Fertility Control in a Cultural and Gendered Normative Context of Rural Oromia, Ethiopia: Implications for Involvement of Young Men

By

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Fertility control in a cultural and gendered normative context of rural Oromia, Ethiopia: Implications for involvement of young men

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In Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Sociology

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Declaration

I, Nega Jibat Gemede, hereby declare that the dissertation entitled: "**Fertility control in a cultural and gendered normative context of rural Oromia, Ethiopia: Implications for involvement of young men",** submitted by me to award of the Degree of Doctor of Philosophy in Sociology at Addis Ababa University, is a product of my original work and it has not been presented for the award of any other Degree, Diploma, Fellowship of any other university or institution. This work has also accredited the views of the research participants. To the best of my knowledge, I have fully acknowledged the materials and pieces of information used in the study.

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Certification

This is to certify that this dissertation entitled: "**Fertility control in a cultural and gendered normative context of rural Oromia, Ethiopia: Implications for involvement of young men**'', prepared by Nega Jibat and submitted in partial fulfillment of the requirements for the award of Degree of Doctor of Philosophy in Sociology complies with the regulation of the University and meets the accepted standards with respect to originality and quality.

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Acronyms and Abbreviations

UNESCO	United Nations for Education Science and Culture Organization
ICPD	International Conference on Population and Development
FDRE	Federal Democratic Republic of Ethiopia
STD/Is	Sexually Transmitted Diseases/Infections
CSA	Central Statistics Authority
EDHS	Ethiopian Demographic and Health Survey
ANC	Antenatal Care
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
EOTC	Ethiopian Orthodox Tewahedo Church
SNNP	Southern Nations, Nationalities and People
CME	Constructive Men's Engagement
HEP	Health Extension Program
HSDP	Health Sector Development Program
FGM/C	Female Genital Mutilation/Cutting
YFRHS	Youth Friendly Reproductive Health Services
MoH	Ministry of Health
FGDs	Focus Group Discussions
HEWs	Health Extension Workers
MCH	Maternity and Child Health
HC	Health Center
HP	Health Post
MCHC	Mothers and Child Health Care

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Abstract

Background: Increasing research and policy attention is paid to fertility control in gendered and cultural normative rural context. This thesis focuses on the domains of fertility control and young men's engagement in a less explored rural context of Ethiopia. Fertility control is a broad field entailing aspects such as sexual restrictions, contraception and induced abortion, and is in the present work explored and analyzed based on prevailing societal norms, perceptions and practices. Implications of the normative contexts for young men's involvement in the three domains of fertility control are also examined. The theoretical framing draws on perspectives from masculinity and gender theory.

Methods: Weberian-oriented and ethnographic-based qualitative research, with in-depth interviews, focus group discussions and observations as research methods, were employed in the generation and analyses of the material. The study participants consisted of community members: young men, (some) young women, sector leaders, adult religious leaders and community leaders, and health workers. The main fieldwork was carried out over an extended period of fourteen months from June 2017 to July 2018 in Nadhi Gibe District of Jimma Zone in Oromia region, Ethiopia.

Study findings: The study found that cultural, gender and religious norms reinforce each other creating dynamics that work towards the maintaining of gender inequality shaping the involvement of young men in fertility control, and hence indicate manifestations of hegemonic masculinity. The most pronounced norms on fertility control are concerned about avoiding premarital sex and premarital pregnancy. Simultaneously strong social norms disapproving fertility control in marital relations were found. The involvement of young men in fertility control vary within the various aspects of fertility control. Young men are engaged in the establishing of love, sexual, and marital relations, but are less preoccupied with contraceptive use and abortion. They largely violate the restrictive social norms against premarital sexual relations and consider fertility control as the domain of women but they have significant influence on women's choice of fertility control.

Disapproving norms against contraceptive use are encountered in parallel with more approving norms and discourse that open for the use of preventive methods. Among young men the perceptions and practices pertaining to contraception differed substantially. However, there seems to be a move towards increasing tolerance and acceptance for contraceptive use. Induced abortion is strongly disapproved normatively, but is exceptionally accepted with reference to diverse arguments, ranging from saving the mother's life to family's economic problems. The Abortion Law of Ethiopia (2005) remains relatively restrictive, but it is permissive procedurally through clinical guidelines developed to assist healthcare workers in their abortion supportive work. Access to abortion care is partly constrained among others by healthcare providers' tendency to refuse abortion services without the involvement of the male partner. Young men's strategies in cases of unwanted pregnancies of their girlfriends range from supportive approaches through marriage or providing abortion costs, to non-supportive approaches such as forcing their girlfriends to abort, denying fatherhood or abandoning.

Conclusion: The study indicates that there continues to be normative influences on fertility control and severe restrictions on young men involvement in fertility control. However, there are a number of signs of opposition against prevailing restrictive regimes, and of young people's agency to act against these restrictive normative and practical orders implying rooms for change. The study has significant academic and policy relevance in rural and youth dominated populated Ethiopia. Priority should be given to social norms and involvement of men in efforts of improving fertility control.

Key words: fertility control; involvement of young men; gendered relations; hegemonic masculinity; norms of fertility; sexuality; contraception; induced abortion;

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CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Human reproduction, sexuality, and gender are often inextricably intertwined and constructed into one another (Connell, 2009; Klepp et al., 2008; Lerner et al., 2006; Setel, 1999). They are culture-specific and normative social phenomena; hence, they are differently treated across cultures and variant systems of belief (Boltanski, 2013; UNESCO, 2013). Fertility is an aspect of human reproduction that attracts the attention of moral thinkers, researchers and policy makers (Poston and Micklin, 2005). Fertility rate, that is, the total number of births per woman, is affected by moral, sociocultural, economic, political and geographical factors, among others. Sexual behaviors, marital attitudes and practices, values and norms associated with fertility; and use of family planning services or the seeking of induced abortion are all aspects that affect birth rates (Suset, 2005).

Fertility is a sequence of events that begins with union formation, first birth, second birth and so on. The events can be broken down to even more refined steps, beginning with the age at first sexual intercourse, conception, pregnancy and birth (Poston and Micklin, 2005, p. 431). Since long time, scholarly debates have been in place on human reproduction in terms of fertility rate, population growth and development issues. However, fertility control with a meaning of its usage in the present study is relatively new. *Fertility control* refers to patterns of human behavior that have the prevention of unwanted pregnancies and births as their primary objective. Individuals and couples adopt these patterns in accordance with their cultural values, reinforced by formal or informal social pressures (Sills, 1968, p. 382). Fertility control is a pattern of behavior regulated by social norms (Chung & Rimal, 2016). The term ‘control’ in the definition implies right-oriented, active and agentic involvement of men and women, individually or collectively, in making decisions about how to manage their fertility experiences. It further implies acquiring power to choose and make decisions (Have and Neves, 2021). The notion of control is relevant given empowering individuals and couples towards willfully regulating their sexual and reproductive lives emerged in response to tendencies of some governments and other actors to resort forced sterilization and even abortion in order to achieve targets set to contain demographic explosion (Benagiano, Testa and Cocuzzi, 2004; ICPD 1994). Sills also elaborates

the contexts in which the behaviors are adopted and reinforced. The definition implies variety of methods that can be used before and after the occurrence of pregnancy, that is, sexual restrictions, all forms of traditional and modern contraception, and induced abortion. Frank (1987, p.181) argues that all societies limit fertility as a result of customary restrictions on marriage and sexual behavior, and use of traditional or modern contraceptives, sterilization and induced abortion constitute means of fertility control. Contraceptive use and abortion are preventive and curative interventions, respectively, in controlling unwanted pregnancies (Centre for Health and Population Research, 2001; Frank 1987).

Fertility behavior, like sexuality, unfolds in a multi-level setting of biological, psychological, social, economic, cultural and political conditions (Huinik et al., 2015). Social, legal and political, and medical discourses surround human reproduction make fertility control a subject of discussion among the rights and responsibilities of individuals. Understanding views and experiences of men and women relating to sexuality, pregnancy, contraceptive use, abortion, and norms of motherhood also requires looking into their gender dimensions (Izugbara et al., 2009). Malhotra (2012) emphasizes that fertility control and gender relations shape each other. Accordingly, fertility control may empower women and men towards a more gender equal relations. However, classical gender analyses have overemphasized the women's side, leaving the men's side less explored. Misconceptions in gender analyses and failure to properly consider relationality, complexity, internal contradictions, and dynamics in the construction of gender characterize the incompleteness of feminist research and programmatic interventions (Connell, 2014; Cornwall, 2007; Courtenay, 2000; Kabagenyi, et al., 2014; Sharma, 2003).

The invisibility of men in the reproductive process is manifested, for instance, in the investigations and treatment of infertility, whereby women's reproductive pathology is emphasized. Men's infertility is given less attention, which presumes that men's reproductive system is more efficient and healthier than women's (Sharma, 2003; Tuloro et al., 2006). For men, to take active roles in maternal services like antenatal care requires their assertive negotiation to involve and healthcare providers' commitment to engage men (Ampim et al., 2021). This study from Ghana found that men are shy to visit maternity clinics with their expecting partners, and nurses and midwifes do not encourage them to actively involve.

Involvement of young men in fertility control has moreover been accorded less attention compared to that of adults - a gap that has attracted the attention of this researcher. Hence, little is known about involvement of young men in fertility control. The concept involvement refers to 'the capacity of the individual to give, or withhold from giving, concerted attention to some activity at hand – a solitary task, a conversation, a collaborative work effort' (Goffman, 1963a: 43). The present study is intended to contribute to filling this knowledge gap in the context of a rural district in Ethiopia. In this study, the three means of fertility control - sexual restrictions, contraception, and induced abortion - are examined in the broader gendered and cultural normative context with emphasis on the involvement of young men from the perspective of youth subculture.

This study is about the conditions (mainly social norms) that make the action (i.e fertility control) possible or impossible, and at the same time about the influence of relevant actors including young men. A qualitative research approach based on the Weberian interpretive paradigm, and the theory of hegemonic masculinity are drawn upon in the study. Studying the issue in a rural context and young men residing there is relevant because they represent the majority but are largely marginalized in research and intervention programs. The results add new insights that inform more inclusive and responsive policy alternatives.

1.2 Problem Statement

Fertility is controlled through a range of normative behaviors of prevention and termination of conception in the course of life. Contraception, sexual restrictions and induced abortion constitute the three means of fertility control or fertility regulation. Sterilization is also a means of fertility control but rarely used (Frank, 1987). The author underscores that extended breastfeeding, rhythm, abstinence and coitus interruption are traditional practices and non-program methods oriented to the surviving children in the earlier births that can reduce fertility but less intended for fertility control. Okun (2001) explicitly states that contraception and abortion as the two primary means of fertility control. Similarly, Frank (1987) considers modern contraceptives as more efficient methods.

Fertility control as defined by Sills (1968) duly recognizes that individuals and couples adopt these patterns of behavior in accordance with their cultural values, reinforced by formal or

informal social pressures. In an article *Fertility Control: Overview,* Okun (2001) defines the concept with similar approach to Sills (1968) and analyzed the variety of reasons humans have desired to control fertility and types of methods they use. Among others, it addresses historical significance, degrees of efficacy, and extents of use of different contraceptive methods. Centre for Health and Population Research (2001) approached the concept with similar meaning.

The need and importance of integrating modern contraception and/or family planning with all other means of interventions than dealing with each aspect in isolation is strongly recommended (Benagiano, Testa and Cocuzzi, 2004). However, there are scanty academic literature that deal with fertility control in this new meaning of the concept although different aspects of fertility including union formation, sexuality, conception, pregnancy and birth have been addressed separately (Poston and Micklin, 2005).

Literature reviewed in the preceding section also exposed that gender analyses have been employed to reveal a rather one-sided, hegemonic, and oppressive paradigm. Women are usually viewed as victims and preys of men's sexual exploitation while men's side gender issues including their potential roles in ensuring gender equality, their victimization and vulnerability are obscured. Such gender analyses result in policies that are based on patriarchal assumptions and hegemonic masculine relations. Less recognized in most of the gender literature are active responses made by men (Connell, 2014; Silberschmidt & Rasch, 2001). It is less contested that fertility control and sexuality are truly gendered social phenomena (Options, 2008). Men and women may relate differently to practices of fertility control; the way they relate to fertility control mainly depends on their gendered views and interests (Izugbara et al., 2009). Gender roles which assume fertility and family planning as a domain of women hamper males' involvement (Sharma, 2003).

Men's involvement in reproductive relations and processes has been recognized by global actors (ICPD, 1994; FWCW, 1995) but remains understudied at local levels (Bayissa et al., 2016; Fekede et al., 2014; Lingerh et al., 2014). Connell (2002) emphasized that masculinity studies benefit in three ways: increasing understanding, solving practical problems, and guiding long-term change. Studies reveal that involving men in traditionally defined as women's domain areas of life such as reproductive matters is very important for multifaceted reasons. Men do have reproductive health concerns of their own health status and health-related behavior that also

affect women's reproductive health. Such concerns include family planning; prevention and treatment of sexually transmitted diseases (STDs), sexuality, sexual dysfunction, and infertility (PATH, 1997).

Understanding the role of male involvement in preventing premarital pregnancy is vital as it helps to mitigate gender stereotypes that shape expectations about sexual behavior (Wildsmith et al., 2013). Men can also constructively engage in the sexual and reproductive lives of women as clients, partners, and agents of change in improving health outcomes, reducing gender-based violence, and achieving gender equality (Robles and Aditi Krishna, 2010). Their involvement in reproductive health matters must moreover be considered as a strategy of addressing gender inequalities (Kabagenyi, et al., 2014). Therefore, explicit inclusion of men in gender domestic spheres like fertility control is of substantial value (Edstrom et al., 2014) for the health concerns of both men themselves and for women (Berhan, 2006).

In Ethiopia, a number of researchers have produced ample evidence on public views about and implications of human sexuality, pregnancy, contraception, and abortion (Astrid et. al., 2019; CSA and ICF International, 2012; Grimes et al., 2006; Kebede et al., 2012 & 2014; Prata & Summer, 2015; Singh et al., 2010). Reproductive health-related problems, females' access to and utilization of reproductive health services and implications of the problems are well addressed (EDHS, 2011; Ipas, 2010; Jones et al, 2014; Rominski et al., 2015; UNESCO, 2013; UNFPA, 2012; Zenebe and Haukanes, 2019). Other well researched themes are knowledge and practices of adolescents about reproductive health, including contraception and abortion (Abebe and Ejeta, 2015; Ayalew and Yeshigeta, 2009; Berhane et al., 2014; Getnet et al., 2019; Mohammed and Susuman, 2013; Options, 2008; Seifu et al., 2006; Setegn and Takele, 2013; Tegegn et al., 2008), and women's negotiation and decision making in sexual and reproductive relations (Kebede et al., 2014; Kebede et al., 2012). Sexual and reproductive health service conditions are moreover well documented (Ayalew and Yeshigeta's, 2009; Ipas, 2010; Options, 2008; Singh et al., 2010).

The involvement of young men in sexual and reproductive health remains a less studied topic in Ethiopia, particularly at the grass-roots level. The above-mentioned studies have not adequately examined the involvement of men in the three means of fertility control. Most of the studies on sexual and reproductive areas have not included the involvement of men, in general, and that of young men, in particular, in their research objectives and questions. Nor have they adequately

addressed how the sexual and reproductive lives of women are influenced by the involvement of men. Studies conducted in different parts of the world indicate that the involvement of men in fertility control is not less significant in generating knowledge through research than the focus on women's engagement (Connell, 2014; Barette, 1996; Edstrom et al., 2014; Cornwall, 2007; Izugbara et al., 2009; Kabagenyi, et al., 2014; Wildsmith et al., 2013).

Young people have particular vulnerabilities and issues regarding their sexual and reproductive lives, which differ from those of adults. That is, even though youth have common characteristics with adults, they have special needs that have to be differently addressed when it comes to reproductive lives and problems (WHO, 2004). The few available studies in Ethiopia centrally focus on adult and married men in family planning contexts rather than young men regardless of their marital status. For instance, Fekede et al. (2014) reported low involvement of male partners in maternal antenatal care (ANC) services. Lingerh et al., (2014) have identified factors affecting the involvement of husbands in their wives' institutional delivery. Bayissa, et al. (2016) found low level of knowledge among husbands about family planning. Low utilization of male methods of family planning was studied by Abraham et al. (2010), whereby effects of religion, education, access to media, and spousal communications were analyzed. Most of these studies are urban-focused surveys and/or public health service oriented, while in-depth sociocultural analysis in rural settings is significantly lacking (Options, 2008; PATH, 1997; Berhan, 2006).

Moreover, this study has the following benefits. First, given rural areas and young men in the rural context represent the largest population yet marginalized in development interventions, the study calls for due attention to be given to them. It is known that the rural area has higher fertility rate and young people in rural context have limited access to information about sexual and reproductive lives as well as the respective services. Second, results of the study informs better policy formulation that fit to the rural context where the majority live than what dominantly urban-based studies do. Finally, employing a qualitative research enables to deeply understand culturally embedded normative factors that shape change and continuity of fertility control than quantitative oriented studies.

In line of the above mentioned points, the present study explored relatively a new area of research with a different level of analysis. Unlike the previous studies of fertility rate and other demographic analyses, this study centrally focuses on social norms, perceptions and practices

related to fertility control. The researcher also sought to capture implications of the gendered and cultural norms, and youth subculture related to fertility control on young men's involvement, experiences and agency in their quests for fertility control. The study also accounted the historical continuities and processes of change. Nadhi Gibe District of Jimma Zone in Oromia National Regional State, Ethiopia, was selected as the study site on bases of its suitability for the research question and fieldwork. Details of the selection criteria is presented in Chapter 3 under Description of the Study Settings.

1.3 Research Questions

The overarching research question of this study is the following:

- ❖ How do cultural and gendered norms play out in shaping perceptions and practices pertaining to the domain of fertility control – sexual restriction, contraception and abortion – and the involvement of young men in a rural Ethiopian setting?

The specific research questions include:

1. How do inequitable gendered norms (perceptions, relations and practices) pertinent to fertility control manifest in institutional settings of the study communities?
2. What fertility related social norms prevail in the domain of sexual restriction, contraceptive use and abortion?
3. How do the gendered and fertility related norms shape the involvement of young men in sexual restriction, contraceptive use and abortion related issues before and after marriage?

1.4 Theoretical Framework: Hegemonic Masculinity

The research questions are enlightened by hegemonic masculinity as the guiding conceptual, theoretical, and analytical framework which refers to views, beliefs, and practices that permit men's collective dominance over women to continue. Hegemonic masculinity is analytically relational in a manner where women have to be taken into account to fully understand masculinities. It involves specific strategies for the subordination of women (Donaldson, 1993); diversified strategies operate across situations, time, and places. Schippers (2007) identified three such strategies. First, hegemonic masculinity, when embodied by men, legitimizes men's domination over women as a group. Second, emphasized femininity is central to men's

dominance over women; yet, it is not the only mechanism for ensuring the domination. *Emphasized femininity*, according to Connell, refers to patterns of behavior that are “organized as an adaptation to men's power… emphasizing compliance, nurturance, and empathy as womanly virtues” (1987, p. 188). Third, manhood acts inherently uphold patriarchy and reproduce gender inequality. Manhood acts are strategies through which males distinguish themselves from females and thus establish their eligibility for gender-based privileges. Effects of manhood acts are observed for example in the division of labor between men and women, with implications for the distribution of decision making power and consequent job successes. Nevertheless, the consequences of manhood acts for the reproduction of gender inequality may be contradictory as compensatory manhood acts can sometimes reproduce inequalities in ways that disadvantage subgroups of men. Men can for example also incur health damage as a consequence of manhood acts (Schrock and Schwalbe, 2009). Identification of how different strategies operate in men-women relations to maintain hegemonic masculinities, on the one hand, and strategies that young men use in the context of Nadhi Gibe District, on the other, were key focuses of this study.

Originally, masculinity was studied to better understand the reproduction of gender inequality. The processes of how specific elements of manhood acts to benefit men at women’s expense and their consequences have attracted attention of researchers (Schrock and Schwalbe, 2009). However, this isolated view has been contested in that hegemony may fail, and the concept of hegemonic masculinity does not fully rely only on a theory of social reproduction. Put another way, the conceptualization of hegemonic masculinity explicitly acknowledges the possibility of democratizing gender relations, of abolishing power differentials, not just of reproducing hierarchy. It emphasizes that a positive hegemony is a key strategy for efforts to reform and that masculinities are dynamic (Connell and Messerschmidt, 2005).

The concept of hegemonic masculinity emerged in response to shortcomings of prior theories of gender and masculinities to explain the dynamic, multiple, and relational dimensions of gender construction in a more comprehensive manner. In fact, like many other theories of gender and masculinity, hegemonic masculinity took form by noting that it would not fully account for social life if it ignored gender inequality. It rejects dichotomized views of feminine and masculine theories. As a result, since the 1980s, the study of male sex role and masculinities has shifted in focus to how men enact diverse masculinities in diverse contexts. Proponents of the

theory have pronounced that masculinity is plural; there is not just one form of masculinity; rather, there are multiple masculinities. Among others, the concept of multiple masculinities promotes value diversity (Schrock and Schwalbe, 2009). With the emergence of hegemonic masculinity, not only were "male sex role" and detached treatment of masculinity highly criticized, but a model of multiple masculinities and power relations was also integrated into a systematic sociological theory of gender (Connell and Messerschmidt, 2005).

Thus, the concept poses a challenge to the ideal and normative role allocation to men and women. It opens room for questioning the dominance of traditional sexual and reproductive norms regardless of their historical significance, in light of contemporary actual lives of young men and society at large. Hegemonic masculinity, with its open approach to the study of the structural dimensions of gender, hence emerges as a useful tool to examine young men's experience of fertility control in relation to the normative standards of sexual and reproductive behavior patterns in a rural setting of Ethiopia.

Hegemonic masculinity also proclaims that gender regimes involve internal contradictions between ideologies and practices. Consequently, how men work through the contradictions could be identified by relational aspects of the theory of masculinity. Critical studies of men's views on masculinity as a dynamic pattern of ideologies and practices constructed into interaction emerge as particularly useful (Barette, 1996). Hegemonic masculinity enables one to explore the relationship between popular ideologies and the daily lives of boys and men - including the mismatches, the tensions, and resistance. How do such contradictions come into existence; how are they constructed into men-women interactions; or how do they manifest in young men's experiences of fertility regulation? The possibility to adopt any gender position in interaction is constrained by embodiment, by institutional histories, by economic forces, and by personal and family relationships. Constraints may also arise from within the person (Connell and Messerschmidt, 2005). This in turn enables one to identify the forces of order and continuity in contrast to the possibilities of change.

Given that the concept of hegemonic masculinity makes multiple social constructions possible, it reveals that masculinity is not a fixed entity embedded in the body or personality traits of individuals. Hence, employing the thinking as a fixed theoretical concept ignores the massive evidence of change in social definitions of masculinity. Rather, masculine domination is open to

challenge and is maintained through considerable effort (Connell and Messerschmidt, 2005). Research has shown that constructions of masculinity have complexity. Although structured relations among masculinities exist in all local settings, motivation toward a specific hegemonic version varies according to local context, and such local versions inevitably differ somewhat from one to another. In this context, analyses of relations among masculinities also clearly recognize the agency of subordinated and marginalized groups (Connell and Messerschmidt, 2005). Both men and women can draw on hegemonic masculinity when it is desirable, and they can divorce from it when it is less desirable (Javaid, 2019).

Learning how to signify a masculine self is a lifetime process for men (Schrock and Schwalbe, 2009). Young men learn to identify themselves as boys and signify masculine selves, and such young men's initial adoption of the identity "boy" is "micropolitical". Young men also learn how gender identities are signified and how to regulate emotional display. Segregation of boys and girls into different groups is part of how gender identities and masculinity are signified. At the local level, hegemonic patterns of masculinity are embedded in specific social environments such as formal organizations including schools. Hegemonic patterns of masculinity in families are socially legitimized models, and they are both engaged with and contested as children grow up.

Groes-Green (2009) uses the concepts of hegemony and dominance to explain power relations between young men and their female partners. Accordingly, the breadwinner ideal stands out as a sign of hegemonic masculinity in sub-Saharan Africa. Young men's ability to live up to the ideals of hegemonic masculinity depends on their place in the social structure. Due to the widening gap between the classes, only upper middle-class youngsters may truly mange to live up to the breadwinner ideal. Groes-Green also states that an ideal man is one who has a job or an education and who can provide for his woman. For unemployed poor working-class youngsters, physical violence against their girlfriends is their source of respect and dominance, which is culturally acceptable in many African countries. That is, alternative to economic status, sexual performance can be seen as serving the purpose of preserving an imagined control over women.

In conclusion, the major tenets and issues addressed and the explanatory approaches of hegemonic masculinity seem to be appropriate as a theoretical backdrop of this study. Its power to explain institutional arrangements, practices, ideals, and ideologies are believed to address

research questions that are intended to identify shared institutional practices and dominant cultural views that underpin masculine and gender relationships. Hegemonic masculinity made it possible to enhance the examination of people's daily activities by tracing manifestations of dominant cultural views, and gendered norms and relations. Young men's fertility control experiences are thus analyzed within this overarching framework.

1.5 Significance of the study

This study explored fertility control in terms of its three domains - sexual restriction, contraception and abortion- that gives a comprehensive picture of individuals' and/or couples' life course experiences before and after marriage, which makes it a new contribution in Ethiopia as far as my reading is concerned. Previous studies dealt with each domain separately. While studies that focus on separate domains enable in-depth understanding of the parts, addressing the three domains in a study is useful to grasp the connections among the domains. The study employed social science perspective as an alternative stance to public health and demographic discourses to understand the influence of social norms on fertility control. It is culturally embedded analysis of fertility norms that are usually overlooked by public health scholars and pure demographers. In this view, the study supplements the individual-oriented dominantly quantitative epidemiological and demographic studies by employing community-oriented qualitative research approach.

Exploring young men's involvement in fertility control in a less explored rural area can also be fairly considered as a new contribution of the study. In fertility control studies and the respective health service programs, young men are overlooked as a group given the studies and programs are framed in line of family planning program that presupposes adult women, and adult men to some extent. Focusing on young men is crucial to better understand and improve delayed first-birth which is a desired pattern of behavior in achieving targets of fertility control. It is also useful to understand and constructively shape their future orientations of fertility control. Exploring the rural contexts does not only fill the knowledge gap on young men's engagement in fertility control but it addresses the largest majority of young men population. Applying hegemonic masculinity to identify signs of men dominance over women that manifest in different aspects of fertility control that are usually considered as women's domain is also a new

contribution of this study. Finally, the study uncovered the change and continuity, and how different fertility norms play out locally in this particular area.

CHAPTER TWO
LITERATURE REVIEW

Introduction

In Chapter One, we are introduced to the research questions and theoretical framework of the present study where the existing literature are highlighted. This chapter presents selected global and local materials in a more detail for deeper understanding of discourses emerging on the topic. Hence, materials discussed in this chapter elaborate the key emerging issues on topic of the study. Most relevant materials are grouped into eight themes in line with the research questions with emphasis on masculine gender and social norms, sexuality, contraception and abortion.

2.1 Gender equality in cultural and religious contexts

Institutional settings and practices are explored in this study with emphasis on identifying gendered power relations, hegemonic expectations and manifestations as suggested by Kronsell (2005). In this subsection intersectionality among gender equality, religion and culture are reviewed. Gender equality refers to the absence of all forms of discrimination, violence, any harmful views, discourses and practices against women and girls. Women's full participation and equal access to opportunities of making decisions on matters that can affect their lives represent elements of gender equality (Adapted from UN-SDG 5, 2015, p.18).

West and Zimmerman (2009) argue that gender needs to be understood against historical and structural circumstances. Gender relations form a particular social structure and it involves a cluster of human social practices – including child care, birthing, and sexual orientation. Bakare-Yusus (2003) and Oyewumi (1997) agree on the primacy of gender structuration in social relations and on the need to be sensitive to the culturally embedded gendered categories and concepts. Studying what appears normal in institutional practices is relevant and a way of generating knowledge about gender relations.

Most religions are considered to be barriers to gender equality although the degree in which they endorse such inequality may not be the same. Different studies reveal that claims against gender equality are made under religion including in Islam and Christianity (Raday, 2003).

Seguino (2011) argues that all religions are gender inequitable and religiosity has effects on attitudes towards gender equality and on everyday behaviour. To Seguino, religiosity is strongly linked to gender inequitable attitudes across countries which in turn result in unequal outcomes for women. However, the effects of religion on gender equality cannot be fully understood without reflecting on the complex relationships between culture and religion. The monotheistic religions recognize the full humanity of women; however, religious norms impose patriarchal regimes that disadvantage women.

According to Raday (2003), culture is a macro concept which subsumes religion as one of its aspects. Accordingly, gender is derived from culture and religion whereas religion itself is derived from culture and is an integral part and institutionalized aspect of culture. Therefore, culture and religion (within culture), are the sources of the gender construct. Gender identity is imposed on men and women by culture and religion. Yet, culture and religion are treated as different categories although they also have much in common and influence each other. For Raday, the dynamic intersection among religious norms, culture, and gender speaks patriarchy. Ejim (2017) also argues that religion can be considered an integral part of culture; yet it can influence the other aspects of culture like values and norms. In this view, gender roles as part of culture relate with religion whereby they are given religious interpretation, gain moral status and thereby become part of the people's relationship with their divine being. In some cultures, gender roles and gender disparity are instilled with religious undertones and they are up scaled to divine mandate to give them legitimacy and ensure adherence to them. However, gender and religious ideologies are most of the times mixed up.

