently?
10. How would you evaluate usefullness of these networks?
11. Who are the important people who live in Harrasaw/Aze Debo? Why do they have such status? (How) are they are related to women's health issues?

Social trust perception

12. To what extent people in the community:
    - are fair for each other? Why do you think so?
    - are helpful for each other? Why do you think so?
    - can be trusted? Why do you think so?

Appendix 3. Graphical elements

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Appendix 4. Ethical approvals and permission for research

GRADUATE SCHOOL FOR SOCIAL RESEARCH
Institute of Philosophy and Sociology of the Polish Academy of Sciences

Warsaw, 27th May 2018

Ethical Approval of Research

I confirm that Agata Frankowska is a PhD student at the Institute of Philosophy and Sociology of the Polish Academy of Sciences in Warsaw since October2015. In the academic year 2015/16 she completed masters studies in Economy and Society 'with Merit'

Currently she is working on her doctoral thesis **'Maternal health and social capital in Ethiopia'.**

Agata Frankowska's work and progress is evaluated every year. She has received very positive feedback for her research project, and based on the information provided by her, has been given ethical approval to proceed.

On behalf of the Institute of Philosophy and Sociology of the Polish Academy of Sciences I would like to express support for Agata Frankowska's project and am aware that if she is to meet the necessary deadline for submission of her doctoral dissertation she needs access to information available in Ethiopia.

I would be most grateful for all assistance you are able to give Agata Frankowska to enable her to complete her research.

Yours sincerely

Dr John Fells

Academic Director

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ለሚመለከተው ሁሉ

ጉዳዩ:- ትብብር ስለመጠየቅ

ሚስ አጋታ ፍራንክፖስካ የፖላንድ አካዳሚ ኦፍ ሳይንስ የዶክትሬት ድግሪ ተማራማሪ በአሁኑ ወቅት በሀዋሳ ዩኒቨርሲቲ፣ የፖሊሲና ልማት ምርምር ተቋም ጋር በትብብር የሚሰሩ ሲሆን፣ በወረዳችሁና በአዜ ዴቦአ ቀበሌ የሚያደርጉትን በእናቶች ጤና ላይ ያተኮረ ጥናት አስፈላጊ የሆኑ መረጃዎችን ስለሚያስባስቡ የመስክ ጥናቱ ውጤታማ እንዲሆን የተለመደ ትብብራችሁን ታደርጉላቸው ዘንድ በአክብሮት እንጠይቃለን።

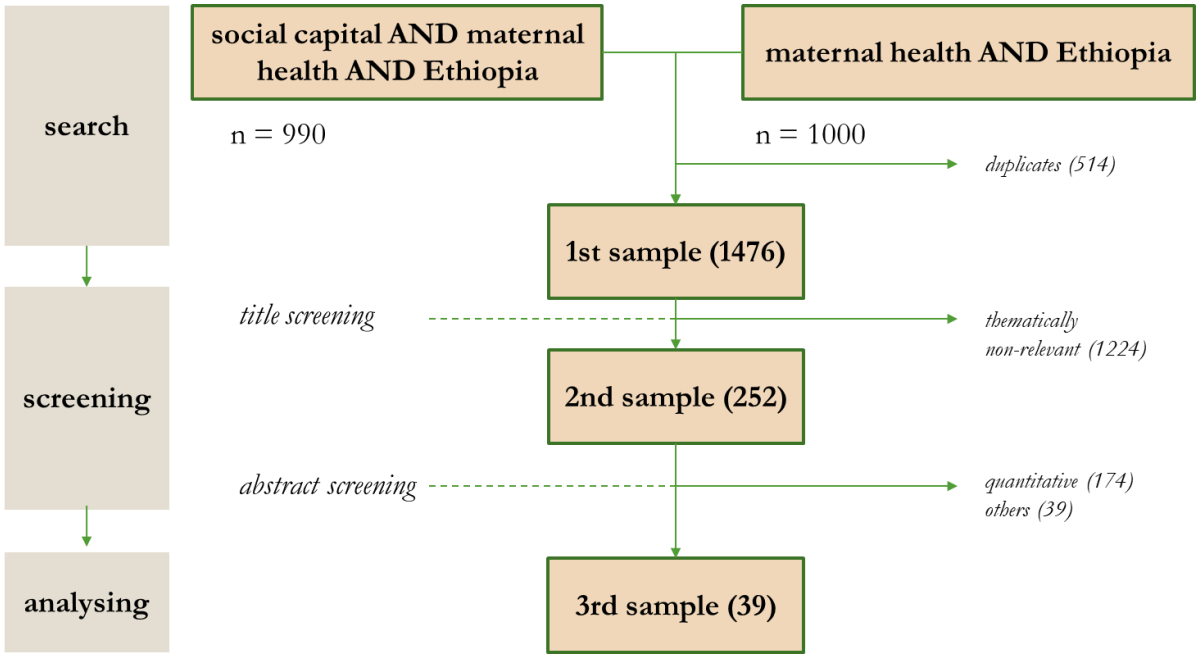
ከሠላምታ ጋር

ተስፋዬ ሰመሳ (ፕሮፌሰር)
የፖሊሲና ልማት ምርምር ኢንስቲትዩት
ዳይሬክተር

Appendix 5. Systemic literature review procedure

The aim of systemic literature review was to identify existing qualitative studies about maternal health in Ethiopia and confronting their results with the thesis. Systemic literature review was based on three stages: search, screening and analyzing.