Seguino (2011) further elaborates the two way relationships between religion and culture in shaping gender. For the author, formal religious institutions shape cultural norms, social rules, and behaviours, and impact the rigidity of gender roles and attitudes. Furthermore, everyday behaviours and decision-making in religious institutions are also influenced by norms and stereotypes embedded in culture. Patriarchal values, norms, attitudes, and behaviours may manifest in religious institutional practices which may inculcate rigid gender roles. Seguino further argues that people who exhibit higher degrees of religiosity hold more gender inequitable attitudes and possibly results in inequitable outcomes. Therefore, religious norms that perpetuate and promote gender inequality may manifest in views held by those at the top

of the religious structure. In support of this position, Winkel (2019) asserts that religious agents, be it leaders or followers, men or women, act in the religious sphere by reference to socio-cultural meaning and orientation.

2.2 Fertility Control: Discourses and Practices

Scholars, states, agents of development partners, civil society organizations, social institutions, advocates, and moral and cultural opinion leaders have different views related to patterns of human reproduction (Coates et al., 2014; Halford and Prasad, 2014; Haslegrave, 2014; Johonson-Hanks, 2002; Kandiyoti, 1988; Kumar et al., 2009; Lerner et al., 2006). Accordingly, whether fertility regulation is a private or public concern has become a debatable issue globally (Coates et al., 2014). Some present sexuality and reproduction as sociocultural, moral, political, and/or legal objects that should be subject to social control. Within this view, there is some resistance against fertility control ideals and practices (Hawkins & Valdez, 2009). A stance against the realization of reproductive rights argues that the use of rights to fertility control should consider the family structure and function. Proponents of this view argue that the sexual and reproductive rights movement is not a genuine concern of gender equality that aims to advance the lives of women in the social context whereby they function as wives or mothers (Coates et al., 2014).

The International Conference on Human Rights in Teheran (ICHRT) (1968) recognized parents' right to decide on the number and spacing of their children. The World Population Plan of Action agreed upon at the Bucharest Conference (WPPABC) of 1974 made it clear that all couples and individuals can exercise such rights. Parents' access to education, information and means of deciding freely and responsibly the number and spacing of their children is included in the latter provision. However, "The International Conference on Population and Development (ICPD) (1994) marked a major ideological shift towards viewing people as agents with reproductive rights rather than objects whose fertility could be controlled by the State" (Coates et al., 2014, p.119). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted in 1980.

In Ethiopia, discrepancies between the moral standards that condemn premarital sexuality, premarital pregnancy, and induced abortion, on the one hand, and actual practice, on the other, is empirically established (Berhane et al., 2014; Kebede et al., 2012 and 2014; Seifu et al., 2006). That is, the condemnatory normative principles and codes (legal, cultural, and religious) usually

emerge in contrast to the actual behavior of people, which in turn result in undesired outcomes, culturally speaking (Gammeltoft, 2001; Hemmings & Rolfe, 2008). However, the prevalence of the practices speaks little about the details of cultural justifications, strategies, local realities, and experiences of different sections of local societies in Ethiopia. How the aforementioned globally competing views and locally dominant normative principles converge in individuals' and couples' efforts of fertility control and their implications on young men's involvement are focuses of the present study. The next three subsections present the three means of fertility control: sexuality, contraception and abortion.

2.3 Sexuality, Love and Pregnancy

Love is obviously a global phenomenon, but like any other social phenomenon, its meaning is socially and culturally constructed, and it is geographically and historically situated. The meaning serves different and dynamic purposes. For instance, in ancient Greece, true love between equals was seen as possible only between two men (Javaid, 2019, p. 17), whereas a close emotional bond with a woman was seen as undesirable, though men married for purposes of procreation (Hendrick and Hendrick, 1992, as cited in Javaid 2019, p.17). Although 'love' is indefinable for many scholars, understanding can be gained from study participants' subjective interpretations, definitions, and constructions of love as they experience and feel it. Love may be characterized as a 'fusion of souls', meaning two persons become one or united or come together with a particular bond that cannot easily be attained through other channels. The meaning of love however differs across contexts - like other social phenomena such as sexuality (Lerner et al., 2006 and Caulfield, 1985), fertility behavior (Poston and Micklin, 2005), and gendered power relations (Brandth, 1995). That is, love is also negotiable and subject to change as theorized by Javaid (2019, p. 6):

> *... while love and emotions relating to love, such as desiring another can be 'made' at a particular historical moment, they can simultaneously be 'unmade'. Love, then, is negotiated through social and power relations. Love is historically, culturally, and socially constructed and rooted.*

Durkehim and Weber, respectively, contrasted 'family love' and 'brotherly love' with passionate or romantic love based on purposes they serve in different contexts. Altogether, love cannot be comprehended outside of the cultural and social contexts in which it manifests, given love becomes cultural based on subjectivity (Jackson, 1993; Javaid, 2019). Examining the contextual

meaning of love and its purposes, enables us to explore the views and experiences of young men. More literature on love are further consulted in Chapter Five. Comtean sociologists were interested in the evolution of sexuality and marriage, and the status of women was seen as an index of progress. Similarly, Spencer wrote about family, kinship, and the status of women (Connell, 2014). Moreover, Ward, Engels, and Sumner were interested in and explored the fields of sexuality, gender differences, the family, kinship, marriage, prostitution, and incest.

The literature shows that in many African countries, including Ethiopia, sexuality and pregnancy are culturally justified only when they occur within the frames of marriage (Johonson-Hanks, 2002, and Kebede et al., 2012 and 2014). With regard to such sexual ideology, traditional sexual morality that relegates women's sexual practice to the institution of marriage features in people's accounts. Kebede et al. (2012), emphasized that premarital sexuality is prohibited in Ethiopia by religions of both Christianity and Islam. In Ethiopian Orthodox Tewahedo Church (EOTC), for instance, young men and women are expected to confess before the clergy whether they have practiced premarital sex as a precondition to arrange religious wedding ceremony, as the type of religious ritual varies depending on their virginity status. Johonson-Hanks (2002) and Kebede et al. (2012 and 2014) in studies from Cameroon and Ethiopia, respectively, have similarly documented disapproving stances against premarital pregnancy. An important contributing factor to child/early marriage in Ethiopia is parents' desire to avoid their daughters' premarital sexual intercourse and the possible consequence of premarital pregnancy, which is deemed socially shameful for both the girl and the parents (Jones et al, 2014). However, there is gap between restrictive moral/social rules against premarital sexuality and pregnancy, and the actual sexual behaviors of young people (UNESCO, 2013). The literature indicate that increasing numbers of unmarried young women and men are sexually active in Ethiopia.

Unwanted premarital fertility may affect individuals, families, and countries if not properly guided (Mariachiara & Rodriguez, 2006). Medical complications from pregnancy and childbirth are among the leading causes of death for young people globally (UNESCO, 2013). It may also negatively affect future socioeconomic lives of young men and women when they become adults by compromising their development and economic potential and participation (Klepinger et al., 1997). It may be challenging for a young mother to properly care for a child while managing her education and job, as these roles may be in conflict with each other. Hence, young mothers and

the children born to them may face complex biological, social, and emotional problems (Cesare & Rodrigueze, 2006). At the societal level, early pregnancy moreover contributes to a higher rate of population growth, as a mother will give birth to more children (UNESCO, 2013). A study from Ethiopia also revealed that, premarital pregnancy endangers social support, which is vital to young women (Kebede et al., 2012). At family level, an unwanted premarital child may become an additional burden to the family by interfering with the socioeconomic lives of the family members. The sources reviewed in this section strongly indicate that fertility control is not merely a personal concern but it is a socioeconomic and political topic to be placed on the agenda at national level. Rodrigues et al., (2022) also argue that sociocultural factors influence fertility preference and fertility behavior in Ethiopia.

2.4 Contraception

Two major revolutions happened in the 2nd half of the 20th century which are named as the contraceptive revolution and reproductive revolution both of which were received with suspicion. The former and the latter respectively permitted sexuality without reproduction, and reproduction without sexuality. Modern contraception significantly contributed in controlling population growth in 20th century in industrialized western countries (Benagiano, Testa and Cocuzzi, 2004). Diczfalusy (2002) argues that contraception has become a powerful common property of humankind and considers the invention of contraceptives as fundamental as the invention of the wheel reminding that more than 500 million couples are using contraceptive methods.

Social norms of fertility shape people's behavior of contraceptive use (Rodrigues et al., 2022). The terms 'contraception' and 'family planning' are usually used interchangeably (Bukuluki et al., 2021) although the latter entails a broader scope. Agha et al., (2021) from a study in Nigeria and Kane et al., (2016) in South Sudan found that social norms affect contraceptive use or family planning by shaping decisions. Lahirir et al., (2023) also writes that in Kenya social norms influence youth modern contraceptive use and these social norms are gendered. Willan et al., (2021) from their study in South Africa identified that social norms and agency differently affect young women's decision making at different times in their lives. During teenager they experience normative pressure to have a baby while young but agency plays most important roles

after having they had the first child whereby they want and start to control the next pregnancies. According to Willian et al., (2021), young women's agentic control over their fertility increases as they grow older although effects of social norms continue influencing their decision.

Kane et al., (2016) argue that a social norm which expects people to have as many children as possible remains well established in Nigeria. However, the norm that expects having many children is under competitive pressure from the existing norm which makes spacing of pregnancies socially desirable and emerging norms of taking good care of one's children with providing them with a good education. The new social norms emerged along changes in people's views that children are not sources of labor rather they require parents' investment in their education (Kane et al., 2016, p.1). Another study from Nigeria reveals that a requirement for women to be accompanied by their husbands to clinics to be able to access contraceptives and clinics' refusal to provide contraceptives to adolescents have changed, and religious leaders pass messages in favor of using family planning (Cannon et al., 2022).

Coast et al., (2019) found that discriminatory gendered social norms and practices hinder uptake of adolescent sexual and reproductive health services in Ethiopia and Rwanda. The study indicated that norms prevent unmarried girls from accessing contraceptives and compel married couples to prove their fertility soon after marriage. They also prevent girls from being able to negotiate contraceptive use with sexual partners. Kapadia‑Kundu et al., (2022) examined how social norms, couple communication and decision making affect modern contraceptive use in Ethiopia. They found that the desired family size of 4–5 children, inequitable gender norms and male-dominated couple communication influence the timing and decision of modern contraceptive use in Ethiopia. Sedlander et al., (2018) note that Health Extension Program and the deployment of health extension workers have widened modern contraception services, increased contraceptive use uptake and addressed unmet needs.

2.5 Abortion

The broader social contexts and cultural settings in which sexual activity and abortion take place influence women's decision to seek for abortion care. For instance, what is considered as "unwanted pregnancy" is culturally defined based on the social norms of proper sexual practice and childbirth (Purcell, 2015). Abortion involves socio-political and moral debates concerning

when life begins and ends (Kaufman and Morgan, 2005), and it is usually politicized and inherently contentious and controversial. Hence, historical and cross-cultural perspectives enable us to analyze changes over time and variations across societies. Legal aspects of abortion also duly attract the attention of the public and of several researchers. Ultimately, it is a controversial social policy issue on which the general public is divided. The literature reveals that abortion is also an emotional and highly contested issue calling for continuous analysis to shed some scientific light. It moreover involves physical, psychological, developmental, moral, religious, familial, and medical considerations (Purcell, 2015; Raymond, 1985).

Globally, abortion is a concern and a source of controversy between pro-choice and anti-abortion perspectives (Raymond 1985). It raises a concern of the right to life of an unborn child and of the mother in light of the Universal Declarations of Human Rights (Coates et al., 2014). At the core of the debates is the question of whether abortion terminates the life of a human being or not. Moral philosophers and abortion-seeking women around the world are confronted with the distressing dilemma of whether to interrupt or maintain an unwanted pregnancy. The dilemma involves questions of personhood, humanity, and the moral justification of intervention in human physiological processes (Gammeltoft, 2001; Kebede et al., 2012 and 2014). Haaland et al., (2019) and Zulu et al., (2019) respectively analyzed how competing discourses shape abortion policy and sexual education in Zmabia. Similarly, Sambaiga et al., (2019) examined discourses that shape hybrid abortion regime in Tanzania.

Abortion is an inevitable occurrence across the globe and the majority of abortions occur because of unwanted pregnancy (Forte 2018). Unsafe abortion has been an important and ongoing health problem in Ethiopia, and both legal and illegal abortion have been practiced. Singh et al., (2010) writes that unsafe abortion is common and exerts a heavy toll on women in Ethiopia. The study also noted that there was a high unmet need for post-abortion care, and it is estimated that there was about one abortion for eight births. Many surveys conducted in Ethiopia focus on the assessment of adolescents' awareness and practice with regard to abortion. Accordingly, lack of knowledge, together with cultural stigma surrounding abortion and barriers of access to services, contribute to persistently high rates of unsafe abortion and abortion-related mortality (Prata & Summer, 2015). Rominski et al., (2015) in a study from Ethiopia affirmed that knowledge about the legal status of abortion and its grounds can affect the behavior of both healthcare providers and service seekers.

Unsafe abortion causes direct and indirect costs to abortion seekers and the healthcare system in the country (Grimes et al., 2006).Women's access to legal and safe abortion is recommended as a vital means to reduce unsafe abortion, maternal morbidity and mortality. The number of women who die due to unsafe abortion has decreased in many countries after the legalization or liberalization of national abortion laws (Berer, 2017; Cohen, 2009). It is argued that universal access to safe abortion is the best way to avoid the complications of unsafe abortions, and as the legal grounds for abortion expand, the number of deaths from unsafe abortion decreases. Accordingly, countries with the fewest deaths from unsafe abortion are those which permit abortion on request without or with very few restrictions. It is quite important to consider the relationship among sexuality, contraception and abortion which is well summarized as follows:

> *The relation between levels of contraceptive use and the incidence of induced abortion remains a topic of heated debate. Many of the contradictions are likely due to the fact that abortion is the end point of a process that starts with sexual activity, contraceptive use (or non-use), followed by unwanted pregnancy, a decision to terminate, and access to abortion. Trends in abortion rates reflect changes in each step of this process, and opposing trends may cancel each other out* (Bajos et al., 2014, p. e91539).

The quotation implies the importance of a careful consideration of the multiple conditions and processes leading to abortion. One of the contradictions Bajos et al., (2014) emphasize is whether abortion rates increase or decrease relative to changes in the prevalence of contraceptive use. An increase in abortion rates is partly a result of failure in contraceptives and, more generally, a failure in family planning services and policies. Limiting fertility is the common underlying reason for using contraception and seeking abortion. However, the decision to terminate an unwanted pregnancy and seek for abortion care services is influenced by the legality, accessibility, and acceptability of the practice (Bajos et al., 2014, p. e91539).

MDGs spurred the development of the new abortion laws in Ethiopia. The Revised Criminal Law of Ethiopia (FDRE 2005) and other policies related to gender, sexual and reproductive lives were formulated. Astrid et al., (2019) comparatively analyzed abortion laws of three African countries, Ethiopia, Zambia and Tanzania and they found that the laws are paradoxical. They further argue that regardless of the legal statuses of abortion in the three countries, access to legal abortion services are restricted in one way or another hence women seek unsafe abortion. Similarly, Getnet et al., (2019) examined strategies and dilemmas in realizing the relatively more

permissive abortion law in Ethiopia whereas Zenebe and Haukanes (2019) explored inequalities among adolescents in accessing abortion care services in the country.

Legalization of abortion may not be a sufficient condition to improve women's health and well-being because of other factors such as limited access to competent care (Grimes et al., 2006). No law has ever stopped abortion. Young women seek induced abortion regardless of clear moral sanctions against the practice. That is, a sufficient legal environment may not guarantee a decline in the rate of unsafe abortion given the dynamics created by lacking services as well as a web of sociocultural factors (Moland et al., 2017). It is also noted that criminalizing abortion does not ensure avoidance of the abortion practice as the service is provided underground as revealed by studies from Cameroon and Kenya (Izugbara et al., 2009; Johonson-Hanks, 2002).

However, there is lack of abortion literature that has explicitly framed from a social norm perspective at grass root level in rural context of Ethiopia, the knowledge gap this study strives to fill. Most studies reviewed on adolescent pregnancy and induced abortions have also given less attention to young men. The existing studies reveal that young people's knowledge about fertility control is incomplete, superficial, inadequate, or distorted (Abebe & Ejeta, 2015; UNESCO, 2013). Abortion concerns young people than other age groups given the rate is higher among them and unsafe abortion for young people accounts for a quarter of all unsafe abortions in Africa (Shah et al., 2004 cited in Grimes et al., 2006, p. 1909). For example, a third of young women's pregnancy ends up in abortion in southern Cameroon (Johonson-Hanks, 2002).

2.6 Gendered Views and Practices of Fertility Control

Different studies from Africa have articulated very well that sexuality, pregnancy, and abortion are gendered views (Izugbara et al., 2009; Kabagenyi, et al., 2014). These studies provide us with exceptional contributions in that they focus on men's involvement in sexual and reproductive matters. Hence, the studies are exemplary in raising a range of sexual and reproductive concerns that involve men. They documented men's experiences both as partners to women and as direct users of fertility control services. The study by Izugbara et al., (2009) in Kenya emphasizes induced abortion (as a curative method) whereas the study from Uganda (Kandiyoti, 2016) deals with the use of contraceptive methods as a preventive mechanism. Overall, men provide less support for their wives with regards to reproductive lives in Africa (Kandiyoti, 2016). Some husbands complain against their wives for unplanned pregnancies

(Izugbara et al., 2009). They often control their wives' use of contraceptive methods by choosing contraceptives for them or not allowing them to use contraceptives at all. In Ethiopia, women have been noted to use contraceptives secretly and if discovered by their husbands, it may cause serious marital disputes (Options, 2008).

Kabagenyi et al., (2014) in their study from Uganda found that men avoid using condoms because they believe that condom use reduces sexual satisfaction or causes an allergic reaction. Condom use has also been associated with distrust among couples. Men also refuse to support their spouses' decision to use other forms of contraception because they perceive that contraceptive methods reduce sexual pleasure, increase women's risk of infertility, and may cause illness. In addition, the permanence and irreversibility of vasectomy makes it unacceptable for men as a contraceptive method because it is considered tantamount to castration, or they believe that it leads to impotence (Kabagenyi, et al., 2014 and PATH, 1997). The use of condoms may be seen as inappropriate for sexually active older men. Providers' misconceptions or biases about male contraceptive methods or men's roles in family planning may also discourage males from seeking the services (PATH, 1997). Both social norms and health care systems in general discourage men's involvement in contraceptive use because of their tendency to see it as a women's domain. Men's fear of their spouse's infidelity when they use contraceptive methods is a formidable barrier. There is a tendency to associate women's contraceptive use as a sign of having multiple sexual partners as its use is common among commercial sex workers (Kabagenyi, et al., 2014).

Men may play supportive or antagonistic roles with regards to decisions made around abortion based on their interest and societal contexts. Thus men's attitudes, practices, and experiences associated with abortion are of importance in any abortion context and need to be documented (Newton et al., 2020). According to Kane et al., (2016), women in Nigeria make decisions themselves of family planning with support and resistance of their husbands. Izugbara et al., (2009, p. 401) write that women require the support of their sexual partners in seeking abortion, but it is challenging for them to secure such support as men and women have gendered and dissimilar views of abortion. Izugbara's et al., study shows that Kenyan men, unlike women, support abortion only on certain grounds: if the pregnancy resulted from rape or if abortion is the only means of saving the mother.

Many men in Izugbara's et al., study argued that abortion was less common in the past when women and girls to a stronger degree respected and feared their husbands and fathers. Women link the increment of abortion mainly to poverty, which influences women's lives in different ways and forces them to opt for termination of the pregnancy. Although men share the view that poverty is a factor for the increment, it is deemed less important than the cruelty and immorality of women. Izugbara et al., also write that women raise men's irresponsibility as a contributing factor for the increasing trend of abortion in Kenya. Men's unsupportive attitude and unfaithfulness lead women to seek abortion. To the Kenyan men, abortion represents their potential loss of control over women's reproductive capacity, which emanates from a belief that men are to decide on the sexuality and fertility of women, and women's bodies are viewed as an object of control for men. Women acting outside these cultural norms are discriminated against (Izugbara et al., 2009). Educated women in south Cameroon condemn abortion; yet, they practice it regularly to manage timing and entry into socially recognized motherhood (Johonson-Hanks, 2002). Accordingly, a woman who terminates a pregnancy deviates from collective interests, using her agency to 'deem a potential life unwanted' and then end that potential life. In so doing, she may challenge the 'moral order' (Kumar et al., 2009, p. 628).

In terms of age, abortion has a higher rate among young people than other age groups; indeed it is reported that unsafe abortion for young people (15–19 years) accounts for a quarter of all unsafe abortions in Africa (Shah et al., 2004 cited in Grimes et al., 2006, p. 1909). A particular challenge is posed by most sexual and reproductive health services designed for the general population and married population and not specifically for young people (UNESCO, 2013). In a practical sense, young men are there with young women as sexual and marital partners. They represent an important target group, which demand particular challenges in reproductive health matters. They moreover face strong social pressure that prevents them from seeking reproductive health information and services. Regardless of the apparent needs, they remain excluded from reproductive health programs (PATH, 1997).

However, researchers usually disregard young men's involvement in fertility control. A few existing research have explored diverse research issues in the field. For example, the literature reveals that men may practically exempt themselves from the burden and responsibility of contraceptive use and thus inherently uphold patriarchy and reproduce gender inequality

(Schrock and Schwalbe, 2009; Tuloro et al., 2006). Globally, only condoms, vasectomy, and withdrawal constitute male contraceptive methods. Some view this as an absence of male contraceptive methods, and the ones available are not suitable for many men and women because of their limitations (Plana, 2017).

There is also a critical lack of studies on abortion from the men's side in Ethiopia. However, some studies are directly or indirectly interested in it. Kebede et al., (2014 and 2012) indirectly implied men's involvement in abortion is minimal and unsupportive given abortion seeking women even do not discuss with their partners to make such decision. Most studies reviewed in this section on adolescent pregnancy and induced abortion have given little attention to young men as their study target with exception of a few emerging studies like by Zenebe and Haukanes (2019). Abebe & Ejeta (2015) and Seifu et al., (2006) also documented that out-of-school youth in Ethiopia have distorted knowledge on contraception and limited access to the services. I will argue that young people emerge as exceptionally worthy of increased research focus pertinent to fertility control in Ethiopia, as the vast majority of the population comprises children and youth and few services seem to be directly targeting them. Girls aged 10-19 comprise 24% of the population in Ethiopia (CSA and ICF International, 2012). Giving more attention to young men in the rural parts of the country where men yield significant decision making power in all matters, including sexual and reproductive regulations, emerges as vital.

2.7 Descriptive and injunctive norms

Social norms have become a growing area of interest among academicians and practitioners (Cannon et al., 2022; Chung & Rimal, 2016; Fried and Udry, 1980). Norm-focused rather than individual-based interventions are strongly recommended to efforts made to promote changes in communities (Bukuluki et al., 2021). Sociologists conceptualize norms as rules of behavior that exist at both the formal and informal levels. Informal norms are considered more salient and reinforced. They view norms as regulating behavior through consensus, as well as exercising control through social sanctions. In this view, norms do have a strong and regular impact on behavior (Chung & Rimal, 2016, p. 5). Norm can refer either to what is commonly done - that is, what is normal - or to what is commonly approved - that is, what is socially sanctioned (Cialdini, Kallgren, and Reno, 1991, p. 202). That is, each respectively represents to what others commonly do and what others commonly approve. These authors define norms that characterize

the perception of what most people do as *descriptive norms* (or the norms of "is") and norms that characterize the perception of what most people approve or disapprove as *injunctive norms* (or the norms of "ought") (1991, p. 203). Accordingly, descriptive norms specify what is done whereas injunctive norms specify what ought to be done. The latter constitute the moral rules of the group and they motivate action by promising social rewards and punishments (informal sanctions) for it. Whereas descriptive norms inform behavior, injunctive norms enjoin it. Cannon et al., (2022) present injunctive norms and descriptive norms as community perceptions and practices, respectively (p. 1386). A distinction between descriptive norms (the perceived prevalence of a behaviour among peers; doing what others do) and injunctive norms (perceived peer approval; doing what others think one should do) can help acquire a more precise understanding of the norms (Svanemyr, 2019).

The dominant norms of a society that are presumably always in place may only sometimes predict behavior because they activate behavior only when they are activated first and incompatible social norms may simultaneously exist. Although it is most frequently the case that what is done and what is approved in a social group are the same, this is often not the case (Cialdini, Kallgren, and Reno, 1991, p. 205). According to Theory of Normative Social Behavior, although norms are often powerful, they do not always affect behaviors because people may refuse to follow existing norms (Chung & Rimal, 2016). Fried and Udry (1980) note that the existence of a norm is not sufficient to insure control behavior but members of the group need to perceive its existence and strength, and they must find the punishment for deviating from the norm and the reward for conforming are real. Members may perceive norms that do not in fact exist (pseudo-norms) or they may be unaware of the existence of norms (pluralistic ignorance) (p. 200). This study builds on these literature in understanding and explaining norms of fertility, fertility control practices and involvement of young men.

2.8 Youth sub-culture and positive deviance

Williams (2007) argues that the interdisciplinary field of subcultural studies is a robust and growing area of scholarship (p. 587). A subculture is a characteristic set of specific norms, values, behavior patterns, and lifestyles that define a certain group within the context of the broader society (Smolik, 2013, p.68). The author further describes the concept as:

> *The term subculture relates to a specific group that is the creator and bearer of its own special, differing norms, values, patterns of behavior, and lifestyles, even as it plays a part in the functioning of the broader society. In every case the important indicator of a subculture is its visible difference from the dominant culture (Smolik, 2013, p.68).*

Youth subcultural phenomena continue to be popular topics in sociological and cultural studies (Williams, 2007) and such studies have bright future (Williams, 2019). *Youth subculture* is broadly defined as meaning and action systems created by young people sharing similar interests, preferences and life-chances (Bell, 2013, p.11). The high or mainstream culture has limiting and moralizing aspects in the lives of young people. The mainstream official norms are represented by their parents, religious leaders, and other significant adults in their lives (Gunes, 2016). The author argues that youth subculture, as a different social deviance, enables young people to oppose the dominant culture of their adult parents and the society to ensure their freedom and independence that they dream in their lives. For example, use of different form of sex put characters of young people into a different position from the perception and understanding of adult people yet without thoroughly detaching from culture and common way of life of their parents (Gunes, 2016). Smolik (2013) argues that the majority of young people support the key institutions such as family, school and employment. Yet, they may also deviate from institutional norms. Positive deviance (PD) is an innovative behavior change approach that is used to solve difficult problems by discovering and amplifying solutions that already exist within a community. Positive deviance recognizes that in every community there are individuals and groups whose uncommon but successful strategies enable them to find better solutions to a problem than their peers, despite all odds (Swartz, 2012, p.30). In Ethiopia, there are limited studies that adopted youth subculture in general and in the context of fertility control in particular.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1. Description of the Study Setting

The Oromo are one of the Cushitic-language-speaking peoples in the Horn of Africa. As far as history can take us back the Oromo originated from the table land of Bale, and the people are today spread across the vast territories of northeast Africa in Ethiopia and the northern part of Kenya. Most Oromo in Ethiopia live in the Oromia National Regional State of the current federal administrative arrangement of the Federal Democratic Republic of Ethiopia (FDRE). Most Oromos speak Afaan Oromo and a significant number can also speak other languages like Amharic. The Oromo are divided into two large groups or principal moieties called the Borana (western branch) and the Barentu (eastern branch). The Borana are considered the senior division and settle in the western, southwestern and northwestern parts of Oromia and are further classified into the Mecha-Tulama, the Southern Borana, and the Guji confederacies. The Barentu live in the eastern, southeastern, and northeastern parts of the region and are divided into three: the Ittu, the Arsi, and the Qallu (Chala, 2017; Gebissa, 2016; Gusarova, 2009; Jalata, 2010). Jalata (2010, p. 11) emphasizes that "*Despite the fact that Oromos claim that they descended from the same family stock, Oromo, they do not limit their kinships to biological ancestry. The Oromo kinship system has been based on a biological and social descent*."

The Oromo in rural settings rear cattle and grow cereal crops, which have been a part of their livelihood in diversified ecological zones ranging from arid lowlands to temperate zones and highlands. They have lived in scattered homesteads or huts, with a patrilineal and extended family being the basic social unit, whereby a man as an *Abbaa Warraa* (literally 'head of the family') has authority over his wife or wives and children (Jalata, 2010). Gender constitutes the essence of core of the social organization of the Oromo across age-based generations, with distinct etymological gender indicators prescribed from early childhood to oldage, chronologically represented as *ilma vs intala* (son vs daughter), *gurbaa vs dubra* (boy vs girl), *dardara vs shamarree* (adolescent boy vs adolescent girl), *qeerroo vs qarree* (unmarried young man vs unmarried young woman), *namicha vs niitittii* (adult man vs adult woman) , *jaarsa vs jaartii* (older man vs older woman), and so on, even though the matching and their use may vary from one area or context to another. Males and females are respectively denoted as *dhiira* and

dhalaa as general sex indicators. However, *daa'ima, dargaggoo, manguddoo*, *nama* or *dhala namaa,* respectively, meaning 'children', 'young people', 'elderly', and 'human' or 'human being' are used as gender-neutral terms.

Broadly speaking, gendered power relations among the Oromo people are constructed around a myth of *Akko Manoyye*, a legendary queen in ancient times who ruled the last term in a women-dominated political system in this Oromo myth. While this story is commonly told across Oromo branches with minor differences in expressions, the myth is briefly summarized as follows, based on Debsu's work on the Guji Oromo (2009, p. 21-22):

> *Akko Manoyyee*, during her rule, ordered her constituents to perform unbearable tasks. For example, she ordered people to bring a bag full of fleas or construct her house in the air. Being terrified with the order, the people asked a wise man (usually said to be a short person) what to do about the queen's orders to avoid subsequent punishment if they failed to do the assignments. The wise man advised them to react to her orders by posing other equally challenging requests as preconditions before they can carryout her orders. The most popular precondition requested of her was to put up the first pillar for the house to be constructed in the air as it is customarily expected of an owner of a house in the process of house construction. She failed to do that and her inability to perform what was requested by the people resulted not only in her death but it also ended the legitimacy of women's dominance in political rule. It is believed that political and administrative dominance shifted from women to men after this mythological event.

This story is commonly recited by the Oromo to justify the marginalization of women from decision making and leadership positions, on the one hand, and the consolidation of power in the hands of men and the hegemony of men, on the other. However, it does not imply that women are totally excluded from exercising power in administrative/political leadership and military interventions as the Gada System and Siiqqee institution regulate, balance, and safeguard gender relations (Chala, 2017; Debsu, 2009; Jalata, 2010). Under the Gada System, a system that encompasses the entire social, economic, and political lives of the Oromo, women make significant contributions in many aspects of life, and there are conditions in which women

exercise power over men under the Siiqqee (Siinqee) institution. This power is exclusive to women, and using this power, they can collectively enforce punishment upon men for violating women's rights or they can take part in warfare as peacemakers.

Under these customary institutions, women can also have control over stationary resources and private spaces, which bring them to higher social status and respect. Women also exercise special religious power under the Siiqqee Institution, and they are culturally protected against violation of their rights (Debsu, 2009 and Jalata, 2010). However, Gadaa and Siiqqee institutions are gendered themselves given they are mainly practiced by men and women, respectively. While Gadaa is organized in line with men's age set where women play supportive roles, Siinqee is attended exclusively by women where their performance is protected by men. Although Siiqqee is an independent institution dealing with peacemaking and women's rights, it is encompassed within the broader Gadaa System.

The Oromo in the Gibe region or Jimma Zone belong to the Borana in the Borana-Barentu division of the people, and is a family of the Mecha in the Mecha-Tulama sub-branches who reside in western and southwestern parts of Oromia. More specifically, the people reside in the southwestern part of the country which is commonly known as the Gibe States. Jimma Zone is one of the 20 zones in the Oromia National Regional State. Its zonal administrative city, Jimma, is located at about 350 km from Addis Ababa, the capital city of Ethiopia.

Nadhi Gibe is one of the 21 districts in Jimma Zone and is located 70 km from Jimma to the east. According to information obtained from the district administration office, its total population was about 142,065 in 2017 with more or less equal proportion of each sex. About 96 percent of its population is rural inhabitants and 92 percent is Muslim. The Oromo constitute nearly 95 percent of its total population. People's livelihood is dominantly customary agriculture mixed with animal rearing and trading activities. The district has 26 first cycle primary schools (Grade 1-4), 36 second cycle primary schools (Grade 5-8), four high schools (9-10 grades) and one preparatory school (11-12 grades) (Source: District Administrative Office, 2017). There are 25 health posts (primary health facilities at the lowest administrative unit called *ganda/kebele*), five health centers, and a newly established primary hospital in the district years after the fieldwork. Health posts mainly provide health education and promotion at the community and household levels with special emphasis on women and children (District Health Office, 2017). Family

planning and reproductive health is one of the four major components of the Health Extension Program (MoH, 2004; District Health office, 2017). Contraceptives are also available at this level. Health Extension Workers, who are trained for at least one year, are assigned to work at health posts which are located in the *ganda*/*kebele*. The health extension workers have very limited clinical training, so they do not treat patients; rather, they largely engage in preventive activities. Health centers are staffed with nurses and public health officers that hold a BSc. Degree. In principle, a health center is mandated to provide first-trimester abortion and contraception services whereas they are expected to refer second-trimester abortion to hospitals (MoH, 2006).

Nadhi Gibe was selected as the research site for this study for the following rationale: First, the study was primarily intended to examine conditions of fertility control in rural settings. Nadhi Gibe is less urbanized than other districts in Jimma Zone, and it is not located along the main route from Addis Ababa to Jimma City. Hence, it was deemed to 'represent' the rural population better than many other districts. Second, the district is a home to residents with diverse religious affiliations. There are larger number of Ethiopian Orthodox Tewahedo Chruch followers in the district compared to other districts that are dominated by Muslims. This made a comparative analysis of religious views and practices relevant to the issue under study possible. Third, historically, the district has been an intervention site for sexual and reproductive health programs by NGOs, which made it possible to examine the dynamics of change and continuities. Given the district hosts a hydroelectric dam called Gilgel Gibe I, there have been widespread movement of people in and out of the area including sex workers and sexual and reproductive health service programs in the area since its construction began in the early 2000s. The district was among the top priority areas of HIV interventions, whereby new sexual and reproductive services like condom use were introduced. Lastly, the researcher had prior exposure to the district during his visit to the area in connection with other studies. Hence, he is relatively familiar with the study context because of the earlier connection which eases entry into the community, build rapport and trust, and undertake the fieldwork. Ethnically, he belongs to the same study cultural group, the Oromo, which benefits him to easily communicate using the same language but being from different religious background (i.e Protestant), and educated urban resident create distance himself from immersing into the lives of the communities.

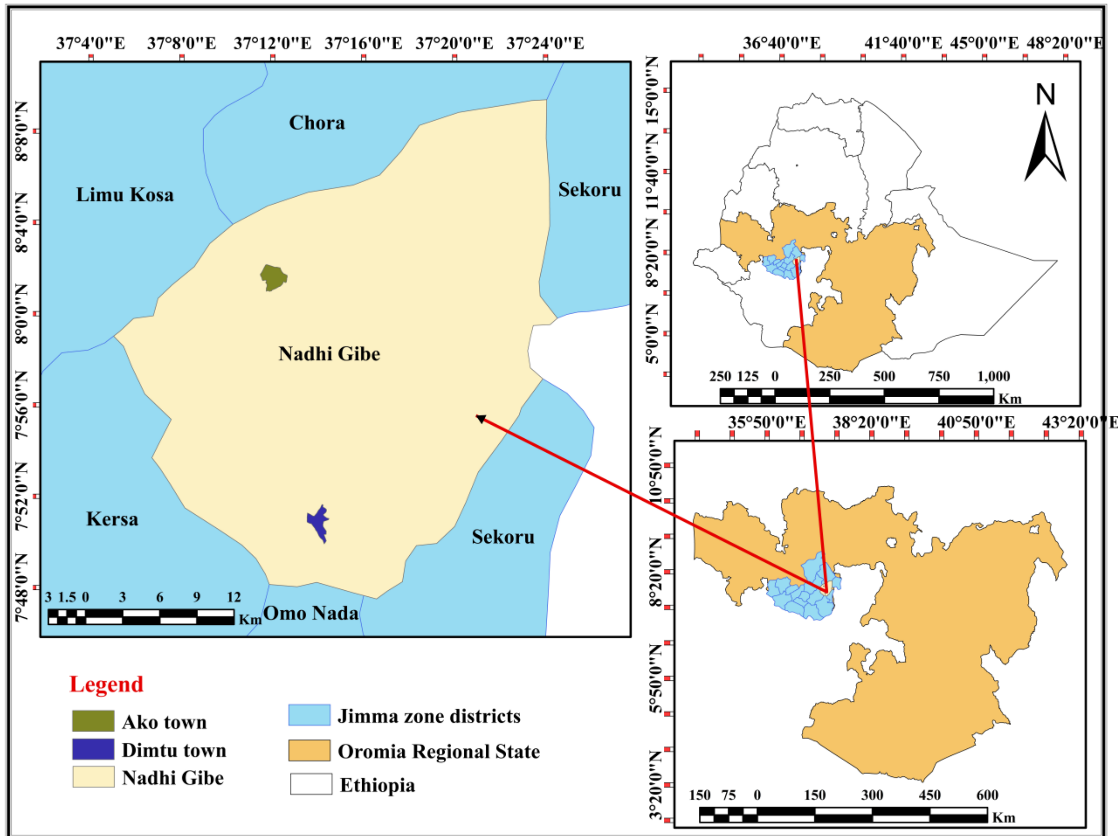

Figure 1: Map of the study area

3.2. Paradigmatic Positions

The study draws upon Weber's philosophical orientations as its theoretical and methodological paradigmatic stances. Weber argues that institutions and concepts like 'society', 'association' and 'community' are rational, affective, and imply social interaction (Weber, 1946). He states that ideas lie behind a concrete end as his ontological position of idealism. Furthermore, his historical idealism can easily be inferred from his argument that "the historical influence of ideas in the development of social life has been and still is so great" (Weber, 1949: 54). According to Ritzer (2011), Weber devoted a substantial attention to ideas, particularly systems of religious ideas, though he did not totally invalidate the material dimensions. In terms of his epistemological assumptions, the most important task of science of cultural life is to arrive at a rational understanding of ideas (Weber, 1949: 54), which signifies rationalism. Weber's fundamental theory on the processes of rationalization is a proof of his inclination toward

rationalism rather than empiricism (Ritzer, 2011). The concept 'r*ational'* for him denotes systematic, rigorous, and disciplined action (Weber, 2005: xxvi-xxvii).

Interpretivism is the basis for the theoretical visions in which reality is not simply to be observed but rather 'interpreted'. According to Porta and Keating (2008), in the interpretive paradigm, the world is not just there to be discovered; rather, knowledge is filtered through the theory that the researcher adopts. The Weberian vision of interpretivism based on the concept of *Verstehen* (understanding from the inside) was followed throughout this work. Weber called his perspective '*interpretative*' or '*understanding*' sociology. For him, 'understanding' is a unique approach of the moral or cultural sciences which deals with human beings rather than with other animals or with lifeless nature. He presupposes that "man can 'understand' or attempt to 'understand' his own intentions through introspection, and he may interpret the motives of other men's conduct in terms of their professed or ascribed intentions" (Weber, 1946, p.56).

His interpretative sociology is different from Comte's and Durkheim's positivist sociology as his sociology seeks to understand the subjective and meaningfulness of particular patterned action by persons in specific groups. "Throughout his sociology, Weber seeks to understand how people view their own behavior and how they justify it to themselves, or lend it "meaning" (no matter how odd it may appear to the observer)" (Weber, 2005, p. xxix). The role of sociologists for Weber could be expressed as "*Sociologists live and suffer from their dual task: to develop generalizations and to explain particular cases*" (Weber, 1978, p. XXXVI).

Weberian *Verstehen* as a method is not characterized by subjectivist individualism and psychologism but it is the rational comprehension or interpretation of the motivations underlying behavior. Weber emphasizes that abstraction of empirically observed regularities is possible using his concept of the *ideal types,* which are forms of social action that are seen to recur in human behavior (Corbetta, 2003). He employs an interpretive methodology, uses rational models or ideal types to develop themes or generalizations in his examination of historical data (Farganis, 1996). Although Weber does not deny the relevance of quantitative methods, he is quite sensitive to the qualitative uniqueness of cultural reality. The 'ideal type', a key term in Weber's methodological discussion, refers to the construction of certain elements of reality into a logically precise conception. His historical comparative methodological stance can be understood from his belief that to understand a sequence of regular events causally, one must

examine comparable conditions just as he attempted to validate his causal analysis of religion and capitalism in the Occident whereby he examined many other civilizations (Weber, 1946).

As a researcher, I am aware of the limitations of Weber's paradigmatic stances and I have critically addressed those aspects. Weber's reactive positions against positivists, mainly Durkheim and Marx, seem excessive at times. His presumption that a researcher cannot be value-neutral and objective appears to compromise the basic criteria of scientific study and opens room for researchers' personal bias to interfere with the research process. His position of pro-value judgmental science, like postmodernists, is in conflict with his own theories of modernism (bureaucracy, capitalism, and rationality). Moreover, his over-reliance on the relevance of value judgment in research sounds equivalent to reducing scientific research to normative evaluation. Albeit to a lesser degree compared to Marx and Durkheim's pro-structural views, Weber is prosocial action as he tends to reduce society to social interaction. His notion of developing the ideal type is quite an important tool of qualitative research but it emerges as too nominal to represent actual social phenomena.

I draw upon his positions in designing and undertaking this study whereby his concepts of social action, rationality, values, interpretive understanding (Verstehen), and ideal types are widely adapted. This is the case because the study considers fertility control and its three means - sexual restrictions, contraception and abortion- are culture-specific, multiple, and dynamic phenomena. Interpretivism is a vital epistemological position to understand the social phenomenon under study. I have attempted to understand and interpret these patterns of social behavior based on his observation of what people say and do.

3.3 The Research Approaches and Designs

Weberian interpretivist research paradigm and ethnographic-oriented qualitative research approaches were employed. Qualitative research is an approach to the study of the social world which seeks to describe and analyze the culture and behavior of humans and their groups from the point of view of those being studied (Bryman, 1988). In the qualitative research approach, a social phenomenon is largely viewed as embedded with meaning which has to be contextually understood, not counted. Meaning is subject to more observable experiences of the study participants than estimations made from numbers representing their behaviors.

For Bryman (1988), the rationale of a research approach and design has to be discussed in relation to a specific research topic. Accordingly, the aim of the present study is to understand how fertility control takes place as a patterned social phenomena. The data collection, analysis, and interpretation approaches followed ‘Verstehen’ tradition. Nachmias and Nachmias (1996) explicitly write about the Verstehen tradition in the following statement: “*Scientists must gain an empathetic understanding of societal phenomena, and they must recognize both the historical dimension of human behavior and the subjective aspects of the human experience*” (p. 280). In this line of argument, meanings, motivations, and strategies of the social actors were analyzed and interpreted in the mirror of the social values and norms. Prolonged face-to-face contact between the study participants and the researcher enabled the researcher to gain a deeper understanding of the phenomenon.

3.4 Selection Process and Engagement of Study Participants

Given the study intends to understand a social phenomenon using qualitative methods, the broad representation of different potential sources of information were considered to include as many perspectives and types of views as possible (Mays & Pope, 1995). Young men and young women (aged 15-29), as per the legal definition of youth in Ethiopia (FDRE, 2004) including in-school and out-of-school, employed and unemployed, married and unmarried participated in this study. Male and female adult community members in different social categories also participated in the study. These include parents, community and/or religious opinion leaders, sector leaders, and experts (teachers, healthcare providers and legal/justice officers). They participated in in-depth interviews and FGDs. Extended informal interviews and field work observations were also conducted. Study participants were primarily recruited based on their age, willingness to participate in the study, knowledge and/or experiences pertinent to fertility control. The number of participants was determined based on the principle of data saturation. That is, the data collection was over when new major information were not emerging but similar ideas recurred. A prior thematic saturation was also used whereby the data were collected to exemplify hegemonic masculinity and Weber’s ideal type.

Key informant interviews were conducted in offices and other work places such as health facilities with officers and healthcare providers, as well as in private houses with parents,

religious and community opinion leaders. Interviews and FGDs with young men and women were conducted in public spaces like schools, health posts, health centers, office settings, and under the shadow of trees. Interviews and FGDs were scheduled at the convenience of the study participants. Some schedules involved repetitive appointments and cancellations, which were more common with officers. Audio of the scheduled interviews and FGDs were recorded except for the interview with three participants who did not agree their voice to be recorded.

I gained access to observation sites formally with support letter when I wanted to undertake interviews and FGDs but I was informally engaging with people with the help of assistant researchers. For example, I was freely moving in the market places, buy commodities and talk to people individually or in group asking them different questions relevant to the study such as their views and practices related to gender, marital and reproductive lives. In the small towns and around government offices, I was not identified as an outsider as such more than a guest for special mission seeking for help. It was easy to interact and ask for help. In the rural area, I was identified as an outsider coming from town yet walking in the community and talking to them was not difficult again given I speak the same language the people use. The local leaders, however, sought to check who am I and the purpose of my presence because of the security concerns at the time hence showing them the support letters from district offices was necessary.

The researcher recruited two assistant researchers, one male and one female, who were familiar with the study setting. The male assistant researcher was Grade 10 complete unemployed unmarried young man who was living in Dimtu town but with a rural background. The female was also Grade 10 complete young woman who was providing voluntary services with different government sectors in mobilizing the community for different campaigns. The male and female research assistants were Orthodox and Muslim respectively. The research assistants' main roles were identifying potential study participants based on my criteria of selection mentioned earlier and they walked with me in the community. However, they did not attend interview and FGD sessions for privacy reasons given they are familiar with many people in the community. The assistant researchers were also consulted during analysis and interpretation.

Engagement of the study participants in discussion with me varies by category and topic of discussion. Accordingly, most study participants except the healthcare providers reluctantly engaged in the discussion on abortion. On the other side, most study participants willingly

participated in gender related topics but religious leaders tended to avoid critical questions seeking to explore gendered religious practices. Young men, experts and leaders of government sectors were more relaxed and open to discuss both gender and reproductive matters. Most of the study participants seem to elicit the narratives that they gained from public opinion more than their own personal experiences and views.

3.5 Methods and Procedures of Information Gathering

Interviews, focus group discussions, observations and review of secondary sources were triangulated in the information gathering process. Overall, three phases of ethnographic-oriented fieldwork entailing 56 interviews and six FGDs (four with young men and two with adult men and women) were conducted using semi-structured interview guides, and FGD topic guides, respectively. While general and cross-cutting questions and discussion points relevant to the research questions were raised to most study participants, questions that required special knowledge or experiences were presented to the respective experts. Healthcare providers, legal and justice officers, as well as religious leaders were requested to elicit particular information in line with their especial roles in the communities.

Table 1: Overview of the study participants by category

Data collection Methods	**Category of participants**										
	Young men	Young women	Community members (adults)			Experts (4 Teachers, 8 Health workers)			Government sector leaders		
			M	F	Total	M	F	Total	M	F	Total
Interviews (Total=56)	18	7	8	3	11	6	6	12	5	3	8
FGDs (Total= 6)	4		1	1	2						

3.5.1 Observations

Ethnographic-oriented observations were made in work-places, schools, streets, market-places, cultural and religious settings, and healthcare facilities. Holding informal talks with people, listening to what people talk about, and asking questions in routine interactions also constituted part of the observations. Overall, men-women interactions, manifestations of young men's masculine behavior, and people's practices in different institutional settings were observed. This helped to capture outwardly expressed, gender-based, and patterned sexual and reproductive behavior in the study communities. Information was gathered in different forms including audios, photographs, text materials, and narratives. People visiting health facilities and conditions of pregnant women's at delivery waiting centers were observed. Healthcare workers did not allow observation of how contraceptive and abortion related processes are managed for privacy reasons. Field notes of the daily encounters with people and events were kept during the entire process of the fieldwork.

I lived among the target community, renting a house for eight months whereas the main fieldwork lasted for more than a year. Regular visits and consultations through phone communications with the study participants continued after the main fieldwork period and during the data analysis. This was important for continuous clarifications of questions that arose during analysis and interpretation, as well as to receive feedback on emerging key findings.

The main fieldwork was carried out in three phases between June 2017 and July 2018. The data was collected through in-depth interviews, focus group discussions (FGDs), and ethnographic-based observations. In the first phase of the fieldwork from June to August 2017, a community mapping was undertaken. The community mapping was done through visits to different places such as schools, health facilities and market places in the community and informal discussions with individuals or small groups of adults and young people. The discussions were carried out with young people (both in and out of school, employed and unemployed, married and unmarried) to explore their perspectives on sexual and reproductive social norms.

Most of the interviews with key informants were conducted in this phase along with informal discussions with young men, adults, and the elderly, in order to sketch out the socio-cultural contexts of the study communities pertinent to dominant gender and masculine views, including

changes and continuities. This first phase aimed at gaining an understanding of the overall community settings, the main institutional arrangements and practices, and major changes in social norms, as suggested by Jones et al. (2014). Gender and sexual norms and current community beliefs about fertility control were moreover explored at the beginning of the first data collection phase. It entailed an initial exploration or preliminary information gathering before the intensive study started. Phase I of the fieldwork was completed in three months, and the information obtained in the process enabled the researcher to develop and refine interview guides or checklists for the subsequent rounds of interviews, FGDs, secondary analyses, and for the Phase II fieldwork. In-depth interviews were also conducted with young men during the first phase. Most interviews, FGDs, and participant observations were carried out in the subsequent two phases.

The second phase of the fieldwork lasted for four months from December 2017 to March 2018. The fieldwork was interrupted at times for days or a week due to the youth-led political resistance (the *Qerro* Movement) in the area, which was part of the nationwide popular protest against the EPRDF Government. This phase was nonetheless characterized by extensive and intensive direct observation of people's interaction in particular study settings such as in villages, on the streets, in the schools, work places, centers of public services, and at market places. I introduced myself to offices, schools and health facilities as a researcher showing supportive letters provided by relevant authorities whereas observations in villages, on the streets and at market places were informal accompanied by the research assistants. Main activities during this second phase included participating in people's daily activities using restaurant services and joining healthcare workers in outreach services, informal talking with people, and mapping the networks, times, and places in which human interaction occurs. It also entailed audiovisual recording of face-to-face interviews. Insights and evidence obtained in the first phase helped as inputs in this second phase of fieldwork to acquire diverse hands-on experience. Phase III of the fieldwork was carried out from May to July 2018 for eight weeks and was essentially a continuation of the second phase. As an extension from the third phase of the fieldwork, the final interviews were conducted from November 2018 to February 2019.

Market places, schools, streets, sport fields, public gatherings, small restaurants and tea/coffee houses, and health facilities were the primary settings for the ethnographic field observations.

Physical conditions and appearances; economic activities; social interactions; and masculine and feminine manifestations of people were observed. In the health facilities, in particular, I mostly carried out informal talks to people available there seeking health services telling them I was from Jimma University and doing research on health issue without going into the details. I asked them where are they from, why coming to the health facility, their views and practices related to gender and reproductive relations. However, talking about abortion with the people and accessing the healthcare provider-patient relations was impossible because of the strict observations of confidentiality and my non-health educational background. Those matters could be gained only through proper interview based on their consent.

3.5.2 In-depth Interviews

In-depth interviews were carried out with young men and young women, community and religious leaders, sector leaders, parents, and experts (teachers, healthcare providers, and justice officers). Young people were interviewed with a focus on events of fertility control, love and sexual relations, induced abortion with emphasis on their awareness, values, perceptions, and practices. In-depth interviews with boys emphasized the roles they play and the strategies they employ in their relationships with their partners while establishing love relations and sexual debuts, premarital sex and pregnancy, and contraceptive use and abortion were key topics discussed. Parents and community and/or religious leaders were interviewed to identify rules of acceptable and unacceptable behaviors about the subject matters, their perceptions on the lives of the young and changes related to sexual and reproductive behaviors.

Mechanisms or attempts of controlling the practices of young people by religious groups or the community, and the consequences of violating normative rules by young people were examined. Parents having young boys and/or girls were interviewed on points pertinent to their relationship with their children, their perceptions of the ideal son or daughter, and the support they provided for their children to avoid premarital pregnancy. Parents' control mechanisms and reactions/responses in cases when premarital pregnancy occurs, and their views and concerns of contraceptive use and induced abortion were also explored. Health professionals provided information on the situation of fertility control activities and services, mainly on contraception and induced abortion from their experience and point of view. The observations of health workers' encounters with young people's sexual practices, including access to and utilization of

reproductive health services, and their own personal value positions on fertility control were also discussed. Interviews with teachers, religious/community opinion leaders, and health care providers - as key informants - were conducted to explore local institutional arrangements and practices, and social norms persisting or evolving over time from the point of view of community leaders.

3.5.3 Focus Group Discussions (FGDs)

FGDs were carried out with community members: young men and adult men and women to capture beliefs, values, and norms related to gender equality and fertility control. The focus group discussions conducted with adult community members also aimed to explore their views and practices related to young people and changes over time with regard to fertility control. Separate sessions were arranged for young men and adults. A minimum of 8 and maximum of 12 individuals participated in each focus group discussion. The participants were homogeneous by sex given the topics of discussions are gender sensitive. Most young men more freely and actively engaged, could articulate their views, and had more shared views and positions on the issues of discussion compared to adult men and women. Some women participants had difficulty of articulating their views partly due to lack of experience in talking to strangers and partly because of shyness. Adult men's approaches seem to be more influenced by political correctness, religious and social desirability. However, they have more diverse views that enabled to identify competing interests leading to further discussion to reach at consensus. The FGD helped to capture shared views and practices across different social groups and the community at large where they enrich the overall interview materials.

3.5.4 Review of Secondary Sources

Relevant secondary sources pertinent to the study objectives were reviewed to supplement the primary evidence. Such documents include prior research, official plans, reports, policy/legal documents, and guidelines. Among others, international conventions on gender and reproductive agenda, national policies and laws such as National Population Policy of Ethiopia (1993), National Youth Policy (2004), 2005 FDRE Revised Criminal Code/The Abortion Law of Ethiopia (2005), Technical and Procedural Guideline of Safe Abortion Services in Ethiopia (2006) and official reports of the local government sectors were reviewed.

3.6 Analytical Approaches

Interpretive qualitative research aims at understanding phenomena through an investigation of the meanings human beings attribute to their practices and to the external world was followed. Hence, this study adopted Weber's approach of understanding (*Verstehen*) of the motivations that lie behind human behavior, a matter that cannot be reduced to any predefined element but must be placed within a cultural perspective. A detailed description of the phenomenon being studied is emphasized (Atieno, 2009).

Thematic analysis technique was employed and there was an iterative relationship between the data collection and writing up of the data (Froggatt, 2001). Accordingly, data analysis in qualitative study is a cyclical process that requires a revisiting of data, its generation, analysis and interpretation. The analysis went side by side with the data collection whereby the information was systematically coded into themes and sub-themes, read and re-read throughout. The research questions and emerging patterns guided theme formation. The coding process involved passing through open coding, axial coding, and selective coding stages. In open coding, initial categories were discovered using in vivo, value, process and structural coding techniques. In axial and selective coding, relationships among categories were searched for and the core categories were chosen for making the story. Emphasis was given to understanding the social pressure and expectations, cultural values and interpersonal relationships, and masculine manifestations in means of fertility control.

Making sense of the data material started during the fieldwork but most of the analysis was done post the fieldwork. Field notes of field observations and the data material obtained through interviews and FGDs were triangulated in the process of the data analysis. Typical quotations are included to support the results with first hand data material and present voices of the participants. Phone conversations with key informant interviews in the study area were used to clarify vague points emerged during the data analysis. Other people who are very familiar with the area but living in Jimma City, the residence area of the researcher, were consulted when clarification was needed. The data analysis and interpretation was guided by hegemonic masculinity as a theoretical lens to understand and make sense of the data. As Froggatt (2001) suggests, meanings were inferred from close examination of underlying social processes, values and norms in their particular social context and individuals' experiences were situated within the broader context.

Whilst the data was segmented into meaningful units, the connection to the whole was retained (Frooggatt, 2001). New questions and interpretative ideas were developed in the data analysis and results of the study were interpreted and attempts were made to reach an understanding about their meaning in relation to the particular context (Walcott 1994).

3.7 Trustworthiness of the Research

In order to ensure the trustworthiness of the research, I committed myself to fulfilling the following conditions in the course of my research engagement. I was aware that proper understanding of the key features of a 'good qualitative research' and high degree of determination to apply them in practice was located at the center of ensuring quality research processes and products. As a student researcher, I worked on improving my knowledge and skills of qualitative research throughout the entire research process by regularly reading the literature and consulting experienced researchers. I attempted to ensure a systematic and careful design to the best of my knowledge. Creating 'an account of method and data', so that other experienced researchers can analyze it for content and consistency was a key strategy I used to prove that the study was methodologically rigorous (Mays & Pope, 1995). Regular consultations with the supervisory team and willingness to work under the guidance of senior faculties are key points. In this regard, detailed descriptions of the assumptions that were followed, the methods of data collection, fieldwork experiences, audio recording, data analysis, interpretation, and documentation processes were carried out to the best of my knowledge.

Inclusion of as many relevant sources as possible in attempts to ensure that vital information is not missed is another strategy to be used to ensure trustworthiness (Mays & Pope, 1995). Variations in participants' experiences were sought, captured, analyzed, and reported. Exceptional or deviant cases considered as quite strange in the society and divergent from the theoretical perspectives in use were separately treated and presented. Rapport and close relationships with community members were established, and sensitivity to culture and careful attempts at understanding the study setting were seriously taken into account.

Credibility of information in a qualitative research also depends on the ability or skills and efforts of the researcher rather than on instrument construction (Golafshani, 2003). I believe my previous research experience was important. Insiders' perspectives were given due consideration.

A faithful description or interpretation to the best of my knowledge and experiences was made while minimizing the threat of 'going native'.

3.8. Research ethical aspects of the study

The research proposal for the study was approved by the supervisors and the Sociology Department at Addis Ababa University. In order to protect interests and the needs of the study participants or those they represent (or are typical of), others who come in direct contact with the researcher, and the society at large (Sapsford and Jupp, 2006: 291), the following ethical principles were considered in the study. Ethical clearance was obtained from Oromia Region's Health Bureau Research Ethical Review Committee with letter of Ref. No. BEFO/AHBMH/1-8/2640 dated 14-7-2009 E.C. Based on the ethical approval at the regional level, support letters were obtained from zonal and district health offices to get permission to conduct the data collection.

All participants were purposely selected, informed and oral consent was secured from each. Concurrently, research assistants were recruited and oriented about the focus of the study and the data was collected based on an enclosed information sheet (Annex I). Carefully designed semi-structured information-gathering tools were employed that were adjusted during the course of the fieldwork. Guardians gave consent on behalf of participants whose age was below 18 followed by assent of the participants. The conditions of the participants and the cultural and religious values of the community were taken into account during the data collection process in a manner so that the discussion would not cause irritation, doubt, or resistance. Interviews with young people, particularly females, were arranged in locally acceptable ways and at day time and in public places, yet isolated from others' interference. The help from a female research assistant from similar backgrounds was also vital. Although it was challenging for a male researcher to contact with a young girl in a rural community, using public places such as schools, administrative offices, and health facilities eased the difficulty where direct contact of the researcher with a participant was a necessity.