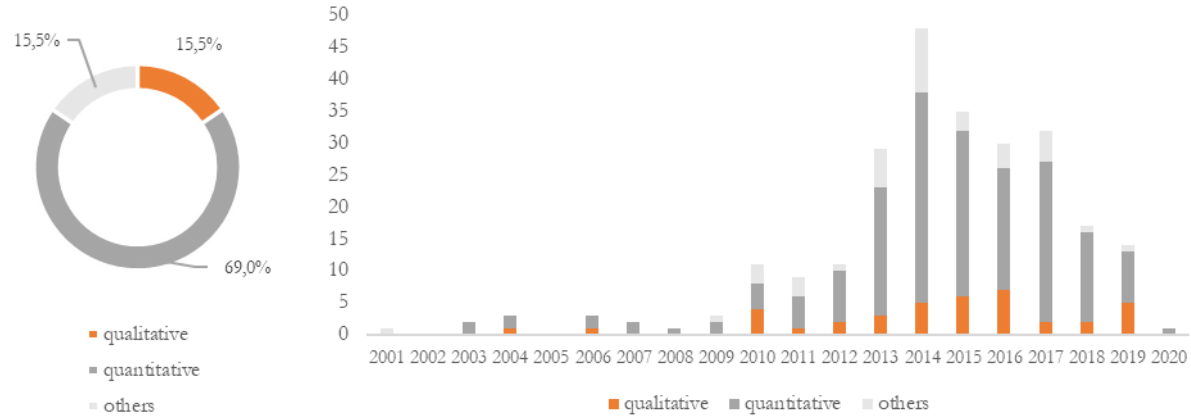
Figure 9. Systemic literature review procedure



Source: own elaboration on the basis of Hook et al. 2020.

Firstly, combination of words (*social capital* AND *maternal health* AND *Ethiopia*) was applied. As a backup, a second combination including only *maternal health* AND *Ethiopia* was used. Given the acceleration of development intreventions in Ethiopia after 2000, I limited the review to the studies published between 2000–2020. Search protocol was applied in Google Scholar database. I merged both databases and limited results of the search to 1476 records, removing duplicates. Secondly, I screened titles and excluded non-relevant studies. Thanks to this procedure, the second sample was limited only to the 252 studies concerning directly the subject of the thesis. Then, I screened abstracts from the second sample, marking methodological approach (quantitative/qualitative/other, including mixed-method studies).

Figure 10. Type and number of works about maternal health in Ethiopia between 2000 and 2020



Source: own elaboration on the basis of Google Scholar query (1-05-2020).

Systemic review pointed out that most of relevant studies had been published between 2013–2017. The majority of papers used quantitative approach drawn upon cross-sectional surveys and Demographic and Health Survey data. Qualitative studies represented only 15.5% of a total, same percentage other approaches (such as mixed-methods, meta-analysis, systemic reviews etc.). This proves that there are significantly less qualitative studies on maternal health in Ethiopia comparing to quantitative ones.

Thirdly, I selected 39 qualitative studies on maternal health for a detailed analysis. Qualitative studies were published mostly in journals such as BMC Pregnancy and Childbirth (3), Social Science & Medicine, Global Public Health, PLoS One, Human Resources for Health, The Pan African Medical Journal, International Journal of Women's Health as well as Ethiopian journals: Ethiopian Journal of Health Development and Ethiopian Journal of Health Sciences. Among 39 studies, most of them covered more than one region (25.7%) or concerned SNNPR (25.7%), followed by Oromia, Amhara, Afar and Tigray. These publications complemented my knowledge about the context of the study and helped me to build arguments in the discussion and conclusions.

Appendix 6. About the Author

Agata Frankowska – a graduate of Economics at Warsaw School of Economics, African Studies at Warsaw University, and Sociology at Lancaster University.

Agata coordinated a number of development projects for international, non-governmental, private and public sector, i.e. evaluation of Polish Aid in Eastern Africa for the Polish Ministry of Foreign Affairs as well as initiated a project aimed at improving access to health services in Southern Ethiopia. In 2018 Agata worked as a research fellow in Ethiopia WIDE project, being responsible for investigating social protection, food security and women's health in rural communities.

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