Confidentiality was ensured and all participants were dealt with anonymously. I kept all records away from third parties. All materials will be safely removed when their functional period is over. True personal names of participants were not mentioned, and potential indicators that could enable others to identify the participant were avoided to the extent possible. Similarly, great care

was taken not to judge participants based on my personal inclinations, positions or on other normative and other socioeconomic backgrounds. In cases where I suspected correctness of meanings derived from interpretations, I shared it with insiders for consultation and confirmation. Research assistants and key informants were the primary resources in this regard. The use of mobile phones simplified communication when physical contact was not possible to arrange schedules of interview.

In relation to the community, given the issue is very sensitive and situated in a context where sexual and reproductive matters are not freely discussed, a cautious approach was necessary. Safer settings were selected for discussions or interviews in order to protect unmarried young participants from being labeled as sexually active or seeking abortion due to their participation in the study. This was of particular importance in such a rural study site where everyone knows one another. In the FGDs participants were oriented and monitored not to mention any personal names. Mentioning the names of others or presenting oneself as an example in the discussion was avoided. Likewise, potential indicators of personal identification were eliminated in the transcription process. Moreover, gender differences, inclusion and representation of different social groups among the study participants and their voluntarily participation were seriously considered in the research process. Finally, by using the above-mentioned mechanisms with maximum care and commitment of the researcher, the "no personal and social harm" research ethical principle was attempted. The researcher's endeavor to maintain academic integrity, observance of rules, and respect for administration procedures contributed to the realization of this work.

3.9 Researcher's Positionality and Reflexivity

I belong to the same cultural group as the communities where I did the research, and the official language in the area, Afaan Oromoo, is my mother tongue. Sharing a similar culture with those in the study communities entails that my background would have its own effect on the data collection, analysis, interpretation and conclusions drawn from the study. As a qualitative researcher, I was aware that I am an integral part of the research process, and that my background can affect the process. Therefore, I have taken all possible cautions to control my personal biases. Speaking the same language as the study participants enabled me to have an

interactive relationship with them (researcher's insider position), on the one hand, and coming from a different religious background (Protestant) and being an educated person from an urban area (outsider positions) worked to create a distance between me and my study participants, on the other. However, I had prior exposure to the study communities as a researcher, something that enabled a smooth entry and interaction with the people. Constantly keeping the sensitivity of religion in mind and carefully managing the interaction helped me to be at ease with them. At the same time, being a Protestant made it necessary for me thread carefully while exploring more details concerning religion to avoid doctrinal-like debates. When probing questions that examine details about religious practices were posed, religious leaders sometimes showed signs of being disinterested in the questions and gave short answers. I tried to carefully handle discussions about religious topics with the study participants, giving due respect to the participants' religion, being open to learn about others' values and perspectives, and appreciating differences.

The thesis was affiliated to a collaborative research project titled "*Competing discourses impacting girls' and women's rights: Fertility control and safe abortion in Ethiopia, Tanzania and Zambia*", financed by the Research Council of Norway. I received financial and supervisory support from the project. The study design and theoretical framework were framed in the broader context of the project, and this is also the reason why the reader will find references to a relatively large body of literature referring to the other two counties in the project, as materials were shared across the project.

The fieldwork was conducted during the popular youth political resistance against the EPRDF government that culminated in regime change in 2018, and analysis and write-up was partly done during the COVID-19 pandemic. Both phenomena affected the research processes and interactions due to the security and health concerns related to them. The environment was stressful; hence, getting the full attention of the study participants was difficult at times. Meeting up with young people and particularly having a gathering with them was difficult as the areas were under strict control. The lengthy state of emergency limited freedom of movement and gathering. Support letters of permission and flexible data collection plans were used to mitigate these problems. Undertaking FGDs in particular required special permission.

The sensitivity of the issue under study also significantly shaped researcher-participant interactions. Topics like sexuality, contraceptive use and abortion are not openly discussed in the

communities. Hence, healthcare providers were the main sources of information in some areas such as induced abortion, where the participants rarely share their lived experiences. Study participants, including some young people, do not feel at ease to share their own experiences in the above-mentioned domains. They tended to avoid personalized questions and were more responsive to questions about the norms and practices. I found study participants' reservations in disclosing personal sexual and reproductive experiences to be more serious than I had expected. The failure to find a woman who experienced induced abortion is a case in point. Study participants feeling uncomfortable to discuss their experiences of condom use and induced abortion, for example, was a reason for me to shorten some interview sessions. Reluctance among some study participants, particularly women, to speak on key topics of interest was among the frustrating experiences I had during the fieldwork.

Direct observation of people's personal lives related to the domains of fertility control was nearly impossible. Ethnographic observations were limited to general activities and social interactions along the street, market places and other service areas. Informal discussions with community members were more widely used than direct observation of intimate behaviors. Therefore, ethnographic observation was used primarily as a general frame for the fieldwork rather than as a method of data collection. This is also the reason why little observational material appears in the thesis.

Being a male researcher interviewing female participants gave me a challenging time in securing their privacy. Firstly, the interaction had to take place in public spaces visible to others, like in health facilities and schools. Participating in interviews while being seen from the nearby distance could be disturbing for some girls and women. However, my impression is that their openness in discussing the issues was not significantly compromised by this factor, as passersby could not really hear what the conversations were about. The research assistants, the school teachers and health facility managers also assisted me by protecting against interference by third parties. However, some young girls and women still felt shy to freely discuss the sensitive issues raised.

Principles of the Weberian interpretive research paradigm guided the research process. Yet, I have become increasingly aware of my biases about the topic, the data participants and the research process. For the sake of building on the social science literature, public health and

demographic discourses are intentionally toned down. This position also affected literature and theory selection, data collection, and analysis. At the onset of the process of analysis and writing, I, for example, tended to define a range of views and practices as manifestations of masculine dominance. My supervisors' guidance was of great importance in this regard, as they advised me not to go beyond contextual realities and empirical findings in applying the theory.

This study is framed within a gender and social science perspective, with focus on men and masculinity. Women's side was approached for relationality purpose and only a few young women were involved as study participants. Therefore, for every issue discussed about men, there may not be an equivalent attention paid to women's perspectives.

With regard to my position on the research issue, fertility control, I believe that large family size could be a threat to a family's income, and frequent pregnancy, birth and child rearing hurt mothers' health and well-being. My observations starting from childhood and my personal life experiences tell me that this is true. I also believe that uncontrolled population growth can be a challenge to the sustainable development of the country. Therefore, I aspire to see people freely control their fertility and enjoy its benefits. When it comes to the details, I am pro-contraceptive use but somehow more critical about rights to induced abortion. I believe that life begins from conception, yet I recognize abortion-seeking women's need under difficult circumstances, including facing strong disapproving norms against premarital pregnancy. My position about induced-abortion has gradually changed in the course of this project, sympathizing with abortion-seeking women based on my extensive reading about the factors and negative outcomes the women bear due to lack of access to safe abortion. One of the undesired consequences is the possibility of seeking unsafe abortion, which can threaten women's health and even claim their lives.

CHAPTER FOUR

GENDERED NORMATIVE CONTEXT OF FERTILITY CONTROL

Introduction

The preceding three chapters introduced the background, problem statement and research questions, theoretical and methodological orientations of the study as well as relevant literature in the field. This chapter explores the broader gendered social and cultural environments nurturing the values and meanings, knowledge, behaviors, and practices pertinent to fertility control. It moreover provides background to the next chapters that specifically focus on the three means of fertility control and involvement of young men. How gendered power relations and masculinity are viewed and practiced in the communities as manifested in the settings of different social institutions are discussed yet at different level of emphasis and depth based on their influence on fertility control. Key actors in religious settings in particular is accorded special attention given religious rules and practices also have influences on actors in other institutions as Ejim (2017) argues.

West and Zimmerman (2009) conceptualize gender as simultaneously interactional and institutional. Itula-Abumere (2013) argues that all institutions in which social interactions occur are gendered in some manner. Connell (2009) also asserts that gender involves a vast and complicated institutional and cultural order and far more than one-to-one relationships between bodies. For Connell (2005), gender is a social practice; everyday conduct of life is organized in relation to the 'reproductive arena', as she terms it, and she sees social institutions as gendered. Barrtte (1996) agrees with Connell and Kronsell that social institutions are gendered by virtue of being dominated by men. Although military, defense, and security institutions are viewed as the bases and primary sites for scholarship on gendered institutions (Barrett, 1996; Connell, 1995; Kronsell, 2005), the theoretical perspective emerges as useful also to understand other institutions like the family, religion, education, and health that have an impact on fertility control and involvement of young men in the three domains of fertility control.

Power is an element of social relationships, and is related to authority, control, influence, and domination. Gender relations are also relations of power that all institutions embody. Marriage, households, religious settings, and communities are among gendered institutions that in many

societies exercise control over women's bodies and sexuality (Murthy, 1998). The author writes that institutional ideology, rules, and practices often conceal the reality and pervasiveness of the dominance of men over women, and holds that men overtly but mostly covertly retain their power over women through institutions. Institutional rules and practices guide power setting agendas, and thereby influence decisions in a way that may affect the interest of certain individuals or groups. However, topics like gendered division of labor, women's rights to property, control over fertility and sexuality are usually overlooked. Preventive health education, childcare, and family planning are more or less exclusively targeted at women. This perpetuates the idea that reproductive health activities are a 'natural' domain for women (Murthy, 1998).

Scholarship on institutions of hegemonic masculinity in particular emphasizes how specific notions of masculinity and gendered relations are made the norm. Hegemonic masculinity is a set of norms and practices associated with men in powerful positions within social institutions (Connell, 1995). Kronsell (2005) holds that norms of masculinity may be revealed by studying everyday practices in different sites in institutions of hegemonic masculinity. Masculinity can also be conceptualized as a configuration of practice organized in the structure of gender relations (Connell and Messerschmidt, 2005).

The connection between fertility control and gender systems is one of the most important agenda of men and women of our times. There are two-way relationships between them given they shape each other (Malhotra, 2012). Malhotra (p.25) stresses that fertility control and shifts in gender relations never occur in a vacuum given the broader contextual factors such as the social, economic, political, and normative conditions shape and accompany the processes. The factors include family, kinship, and marriage systems; educational and economic systems; state and international actors; the legal and political contexts; and gender and social norms. In this chapter, gendered institutional norms are explored generally while specific cultural norms pertinent to the three means of fertility control are analyzed in the upcoming chapters. Yet, there is no strict demarcation between the themes given gender and cultural normative aspects are intertwined on issues discussed among the chapters.

4.1 "Gender equality is there in talks of government officials": Gender equality from community perspectives

In this chapter, study participants were asked about their perceptions and practices of gender equality in their communities. There were strong approving responses for the questions that participants from different social categories confirmed they believe that women are equal with men. Male and female key informants from different government offices and social institutions, and young men and women participants in FGDs and in-depth interviews expressed that women are essentially equal with men. No direct disapproving responses were obtained. Young men also endorsed the view that men and women are equal in principle. However, most study participants agree that gender inequality prevails in people's interaction, institutional settings, and practices, and hold that gender equality is more rhetorical than practical. One adult male participant expressed the point as follows: "*Walqixxummaan dhiiraafi dhalaa waraqatarra malee lafarra hin jiru*" meaning "There is gender equality on paper but not on the ground," which is a typical expression and shared perception among the study participants. This idea indeed is shared among most study participants including young men and women. A young man stated the following:

> *There is no gender equality in the community, but it is there in talks of government officials. I don't think there is gender equality in practical sense. Gender inequality is practiced at home and in the community. For example, men are considered as superior over women and they are given better positions. Even in children's schooling, many parents believe that sons are more successfully educated than daughters even if they send girls to school. Even sending girls to school started recently after parents got awareness about advantages of educating females (*Youngman, Grade 10 student, Ako High school*).*

FGD participant young men in Dimtu agree that men and women are not considered equal in their communities that begin with preferential welcoming of a newly born baby boy and baby girl. Recalling that in delivery cultural ceremony, people ululate joyfully five times for a baby boy and only three times for a baby girl. Alternatively, the number of ululation could be seven and five respectively. For the participants, doing this shows that different values are attached to boys and girls. The informants argue that the society and the family are not considering young men and young women equal. They refer to distinctions between what men and women should do as indicators of gender inequality like mostly women work in the home and men outside. A key informant from a government sector also underscored that it is not only the views of the

community that favor men, but women also legitimize men dominance over women by endorsing the community's pro-men gender views and subordinating themselves:

> *The broader community view still undermines women's ability to do something valuable and women also accept the same view. There is no direct resistance against women by men as such but the internalized cultural norms by women pull them back from moving forward* (Male, 32 year old, District Officer).

In support of the key informant's view, an elderly Christian woman in her 60s expressed her perceived roles in the community as "*Waan golakoo qofan beeka*" (my knowledge is all about my inside home) when I asked her to tell me about gender relations in the community. When asked for her views about her versus her husband's roles in the family's economic activities, a young educated public employee Muslim woman mentioned that her earning is extra given providing the household is the duty of husbands.

Most study participants' positive answers to questions about gender equality seem politically correct as parallel discourses emerge side by side. In the present study, the dynamics of culture, religion, economic and political contexts result in contrasting discourses about gender equality. During the fieldwork observation, I understood that the people reflect that gender equality is a government agenda hence directly speaking against the agenda was unacceptable. The agenda was officially framed as men and women are equal in principle but gender inequality was prevalent that the government and its partners such as NGOs were doing to change the condition. Therefore, the study participants' expressions tend to endorse the pro-gender equality official discourses on the one hand while they contradict with officially framed discourses on the other. For instance, many study participants including religious leaders strongly argue in favor of gender equality but they have difficulty to articulate why women are practically denied opportunities in institutional settings and interpersonal relations. It is particularly the case when discrimination against women has religious bases like gendered religious services and leadership.

Shared resource limitations and economic disadvantage seem to be more challenging and primary concern for most women in the rural area than gender-based economic oppression they experience in relations with men. Community and family poverty is pervasive in the area because of less productive small farm agricultural livelihood as many key informants emphasis time and again. Alternative discourses also surface in women's participation in socioeconomic spheres. For example, there are strong discourses that emphasize women are oppressed in all

dimensions of lives and in all institutional settings. However, the same study participants also witness that many girls are schooling that is resulting in positive changes, women engage in out-door economic activities like agriculture and trading, and they are increasingly taking part in leadership positions. Such co-existing discourses are more commonly observed among people in position than the lay people and among adults than young people.

Men dominance over women in all aspects, although some changes are emerging, implies women's lack of control on matters affecting their lives to which fertility control is not an exception. Lack of genuine gender equality in the community and institutional settings likely extends to making decisions about sexual and reproductive lives where superiority of men could easily manifest. The evidence reveal that women are in disadvantaged positions in the socioeconomic systems in manners their ability to control their fertility is compromised individually and dominated by men as sexual or marital partners. Women are not empowered in such male-dominated gender environment to make life choices like whether, how, when and how many children to have. However, the existence of men dominance over women's fertility control does not automatically imply that men are advantageous of their gender positions nor they have control on their fertility by virtue of relationality. The gender system, as revealed in the data, also involves role distinction between men and women where fertility control are considered as women's domain but they are denied decision making power.

4.2 Gendered power relations and masculine manifestations in religious settings

Evidence reveal that gender disparity is clearly observed in formal and informal institutional settings in the study area. People's engagement in religious matters and the effect of religion on their lives is deeper and extensive. Religion touches every aspect of people's lives regardless of their socioeconomic statuses. Religion also overtly or covertly affects many other aspects of personal and collective lives. Among others, the religious followers are expected to select their partners in marriage and establish marriage with members of the same religion although exceptional inter-religious marriages take place. Religion also strongly influences people's dressing and feeding styles. Churches and mosques serve as venues of social gatherings and communication centers. Inter-personal communications involve pledging with religious terms like calling names of prophets, saints, angels, or God/Allah as confirmation

that the information is true or the promise will be kept. Religious leaders actively engage in public meetings organized by government or civil society organizations representing their religious communities.

Religious leaders of Islam and Ethiopian Orthodox Tewahedo Church (EOTC) in the study area explained that men and women are considered equal in their religions, and reportedly the same is addressed in the local religious teachings. Key informants from both religions link the basis of the principle of gender equality to the respective Holy Scriptures. However, they believe that gender equality does not prevail between men and women in their actual relations in the study communities, and they mainly attribute this to the influence of a patriarchal culture, not the religious texts. For example, they do not reflexively question implications of their religious teachings of husband as the head of the household which is equivalent to culturally gendered breadwinner norm.

4.2.1 Islamic teachings and practices: gender discrimination or women protection?

Islam religious leaders I interviewed claim that men and women are considered equal as per the Sharia rules, and they are equally addressed in Islamic teachings. The religious leaders claim that Islamic teachings are cognizant of the principle of gender equality and that they practice the same. They added that they teach in favor of women to some degree. One religious leader also argued that historically the bad treatment of women has changed after Prophet Mohammed. Hence, practices carried out in the name of Islam, be it prescription or proscription, are all considered primarily to protect women, and not to oppress them. An Islamic religious leader explained it in the following way:

> *We strongly preach the equality of women and men. We even favor women somehow. We strongly advise men to provide the necessary support and protection to women in all aspects of life. In the past, there was discrimination against women across the world. There had been killings of female infants in different parts of the world. However, discrimination against women has been eliminated after Prophet Mohammed. Some raise the question of Muslim women's dressing style or their wearing of hijab as an issue of gender inequality and argue that 'Islam does not allow women to dress based on their preferences.' But we advise women to wear hijab for their own safety. It is in their best interests. To speak frankly, Islam promotes the rights of women; it does not undermine them. They wear hijab just to protect themselves from different risks that may come to them from men* (Male, 62 year old, Dimtu).

The central argument of the religious leaders on the treatment of women is that Islam is essentially and historically not discriminatory against women. Accordingly, women are protected in the community by limiting their exposure to risks and hazards. 'Others' or 'outsiders' may view this as discrimination against women, but according to the religious leaders, it is not. Hence, men do not allow women to travel alone long distances because "women have no strength"- *gannootni fikiraa hin qaban* - to protect themselves from any danger they may face on the way. Therefore, the religious leaders advise husbands or relatives to accompany women whenever they travel far away from their residential places. The risks referred to in this narration are gender-based violence, mainly in the form of sexual abuse and abduction.

Generally, according to the key informants, Islam demands men to provide and protect women, not to dominate or oppress them. Furthermore, the religious leaders claim that their religion, as practically preached in the local context of the study communities, maintains this foundational principle of Islam. Another Muslim religious leader defended that:

> *The idea that Islam oppresses women is defamation against the religion because of its followers' failure not to live up to the expectation of the religion in giving respect for women; the religion is not to blame*.

However, he also stated his own gendered view in the same interview that "*Men, not women, are responsible to fulfil economic needs of the family*". Attributing gender inequality to individual differences with the religious and cultural contexts, a Muslim religious leader shared his democratic and egalitarian approach in marital relations as follows:

> *I have no adequate information about relationships between spouses in our community. What I can tell you from my family's experience is that we discuss everything together. I don't decide alone. My wife and I discuss every issue together and we also make decisions jointly. I don't know the practice of other families, but from my side, there is no such power difference between me and my* wife.

Although the religious leaders strongly promote what they see as gender equality in the best interests of the women, their view casts women as being dependent upon men for support and protection. That is, their conception of gender equality is based on an understanding of women as being "the weaker sex". The view emphasizes that women are weak, insecure, and vulnerable,

hence requiring men's support and protection, whereas it implicitly assumes that men are strong and self-reliant, and as being providers, protectors, and at times abusers. It also implies that men have control over women.

4.2.2 EOTC teachings and practices: Gender discrimination or a divine ordinance?

The religious views and teachings in the EOTC emerge as very similar to those of Islam, in that leaders of both religions claim that views of gender equality are embedded in the scriptures. The religious leaders consider differences in the gender-based role division in religious services, whereby women do not lead prayers and preaching as given in the scriptures, a view that can be contested from gender perspectives. A key informant from EOTC argues that men and women are equal referring to the Genesis in the Holy Bible. He explained that the EOTC provides religious education to its male and female followers in a way it promotes gender equality. The religious leader moreover argues that the church's education on marriage for young men and women promotes equality of men and women. On Sunday school programs, women and men jointly receive gender and sex education with an intention of creating similar awareness about the issue among them. The religious leader argues:

> *In the Bible, there is a verse which says 'a wife shall obey and respect her husband'. There is also another verse which explains that 'as Jesus loves the church, a husband should love his wife and head the household'. Some people argue that this teaching puts women in a lower position, but, it does not. If we take how Eve was created in the Bible, God molded her from Adam's rib. Why did He not create her either from Adam's head or leg? Why did God mold her from the middle of Adam's body? It is to ensure equality between both sexes. If she was created from the head, she would have been superior to man, and if she was from the lower parts of the body like the leg, she would have been subordinate to man. She was formed from the middle, which indicates equality of both sexes. This is how we teach the equality of men and women in the church* (Male, 53 year old, Dimtu).

These explicit views of gender equality were said to be expressed in the church, and are based on the scripture and its subsequent teachings. However, again elements of gender inequality are embedded in the division of the church services among men and women, as neither in churches are women allowed to teach in congregations. The EOTC key informants defended women's exclusion from preaching by stating that it is a doctrinal provision and not a reflection of gender inequality. A key informant explains the church's doctrine as such:

Women cannot teach members of congregations. There are, however, different programs in which females can participate in the church. For instance, women can provide counseling services. Other programs in which they serve are Sunday programs and church choirs. In my church, there are three women who actively participate in different church services and structures. Nevertheless, they cannot preach the Bible to the mass of church attendants; this is religiously prohibited for women (Male, 41 year old, Dimtu).

Hence, he identified preaching the Bible as a gender-based church service which is exclusively reserved for men. Women can participate in church choirs or other service programs like counseling but cannot publicly preach the Bible in the church, and explains this is a Biblical ordinance. The key informant recited that in the Bible itself St. Paul directed that women are not allowed to take the stage/podium and preach the Bible to followers. They also cannot take part in priesthood. He recalled that the church has not yet received any complaints from women in this regard; that is, he believes that the principle is endorsed by female followers. Similar views of role assignments, justifications, and practices are there in Islam, as reflected by the Islamic religious leaders: women do not teach the Quran or lead prayers.

4.3 The family as a gendered institution: Views, values, and practices

From interviews and observations, it emerged that a son is more valued than a daughter right from birth. For a woman, giving birth to a son is much appreciated and is warmly welcomed by the family, relatives and the neighbors. Sons and daughters experience differential treatments as they grow up. Feminine and masculine values and behaviors are also manifested in the role distribution of household chores whereby men are favored. Wives bear more burden than husbands and they have different sleeping patterns; women have shorter time to rest. The key informant from the EOTC clarified the conditions as:

Both parents and neighbors feel the same way about the sex of a new-born baby. When a mother gives birth to a son, people say 'good', 'bravo' and similar expressions to show their appreciation. However, when a mother gives birth to a daughter, people would say 'let it be'. The wife goes to bed late at night and gets up early in the morning because of the heavy family burden she shoulders. A woman carries out the household tasks during the night even after long hours of work on the field with her husband during the day. On top of this, a woman is expected to provide care for her children and husband. Therefore, we need to raise awareness of the people so that gender equality is respected in our community (Male, 53 year old, Dimtu).

Similarly, Islamic religious leaders agree that women are not equally treated with men in the families, which they attribute to cultural influences. The 53 year old Islamic religious leader quoted above admitted: "*I know that women are dominated in the communities because of the cultural expectations of male dominance*." A young man stressed the manifestations of gender inequality in the family context in the following manner:

> *Gender inequalities could be manifested at home in the family relationships between a husband and a wife as well as among brothers and sisters. There is deep-rooted discrimination against young women. I have a sister and two brothers. While I am the last child in the family, my sister is the second child and the only daughter. Three of us* (sons) *have gone to school but she never went to school; instead, she was married when she was too young. So, I don't see equality between men and women (*EOTC follower, Grade 10 student at Ako High School*).*

Many stories similar to this are evident in the study area showing that gender discrimination in favor of men is manifested in different ways. However, the above presented narrations are only possibilities because those scenario may not occur in all gender relations in different conditions. For example, favoring a baby-boy at birth more than a baby-girl does not work for all families at all times. Families with more number of female members prefer to have a baby-boy next and vice versa and individual preferences for sex of children may vary. There are people who do not give much attention to the sex of their children. Some men take roles in caring for children at their spare time. Evidences also show that men have become more caring and cooperative with women at home and in institutional settings. Some women are engaging in activities previously considered as men's domain such as public office leadership, teaching and healthcare services that create better opportunities to become self-reliant and part of decision making. Families vary in terms of their perceptions and practices associated to gender. There are families who send their sons and daughters to school equally and consider education as a way for desired changes in the family. Educated parents tend to be more gender sensitive than those who did not attend schools although this should not be taken as a rule for all parents.

The fact that women are over burdened with the gendered distribution of domestic works in the family context implies that there is a tendency of considering the reproductive roles as women's domain where men may play limited responsibility. Moreover, their culturally endorsed dominant positions as head of households and breadwinners also indicate that men can influence women's choices and decisions about fertility control in their favor. The husband-wife

inequitable gender relations in the family also socialize the young members of the society thereby boys likely develop similar perceptions about men involvement in the reproductive lives. Yet elements of changes in favor of gender equality that are strongly supported by young people that allow them to play constructive roles in reproductive relations.

4.4 Gendered perceptions and practices related to education

Although the education of girls nowadays has got public support in the study area, the support decreases as the level of education increases, because education is not considered as the final destiny for women as they are expected to get married or migrate abroad after they complete elementary or high school. For instance, there has been a general tendency in the study area to appreciate young men as they advance to higher levels of education, while young women are either prepared for marriage or encouraged to migrate to Arab countries to work as domestic servants. It is imperative to note that it is strange that encouraging women to migrate abroad is not linked to danger, when even going to a public space in the community is perceived as dangerous. In contrast, families send young girls to the Arab countries to serve as domestic workers covering the high costs necessary for the migration process. As a result, many young women drop out of school and migrate to the Middle East. Even some married young women migrate, leaving their children and families behind, with the consent of their husbands so that they send money home.

The education of men is intended to bring about long-term economic returns from engaging in professional services, whereas the migration of women only exposes them to labour intensive experiences. That is, success in education is socially expected to be the end goal primarily for young men whereas women are partly expected to be literate enough to be able to work abroad as domestic workers. An adult man explained the differential treatment between the two sexes: "*If both a boy and a girl fail the national or university entrance exam, parents give the boy a chance to study in private colleges, but force the girl to quit education and get married or migrate abroad.*" A young man in Grade 10 similarly described the differential treatment of boys and girls in accessing education:

> *Girls are discouraged from going to school just for being females. Many families never support their daughters even when they send them to school. Even when girls perform well in the university entrance exam, some families*

refuse to let them go away from home to join colleges or universities. This shows that there is no equality between men and women.

However, these comparisons are less than conclusive as there are successful female students who joined universities and drop out males who migrated to the Middle East. Evidences indicate that both male and female students drop out schools and turn to income generating activities like trading or migrate abroad or to domestic urban areas due to economic hardships. Not all, even not most, drop out females migrate abroad but it has become a more desired choice in the study communities. Alternatively, they may seek low level jobs in formal or informal markets including engaging in petty trade. One more, they can turn to marriage.

Limited support from parents to female students compared to their male counter parts was reported by the large majority of the study participants, including by religious leaders, teachers, and students. However, I did encounter some community members who showed pro-equality attitudes and permitted girls and young women to have access and opportunity for schooling. In contrast to the historical and dominant views that undermine the education of girls, some of the parents, students, and teachers believed in and emphasized that educating girls has advantages. In the words of a teacher:

> *The public must be taught that women are equal to men and educated women can change the world. If we see it globally, women are doing great in leading and changing countries. Thus, educating women is educating the society. The time girls spend in education also delays first pregnancy, hence reducing birth rates. For example, if a girl starts Grade 1 at the age of seven, she completes her first degree at twenty-three or twenty-four. Therefore, many educated girls are not married until they turn twenty-five. That means the total fertility rate and population growth would decrease if women were educated. If the total number of population decreases, quality of education will increase; this in turn will increase job opportunities, making government budget proportional to population size. So, the government should focus on the education of girls to bring the desired changes* (Key informant, young adult, high school teacher, Gabara High School).

Women's limited access to education and increased drop out from schools result in early marriage, lack of information about sexual and reproductive services. In such conditions, they less likely delay the first birth and use contraceptives for birth spacing that in turn ends up in bearing and rearing larger number of children than if they should have spent more time in schooling. It also limits women's chance of participating in labor force and increase their economic dependency on men's earnings. All these lead to women's control over their fertility

choices whereas men may disregard to play reproductive roles as clients or disapprove women's seeking for reproductive services as partners due to other gendered normative expectations.

4.5 Gendered division of labor and male-dominated economic activities

The men-women economic inequality was not a controversial issue among the study participants as they all agreed that men highly dominate over women both in the formal and informal economic sectors. Unequal gender economic relations prevail mainly because of the gendered division of labor that disproportionately assigns productive and reproductive roles to men and women respectively. It is generally believed that women, especially those who live in the rural areas, cannot do many of the productive activities that men are culturally privileged to do. Dominant views that normalize the norm that men are the breadwinners while women are in charge of the domestic chores further reinforce the gendered division of labor and gendered power relations. An unmarried young man said that access to and control over women depends on their economic status: *"Now men who have money can marry and control women, whereas a girlfriend is taken away from a poor young man who loves her."*

An adult male key informant from Gabara explained that division of labor in the productive sector is unquestionably in favor of men. Accordingly, the men plough as their main role but still they can participate in other farming activities like weeding and harvesting; they also plant and grow trees for sale. Men sell valuable goods and have control over the income. Women, on their side, engage in weeding and harvesting as supporters for men but do not own the product. Moreover, they clean houses and the home environment for which they are not paid and recognized. This study participant, like many others, emphasized that domestic activities, like cooking are considered as women's duties even for the women employed in the formal economy. Childcare is mainly the duty of women, but a few men could assist them when they are at home. Besides, when there is a vacancy for sanitary work in formal employment, it is exclusively announced for women whereas only men are recruited for security guard positions and labor-intensive outdoor economic activities. This implies that tasks in economic settings are also gendered like activities in other social institutions.

Evidence obtained from interviews underscores these broad findings and indicate that economic activities undertaken by men only, include cultivating land and managing valuable assets such as

land, large animals, and crops. Women's exclusion from these economic activities and resource management on the one hand, and their high engagement in non-paid house chore activities like cooking, cleaning, and caring for family members, on the other, reinforce men's economic dominance. A young man underscored that there is no gender equality in the community he belongs to:

> *The community keeps the social values and roles of customary principles of economic activities whereby women are significantly excluded from having access to and control over resources. Therefore, engaging women in those customarily men's economic activities would be a good way to ensure gender equality (*Grade 10 student, Ako High school*).*

Most women similarly view household chores to be only women's duties, and most out-door activities or activities that require physical energy as men's tasks. Male and female study participants agree that wives rarely ask their husbands to share household activities with them, and vice versa.

In all government sectors, there is a gender mainstreaming strategy that intends to ensure gender equality, and one of its targets is empowering women economically. But the study participants agree that women's participation in paid economic activities is still very low. For instance, a key informant from the Office of Job Creation of the district expressed that out of about six million Birr allocated for job creation for youths in the district, far fewer young women than young men were able to benefit from the fund. One key informant from the Youth and Sport Office attributes women's limited participation in economic activities to a problem he terms "internal". According to him, gender inequality in economy is not related only to government policy, religion, or culture; it is also caused by the women themselves. He pointed out that women fear to compete with men; they are afraid to take loans; and they are less motivated to work outside home. He added that they suffer from an inferiority complex, which leads them to think that they are less able and hence lack the confidence to work with men. In contrast, he witnessed that there are exceptional women who work well in the economy. In his words, *"We see a few competent and hard-working women who are willing to work with others."*

Gendered and masculine economic relations manifest not only between men and women but also within similar sexes. Men with a better economic status dominate over women as well as over economically weaker fellow men. The expectations of men's economic achievement reinforce

and intensify competition among men in accessing and controlling women. The study participants agree that economic status is the main indicator of inequality among men. Men who are economically well-off are allowed to have more than one wife and they are more likely to receive more positive responses from women in terms of love, sexual or marital relations than poor men. Unemployed and in-school young men complain that employed young men and adults snatch their girlfriends by giving the young women money and sometimes even false promises of finding jobs for them. They added that unemployed girls who completed grade ten and are searching for jobs are particularly targeted by employed men.

Fieldwork observations revealed more economic features in the area most of which are shared among men and women hence need to be understood in association of the dominant and general gender order presented above. Large population in the area, compared to other districts of Jimma Zone, live in multifaceted poverty conditions. Unlike many other districts in the zone, people in Nadhi Gibe do not produce adequate coffee and they complain low productivity of the land. Moreover, due to the population pressure, access to means of production, both land and cash, is limited for the young generation. Agricultural land is owned by elder people because of the land tenure system of the country that there is no land redistribution. There is also low job opportunity in the formal and informal sectors hence many young people regardless of gender have frustrations like young people in other districts, the zone, region and the country given the national economy is unable to sufficiently create jobs. As a result, young men and women consider migration to the Middle East as alternative means of livelihood although more attention is given to women's migration partly because of better demand for women at the destination where they serve as domestic workers. Some women who were successful in gaining better income sent money or returned home to start business which motivates other young women to migrate and families to encourage them. Therefore, not all women's economic challenges are attributed to their gender subordinate position in the economic structures but also to societal economic limitations that also affect men.

There are also positive changes in women's economic participation in the study communities. Sizable number of women increasingly engages in outdoor economic activities like serving in formal sectors. For example, most elementary school teachers, all health extension workers and many healthcare providers, and some administrative staffs in public sectors are women.

Moreover, women are heavily engaging in petty trading and earn income to support their families. Using the available three large markets in the area, namely Ako and Dimtu markets-both in the same district, and Asandabo in the adjacent district of Omo Nada, many women frequently travel from one place to another for the market exchange. There are also policy and legal changes relevant to women's economic lives that potentially improve women's property ownership and economic participation. Recognition of women's right to own land through the land certification program and the family law that entitles women to get equal share of property upon divorce are the two remarkable examples.

The economic system and practices have direct implications on men's and women's fertility control by alienating women's from good earning productive economic activities hence reproductive domain is associated with women. Moreover, men's cultural privilege to dominate the economic activities tend to negatively affect couples' involvement in the means of fertility control. Men are entitled to control income and cost of the family hence women rely on men to pay for fertility control service related costs.

4.6 Gendered and masculine leadership

Generally, women's participation in leadership positions is very low in the study area. Most formal and informal leadership positions are occupied by men. Men are culturally entitled to lead the family, including their wives. As evidence from interviews reveals, even though there are a few women who make joint decisions in consultation with their husbands on family issues, the majority are not embedded with power to make decisions on property related matter, nor on child-related issues. Even in the case of divorce, many women face challenges of getting their share based on the decision of the court, particularly when it comes to the immovable properties like land and plantations. This is the case because of the "*sumune*" rule and practice, which customarily entitles husbands to give only a quarter of the shared resources to wives upon divorce. Although the practice has been abolished by the state laws, it is still operational when divorces are customarily handled given it is reinforced by religious views that give more power to men upon divorce. There is a strong influence of men over women in finance-related decision-making at both family and community levels. A more restrictive situation of women under men's influence is shared by a study participant from Dimtu:

> *Regarding decision-making in the household, we can say that women in the district have no authority to decide on matters that concern them personally or their family. Some are not allowed even to divorce when they want; a woman cannot decide on her children's education, and at times she is not even allowed to be seen by others and to communicate with someone who visits her family. Some of the men's influences have a religious backup to the extent that it may not be possible for their wives to welcome guests at their home. So, they are confined to homes* (District officer, Christian, Female, 29 year).

The scenario presented thus far in this chapter, including in the quote above, stands in stark contrast to the rhetoric of the religious leaders and the messages of their teachings to their followers, which speak of gender equality in religious texts. Observations obtained through fieldwork do not strongly reveal subordination of women to the extent presented in above quote. Such excessive men's dominance at present time seem less likely for most couples in the communities as women are usually observed in children's education, welcome guests at home and communicate with others in and outside home. Points presented by this study participant may be exceptional to a few families. Moreover, it is equally important to note that women's political participation has been increasing as part of the emerging powerful Muslim women in the public sectors of the region and the country. Nowadays, many Muslim women are in high level political or administrative positions at zonal, regional and country levels unlike in the district. At the community level, women's engagement in trade activities is considered normal hence some women generate their own income and manage it.

But community and/or religious leaders in the study areas are almost solely men. All *kebele* leaders (the lowest administrative unit), school directors, and health center heads in the district similarly were men. Concerning the formal political leadership, women in the same way assume very few leading positions. While it was considered that many young women were entering leadership positions at district level, only 15 out of 65 top and middle-level leadership positions in the district were held by women. Although the government's intention is to improve the male-female ratio in leadership to 50-50, the reality on the ground at the district and *kebele* levels is very far from reaching the target; to date only a few women are in leadership positions.

Even though a few women are being politically empowered, there are critical challenges that prohibit a large majority of the women from exercising the authority they assume. Men, including those who give women the positions, that is, the policy implementers, perceive that

women cannot shoulder the responsibility of leadership. The male-dominated cabinet does not rely on women as capable leaders, although they assign some positions to women based on the quota allocated for them. A key informant woman who was among the top leaders at district level explained it as follows:

> *In fact, women have become members in administrative councils. The problem is that issues raised by women are not given due attention, and there is resistance against the power exercised by women, even though they are officially assigned to the position. At higher level, too, there are women who assume leadership positions (as sector leaders) but they are still afraid to fully exercise their power. They lack confidence to play leadership roles even if they are not under the direct influence of other actors* (District officer, Female, Christian, 34 year old).

Based on the discussion with key informants there seemed to be two reasons why women in leadership positions do not properly exercise their authorities. Men's indirect leadership is in place whereby positions are officially assigned to women whereas the actual leadership power is exercised by men. Field observation reveals that there are conditions whereby women are nominally assigned to leadership positions, but they are represented by men executing the roles. For instance, the gender focal persons at the *kebele* level are women, but most of their tasks are actually executed by the *kebele*s' chairpersons, who are all men. In the sector offices, except for Women, Children, and Youth Affairs Office where all leaders are women, men in the deputy- or other directorate levels exercise more power than the women assigned to the position at the top. A male key informant from the district's Office of Youth and Sport pinpoints the major challenges of women in leading positions in the district as follows:

> *Some women raise important ideas in public discussions but they have less acceptance by their fellow leaders, most of whom are men. Female leaders may show some weakness just like some men, but a woman's weakness in leadership is exaggerated and easily associated with being a woman for its cause. Such views of associating defective performance with the sex of the leader are held by men and women alike (Distric officer, Male, Christian, 37 year old).*

In school settings, some male students do not accept the leadership exerted by female students when they are assigned as class monitors or group leaders for different club activities. Teachers and students associate it with cultural influences, hence suggesting the importance of bringing further attitudinal changes among students. Study participants also pointed out that women who assume leadership positions have weaknesses compared to their male counterparts. The above key informant added:

There are pro-women changes in the political environment, but young women fail to make use of the potential advantages. Female leaders fail to actively participate in public decision-making meetings. Now women have positions reserved for them and there is little external pressure upon them as the government policies and regulations give priority to women. However, married young women have difficulty in setting themselves free from cultural influences and ideas and going outside to fully exercise their leadership roles. Yet, there are a few active and effective female leaders who serve as role models.

Therefore, explanations in the quotes are not conclusive to all women in leadership position as the participant himself pointed the the exception in his last statement.

Gender inequality in leadership involves the power to make decisions on issues that concern both men and women hence it has direct and indirect relations with fertility control. The gendered and masculine leadership of most institutions, over properties, women, children and children related affairs clearly entails that women cannot make free decisions on their sexuality and pregnancy choices and experiences.

4. 7 Expectations of an Ideal Man/Boy: Implications for young men involvement

This section identifies social and cultural normative expectations about desirable characteristics of 'being a man' based on empirical evidence and in line with Weber's ideal type. It also touches on expectations of 'being a woman' for better understanding of the ideal man in relational perspective. Terms like "good boy" / "good girl", "good husband"/"good wife", and "real man/boy" / "real woman/girl" are used in this text. In this usage, the terms are best represented by a notion of "the ideal man/boy" and "the ideal woman/girl" to adopt a sociological concept of "the ideal type", as developed by Weber. Based on the in-depth analysis of interviews and FGDs, and using the Weberian analytical approach, characteristics or qualities of an ideal man/boy and an ideal woman/girl were identified. Accordingly, an ideal man is characterized as protective, socially and economically successful, knowledgeable (persuasive), self-reliant, decisive, and an ideal woman is marriage and fertility centered, dependent, obedient and domestic. A 24-year-old married young man in Dimtu narrates socially expected characteristics of 'a real man' as follows with some comparative reflections on 'a real woman' as well and their respective responsibilities:

> *Men who work hard in agriculture and trade to earn money are real men. One who knows about women is also considered as a real man. Men who trust women and act based on whatever the women told them are undermined. There are women who spend much of their time outside their homes who might be considered incomplete or deficient. They have difficulty staying in the home and do not properly manage domestic chores. Women swiftly make decisions; they are not far-sighted, and sometimes they act based on crude evidence. They think narrowly; so men should check the information women give them rather than directly taking their ideas. Men should not develop such behavior. A husband is a leader with bigger responsibilities followed by his wife. He is responsible for controlling children, checking their clothing, visiting relatives, and providing all that the household needs whereas she is responsible for cooking what is provided by her husband. On top of these, agreement between a husband and a wife is important.*

The quote is presented to inform how the ideal type of men and women, and hegemonic masculinity as an ideal form of masculinity, are constructed in the study community. He characterizes a real man as knowledgeable or intelligent and hard working. He also perceives the real man as the front leader in the household. Moreover, a real man is expected to be a critic, a supervisor, a controller and a provider for his household, children, and wife. This ideal man is also expected to visit relatives. On the other hand, the participant views a woman as a domesticated and passive person in a man-led household. He depicts women as unreliable and less intelligent than men; women are also seen as the second leaders in the households and cookers; women require their husbands' supervision in what they do. Parallel to his categorical view of putting men and women in different baskets based on what they are supposed to do, he expects agreement between men (husbands) and women (wives). In the same interview, he also characterized real men as they manifest constructive engagement with their wives in the form of having discussions on shared matters. The characterization of the real man and the real woman by other study participants and ethnographic observations of the community environment is fairly consistent with that of this young man. His narration about 'a real man' lends itself to evolving and multiple explanations of masculinity. A range of hegemonic and non-hegemonic masculine manifestations are reflected in the narration.

Proverbs like "*Nadheen beektuu hin qabdu dheertuu malee*"- there is no knowledgeable but tall woman- and "*Beekumsi nadheenii karra cufaatti oolcha*"- a woman's knowledge keeps a gate closed at best- are expressions of such views. Evidences revealed that a boy is said to be good if he goes to school and studies hard. If one is a farmer, he also has to do well in farming.

Expectation of success in general and educational success in particular, is commonly attributed to sons, a little to daughters although improving these days. In contrast, one of the reasons to deny females access to education is the belief that they will not be successful considering the field as a men's domain. A high Grade 10 student from Ako/Chora Botor characterizes a good man as follows: "*A good man is one who is free from any addiction and a role model for others in economic achievement"*. While women's obedience to men are much emphasized, adherence to and respect for institutional and cultural beliefs and practices is given priority with regard to the extent of men's obedience as evident in an expression of an unmarried young man from Gabara:

> *In our community and as per our religion, a good boy is adherent to his religion, respects his family and other people, keeps himself away from bad behaviors, and marries legally and culturally seeking the consent of his family and approval of his relatives.*

Another study participant young man added: "*A good boy is one who respects his family and the elders, is obedient to one's family, and is a role model in the school"*. At the interpersonal level, obedience of young boys is associated with the quality of their relationships with their fathers, unlike that of young women whereby relationships with husbands are emphasized:

> *Good boys are those who respect their father and listen to and accept their advice. A good boy thinks that his father never tells him something worthless. If I do something wrong, my father should stop me. A good boy accepts whatever his father tells him. If the father tells him to go to school, he has to do it, given that a father chooses something good for his children* (Yong man, 23, Ako High School, Bidaru).

Marriage is considered as the fate of women; hence, a timely entrance into it should be their primary objective. The notion timely marriage is more important for women than it is for men is a shared view in the area. Parents and the community at large appreciate the timely marriage of young women to avoid the risk of missing a marital partner and falling into premarital pregnancy. Yet, there are some parents and community members like teachers and health extension workers who encourage girls to go to school rather than enter into early marriage.

Some remarks are important about the above stated characteristics and qualities of an ideal man and an ideal woman. The first and the most important one is those characteristics are ideal types but not necessarily the most recurring manifestations among young people. Rather they are

expected by the majority community members but not necessarily dwell within most young men and young women. Close observations of materials obtained from the fieldwork revealed that young people significantly deviate from the expectations. There are a lot of parallel discourses about each characteristic and different cases are presented. Second, many of these characteristics are expected from young men as well although at a lesser degree. Therefore, the characteristics are shared among men and women, not essentially categorical. For example, obedience is expected from both sides but from different angles like women are expected to be obedient to many entities than men. Third, women are increasingly expected to meet many expectations set as ideal type for men like becoming successful in education and economic lives.

4.8 Is culture to blame for gender inequality?

In the study context, gender, cultural, and religious perceptions and practices are intimately intertwined in a manner where one cannot be meaningfully understood without reference to the other. For example, religious and cultural marriage rules and rituals are very similar and reinforce each other. Roles of men and women in religious settings are influenced by cultural prescriptions and proscriptions of the role of men and women in the familial and community lives. Yet, the religious leaders insist that it is culture and not religion that upholds gender discrimination. There are also notable overlaps between Islam and Orthodox Christianity. Religious leaders in the study communities not only defend against the view that religion nurtures gender inequality, they also attribute the sources of inequality to culture other than religious rules and practices. By culture the religious leaders mean non-religious elements that are not directly provided in religious scriptures but commonly believed and practiced in everyday lives. The religious leaders thus claim that the cultural views and practices dominate over the religious rules and teachings, and culture keeps the women in subordinate positions in several dimensions of lives, not religion. An EOTC leader described it as follows:

> *Our church teaches equality of men and women, but the people remain under cultural influences. Cultural factors external to the church put pressure on the people in favor of unequal women-men relations. For instance, even though the church treats both sexes equally in its teachings of reproductive health issues, pregnancy and childcare are culturally considered as the sole roles of women in the community* (Male, 53 year old, Dimtu).

Likewise, the Islam religious leaders attribute the gender inequality to cultural expectations that demand women's subordinate positions to men. A Muslim religious leader pointed out that a few men attempt to translate the teachings into practice presenting his experience as a reference. He said:

> *Even though most men dominate over women in the society, a few men - including me - exceptionally treat their wives as equal. Personally, I discuss all family matters with my wife and we make decisions jointly. But I know that men are dominant over women in our culture* (Male, 54 year old, Dimtu).

Tone of this argument tends to be political correctness and social desirability answer given the actual lives do not strongly support it. Nearly, all men participated in this study reflect the same notion that women are dominated in the community but they do not dominate over women in their own gender relations that indicate they do not own such idea of men's universal domination over women. The ethnographic observation of the general environment also revealed that girls and women freely move along streets, men sympathize and they are respectful for women in their interaction in schools, workplaces like health facilities and offices. Moreover, women participants in the study have similar perception that men excessively dominate over women in the community but they do not witness that they experience the same level of subordination. However, these analyses should not be taken as conclusive remark against the existence of gender inequality in the study communities rather as the co-existence of parallel discourses among the study participants.

Although many study participants attribute the major sources of gender inequality to cultural influences, some are critical that religious rules and practices also reinforce gendered cultural elements. For instance, EOTC key informants' explanation of the women's exclusion from the teaching or preaching services or priesthood and that of Islam justifying women's exclusion from leading prayer tend to endorse a cultural view evident in interviews and FGDs, that men are more knowledgeable than women. The doctrines and the practices also reinforce the cultural view that women should not speak in public.

Women's limited participation in public events is shaped by religious and cultural forces. A key informant from district Youth and Sport Office reported that there are some limitations with regards to gender relations and participation. According to him, fewer young women participate in public meetings compared to their men counterpart. There is also a tendency of excluding

unmarried young women from such participation based on the view that Sharia rules out. That is, there is a view of keeping young unmarried women from participating and giving opinion in public meetings. Hence, both culturally and religiously, there is a tendency of keeping women at home. Islam and EOTC at least impart in their religious followers that there are some religious practices that only men can do but not the other way round. The religious leaders normalize the exclusion and segregation by reciting scriptures and giving logical explanations at times whereas the lay people tend to endorse the religious leaders' views.

Leaders of both religions attribute women's less representations at local level in services acceptable for both sexes to women's lack of preparation to qualify for the positions like passing through lengthy theological study. An EOTC religious leader, for example, argued that there is no doctrinal rule that prohibit women from taking church leadership at higher positions reminding there are such women at central offices. He noted that there are few women in higher leadership positions at Addis Ababa while reemphasizing that women cannot teach in congregation which is doctrinal. Exceptionally, a Muslim study participant remarked a possibility for women to become religious teachers if they fulfil the requirements. He mentioned that his daughter was studying at theological college in Addis Ababa.

Given religions influence every aspects of family, marriage, sexual and reproductive relations, their pro-gender inequality values and norms directly shape couples' views and practices of fertility control. Religious gender inequitable norms and patriarchal culture reinforce men dominance over women in controlling their fertility. The religions endorse the cultural norms of men's entitlement of making decisions on family matters that it works for the three domains of fertility control. Women's subordinate positions in the gender relations implies their limited control over their fertility. The religions also reinforce gender-based role division among partners where men are leaders and providers (productive domains) that by implication restrict their involvement in reproductive practices like contraception use and abortion as their main responsibility.

4.9 Discussion

A large body of literature reveals that gender inequalities are institutionalized in Ethiopia (Semela et al. 2019; Burgess 2013; Gella and Tadele 2014; Lavers 2014). Lavers (2014) has

concluded that social institutions in Ethiopia are discriminatory and reinforce gender inequality. Based on a comparative study on Ethiopia and Mexico, Wright (2020) argues that gender inequality prevails in Ethiopia. The study participants' responses to the questions about gender equality in the present study are in favor of gender equality though it is at discursive level. The positive answers to the questions largely seem to be political correctness and accompanied by several parallel discourses that tend to question correctness of the answer. A study on early pregnancy and schooling in rural Zambia found that community level discourses substantially support the official discourse about early pregnancy as a problem and schooling of girls as a solution. However, a parallel and contrasting discourse that questions schooling as a solution is articulated by the same study participants (Blystad et al., 2020). According to this study, the parallel discourse emphasizes that early pregnancy may emerge as rational because of many reasons hence schooling may not be the only solution. The study concluded that grasping the complexity of local discourse in the socioeconomic dynamics in the study context is vital mentioning that material constraints condition and reinforce a culture of early childbearing.

Many men or women study participants also argue that gender inequality prevails in the community but they do not personally practice or experience it which is in line with findings of Blystad et al., (2020) that the study participants do not own ideas they endorse. That is, the general discourse that endorses the official position that women are oppressed are not as such supported by actual practices encountered in day-to-day routine lives. The study participants endorsed the official discourse that gender inequality prevails in the community yet they attempted to defend themselves and their religion from being portrayed as factors or actors of gender inequality by attributing it to non-specified individuals, women themselves collectively and the culture. What happens in practice remains to be seen in the coming paragraphs. They say that men and women are essentially equal. Claims of religious leaders in particular rely on divine principles whereby equality is emphasized and religious teachings are recited rather than actual men-women relations in daily lives. The actual men-women relations, including in religious settings, sufficiently show that views and practices of gender inequality go against pro-gender-equality rhetoric. This could be the case because actual relations may be something very different from cultural ideals/discourses on relations. What people say is not necessarily the same as what they do.

Islam religious leaders believe that women are weak and insecure; hence, they should seek the protection of men, which portrays that men are self-reliant and women are dependent. Men are presented as both protectors and providers, on the one hand, and abusers and controllers, on the other; all emerge as manifestations of hegemonic masculinity. Women are also excluded from preaching and leading in Islam and EOTC whereby both public teaching and leadership are culturally considered as a men's domain. Consistent to this finding, Eresso and Bruzzi (2015, p.12) found that religions in Ethiopia contribute to fostering gendered ideologies that are linked to cultural heritages; political and moral values; and forms of authority and hierarchy. They pointed out that ritual practices are divided along gender lines whereby men dominate the formal ritual practices and women are marginalized in the liturgy of the EOTC. They also stressed that women are excluded from healing practices in the church.

Findings of this study concur with the existing literature that men are culturally viewed as superior to women in the family and community settings in Ethiopia, a view also shared by many women themselves as they believe in their subordinate positions. Burgess (2013) shed light on how gender inequality prevails in the family and community contexts in Ethiopia. Accordingly, women's dominant gender identity is closely linked to family and the prescribed gender roles in the private space of the home whereby their public roles are hidden. This argument is very similar to the findings of Gella and Tadele (2014) that boys have more space, time, and freedom to play, study, work, and participate in public activities. Similarly, Zenebe and Haukanes (2019), in their university-based study on female students' access to abortion, found that parents' high expectations from their daughters strongly influence young women's decisions on their sexual and reproductive lives. Besides, parents can excessively ostracize their daughters in case they fail to meet those expectations. A family case with three sons and a daughter whereby only the daughter did not access to schooling is an indicator of gender-based inequality at the family level.

Kronsell's (2005) argument that institutions are largely governed by men who produce and recreate norms and practices associated with hegemonic masculinity is supported by the findings of this study, given that most formal and informal institutions in the study area are governed by men. Building on literature on institutions of hegemonic masculinity, we would argue that male leadership is normative because all household, religious, school, and health center leaders, as

well as most sector leaders, are men. Burgess found that community-based associations like '*iddir*'s (community-based organizations that mainly provide funeral services) are male-dominated in Ethiopia although there are Iddirs exclusively for women which are led by women themselves. For example, chairpersons of 3567 '*Iddir'*s were male, and only 54 were female in Addis Ababa in 2004 (Burgess 2013). The husband is the head, the breadwinner, and the representative of the family. Public representation of families by men as husbands and fathers and having the final say on families' internal matters is a good indicator that masculinity is the norm as stressed by Kronsell (2005). A family with a female head, that is, when the husband is missing, represents deviation from the normative expectation of a normal or acceptable family. Connell (2005) takes such scenarios to indicate that masculinity is the place of symbolic authority and femininity is symbolically defined by lack. Domestication of women as opposed to allowing men to do outdoor activities is an expression of masculine norm revealed through emphasized femininity. The classification of men's and women's roles on unequal bases in the family, community, and sector leadership emanates from cultural influences. Finally, the desired characteristics of an ideal man or an ideal woman align with manifestations of institutional, interactional and interpersonal gendered norms and practices.

Implications of the gendered views and practices on fertility control among men and women in institutional settings are manifested in men's holistic dominance over women although there are exceptions and emerging changes in favor of gender equality. Accordingly, women lack control on matters of reproductive lives whereas men either ignore them as less relevant or have adverse influence on women's rights, interests and needs. Central to all women's inability to make decisions on the three domain of fertility control and lack of support from their partners in seeking reproductive health services imply that they are yet to be empowered.

4.10 Conclusion

Ethiopia has committed to Goal 5 on gender equality of the Sustainable Development Goals. Consequently official discourses about gender equality is in place. As a result, pro-gender equality discourses are shared among members of all social categories but gender inequality prevail across all institutional settings, men-women interactions, social values, norms and practices in the study communities. Elements of gender equality are only emerging and exceptional rather than a norm. No one explicitly argue for gender inequality from any

perspective but a few people's practices reveal concrete men-women equality shows a big discrepancy between the discourse and the practice. Parallel and contrasting discussions on institutional and social norms relevant to gender equality and inequality are interwoven in subtle ways. Among others, religious leaders and followers at the same time endorse government's discourse about gender equality (i.e political correctness) and defend pro-gender inequality rules and practices embedded in their respective religions.

Men dominance over women is evident in institutional norms and practices of the study communities as elsewhere in the country. Cultural resources, institutional arrangements, rules and practices, men's collective and individual influences, and women's endorsement of their subordination played roles in maintaining male dominance. Masculine and gendered power relations are more clearly apparent in the most desirable characteristics of an ideal man and an ideal woman regardless of the emerging changes in the expectations towards eliminating differences between men and women. Gendered power relations and hegemonic masculinity are apparent in family, religious, economic, and political rules; they are also seen in settings and practices, as well as people's interactions in the communities. Moreover, some norms and practices intended for improving gender equality or women's protection are gendered themselves. Elements of gender inequality reinforce one another among different institutional settings whereby the role of religious norms is central and most influential. However, modern education has become a real and potential driver of change given people have hope in education as a powerful tool towards ensuring gender equality.

Notions of gendered power relations, hegemonic masculinity and Weber's '*Ideal Type*' assisted in enhancing the interpretation of the material. The application of '*Ideal Type*' to the material in explaining the 'ideal man' enabled the researcher to identify features of hegemonic masculinity and gendered power relations in the study communities. All these give us clues about the relationship between gender system, fertility control and involvement of young men in fertility control. Young men and women are found to be largely bearers of gendered power relations and hegemonic masculinity or they are partly proponents of gender equality. However, young men's involvement in fertility control as change agents is yet to emerge.

CHAPTER FIVE
SEXUAL RESTRICTIONS IN LOVE AND MARRIAGE CONTEXTS

Introduction

Chapter Four presents background information about how the broader contexts of gendered power relations are constructed and practiced in institutional settings and their implications on fertility control. In this chapter, experiences of young men pertinent to sexual restrictions or abstinence are analyzed in the contexts of norms of love and marriage. The construction of love, sex and marriage are explored based on Weber's notion of ideal type and Gramsci's cultural hegemony. The analysis is theoretically informed particularly by works of Javaid (2019) (*Masculinities, Sexualities and Love*), Jackson (1993) (*Even Sociologists Fall in Love*), and Reiss (1986) (*A Sociological Journey into Sexuality*).

Jackson argues that love, romance, and emotions are culturally constructed and institutionalized; they are cultural forms and a part of everyday life. For Jackson, love is pervasive due to its institutionalization through marriage and family life, and it serves to bind the involving parties to the existing social order. Javaid (2019) maintains that different identity markers such as gender, ethnicity, age, sexuality, culture, and religious beliefs shape the ways in which men perform love, intimacy, and emotion. Like Jackson, Javaid stresses that love is socially and culturally constructed in and through social and power relations. He also emphasizes that men's emotional in-expressiveness in love relations is a cultural privilege and manifestation of hegemonic masculinity as implied by Gramsci. Both authors agree that women invest far more in love, giving much more affection and intimacy to men than what is reciprocated. Their view that men and women experience love relations differently and that women might be subjugated in the relations was introduced by Weber in his pre-feminist theory (Jackson, 1993; Javaid, 2019). Reiss (1986) points out that sexuality is learned in societal contexts; it serves as a social bond and it is important in all societies, but its normality varies from one society to another. The author adds that sexuality is linked with the strong emotional ideologies of a society and that men have more rights and privileges of sexuality over women by virtue of their dominant position in the society and in interpersonal relationships. The three authors -Jackson, Javaid, and Reiss - agree that sexuality and patterns of love relationship are gendered, institutionally framed, and culturally hegemonic.

The analysis and interpretation of materials in this chapter builds on these theoretical lenses to explore how the ideal and hegemonic forms of love, sex and marriage are socially constructed in the study communities in the course of time, and how young men experience those phenomena. In line with Gramsci's theory of cultural hegemony and Weber's theory of ideal type, hegemonic and ideal forms of love, sex and marriage refer to culturally superior or socially the most desired types of each phenomena but not necessarily the most prevalent ones. In these theoretical formulations, there could be discrepancies between the expected discursive presentations of the shared views about what characteristics constitute hegemonic and ideal forms of the three phenomena and the practical lives of the young men. Such discrepancies, forces of changes and continuity are emphasized in the interpretation of the study findings.

5.1 Cultural and religious backdrop of love and marriage

5.1.1 *Michu*: Love without premarital sex and marriage

A cultural premarital love relation called '*michu*'- etymologically meaning "acquaintance or friendship" - has been practiced among unmarried young men and women as far as participants' oral account of history can take us back in the study area. According to information obtained from community members in their 70s and 80s through informal interviews, *michu* is a premarital play among the youth involving kissing, touching, petting, and other kinds of sexual conduct, but it rules out sexual intercourse before marriage. It also involves gift exchanges. This practice is widely known and recognized in the Oromo society, and it is also known as "*Qabdoo*", "*Wadaaja*", and "*Dhungoo*". The culturally celebrated and socially valued "no sexual contact before marriage" principle is derived from such pseudo-husband-wife cultural practice of love relationships taking place at early stages in young lives. In this customary practice, young men and women occasionally meet in forests, at river sides, or under trees to enjoy kissing their girl/boyfriends.

In *michu* love relations, boys select their *michu* partners, and they are expected to be the watchdogs and guardians of the girls against sexual attacks by other predatory men who could potentially deflower or impregnate the young women, hence playing a protective role. The young man is socially accountable to the girl's sexual purity (that is, keeping her virginity intact) until the marriage day. Doing so is a source of social pride for him. Hence, considerable responsibility is placed on the young male partners. Parents may know whether their son or

daughter is in such love relationships with someone, but they usually pretend as if they do not know, where as other community members are aware of it. In the communities where I did the fieldwork, I came to know about *michu* while I asked older men and women to share their love experiences in their early days. It seems that the *michu* experience and the sense of intimacy remains one of the most important events for the lovers in their life. Adults and older people enjoy narrating their past *michu* experience with a sense of pride.

Normatively, *michu* love partners are not culturally permitted to extend to marital relation as each is expected to get married through an arranged marriage to someone else whom they have not selected by themselves or may not even have known before. Permitting love in *michu* relations that are not expected to end in marriage and refusing contact between the would-be couples until marriage seems a paradox. Bestowing the responsibility of keeping sexual purity of a girl on relatively younger boys equally seems paradoxical. The logic behind preventing *michu* relationships from ending up in marriage is that the desired socioeconomic statuses of the two families are to be assessed by parents, not by the two couples, hence it implies the dominance of the norm of arranged marriage. That is, the interpersonal love relation of *michu* partners is not a sufficient condition for a socially acceptable marriage. As a result, within the frames of the arranged marriage, no physical contact, let alone premarital sexual relation, is allowed until the wedding day. Therefore, *michu* can be considered as an interpersonal love affair implicitly over seen by families, whereas marriage is an inter-group institutional matter whereby social relations are given primacy over the couples' intimate relations. In such a social construction of love, a couples' love relation is built along the process of a marriage arrangement, marital lives being accompanied by numerous social expectations.

Another key feature of the *michu* custom is that the love relations between the partners may not end even if the partner marries another person. Rather, there is a possibility of extending the relation in the form of extramarital sexual affair in a secretive manner. This is culturally tolerable, though not necessarily expected to occur. The marital partners are well aware of the possibility of such relations between *michu* lovers; hence, tension commonly develops between the counterparts, particularly among the men. A common feature of *michu* and arranged marriage is that both rule out sexual relations before marriage (premarital sexuality) and among relatives (incest).

However, the cultural value and practice of *michu* is said to no longer be properly intact as the relationship between the *michu* lovers today has gradually shifted to involve sexual intercourse. *Michu* lovers also moreover started to extend their love relations to marital relations contrary to the normative rules. Along with such changes, *michu* relations themselves have been fading in the study communities. It is estimated that the change has occurred in the last fifty years that marked the start of ending *michu* relations in sex and/or marriage among young people. Older people in their 70s and 80s witness that they experienced intact *michu* love relations. In other words, the *michu* practice has gradually become a window of opportunity for young men and women to practice premarital sexual intercourse. Because of these emergent patterns of behavior, along with the introduction of modern education and other changes as commonly mentioned by the study participants, the *michu* cultural practice has become outdated and is suspected by community members of serving as a pretext for premarital sexual relations.

Nevertheless, a *michu*-like practice still partly persists in Gabara/Dacha Gibe and Rukinsa areas, which indicates that the practice is fading away at an uneven speed in the study communities. The continuation of the practice in some places is considered as an exception and has no community support, given that it does not stick to the original content of the custom because it entails sexual intercourse and subsequent premarital pregnancy. An eighty-four-year-old man underscored that a culturally acceptable *michu* practice is no more in place. In his words: "*The current love relationship among young people by the name of michu is just a pretext to have sex*." Therefore, the practice in itself is now considered by the communities as a violation of sexual norms that indicates how social norms change overtime along changes in meaning for particular practices. Young people believe that limiting the love relation to kissing is challenging nowadays. A student put the historical 'only kissing' practice, which is far from happening at present as follows:

> *I have heard that there was only kissing among young lovers in our parents' time. We also talk with elder brothers about how they could have managed to limit their relationship to kissing alone. They tell us that there was no sexual contact before marriage in the customary kissing practice. Even lying down during kissing was unacceptable. They properly sit only in a way it is suitable for kissing. But in my love experience, I proved that it does not work now. These days, if I call a girl for a kiss, she comes prepared for sex. They come only for that. If the boy is new for sex and leaves the girl who is trying to seduce him, the girl never comes to him*

> *again. The girl may insult him saying 'Are you really a man?' or "You wear trousers for nothing"* (Yong man, 23, Ako High School, Bidaru).

In the last sentence, the young man hinted that being a man and the expression "wearing trousers for nothing" is perceived women's response disregarding the man doubting his masculinity. Discourses and practices presented above indicate that *michu* is redefined and given negative connotations in the present dominant public views. The cultural definition and meaning attached to *michu* has changed in the course of time but the values and norms of abstaining from premarital sexual intercourse until marriage remains intact socially expected norm (continuity) regardless of young people's deviant practices. The difference between the two, social expectation and young people's actual lives against the expectation, is best explained by the concept of youth subculture.

5.1.2 Arranged marriage: Marriage without premarital love and sex

While *michu* denies a young man and a young woman in love the right to have sex and get married, arranged marriage forces a couple to establish marital relations without premarital love. Arranged marriage, in the strict sense from cultural perspective whereby decisions are made solely by parents of the bride and the bridegroom, is considered as the most appropriate type of marriage by the older generation (the ideal type). There are interesting inter-generational culture vs religion dynamics with regard to arranged marriage. The practice is not appreciated by young and educated people, and neither is it supported by religious leaders. Arranged marriage in purely cultural context is clearly different from that in religious settings whereas most religious and cultural norms seem overlap on matters analyzed in this study. In both EOTC and Islam, arranged marriage involves young people in the decision making process where the young man choose a girl of interest, request for love and secure her willingness for marriage, and present the case to religious leaders. It is the religious leaders who ask and convince parents of both young men and young women to allow the marriage. Alternatively, the young men and young women can inform their parents about their interest and request them to arrange the marriage among Muslims.

Although it is viewed and expressed by most study participants as arranged marriage is drastically diminishing, experiences of some young women show that the practice still exists. A

27 year old married Muslim pregnant woman I met at the delivery waiting room of Dimtu Health Center recalls her marriage process as follows:

> *I didn't know him* (her current husband) *very well before we were married but he knew me pretty well because he was my brother's friend. We had no contact before marriage. But he had another wife before we got married; that is, I am his second wife. He is far older than me. Now he is 56 years old. As the marriage was arranged by my parents, I didn't complain about the age difference; you cannot refuse your parents' order. I simply accepted the marriage arrangement as decided by my parents and I got married.*

Another young woman also had a similar experience. She dropped out of school because of the arranged marriage by her parents and got married. She underscored that she had not met her husband before the wedding day. She notes,

> *We both heard after our families had arranged everything. We heard it after people started talking about our marriage arrangement. After that, we knew each other from a distance but we didn't meet in person until the marriage day (Muslim, 25 year old, Afeta).*

Another 25-year-old Muslim woman from Raga Siba area explained that she did not have any face-to-face contact with her husband before their marriage. However, they used to see each other from a distance at market-places with no direct personal contact until they entered into marriage. She has the following account:

> *We met face-to-face on our wedding day. We did not meet in person until the wedding ceremony. I was too young at that time. I did not know anything about love affairs. I got married before knowing matters about girlfriend and boyfriend relationships. In general, I didn't know love-related affairs before getting married.*

People's views and expressions that arranged marriage is diminishing might be influenced by the official discourse, including in the media, against early marriage and marriage of young women to older men. In this view, there is a tendency of associating culture-based arranged marriage as forced by pro-women government and non-government initiatives like modern education and health extension program. Girls' drop out from school is usually framed from this perspective. In addition to these expressions of political correctness, there are parallel discourses that tend to justify arranged early marriage. Marriages are arranged for minor girls as a solution for premarital pregnancy and as a means of securing future better lives through getting married to educated or economically well men regardless of age of the latter.

Polygynous and monogamous marriages and family structures co-exist in the study communities. Monogamy is common to both Muslim and Christian communities whereas polygyny (having more than one wife at a time) is widely practiced among Muslims. Polygnyous marriage is legally banned by Ethiopia's Revised Family Code and Criminal Code (FDRE, 2000 and 2004), but it does nonetheless occur. In this cultural and political dynamics, the state categorizes the practice as crime but it widely occurs in the area. Similarly, EOTC prohibits polygynous marriage whereas Islam conditionally allows it. In practice, polygynous family patterns tend to decline among the schooled, urban dwellers and the younger generation.

Children and the household are commonly named after the father/husband. Unlike other parts of Ethiopia whereby women keep their family names and do not take their husbands' name, wives in this area also are named after their husbands' first name. Although there are pushes towards using fathers' name instead of their husbands' due to practical challenges related to women's rights to inheritance of their parents' property, some women still use it and others use both alternatively. As a result, some women ask back as "*my father's or my husband's name*" when one asks them for their second name. In the presence of the husband, the wife is considered as the second person in making decisions, except in rare emerging cases where the husband and wife equally share decision making roles and power on common matters. The husband is mainly responsible for economic matters outside the home. The wife manages the home and in-house resources, and she cares for children and the entire family. Control of children is a shared responsibility though the husband's responsibility increases as the children grow older. Members of a monogamous family share residence and economic activities whereas polygynous families may or may not have separate resources but they have separate houses. Ethnographic informal interviews revealed that relations between co-wives are sometimes rough and there may be severe conflicts over shared resources, including over the husband. A sense of rivalry tends to pass on to children born to them.

5.1.3 Negotiated marriage: Premarital love for marriage where premarital sex is likely

Both *michu* and arranged marriage practices have been diminishing and giving way to premarital sexual and/or marriage-oriented relations that are subject to negotiation between interested parties, including the partners, their parents, and religious leaders. An emerging popular expectation from love relations between young men and women is that love partners should

consider marriage as their end goal. Lack of such a commitment between the partners is commonly labeled as "*false love*". *False love* refers to an intimate relation between a young man and a young woman which is driven by sexual desire and temporary sexual attraction without targeting marriage as its end goal. Love relations among young people are talked about as commonly involving sexual intercourse but do not target marriage; hence, the relations are characterized as *false love,* which is commonly expressed as "*Fedhii foonii guuttachuu*"- the mere satisfaction of sexual desire. "Foon" is literally means flesh. The notion that love relations should last up to marriage (although not in the *michu* institution which did not lead to marriage) prevails as a dominant view among religious leaders and parents. This notion of "love for marriage" is also upheld by young men, although the actual practices are significantly different from their rhetoric. That is, young people in principle believe that proper love is characterized by a lasting relationship leading to marriage, and it is not simply rushing to have sex:

> *I was telling her* [referring to his girlfriend] *that our love relation should end up in marriage rather than rushing to sex if we think about tomorrow. My girlfriend also told me that she did not want to be engaged in love relationship just for temporary sexual enjoyment* (Young man, 18 year old, Muslim, Grade 11 student at Dmitu Preparatory School, Gura Bidaru)

Another young man underlines that negotiating for agreement to take the relationship up to marriage is at the base of their love relations:

> *Had it been just for sex, our love relation would not have been intact for two years. We discussed and reached an agreement that living together in marriage should be the purpose of our relationship. Otherwise, the relations could have been short-lived. It is the marriage plan that has tied us together* (Young man, 22 year old, EOTC Christian, non-married, Busa).

Contrary to this dominant view, some study participants argue that love relationships among young people today mainly target sex, and the discrepancy between the normative prohibitive expectations and actual practices is huge. They think that sex-oriented love relations, rather than those that aim for marriage, have become more common. They also see that love relations are short-lived, mainly due to challenging economic conditions young people find themselves in because of their lack of access to land and increasing youth unemployment, which may force them to separate, in contrast to the strong expectations of marriage-oriented, long-lasting relations.

It seems like the *michu* customary practice has influenced public views of love, sex, and marriage in the study communities in some ways. As a cultural backdrop, the basic principles of love, sexual, and marital relations are derived from the *michu* concept and practice, and their recent modifications although *michu* institution did not entail sexual intercourse and did not lead to marriage. In the past, conventional marriage was arranged through parents, significantly based on families' preferences or approval. At present, negotiated marriages seem to be dominant (an emerging ideal type) whereby features of *michu* and arranged marriage practices are interwoven in the sense that love but not sex before marriage is possible (derived from *michu*) and marriage must be an end goal of the relations which is a trait of arranged marriage. Marriage-oriented love is permitted among young men and women as long as it excludes premarital sexual intercourse. Young men and women can negotiate love and marital relations with a significant involvement of parents and/or religious leaders in the decision making. In the process of change, arranged marriage remains an acceptable alternative practice appreciated primarily by the older generation. Moreover, marriage is culturally expected once premarital sex is practiced or premarital pregnancy occurs.

5.1.4 Love, sex and marital relations from religious perspectives

Having premarital sexual relations and entering into marriage without significant involvement of families and/or religious leaders is strongly condemned (both culturally and religiously) in the study communities. The two dominant religions in the study area, Islam and EOTC, equally prohibit premarital sexual relations and religiously unregulated marital ties. In both religions, self-confession about premarital sexual status is expected upon marriage although actual practices vary. Within the frames of both religions, young men and women are expected to confess their sexual experiences before religious leaders. However, confession applies only to those who want a religiously acceptable marriage ceremony, and not to all marriages. For instance, confession is required if the partners want to tie their marriage in the church in the case of EOTC and if they want to enter into '*nikha'* in Islam. *Nikha* is a religious and cultural ritual of recognizing and publicizing the marital relations of a man and a woman. Hence when the couple wishes that their marriage is formally recognized.

The role of parents is essentially normative in both religions in approving a proposed marriage by their sons or daughters. A young man chooses his marital partner within culturally and

religiously acceptable requirements, request her willingness for the marital relations and then they present the case to their parents or religious leaders. Practically, however, the influence of parents is a thing of the past. Nowadays, elders are often sent to request permission from the girl's parents just to 'rubber stamp' a relationship that is already concluded. Some might have already started living together, and in some cases the girl could be pregnant. In what follows, we will however first present the restrictive views and norms of religion as shared by the religious leaders of the two religions I interviewed and engaged extensively with during the fieldwork.

In Islam, love, sexuality, and marriage are institutionalized based on the Sharia Rule and the *nikha* practice. With regard to love relations before marriage, Islamic teachings not only rule out premarital sexual intercourse, but prohibit unmarried young men and women even to sit together. Behaving against these rules is considered as a personal failure and a sinful act. Sexual intercourse is considered as a blessing only when practiced within the frames of marriage; otherwise, it is viewed as temptation by Satan. A religious leader presented the religious rules and expected young people's sexual lives as follows:

> *According to the Sharia rule (Islamic Law), let alone engaging in premarital sexual intercourse, physically appearing together in private places or sharing the same seat is strictly prohibited. It is believed that when a young man and a young woman are together in hidden places, there is a possibility of committing the crime of premarital sexual intercourse. In this respect, Satan may tempt them to commit a sin by practicing unblessed sexual intercourse. Therefore, our religion strongly prohibits a young man and a young woman to meet in hidden places, even in open public places. Hence, in our religion, premarital sex is strongly condemned as a sin* (Male, 62 year old, Dimtu).

The religious leader further elaborates that their teaching primarily focuses on telling their followers that premarital sex is a sin saying:

> *Primarily, we teach them that premarital sex is a sin. But if they refuse and prefer to involve in premarital sex, Allah will punish them with untreatable illnesses. Even other punishments may come to them after death. So, they will bear double punishment. Firstly, it is a sin in the religious teachings. Secondly, young people who engage in premarital sex may acquire STIs like HIV/AIDS. On top of these, worldly curses like poverty may come to them.*

Nikha assures both social acceptance and legality of marital relations. Interviewees unanimously agree that *nikha* is based on the interest of both parties, that is, engaging partners and their respective parents. According to the religious leaders, the Sharia rule prohibits a young man and

a young woman from entering into marriage without the knowledge of their parents. Originally, *nikha* was a religious rule and practice based on the Sharia Law, but it appears that later it has evolved to become a culturally common form of marriage among the Muslim communities. Nowadays, the ritual can take place even in the absence of religious leaders, but parents or relatives must be part of it. That is, the *nikha* ceremony can be performed by parents themselves without a mandatory engagement of religious and/or administrative leaders. Yet, if they want to invite a Sheik to offer prayers for the newly-marrying couples, it is possible.

A Muslim religious leader said:

> *Regarding premarital sexuality, we provide education for the followers including young people during prayers at mosque or other occasions of preaching the Holy Quran. To prevent premarital sex among the youth, we strongly advise them not to be together in unsupervised areas or hidden places. In this regard, our religion provides in-depth awareness on how the youth should prevent themselves from engaging in premarital sexual relationships. When a young man and a young woman meet in hidden places, the third person is Satan, tempting them to engage in premarital sex and forcing them to commit a sin. Therefore, in order to prevent this evil act from happening, we seriously teach the youth to protect themselves from engaging in premarital sex. They can simply tie nikha if they want to have sex* (Male, 54 year old, Dimtu).

According to the information received during the fieldwork, before entering into the *nikha* process, if a boy loves a girl, his parents (commonly the father) will inform the girl's parents about it and propose for marriage to his son. Then, the father of the girl asks his daughter if she is willing to marry the young man even if he knows or suspects that she has already consented or in relationship. This is based on a seeming liberal approach seeking the consent of all parties, which in practice is not the case in many rural areas, as most arranged marriages are said to be decided by the parents alone. Next, when the parents of the prospective couples reach agreement, they organize the *nikha* ceremony. The *nikha* agreement is concluded in the presence of relatives, friends, and witnesses of the couples, and it is undertaken in accordance with the local customs and Islamic rules. For the *nikha* ceremony, parents who are well-off can prepare food and drinks for the attendants, whereas those who cannot afford this are not forced to do so. There is no mandatory bride price or money to be paid by the bridegroom's parents to the parents of the bride during the process. That is, a person can enter into the *nikha* arrangement regardless of one's financial capacity. In the *nikha* process, parents of the bride declare their agreement that

they have given their daughter to the son of the bridegroom's parents. The bridegroom's parents also agree that their son has married the daughter of the bride's parents. After that, they share meals together, if food is available. Finally, they conclude the ceremony with a prayer service.

In the *nikha* ceremony, it is declared that a young man and a young woman are united through marriage even if they may not immediately start living together. Based on their interest and preparation, the couples can start living together or continue living with their parents until they decide to come together. However, they can initiate sexual relations regardless of whether they are sharing residence. The primary reason to stay apart after the *nikha* ceremony is said to be economic. Some young men bring their wives to their home only after they complete their education or secure a means of income.

Nikha is inherently different from a Christian wedding ceremony; yet, legally and socially, it symbolizes an acceptable and binding marriage tie. Sometimes, after the *nikha* ritual, couples may celebrate their wedding ceremony with festivity and widely announce their marriage to the public. However, Sharia requires just the *nikha* ceremony as a criterion of a religiously acceptable marriage and sexual debut. During the fieldwork, I met many Muslim young men and women, including students, who tied *nikha,* but were not living with their partners. Nevertheless, they said that they have sexual intercourse when they can meet. There were other young men in the community whose partners were attending college or university with whom they had tied *nikha* but never lived together. A young man revealed that he tied *nikha* with his girlfriend, but they exceptionally agreed to abstain from sex until the wedding ceremony. Young people who cannot live together right away after the *nikha* ceremony seem to primarily use the ritual as a means of securing a marital partner and to gain a social license to have sex. This pattern of passing through the *nikha* ritual long before starting to live together was seen to be a growing trend among young people in the study areas. *Nikha* is widely accepted in the study communities, and parents encourage their children to tie *nikha* as a preventive mechanism against premarital sexuality and premarital pregnancy.

Islamic religious teachings about young people's sexual lives also address parents as primary socializing agents. In this view, parents are considered partly responsible for their children's violations of sexual norms with primary focus on advising them to meet their parental responsibilities in properly nurturing, guiding, and supervising the children. The Islamic teaching

approach in this regard is considered as an invitation to a voluntary conformity, not as an imposition, to the rules, which results in a serious divine punishment if violated. These points could be captured from a religious leader's testimony presented below:

> *Our teaching extends to parents of the young people. We mainly provide fatherly advice for the parents to support the education of their children, particularly girls. We also guide parents to follow up their children's daily activities. Parents should supervise their children's doings, where, and how they spend their time during and after school. We, as religious fathers, help parents to facilitate their children's marriage in line with our custom when they want to start their own lives and family. Broadly speaking, we use the above-mentioned strategies to prevent our young men and women from engaging in premarital and extramarital sexual affairs. However, we cannot impose it on anybody as our religion requires voluntary acceptance of the teachings. There is no mechanism of coercing anybody to abstain from premarital sex without the will of the individual. It requires that people have to be whole-heartedly willing. There are young people who obey the teachings of the religious fathers but many of them don't accept our teachings* (Male, 54, Dimtu).

A father expressed his parental commitment as follows: "*I tell my son that having premarital sex without nikha is shameful according to our custom and Sharia. I also tell him to marry if he loves someone, rather than having premarital sex*." He also expressed his view about other parents: "*If a daughter loves a boy, parents should advise her to tie nikha and marry him.*" Therefore, if the couples do not live together after *nikha*, the ceremony can be seen as a socially negotiated and tolerable road to "premarital sexuality", and a way or disapproving norms against premarital sex. Hence, the current practice of *nikha* emerges as an implicit permission to premarital sex just based on future plan of marriage between the partners.

In EOTC, premarital sex is similarly strongly prohibited, and the rules are addressed in the teachings of the church. The prohibition is very clear and straightforward, and commonly understood among the religious leaders and followers. Simply put, sexual intercourse is considered acceptable and holy only in marriage, as it is the case in Islam. Interviews with a religious leader and followers of EOTC revealed that the church expects the bride and the bridegroom to confess before the clergy their experiences of premarital sexual relations if they want to get married through a religious wedding ceremony. Religious teachings about rules of the game are described by the religious leader as follows:

> *Premarital sex is strongly prohibited in our religion; it is strictly forbidden. We teach our followers about marriage and opposite sex relationships in teaching programs on appropriate practices before marriage, during marriage, and within marriage. Young men and women who are interested in each other should inform the religious heads or priests before having sexual intercourse. In this way, each examines the behavior of the other for a given time under the guidance of a priest or a religious head. Then after, parents of both partners are informed about the case and asked to allow the union of their respective children through priests or religious heads. If parents of both sides accept the request, religious leaders provide marriage education for the partners. During this marriage education, among others, they learn about roles and responsibilities of each partner and what is acceptable and unacceptable in marriage, before entering into the marriage. In addition, they learn about the necessary requirements for the marriage to take place. One of those teachings concerns premarital sex in which the young people are advised to avoid sex until the marriage day. On top of this, these days, it is not only confession for not having practiced premarital sex that is expected of the couple, but the church also requires the partners to undertake a blood test for HIV/AIDS before the marriage happens. We demand partners to undertake an HIV test in order to reduce the risk of infection. Actually, this practice is not uniform in all places and churches* (Male, 53 year old, Dimtu).

Like Islam, EOTC requires the involvement and permission of the respective parents before making a decision on the marriage proposal although their roles seem more of symbolic. Therefore, the involvement of parents in their children's marriage process is institutionalized. According to the above quoted religious leader, EOTC recognizes the marriage of those who have practiced premarital sexuality and facilitates their wedding ceremonies. A groom or bride is made to repent his/her sin before the clergy after confession. However, different forms of religious dressing prepared for the same purposes are moreover used publicly on the wedding ceremony as indicators of the premarital sexual status of the couples. For those who have practiced premarital sex, as revealed in their confession, a less respected wedding ceremony is arranged. As per the religious leaders' explanation, religious/community members also clearly know these status differences and offer the partners a different level of social recognition. Like the *Nikha* among Muslims, EOTC also tolerates premarital sex among partners by arranging wedding ceremony adjusted to the conditions that deviates from the ideal type of sex and marriage. The difference between the two, Nikha is prospective and repent through confession is retrospective with regard to sexual practice of the couples. Next, we will look at the discrepancies between the religious and cultural expectations about premarital sex and young people's actual practices.

5.2 Young people's views, beliefs, and practices of premarital sexuality

Young men know that premarital sexuality is deemed culturally, socially, and religiously unacceptable. Rhetorically, they accept views of religious leaders and other adult key informants that sex before marriage is religiously and culturally wrong. A 26-year-old Muslim young man, a widower from Busa, pointed out:

> *Sex before marriage is wrong and harmful, in my view. Culturally and religiously, it is not right both in the sight of people as well as God. Premarital sex makes one loses family respect; the parents of that young man are also ashamed when rumors about the wrong deeds of their son circulate in the society. Premarital sex is not what God intended for us. Yet, it is up to the personal wishes of people to observe the rule or not.*

A 20-year-old Grade-10 Orthodox Christian male student from Gabara has the following to say to his fellow youths: "*Young men and women have to avoid premarital sex. They should respect the norms of their society and observe the rules of their religion."* An 18-year-old Grade-12 Orthodox Christian girl from Dimtu, who also disapproves premarital sex says: "*... Thus, we consider early sexual initiation as useless and try to refrain from it."* Similarly, an out-of-school 26 year old Muslim young man from Gabara told me:

> *My girlfriend was testing me in different ways as she heard a rumor that I was incapable of making sex. Once, she spent a night with me with the intention of having sex, but I refused it, telling her that practicing sex before marriage is not right as we should respect our families and religious rules. I advised her that sexual initiation before marriage is not acceptable and that kissing would be enough.*

In the last phrase in the quotes, it seems that the young man did not know that even kissing is not acceptable before marriage or he has a different position about it. Actually, this young man later on admitted to practice premarital sex with the same girlfriend to prove he was capable of performing sex, to disprove the rumors and because of the pressure coming from his friends. Young people seem to have internalized the norms, so those who practice premarital sex feel guilty of breaking the rules because of the strong social and religious disapproval. Thus, having sex and even maintaining multiple partners are not something to brag about in the research area; it is rather something to feel guilty about. A young man tended to rationalize premarital sex based on the principle "the end justifies the means" – if the love relations intend marriage, sex is possible, saying:

When I think about doing good things, I consider rules of my religion. I should observe rules of sexual lives. If I need to have sexual intercourse before marriage, I have to decide to make the relations to end in marriage. Normally, it goes like this but sometimes disputes occur in relationships. What matters here is the degree to which the partners know each other, their determination to sustain the relation, and whether they have common goals (Christian, Age 24, completed Grade 10, non-married).

The participants often accepted the religious norms as a golden standard but they found ways to justify premarital sex by redefining the religious rules. In response to the ever-growing practice of premarital sexuality by young people, there is a tendency to replace the "*Don't touch her/him*" restrictive religious rule before marriage by "*You must marry your partner if you touch her/him*". This makes sense given entering into marriage is expected from partners who have practiced premarital sex. In this sense, as some young men tend to argue, sexual intercourse practiced in marriage-intended love relations could be considered as a tolerable practice that they innovated in constructing youth subculture. They moreover tended to attribute their premarital sexual practice to their inability to control their sexual desire, for which they think God may forgive them. The discrepancies between the ideal forms of sex and marriage, and the actual practices of young people, are nice examples of stretching norms (flexibility without breaking the norms), ensuring both continuity in normative principles but at the same time ensuring flexibility and transformation.

Although the study participants unanimously agreed that their religions do not permit premarital sex, many young people admitted that they overlook or ignore the religious rules in practice and engage in premarital intercourse. A young Orthodox Christian woman stated: *"At the community level, sexual intercourse is widely practiced among young people. We hear and see it happening."*A married young Muslim man describes the situation as follows:

From the religious perspective, premarital sexuality is strongly forbidden. It is not tolerable and is religiously considered as an evil act. But some young people believe that God will forgive them if they ask Him for forgiveness for their bad behavior. Some also do not bother much about religion when it comes to their sexual desire.

Some young people revised their original agreement to abstain from sex until the day of marriage and engaged in premarital sex:

> *At the beginning, we agreed not to start sex until the day of marriage to observe the religious rules. However, we started it as of last year after staying in love relations for three years. Before initiating the sex, we promised to each other to keep the relation intact until marriage. I took her virginity and then continued using condoms. All occurred based on mutual agreement* (Non-married young man, 24, Grade 10 complete, Dimtu).

Friends of the earlier-mentioned young man who was labeled as sexually impotent, challenged and indirectly were said to have pushed him to have sex with his girlfriend to prove his potency. He expressed the peer pressure and his consequent change of mind as follows:

> *… But later on, I gave up my plan to abstain from sex because of the pressure from my friends and decided to have sex with her. The first meeting for sex was arranged by my friends in somebody's house where we had the experience. There, we had no problem having sex. She was in tears understanding that other people were interfering in our love relation. After that day, when I want to have sex, I go down to the market place* (i.e. in Gabara) *and call her, and whenever she wants it, she calls me. After we started having sex, our intimacy has increased.*

Religious leaders are aware of the fact that young people practice premarital sexual intercourse. An Islamic religious leader said:

> *There are some boys and girls who obey the Sharia rules and refrain from engaging in premarital sex. In contrast, some don't obey our teachings and do as they like. It is about rights; in fact, it is a choice to conform to or to rebel against the rules. Our job is to inform people of what is appropriate and the consequences of their sexual behavior* (Male, 54 year old, Dimtu).

Similarly, an EOTC religious leader explained:

> *Practically, there are young people who are not governed by the teachings of the church and they engage in premarital sex, and they experience unwanted pregnancy and induced abortion. The major responsibility of the church is to teach the youth what is expected of them as followers of the religion. Those who are disobedient to the teachings of the church bear the consequences* (Male, 54 year old, Dimtu).

The same religious leader further explained why young people violate the norms:

> *I do not think that it is due to lack of awareness that some young people violate religious rules. Rather, I think the main reason is that they do not give emphasis to or they undermine the teachings of the religion. Thus, those who engage in risky sexual behaviors do so due to their carelessness or lack of concern for the teachings of the church.*

Other opinion leaders, including teachers and health extension workers (HEWs), confirmed that young people increasingly practice premarital sex. A high school teacher stated that many young men and women do not observe religious rules of sexuality. HEWs reveal that many young people in the study area are sexually active, as evidenced by the increasing number of unmarried young men and young women consulting them for sexual and reproductive health matters. The number of young women who get pregnant and consequently dropout of school is moreover increasing. A HEW states the sexual lives of young people as follows:

> *The moral teachings and the practical behavior of young people are not related. Despite the existence, in the community, of disapproving cultural and religious norms, premarital sexual practice among young men and women is rampant. In our community, young people's practice of sexual relations before marriage is growing* (Female, 32 year old).

Thus, regardless of religious sex education against premarital sex, many young people were found to lead a way of life defined as unacceptable. That is, the actual lives of many young people were not in line with the religious values and expectations. We see discrepancies between what ought to be (normative conduct) and their actual behavior, i.e. practicing premarital sex.

It was confirmed that young people know that practicing premarital sex is religiously forbidden and socially unacceptable, but they were nonetheless said to widely practice it. Why do many and an increasing number of young people practice premarital sex? Why is there an apparent paradox between religious and cultural prescriptions and actual practice? Young men provide excuses for their failure to conform to the rules. Failure to control their sexual desire is the most common explanation for practicing premarital sex. A young man responded to the question "Why does non-normative premarital sex occur?" saying: *"It happens because of people's failure to control their sexual desire. It is just failure to control one's emotions and giving priority to sexual desire over observing the rules*."

The notion of youth subculture is quite useful to interpret the above described data about the discrepancy between the expected sexual norm (i.e avoiding premarital sexuality) and the actual widely practices sexual relations among young people. The fact that young people rhetorically recognize the expected disapproval cultural and religious norms against premarital sex but collectively find themselves widely practicing it reveal the existence of specific shared ways of life. Peer pressure and increasing exposure to opposite sex in schools and market places, and

widely use of mobile technology are the major forces behind the current youth subculture which are labeled as disobedience and carelessness by the religious leaders and adult community members. As could be understood from changes in *michu* practice, *nikha*, arranged and negotiated marriage forms, the youth have been developing innovative responses to their situations like giving new meanings to their practices that violate the dominant views. For example, they tend to justify that premarital sex is tolerable if it is practiced in marriage intended relationship and God forgives them for what they have sinned for reasons beyond their control like sexual desire.

Therefore, the paradox between societal expectations and young people's actual lives can be fairly attributed to the changing and challenging living conditions young people encounter nowadays, not just inability to control biological sex desire. Premarital sex and subsequent instances of pregnancy are mainly associated with the temptation coming from the growing exposure to suitable sexual partners. It also has to do with the economic situation of young people, which causes the delay in the marriage and makes premarital sex inevitable. Another factor may be increased school enrolment, which somehow was said to transform or 'liberalize' young people. As compared to farming, business, and other trades, schooling also motivates young people to postpone marriage, and it is not easy to abstain from sex for such a long time. As a result, premarital sex is by many considered as inevitable among love partners, sooner or later in the relationship.

The implication is that sexual abstinence before marriage is still highly valued in the study communities. Some young people also claim using it at sometime in their love relations while others revise their decision and initiate premarital sex. However, community members including religious leaders, parents and most young men think that premarital sex has become a common practice. As the general evidence obtained from healthcare providers show, early resumption of sexual intercourse after childbirth is a common practice in the study communities. As a result, they administer contraceptive methods as early as possible after delivery. That is postpartum sexual restriction is not practiced as well. Therefore, sexual restriction before marriage as a means of fertility control currently seem to be obsolete or at least considered as an inefficient approach for most young people. Besides, postpartum sexual restriction is not norms of sexuality

in this specific rural context. It also implies that young men's involvement in using sexual restrictions before and after marriage in this community context is insignificant.

5.3 Discussion

Love, sex and marriage are institutionalized and culturally situated in the study area in line with arguments of Javaid (2019), Jackson (1993) and Reiss (1986). In correspondence with Jackson's (1993) argument that love serves to bind the involving parties to the existing social order, different forms of love relations among young people establishes religiously and socially desired families. The three authors -Jackson, Javaid, and Reiss – also agree that sexuality and patterns of love relationship are gendered and culturally hegemonic. Javaid's (2019) conclusion that love relations maintain hegemonic masculinity is manifested in the young men's expected protective roles in *michu* practice, and young men or their families' leading roles in the partner selection process is cultural (Reiss 1986) as implied in Gramsci and Weber's classical theories (Jackson, 1993). Kebede et al. (2012 and 2014) and Singh et al. (2010) emphasize that there is more restriction on young women than on young men against premarital sex. Kaba (2012) documented gender, sexuality, and vulnerability to HIV infection among the Borana Oromo in Southern Ethiopia and he found that sex before marriage is a serious violation of sexual norms as they are expected to remain chaste until marriage.

Regardless of its fading away, social values and norms that constitute the *michu* institution in the study communities seem to remain a cultural resource reinforcing the definition of love, sexual engagement, and marriage relations as a form of Gramsci's concept '*cultural hegemony*' (Lears, 1985). Religious and opinion leaders, together with parents, are important actors who vocalize established religious and cultural norms concerning acceptable love, sexual engagement, and marriage relations of young men and women. To Gramsci, hegemony is a social control from the top down and the concept is a useful tool to understand how the dominant ideas shape social relations of fertility control in historical and institutional contexts (Lears, 1985). Weber's ideal type as a comparative tool for causal explanation of differences in social construction of historical rules of experience (Weber, 1978) enabled to compare the three forms of love, sex and marriage relations. The dominant views of love in the present study such as 'love without premarital sex' and 'love for marriage' are congruent with Durkheim's and Weber's theoretical stances of 'family love' instead of romantic love (Jackson, 1993; Javaid, 2019).

Michu and arranged marriage practices in the study communities make up the historical roots of the present disapproval norms of premarital sex. Young men's masculine expectation of safeguarding young women against sexual attack by others also has its root in the *michu* love relations. However, premarital love relations have evolved through time from the '*michu'* practice to the negotiated marriage. The avoidance of premarital sex as a typical feature of the *michu* practice gradually faded away among young people if it was ever fully present. As a result, *michu,* which was once an acceptable practice, is now considered as an outdated one and if mentioned at all, it serves as a pretext for premarital sexual relations.

The concept 'cultural hegemony' helps to understand how ideas reinforce or undermine existing social structures (Lears, 1985, p.568). Accordingly, *michu* institution and arranged marriage are undermined following changes in the meaning attached to their features while family persists. We found some features of *michu* and arranged marriage are also deinstitutionalized in the process of change. *Michu*, for example, is severely challenged to sustain as an institution whereas its core element – the disapproval of premarital sex- remains a desired conduct in the negotiated marriage. Parents' absolute cultural hegemony as the prime decision makers in the choice of mate selection for their children in arranged marriage is increasingly contested although it is sill practiced to some extent. However, arranged marriage is transformed as important part of the negotiated marriage where the couples may present their negotiated consensus of love, sexual and marital relations to religious leaders or parents for their blessings through rituals. Yet by-passing a seemingly arranged marriage process has become increasingly tolerable, if not a norm, where the couples cohabit or enter into marriage without involving religious leaders or parents. It has not become a norm because the practice has no strong social acceptance even among couples practicing it although increasing number of young people prefer it partly for satisfaction of sexual desire in the context of delayed marriage which in turn is mainly related to economic reasons.

Disapproving cultural and religious stances against premarital sex in non-Western societies, including Ethiopia, are well documented (Johonson-Hanks, 2002 and Kebede et al., 2012 and 2014). We also have seen that the actual practices of young people do not neatly correlate with the religious norms and teachings. The mismatch between the normative views and actual sexual practices is mainly attributed to education-induced changes and economic challenges that

increase access to love partners and delay marriages. The expansion of modern education and the involvement of girls in education and trade are moreover considered as the main forces of change as repeatedly expressed by many study participants mainly the young people.

5.4 Conclusion

Love and sexuality are normatively institutionalized through religious norms and social expectations of marriage as their shared end-goal. But, sex-oriented love relations are emerging patterns. The ideal type and cultural hegemony were duly applicable to love, sex and marriage analysis and interpretation. They also enable identification of the historical changes from *michu* to negotiated marriage along the forces of change. Weber's construct of the 'ideal type' enables us to comparatively explain the substantial discrepancy between the prohibitive norms against premarital sex and the practical lives of young people. It also helps to compare the differences between the present and the past along patterns of conduct and its possible causal factors.

Rhetorically, premarital sex persists as unacceptable behavior; yet, the norms would logically demand that partners who engage in sexual activity should enter into marriage. The Islamic institution *Nikha* is considered as a warranty to sustain marriage as an institution, establishes a holy and legally acceptable marriage, and enables the partners to have sex regardless of a wedding festivity. It integrates religious rules and customary expectations, and must involve parents/relatives of both partners. It also allows partners to have sexual contact without necessarily sharing residence, which is an expected pattern of life after marriage.

Disapproval of premarital sexuality remains a normative principle of *michu*, arranged marriage and negotiated marriage regardless of their differences in the social construction of culturally hegemonic and ideal type of love. Young people's premarital sexual behavior is normal but not normative. It is normal because many young people practice it, but it is not normative as it is socially disapproved, including by the young people practicing it. But the young people also find ways of making premarital sex acceptable by tying *nikha* quickly, by promising each other that they will marry later or through confession before clergy.

The radical discrepancy between the normative expectations and actual modes of young people's conduct implies that parents and religious leaders as agents of their respective institutions have to some extent lost control over the social actors. Compared to culturally dominated arranged

marriage, roles of religious leaders and parents seem residual in negotiated marriage given the engaging parties emerge as the main decision makers. Moreover, the disapproval norms against premarital sex are not as tough as they appear in the official religious discourses because there are rooms of tolerance for the practice. The official discourses against premarital sexuality as worldly and heavenly merciless punishable sinful act coexist with parallel discourses that give rooms for the acceptance of premarital sexual practices prospectively or retrospectively to marriage as we understood from the religious marriage related rituals. Political discourses about notions of freedom and rights as well as associating culturally dominated arranged marriage as a means of forced marriage within gender perspectives also seem to constitute the alternative politically correctness discourses.

Youth subculture that promotes premarital sexual intercourse significantly deviates from and outweighs the dominant disapproval norms against the behavior. Postpartum abstinence from sexual intercourse is not a valued practice in the study communities. However, the risk of experiencing unwanted pregnancy is very likely among young people that deserve special attention to fill the gap in fertility control through sexual restriction. There is a missing link between less binding disapproval cultural and religious disapproval norms against premarital sex and healthcare service programs that overlook unmarried young men in particular. As a result, delaying first-birth and birth-spacing among young people which are significantly important was to curb unwanted pregnancies left not addressed. Therefore, meaningfully involving young men in identifying and implementing workable strategies is highly commendable.

CHAPTER SIX
FERTILITY NORMS AND CONTRACEPTIVE USE

Introduction

In Chapter Five, we learnt how love, sex and marriage are interrelated, institutionalized and negotiated. We have also seen how young people's views and practices about the three phenomena are influenced and manifested in the normative expectations of the study communities' context. In this chapter, we continue exploring about fertility norms with emphasis on contraceptive use and involvement of men in it.

Cannon et al., (2022) states that understanding the mechanisms through which social norms shape contraceptive use is helpful for interventions to prevent unintended pregnancies. Emphasized femininity and manhood acts (Connell, 1987; Schippers, 2007; Schrock & Schwalbe, 2009), specific strategies for the subordination of women that hegemonic masculinity relies on (Donaldson, 1993), are central to young men involvement in contraceptive use both as service users and partners. *Emphasized femininity* is mechanism for men's dominance over women through patterns of behavior that emphasize womanly virtues as an adaptation to men's power. *Manhood acts* are how males perform to distinguish themselves from females and thus establish their eligibility for gender-based privileges. Effects of manhood acts pertaining to contraceptive use have implications for the distribution of decision making power with regard to whether, who, and when to use contraceptives (Connell, 1987).

Plana (2017) writes that limited choice of male contraceptives implies limited participation of men in pregnancy prevention, which in turn means women disproportionately shoulder the responsibility of contraceptives and of preventing pregnancy. Moreover, it implies that men have less control over their fertility (Plana, 2017; Reynolds-Wright et al., 2021; Tuloro et al., 2006). Gender norms which assume fertility and family planning as being a domain for women only hamper the involvement of men by discouraging them from participating in reproductive health issues (Sharma, 2003). Fear of stigmatization and the belief that men should not participate in female reproductive health matters were identified as major barriers to male involvement in a study by Osman et al. (2014) in sub-Saharan Africa. Men perceive contraceptive use to be

located with the feminine domain and consider using contraception as a threat to their masculinity (Reynolds-Wright et al., 2021).

How social norms of fertility shape contraception use are still unclear given far less attention has been given to the topic in research literature. Chapter Six, discusses about norms of stigma against infertility, norms of childbearing in and outside wedlock, norms of having more children, norms of child's sex preference, disapproval norms of premarital pregnancy, and gendered norms of contraceptive use in the study area. In the sociology of fertility, social norms that have important effects on fertility are to be distinguished from structural pressures that may ultimately derive from some general hierarchy of values in a society but they do not necessarily directly represent the operation of norms (Fried and Udry, 1980, p. 199). Social norms of fertility in this study hence refers to group or community level expectations of acceptable behavior about whether, when, why, how and how many children should a person or couples have vis-à-vis the actual practices in a rural context of Ethiopia.

6.1 Cherishing the fertile, scorning the 'dry': '*Abaaramuu'- Being cursed*

In Nadhi Gibe, proving ones' fertility potential is highly expected from couples immediately after marriage; and pregnancy and childbearing within a few years after marriage is common among most couples. Indeed, there is a strong social pressure placed on the new couples from the families of both sides to have children. The expectation of bearing sons in particular implies additional pressure. Culturally, children are considered as a resource and a source of social pride of utmost importance, and having many children - and sons in particular - are socially valued as symbols of power for the family. Muslims in Nadhi Gibe are in favor of having a large number of children born to a woman/family. They moreover entail practicing polygynous marriage. When asked whether having large numbers of children per family and practicing a polygynous marriage is encouraged in the study community, an Islam religious leader responded as follows:

> *Yeah. It is true and we have reasons for preaching a polygynous marriage. As we believe, and it is stated in our Sharia rule, the number of female births is greater than that of males. That is, female infants are larger in number than males. Also, men live shorter than women for different reasons like conflicts. Hence, if a woman becomes a widow, one of the relatives of her husband (most likely her brother-in-law) marries her. This is to save the children and the family from disintegration. According to our Sharia rule, a widowed woman cannot marry another person*

outside the relatives of her deceased husband. Regarding the number of children per family, in Sharia rule again, there is no restriction. Hence, we don't limit the number of children per family. We believe that having a large number of children is good. Therefore, we don't teach the religious followers to reduce the number of children born to a woman. Children are gifts from Allah. We don't think that poverty or other social problems are due to the number of children or due to population increment. Allah orders us to work hard and feed ourselves. In general, there is no religious restriction about the number of children to be born per woman (Male, 62, Dimtu).

According to this religious leader, both large families and polygynous marriage are encouraged among Muslims. He holds - in line with what he argues is the general position in Islam - that the birth of female babies is larger than that of male babies and that women have a longer life expectancy than men, which results in a shortage of men in a society. Hence, it would be difficult for every woman to get a husband if polygyny was not ensured. This religious leader also holds that it is in the best interests of children who have lost a father that the widowed is married to the deceased husband's brother or a relative of the deceased husband for the well-being of the woman and the children. This institution intends to retain a family environment with biologically-related members in order to maintain the family relations in the event of death.

The views of the religious leader imply that polygynous marriage is practiced essentially for the benefit of women and children whereby men play protective roles in the family institutional setting. The ideal number of children to be born per woman/family remains open to the parents' choice, given that the scriptures are silent about it. Nonetheless, the meaning of the Sharia rule is interpreted by the religious leader in favor of a large family size, and the number of children per woman is predetermined by Allah, implying that it should not be interrupted by human influence. This study participant does not believe that large population size can lead to social problems and poverty, as children are considered gifts from Allah. Parents also have to work hard to generate resources necessary to nurture their children. Therefore, the study participant raised a moral question against the use of modern contraceptives with the intention of preventing pregnancy to reduce the number of children, and to imply that contraceptive use is undesirable for his community. Yet, the position of the religious leader again obscures male dominance over females which a midwife hinted at in the following way:

Many women use contraceptive methods without the knowledge of their husbands. The reason is clear. If husbands are aware of their wives' use of contraceptives,

> *their marriage may end up in divorce. Most men want their wives to give birth up to their natural capacity. If a wife refuses to do so, the husband may divorce her. Since many women are afraid of family breakdown and loss of their marriage, they take family planning secretly without the consent of their husbands* (Female, 36, Dimtu).

Based on the material collected, it seems that having a larger number of children is a normative pattern among some families in the study community. Fertility - having a large number of children in general and sons in particular –constitutes a source of cultural hegemony in the sense that men's preference for large numbers of children is rooted in cultural norms and social institutions. A norm that encourages couples to appreciate having many children and proving their fertility by a birth shortly after marriage implies an important rite of passage for men and leads to an enhanced status of women. Upon the first birth, regardless of the sex of the child, a man assumes a new type of social status, such as having a double name (named 'the father of' and the name of the child), which entails securing respect from community members and he gets opportunity to play new social roles. Attaining the status of fatherhood moreover makes a man socially fit for public roles, and it is assumed that one is ready to shoulder social responsibilities, including assuming leadership positions in the community.

Ethnographic observations and interviews with men, women, and health service providers, demonstrated that couples want pregnancy in the early years of their marriage since their fertility status has huge implications for the personal, interpersonal, and broader social lives of the couples. A couple's infertility over time reduces the social acceptance of their marital union in the community, and negatively affects their self-esteem and lead to the development of an inferiority complex.

As much as it is for men, proving fertility is vital for women, because being infertile is considered as highly undesirable and unfortunate by the community. Findings from the FGDs, interviews, and ethnographic observations demonstrate that a woman being infertile, is a source of gossip, negative judgment, and social exclusion in everyday life. For instance, in interpersonal disputes in the neighborhood, particularly among fellow women, insults against women are commonly associated with their failure to bear children, even though the point of departure of the dispute has little or no logical association with the fertility status. People thus use infertility as a basis for shaming childless couples, particularly women, giving them nick names like "*dubartii*

abaaramtuu" meaning 'a cursed woman', "*dubartii gogduu*" meaning 'a dry woman', or "*gaangee dhaltuu*" meaning 'a female mule', all pointing at the failure to give birth. There is also a parallel discourse in the community that an infertile woman is also sympathized being considered as a victim of fortune with the notion that infertility is involuntary and beyond the control of women and couples. Terms and phrases like "*dhabduu*"/"*dhala dhabduu*"- lacking woman/ offspring lacking woman, show expressions of sympathy where as "*garaa dide*" - ovarian refusal or "*garaa cite*" - ovarian pause, whereby '*garaa*' is literally means belly. Each denotes inability to conceive at all and interruption to conceive after having one or more children, respectively, that imply the conditions are beyond the will and control of the women. A prayer is also made or good wishes are addressed for infertile women with hope to see her fertility status is changed.

In these notions, being childless is culturally considered to be a result of being cursed, which extends from the Oromo dominant view of fertility in general, including productivity in agriculture and animal husbandry, which is associated with blessings of *Waaqaa* (Almighty God). It is believed that infertility is punishment from *Waaqaa* for something wrong (unjust) the couple or their ascendants did against divine principles, which implies that they have to take the responsibility.

> There is a popular myth among the Oromo that the mule was fertile and God was close to earth (humans) once upon a time until a female mule kicked Him. According to the myth, God cursed the mule, saying '*Gogi*'- Dry up - meaning 'May you not be able to reproduce your kind' and moved far away from earth. Soon after, the mule became infertile which caused women to become more responsible for fertility including the likely cause for infertility. Therefore, childlessness is symbolized as being distanced from the source or the provider, that is, God, and women's disobedience to God is a primary reason for infertility.

The myth has a resemblance to the story of Adam and Eve in the Bible that Eve was a cause to turn disobedient to God's order that terminated God's fellowship with human beings. It seems that attributing infertility to women and equating childless women with the female mule is associated with narrations derived from this myth. In general terms, 'trouble making women' are

commonly described as "*Dubartii Waaqni irraa fagaate*", meaning 'a woman even God distanced Himself from'.

The inability to bear children may also lead to divorce or a polygynous marriage, as the man will seek a new partner in order to get children. In short, infertility causes stigma to both the man and the woman in a couple, but it is a particular cause of harassment against women as wives. Although being infertile is a highly undesired condition also among men, it signifies a more substantial burden on women than men. In the first place, infertility is by default considered as a woman's biological deficiency, at least until proven otherwise, because a child is conceived inside a woman's body. Establishing whether the cause of infertility is the husband himself may take many years and it is demonstrated only after unsuccessful trials of bearing children through polygynous marriages. Hence, a way for a man to respond to a woman's failure to become pregnant within a few years after marriage is to look for another wife. This option may be considered time and again until it is proven that the man himself is infertile.

The polygynous marriage arrangement indeed continues to negatively affect childless women throughout their lives, as it also implies experiencing poorer treatment by their husbands and exploitative socioeconomic relations with a co-wife or co-wives who have children. With the immense value placed on bearing children, a newly married woman will be anxious to see whether she is capable of becoming pregnant and give birth to a child, and young married couples will be eagerly engaged in fulfilling the ideal of securing the first three or four children with an 'acceptable' sex composition, implying that at least a boy or two are born.

High social expectations of proving fertility immediately after marriage, according to the study participants, lead couples to disregard or avoid any intentional fertility control. Rumors and beliefs that the use of contraceptives can cause permanent infertility is another important factor leading to avoidance of contraceptives. Thus, except in rare cases of highly educated married young couples, fertility control methods are not likely to be used until couples have given birth to the first three or four children. Health extension workers and nurses working in maternity and child health (MCH) departments in health centers explained that young women's reluctance in seeking contraceptives in the early years after marriage is a barrier to effective implementation of family planning services. Many pregnant young women observed and interviewed in delivery waiting rooms in health centers for their first, second, or third pregnancy similarly reported that

they had never used any contraceptive methods and do not have plans of using it in the near future.

6.2 "God controls birth, not modern drugs": Religious views of contraception

In the preceding sub-section, we have seen that the very strong social values attached to fertility and large numbers of children discourage couples from using fertility control methods, at least in the early years of their marriage. In this sub-section, religious views and practices related to fertility control through contraceptive use are examined.

Religious leaders of Islam and EOTC are in favor of larger numbers of children born per family; hence, they support the idea that population size should keep increasing. Therefore, fertility control is not a central issue, if at all included, in their religious doctrines and teachings. Fertility and child bearing is however a central concern to them. This religious view is in line with and is apparently reinforced by the Oromo view of fertility, usually represented as conveyed in the saying: "*Dhalaa fi mirga hin quufan*", meaning 'there is not enough when it comes to children and victory'. As stated above, the religious leaders believe that human fertility is controlled by God Himself, and that human intervention has little or no effect (or none at all) on human fertility. The religious leaders do not explicitly oppose contraception, but they believe that God is in control of the number of children born per woman. They also share a view that modern contraceptive use is not supported by the Holy Scriptures, as it works against God's general principle and intention of fertility. It seems that the religious views are in agreement with the general belief of associating fertility with supernatural holy powers, manifested in expressions like "*dhalli kan rabbiiti*", meaning 'an offspring belongs to God or it is from God', implying that humans have no decisive roles in conceiving.

However, there is a basic difference between leaders of Islam and the EOTC in their views about intentionally limiting the number of children born per woman or family. While religious leaders in Islam and their teachings are against the idea of limiting the number of children by using modern contraceptive methods because they believe the number of children to be born is decided by Allah, the teachings of the EOTC believe in the importance of limiting family size in accordance with the economic capacity of the family. The prevention should however only take place through natural contraceptive methods. The EOTC religious leaders hence do not

appreciate modern contraceptive use, and argue for natural contraceptive methods such as the calendar method and extended breastfeeding, which they perceive as natural and 'Biblical'. The EOTC leaders explain that the Holy Scriptures recommend natural contraceptive methods. One of the EOTC study participants who rejected the modern contraceptive methods in favor of the natural methods explained:

> *Regarding the number of children, the church believes that a woman can give birth to her full capacity. We believe that couples can give birth to as many children as their economic capacity allows them to raise. If the family can rear ten children, they can have ten. Hence, the family should decide by themselves depending on their economic capacity. If they do not have enough capacity to care for the children at hand, they should not add more. Therefore, our church promotes that couples should give birth to children based on their ability to raise them. The stance of our church regarding modern family planning is that we do not encourage believers to use those drugs because it is considered as interrupting the natural process of reproduction. Therefore, the church does not encourage her followers to use modern drugs to control fertility; it encourages them to use the natural methods* (Male, 53 year old, Dimtu).

The EOTC religious leader explained that the church encourages the followers to space birth using the natural methods, that is, breastfeeding and the menstrual cycle:

> *… For example, using the natural calendar of the menstruation cycle is one option that a woman can use to control fertility; we advise our followers to apply that. In addition, they can use the breastfeeding approach to control their fertility. The breastfeeding approach is both scientific and acceptable in the teachings of our church. There is a belief that if a woman breastfeeds her newborn child for a long period, like for three years, there is less probability to get pregnant for the following three consecutive years. This is the second natural option to control fertility without relying on modern drugs.*

Regardless of their disapproving positions against modern contraceptive use, religious leaders of both religions stated that they do not publicly teach their followers not to use modern contraceptive methods. They thus seemed to be somewhat indifferent about the use of modern contraceptives in the sense that they do not directly oppose the practice, nor do they encourage their followers to use them. In their teachings, the religious leaders refrain from directly talking about them or publicly declaring their positions. A religious leader from Islam stated:

> *We don't teach our followers to use contraceptives to control fertility even if they choose to use them. If they want to use modern fertility control drugs, they can. But, even while a woman is taking a fertility control drug, she might conceive.*

> *Thus, we believe that Allah has already fixed the number of children a woman can give birth to, and the number of people who live on the planet Earth. For this reason, we don't believe in using contraceptive drugs to control fertility* (Male, 54, Dimtu).

This notion of Allah determining the number of children is supported and reinforced by some women's experiences of getting pregnant as some study participants were telling us while using a contraceptive method. Healthcare providers on their side attribute such occurrences of pregnancy to women's failure to properly use the contraceptives.

However, disregarding the topic of modern contraceptive use by religious leaders in their public teachings does not necessarily mean they do not have concerns about it. They rather consider modern contraception as the mandate of the government. A religious leader argued, '*We do not interfere with the government's work as the government does not interfere with ours*', which implies that they do not want to confront the government's interests of the family planning service program, which is designed to control population growth and to improve reproductive health. This position indicates the mutual respect that exists between religious leaders and the government. As mentioned earlier, however, a close observation of the religious leaders' stand on women's modern contraceptive use reveals that they are generally against it. But although they are inclined to reject the use of modern contraceptives, they do not publicly denounce their followers' use of the methods because of fear of the government. The apparently ambiguous position of an Islamic religious leader's is revealed in the following expression:

> *In Islam, we never teach or encourage women to use modern contraceptives. We don't at all teach women to take drugs to prevent pregnancy. Actually, we don't also warn them not to use the drugs; we just don't encourage the use of drugs for controlling fertility* (Male, 54, Dimtu).

Ethnographic observations support the argument that there is a silent agreement between the government and the religious leaders on matters of family planning or contraceptive use. The government does not allow religious leaders to interfere with its development activities, one of which is the family planning services program. The above religious leaders' position with regard to contraceptive use is quite restrictive for unmarried young women or implies a challenge for unmarried women:

> *From our side, we don't generally encourage people to use contraceptives to control fertility. For married couples, we are not as such strict about their using*

modern contraceptives. We don't strongly discourage them from using modern contraceptives for birth spacing. The decision is up to the couples. If they want to use contraceptives, they can. Given the decision is left to the couples, it is their choice to use them or not. Rather, we are very much strict about unmarried young people not engaging in premarital sex, and if they happen to engage in it, we don't allow them to use modern drugs to control pregnancy. We believe that teaching the youth to use modern drugs to control pregnancy means implicitly encouraging promiscuous behavior among our religious followers. Thus, we teach our young men and women to abstain from premarital sex or to get married and live in a one-to-one sexual relation within the marriage. The point is, we don't generally promote the use of contraceptives in order to control fertility. Thus, we don't openly teach the use of contraceptives for controlling fertility.

Regardless of the disapproval and prohibitive tendency of religious views and teachings against contraception, the number of women using it is increasing significantly as evidence obtained from healthcare providers. According to a midwife, people's interest in and religious leaders' tolerance towards modern contraceptive use have been growing over the years. The midwife described changes (increasing tolerance for contraceptive use) in the propensity for Muslims to use contraceptives as follows:

Some years back, people thought that using contraceptives was forbidden for Muslims and nobody came to health facilities seeking contraceptive services. But we have advised them the other way round. We told them that contraceptive use is not forbidden and they should not expose their partners or wives to take risks by denying them the opportunity to use contraceptives. We advise them to have a baby only when they need one. Some have changed their minds and begun to use contraceptives. Now, some religious people have started supporting contraceptive use. Earlier, it was believed that females should not even go to a clinic at all, according to Islam. Later, religious fathers came to comprehend this in detail and realized that it is not forbidden by the religion. They accepted it and started to inform people that they should seek treatment at health facilities when they have health problems. After that, it has become more open, and many have begun to use contraceptives. However, contraceptive use is yet to be widely practiced in the community (Female, 36, Muslim).

Exploring people's responses or reactions to the sexual and reproductive education provided for example by the Packard Foundation (an international NGO working on reproductive health) enhances the understanding of how people gradually come to accept and get used to contraceptive use. A key informant explains:

Responses of the community members to our education vary from consensual rejection by husbands and wives to the opposite stands between the two. Some couples reject contraceptive use saying: 'We can raise our children'. Others

> *gradually accept it. In some cases, the husband may refuse while the wife accepts, and it may be vice versa in other cases. We are trying to reconcile such issues by advising them to agree to use it* (Male, 32 years old, Muslim, Dacha Gibe/Gabara).

There seems to be a growing tolerance for contraceptive use among religious leaders and interest of using among the public at large. Although it seems that there is a tendency to open up for modern contraceptive use, a clear stance is held against premarital use of contraception as it will encourage premarital sexual relations.

6.3 The shame of 'giving birth at home': '*Manatti dhaluu*'

In Chapter 5, we have seen how sexual relations are normatively institutionalized through marriage which justifies sexual debut between partners and how premarital sex is normatively ruled out. The chapter also revealed how couples may tie *nikha* and even have sex before marriage or have sex if they have promised each other marriage. Hence there is a discrepancy between norms/institutions and actual practices.

Etymologically, the phrase '*manatti dhalte*'- meaning '*giving birth at home',* does not refer to the actual physical place where delivery occurs; rather, it is an expression of stigmatization that the pregnancy is premarital, unwanted, and socially disapproved. An appropriate term for women's delivery under normatively acceptable conditions is '*deesse*' (a term describing an acceptable delivery) whereas '*dhalte'* exclusively refers to that of animals; hence '*dhalte'* is derogatory and shows disrespect when used for humans. The use of the term '*dhalte*' to refer to a non-married woman thus implies a rejection of the young woman who got pregnant including her family.

Among Muslims in the study area, *nikha* is, as described above, the acceptable form of marriage and is tied only after it is proven that the young woman is not pregnant, as a local mechanism of screening premarital pregnancy. When a young man and woman want to enter marriage through *nikha*, normatively and historically they had to stay in separate places for three months for the 'screening'. However, it seems that the practice is currently losing ground, as no study participant reported an actual case or experience of it. Children born from a premarital pregnancy are also normatively/historically considered highly illegitimate among Muslim communities in the study area or, as is the case among Muslims globally, given that the notion is

religiously grounded. The religious leaders who participated in the study recited that a child born to unmarried parents is called '*zina*' in Sharia rule; that is, the child is not considered as a proper child and is treated as inferior compared to children born in wedlock. *Zina* denotes that the child is illegitimate in the sense that the sexual relation that resulted in the pregnancy was not religiously permitted or blessed through *nikha*. A child who is born outside marriage is not named after one's father; rather he/she is named after his/her mother, which is considered as a disgrace. A child born outside wedlock (i.e *Zina)* also cannot inherit resources of his/her father.

The ethnographic and interview material revealed that parents of young women who experience premarital pregnancy face extreme degrees of shame. As a result, they attempt to push the partners to enter marriage or hide their child from the public. Neighbors and relatives also get angry at the misbehaving young women for premarital pregnancy as well as the parents for their failure to control their children. Although all parents seem to become sad and are ashamed of the misdeed, their responses to their daughters' premarital pregnancy was observed to vary in intensity of reaction. Some parents beat the daughter, some ask the girl to leave the house, while others have more tolerant reactions and provide care to the young mother and the child. Healthcare providers at a health center told a story of a family who refused to take their daughter home after her delivery at the health center. The young man who impregnated the girl was arrested by the police and was forced to provide financial support to her. Parents of the young men also become ashamed of their sons in cases of such cultural and religious breaches of norms, as it is regarded as a result of their bad nurturing. A 32-year-old man reflected on the likely responses to girls who experience premarital pregnancy as follows:

> *Premarital pregnancy is really a great shame, but once a girl has given birth to the child, nothing could be done except trying to persuade her to get married to the boy who impregnated her. Otherwise, she runs away. There are also young men who flee after impregnating their girlfriends. It is only in very few cases that young mothers who give birth to children 'at home' are treated well by their parents. Later, the girl can marry someone else if her partner flees (Muslim, 52 year old, Dacha Gibe).*

To the question of why a young man runs away after impregnating a girl, the same interviewee responded as follows:

> *He flees to escape from accusations by her family because he may not be able to provide financial support to the mother and the child. Parents of the*

> *girl may file charges against him if he stays around. The young man is then made responsible for providing food for the child or he may be forced to marry his partner.*

Study participants reported that community gossip is a main social control mechanism against violations of reproductive norms. When premarital pregnancy occurs, both the pregnant young women, the children born to them and the parents of the young women are subject to social stigma and disgrace. Normatively, young men who impregnate the girls are also subject to disapproving reactions from the community and they are expected to marry their sexual partners once the premarital sexuality resulting in premarital pregnancy is established. Families of the young men are also disturbed by the occurrence of a premarital pregnancy, and if it becomes known, this also becomes a source of gossip and disrespect in the community. Although premarital pregnancy is accompanied by rumors and gossip against both partners and their parents, young women encounter more personal challenges, and will commonly suffer a lot more from the family's disapproval and the social stigma. It may indeed become shameful for the young woman in question to the extent that it may be difficult for her to appear in public in her home community.

The event will also have implications in terms of young women dropping out of school, getting married early, and becoming a highly dependent young mother. The young woman could also face difficulties of getting married in the future or enjoying love and respect from her husband if married. Nearly all study participants communicated this view and it has severe repercussions in one way or another. A young man summarized the psychological and social implications of premarital pregnancy as follows:

> *There are female students who become pregnant and go back home dropping out of schools. As the fetus gets bigger and bigger, they are ashamed of it and are forced to quit schooling. Some parents accept such daughters while others ask them to leave home. As a result, they never go back to their families. They also fear social stigma. Some stay at someone's house and give birth; they then kill the baby or give it to others who might be interested in raising it. Some throw it into the toilet; others just put it in a forest.*

Where the family is presented as tolerant, non-married young women give birth to the child at home and leave the child with their parents. No matter how sad they feel about the occurrence of the baby born out of wedlock, some parents will provide care for the mother and the infant. The

last point in the quotes is rather extreme statement and it looks an emerging practice in the study area.

6.4 The calamity of premarital pregnancy

Like premarital sex discussed in Chapter Five, premarital pregnancy does occur in the study communities regardless of the prohibitive norms. A young man gave a witness as follows:

> *In rural areas, female students have to walk far away from their homes to school passing through forests. They may walk alone or with their boyfriends. For example, a Grade 6 female student of about 17 year old had a boyfriend. He was a young farmer and had completed Grade 10. The girl got pregnant after having sex in the forest. She recently gave birth and dropped out of school* (Young man at Ako High school, Grade 10 student).

A 26-year-old unmarried young man also told stories about a premarital pregnancy occurring among high school students. He recalls his personal observation of students' sexual relations and the precarious situations it may lead to:

> *I know students who come to this town (*Dimtu*) from rural areas to attend high school education where they are exposed to new ways of life. The most important one is they begin sex. They usually give birth and throw the baby in the woods. I know two high school students who lost their lives because of premarital pregnancy. I saw a young woman who was found dead in a house due to a post-abortion complication, and I was the one who reported the case to the police. She wouldn't have died if she had used different scientific methods. After her death, I worry much about premarital sexual intercourse. This is stuck in my mind* (Young man, 26, unmarried, Tubena/Dimtu).

According to this participant, the second young woman came from a remote rural area. Reportedly, he knew her in person. He suspected that she experienced an unsafe abortion. She gave birth to a live child, but the infant died within a few days and the teenage mother herself died after two months having suffered from the post-delivery illness (suspected to be a post-abortion complication) without getting care and support. He noticed that her sexual partner was not with her during her suffering. At the end, when she had become seriously sick, her parents were called from the rural area and they brought her home. He recalled that she had been suffering alone and her body was swollen when her family arrived. She died within two days after arriving home. Another high school male student at Ako shared a premarital pregnancy experience of a female student in his class in the following story:

> *Pregnancy sometimes happens among students. For instance, last year, when I was in Grade 9, a girl dropped out of school because of unwanted premarital pregnancy. The student had been wearing loose clothes until she gave birth to the child with no prior preparation. We did not notice why she was wearing clothes like that, and it was only after her delivery that we realized that she was pregnant. One day, she left the class in the 6th period telling the teacher that she was sick. Later, it was found out that she had given birth to a child in the kitchen of a family located close to the school. Nobody had seen her and assisted her with the delivery. She could not reach a health facility in the town because of the urgency of the labor. She managed the labor and delivery processes by herself and eventually ran away, abandoning her baby in the kitchen. Later on, people in the house heard an infant crying at their backyard and discovered the abandoned baby. A motorist followed her while she was on her way to her family's home in the rural area and brought her back to the baby. The police brought her to a health center with the baby for a check-up. It was proven that she was the mother of the abandoned child as she was bleeding. She also admitted the case. Finally, she went back to her family with the baby. Until now, she has not returned to school.*

The student who presented this story explained that this girl's experience initiated a process where the school arranged an orientation program on sexual and reproductive lives in collaboration with the health facilities. Some young men stated that premarital pregnancy happens because of a girls' lack of knowledge about its prevention. Even girls or boys who have awareness of contraceptive methods will be too afraid or shy to visit health facilities to ask for contraceptives because of their non-marital status. Such obstacles were said to result in unwanted premarital pregnancy. A young man explained:

> *Some young women come for education but they unfortunately get pregnant. Even those who properly follow education may also encounter premarital pregnancy because they do not know how to prevent it. Young girls from rural areas do not know how to use technologies of pregnancy prevention. As a result, they bring an additional burden of caring for an illegitimate child to their parents* (High school student, EOTC Christain, Grade 10, Dimtu).

Young men in the study communities explained that the majority of young women who experience premarital pregnancy are students. They emphasized that premarital pregnancy is more prevalent among girls from rural areas who come to small towns for high school education where they start enjoying life away from their family's tight control and supervision. A young man said:

> *Those who come from rural areas and live in a rented house in the town engage in premarital sex, thinking that nobody prohibits them from doing that. When they*

> *get pregnant and give birth, some of them bring the babies back to their parents while others throw them into the toilet.*

Many young men would keep themselves away from their girlfriends when pregnancy occurs.The following two stories illustrate the point:

Story 1: ***Fatherhood is a choice whereas motherhood is a liability***

According to a story obtained from the district's Women and Children's Affairs Office (Adult, Female and Officer from Dimtu):

> A young woman who experienced premarital pregnancy presented an allegation to the named office that her partner refused to support her after impregnating her. The office took the case to court, but the court could not resolve it until the child was born because there was no evidence, given that the relationship was a secret. The court could not settle the case based on scientific evidence as DNA examination was impossible in this context. The court referred the case to the customary dispute handling committee. A cultural way of proving the alleged sexual relationship is making the suspects swear in public, which people usually fear to do. Finally, the young man disappeared; the girl gave birth to the child, and she was forced to drop out of school and bear the responsibility of caring for her child as a single unmarried young mother.

We learn from the story that young women had to bear the extra responsibility of providing proof as to who the father of the conceived child was, whereas young men could easily refuse and escape from being held accountable for impregnating girls.

Story 2: ***A girl's burden of bearing a child without a father's name***

A second story obtained from the same office, the narrator presented the case as follows:

> A young woman accused a young man of impregnating her, but he denied being the father of the child. Both had jobs, and her motive was not to obtain any material or financial support from him; she only wanted the child to be named after him as a father. She asked him to swear in public whether he never had sexual relations with her and that he is not the father of the child. The young man was not willing to swear publicly. Rather, he finally admitted to the court that they had a sexual relationship, and that he was the

one who got her pregnant. He was made accountable to his actions and ordered to provide financial support for the child, but she was not interested in his support. She was satisfied with the fact that her baby had his/her father's name which was her primary cause to file the case.

Both stories narrated above imply that young men were not held fully accountable for impregnating the girls, regardless of the girls' agency attempting to make them responsible for their actions except the girl in the final case got her will as the child got his/her father's name. Young men can thus choose their parenthood whereas girls are forced to become single parents and to ensure that their children have a father's name.

6.5 Condoms are for pre-marital and extramarital affairs: Young men's contraceptive use

The possibility of young men's contraceptive use is in practice limited to condoms, given other potential alternative methods like vasectomy, abstinence, and natural methods are not practiced in the study area. Vasectomy, which is in fact not available as a family planning service at health posts and health centers, is not known to be carried out at all. Neither coitus interruption is a familiar practice in the study area, while abstinence is - as we have seen above- highly encouraged culturally and religiously but not observed among young men and women.

Public views about condoms as a contraceptive method are important in order to grasp young men's views and experiences of contraceptive use in a broader context. Of importance is a prevailing notion about condom use is based on a history about the introduction of male condoms to people in the area. As condom was introduced in relation to HIV prevention for men who have sexual relations with commercial sex workers, and for other forms of extramarital sexual relations, its use automatically instigates the idea of distrust between the sexual or marital partners. A key informant who had worked for the Packard Foundation for eight years as a promoter and distributor of condoms mainly for HIV prevention shared his observations related to local people's perceptions of condom use. This key informant had the following to say about men's use of condom: "*Condom was there and people were aware of it, but nobody came to collect it. We had tried our best but they kept silent*." He noted that married men rarely use condoms, and it is used only for extramarital sexual affairs, if used at all. He stated:

> *No one uses condoms with one's wife, and going out* (which refers to having extramarital affairs) *is not common here. They never want to see it. We told them that they could come and take it. But nobody took it while I was working there for eight years. We gave the condoms back to the organization* (Male, Muslim, 32 year old, Dacha Gibe/Gabara).

Another participant similarly suggested:

> *A man should not use 'sensation'* (refers to condom*) to prevent pregnancy because his wife belongs to him. Unless it is based on their full agreement, using condom is not as such advisable. Instead, it is better if she uses women's contraceptives. If there is trust between them, it is better to avoid condom use and look for other methods* (Male, Christian, 24 year old, Gabara).

It appears that such a historical association of condoms as being a method of HIV prevention has limited people's propensity to consider condoms as an acceptable and 'serious' contraceptive method. The study participants - including women - also say that women themselves are not willing and comfortable with men's use of condom based on the same assumption that it means a lack of trust between the two partners. The strong belief that condoms are meant for commercial sex workers prevails today in the society at large. Evidence from healthcare facilities further shows that married men use condoms only in special circumstances, and not primarily for the prevention of pregnancy. Rather, they may use it to reduce sexual discomfort during extended menstrual bleeding, which was said to be a side effect of women's contraceptive use. A midwife explains:

> *We tell men to use condoms, but the married ones do not want to use condoms unless there is a problem. For example, they use it if their wives who use injections are experiencing menstrual bleeding for a long time. In such rare cases, it is not possible to have sex while there is bleeding, and some men ask us what to do until the three months come to an end. Then we give them condoms* (Female, Christian, 32 year old, Dimtu).

Hence, condom use is not the norm or the rule of marital life, but emerges as an exception to tentatively respond to a problem. Young men's views and experiences about condom use largely reflect the dominant public views discussed in the preceding paragraphs. They emphasize that condom use implies distrust and is thus unsuitable; they also perceive condoms to be unreliable and ineffective in preventing unwanted pregnancy. They further hold that condoms are not feasible, as sex among the youth is usually accidental or unscheduled. As a result, many young men tend to ignore condom use as a useful contraceptive method. Young men's tendency of

avoiding condoms and their implied unpreparedness to use it is fairly represented by the points raised by a 24-year-old participant. He explains it as follows:

> *A young man may not consistently keep condoms with him; hence, unwanted pregnancy can occur. If two partners trust each other, they should not use condoms. Rather, young women should use females' contraceptives. Male condoms may be forgotten, but an injection for women is taken only once in three months.*

According to a study participant, for example, condom is 'unfavorable'. He says that he does not believe in intentionally using it to avoid unwanted pregnancy, but would rather use it to prevent STIs. This is implied or hinted in his concern of 'trust' between the partners. He also sees female's contraceptives, in injection form in particular, as more feasible, easier to use, and more effective in preventing pregnancy. Other unmarried young men reported that condom has to be used mainly with the intention of preventing STIs and particularly HIV.

Asking about the involvement of young men in preventing unwanted pregnancy, a young man similarly stated that men can use condoms mainly to prevent STIs, saying: "*A young man may use condoms for sometimes if his girlfriend is a returnee from another town, as she could have been infected with HIV/AIDS*." Young men said that young women also consider the use of male condoms when they think that the partners may have acquired STIs from other towns, like if they have had sex with commercial sex workers.

6.6 Young men negotiating women's contraceptive use

This sub-section presents young men's involvement in negotiating women's contraceptive use as partners–both before and after marriage.

6.6.1 Women choosing contraceptives, men supporting: Consensual negotiation before marriage

Many young people stated that young men may also have constructive involvement in women's contraceptive use before marriage. Yet, they are reluctant to actively and fully engage in the prevention of unwanted pregnancy. The main reason for their reluctance is the perception that pregnancy and its prevention are domains of women and an extension of other productive-reproductive gender-based division of tasks. To the question: "How have you prevented premarital pregnancy?" a 24-year-old unmarried young man whose girlfriend was studying at the university, replied:

> *It is injection. She chose that and used it. She raised the issue and I agreed with her. In the first place, I didn't even think about the subject until she raised it. I actually tried to have the first sex with her without any contraception, but she refused and warned me to stop trying again. We postponed our first plan for sex to another time, until she received the injection. I thought she had been using it before, but she told me that she had not. We started having sex after she received the injection* (Muslim, Unmarried, Grade 10 complete, Busa).

A student however shared his understanding of how young men can become involved in the prevention of pregnancy based on his friends' experiences. He said:

> *A young man is expected to accompany his girlfriend or wife to a health center when she seeks contraceptives. Going there, he should report that the girl he is accompanying is his partner because they never give her services if she goes alone. He should be with her. I have friends who take their girlfriends to health centers seeking contraceptives. However, they never go with them after the first time. Once a young woman begins to take the pills or the injection, she can continue doing so* (Unmarried, 23, student at Ako High School, Bidaru).

Many young men seem to have substantial awareness about contraceptive services, as they know the presence of different contraceptive methods for women, and they can inform about their characteristics. For instance, the young man quoted above argues that:

> *Using injection is preferable for unmarried young women because the pills could be seen by her family members. Young women may also make a mistake in taking the pills or forget to take them. It is not the right time for girls to use pills; it doesn't work. Instead, injection is there for them to use only once in months or once a year. It is said that the injection is available and serves three, four, six, nine months or longer.*

Those who regard young men's responsibility in preventing pregnancy positively, state that young men need to encourage their girlfriends or wives to use contraceptives and follow the instructions of usage properly. Reminding and permitting women to visit health facilities and regularly using the methods is considered as a significant contribution boyfriends or husbands can make, and accompanying women to health facilities is viewed as a progressive action, given doing so is not broadly appreciated in the community. The assistance young men can give to women in using contraceptives is expressed as follows:

> *She knows about family planning, but I also remind her. I encourage her to consistently use it. When I tried to persuade to start having sex, she resisted mainly due to the fear of premarital pregnancy. Hence, I should assist her to avoid unplanned pregnancy* (Young man, Muslim, 22 year, Unmarried, Busa).

Unmarried young men in the study area indeed by and large emerged as rather supportive with regard to young women's contraceptive use though a few exceptions were found. Yet, there are also others who even do not think about contraceptive use when they plan to have sex with their girlfriends as the one presented earlier. Consensual negotiation and interpersonal commitment driven by a mutual interest of avoiding unwanted pregnancy largely prevailed before marriage. This shared interest of young men and young women is backed by social norms that strongly disapprove premarital pregnancy and may lead a couple to premarital contraceptive use.

6.6.2 Women seeking contraceptives, men responding differently: Evolving forms of negotiation after marriage

After marriage, young men's negotiation of contraceptive use evolves over time. In response to the social expectation of bearing children immediately after marriage, most couples do not start using contraceptives until they give birth to some children, as stated earlier. That is, women are interested in using contraceptives when they have had some children. Consensual negotiation seems to take place among most couples and ends in favor of avoiding contraceptive use. As a result, their timing of using contraception emerges at odds with the family planning service program, which emphasizes delaying the first birth after marriage as an important strategy to reduce the number of children born to a woman, thereby controlling population growth, as health extension workers explained. The practice of delaying the first birth is further strengthened by social referral (i.e being guided by members in one's social network), which relates to the belief that contraceptive use could result in infertility. As a result, many women come to HEWs after

they have given birth to some children. This practice is evident among young women and is confirmed by healthcare providers. In contrast to this pattern, and although their number is small in the district, government employees seem to delay the first birth of a child till some time after marriage, using contraceptives, which is unusual for rural women. A 24-year-old married educated young man in Dimtu told me how he and his wife delayed the first birth after marriage:

> *We do not have a child as she is studying at college in the summer program. I would be happy if I could have children. If it were not for her education, we would have children by now. She is using contraceptives, and we will not have children in the coming three years. I support her in using contraceptives. I assist her by reminding her to use contraceptive and accompany her to the health center. She is very happy about that as she wants my involvement.*

Contraceptive use in the later stages of married life, meaning after the couples have had three or four children, is characterized by diverse views and experiences. With regard to women's contraceptive use at this time, diverse experiences are observed in the couple's negotiations over contraceptive use. The positions of married young men over women's contraceptive use after the couple have had three or four children vary. They range from totally rejecting contraceptive use, to being negligent and permissive, to being cooperative and encouraging. Some couples reach consensus and jointly decide to use contraceptives. Those who refuse contraceptive use question the relevance of preventing pregnancy, spacing birth, and limiting the number of children. They tend to associate their position with religious norms, the social value of children, and their personal interest to enjoy sex. Expressions like "*Carrying foreign objects in one's body is 'haram'* " and "*I want more children*" are common justifications for the refusal to use contraception.

Though it has gradually become less acceptable, there were ideas that a woman who dies with a foreign object in her body (that is, contraceptive products) does not inherit the Kingdom of God and her prayers to God are unheard when alive, carrying the object in her body. This belief, is in particular, held by some Muslims. However, currently, this notion is reportedly held by very few people after health extension workers had discussions with religious leaders to secure their support. As a result, many people have recently become less resistant to contraceptive use. Nevertheless, the belief "*God gives children and He takes care of their growth*" prevails among many people with diverse religious backgrounds.

Other men are more permissive in the sense that they do not oppose contraceptive use. Some of these men do not cooperate with their wives; rather, they keep silent or become negligent even if they know that their wives are using contraception. Those who have a favorable view towards contraceptive use, motivate and assist women to use the services. They accompany their wives to health facilities and remind them of the time they should take the next dose or round of contraception. A young man analyzed the benefits and dilemmas of using contraceptives, which seemed to be shared by the majority, as follows:

> *There had been a child-spacing problem in our community. Women used to give birth nearly annually, and its negative effects had been substantial. Now people use contraceptives even if there is suspicion that once the contraceptive is used, menstrual return might be delayed or permanent infertility might happen* (Male, Christian, 23 year old, Dacha Gibe).

Some husbands however totally reject their wives using contraceptive methods. They usually attribute their position to religion and/or interest in having more children, holding that they believe that God is responsible for how many children they get. In such instances, women may use contraceptives secretly, considering the practice is religiously unacceptable, primarily in Islam, but more importantly because of the rejection by their husbands. Marital disputes may occur if husbands discover their wives' secret use of contraceptives as healthcare providers reflect their fears. A health extension worker expressed it as follows:

> *If we see it from the rights-based approach, it is a woman's right to decide whether or not to use the service. However, we referred her to the health center for the removal of the implant to prevent the disintegration of the family. Her husband would go for divorce unless she stopped using the family planning method, but she does not want the divorce to happen. Before that, we tried to persuade him to tolerate it for a while, but he was too aggressive and he did not want even to talk to us. Finally, she went to the health center and got the implant removed* (Female, 34 year old, Dacha Nadhi).

According to the HEW, the primary reason for the husband to refuse his wife's use of a family planning method was his preference to have many children. In another instance, a woman removed an IUCD by herself shortly after it was administered because of her husband's strong disapproval of the use and pressure to remove it. He opposed her secret use of the contraceptive and complained that the object would make him feel uncomfortable during sexual intercourse. She did not seek help from healthcare workers to remove the IUCD, thinking that they may refuse removing it. As reported by the healthcare workers, the woman visited them only for

checkup whether it was properly removed. The dominance of the interest of husbands over wives is vividly observed in these cases.

6.7 Discussion

Cultural context and location had an influence on access to contraception (Bukuluki et al., 2021). These authors identified social norms that inhibit contraception use in the community in Uganda. Cannon et al., (2022) in a study from Nigeria examined norms about acceptability of contraceptive use and changes resulted from different interventions. In Nigeria, some people consider having sex, using modern contraceptive, or having a child out of wedlock would decrease the adolescent's chance of finding a suitable husband in the future (Cannon et al., 2022, p. 1383). In the study community, as is elsewhere in Ethiopia, premarital pregnancy is more disapproved than teen pregnancy. There are norms that encourage childbearing at younger age and having many children that coexist in the community which are reinforced by proverbs "*Dhalli ganma nama hafa*" (bearing child when young should not be missed) and "*Dhalaafi mirga hin quufan*" (there is no enough when it comes to children and victory). The proverbs disapprove delaying births and limiting the number of children, respectively.

Dominant norms of fertility in the study area support having many children whereas the gender norms tend to exempt men from sharing responsibility in contraception. In unison, they manifest strategies that emphasize femininity and manhood acts of male dominance over women in matters of contraception. There are also many examples where women refuse to have sex without contraception and where women secretly seek contraception. We found diverse types of men's involvement in contraception with a range of influences (positive and negative) emerged. It was found that limited involvement of young men in contraceptive use goes in line with the dominant norms of fertility, marriage, and gender, all of which result in the subordination of women and the dominance of men.

In Zambia, some agreed that a pregnant girl or a girl with a baby brings shame to her family. Early pregnancy of a girl is shameful for the family because it implies that the girl's parents have not guided her but this concept of shame does not seem to relate primarily to morality (Svanemyr, 2019). However, in the present study in Ethiopia, nearly all participants agree that premarital pregnancy brings shame to a woman's family whereas parents are impliedly

responsible for premarital pregnancy of their daughter. Unlike in Zambia where only a very few young people said it was a sin to have sex before marriage, the shame primarily relates to morality in Ethiopia given both premarital sexuality and pregnancy are considered sin. In Zambia, it seems that a shame of getting pregnant for a girl is linked to her age and its negative consequences by virtue of the age whereas marital status and disapproval social reactions are given more weight in Ethiopia. This might be the case because early marriage is culturally more tolerable in Ethiopia although state rules are against the practice. The studies also indicate that girls' education is more valued in Zambia than Ethiopia because early pregnancy is disapproved in the former primarily for it results in girl's school dropout which is not given a due attention in the latter. Rather, parents may convince or force girls to drop from school and get married. Likewise, consequences of early pregnancy on a girl are not comparable to its negative effects on family pride in Ethiopia although some young men have concerns related to the consequences. In general, getting a baby earlier is positively regarded for women so long as the pregnancy happens within a socially or legally approved wedlock which clearly manifests in disapproval reactions against delaying the first birth after marriage.

Religious leaders in the study area favor having many children per woman or family, and subsequently they envisage larger population citing verses from the Scriptures. Hence, they tend to oppose modern contraception, which is commonly referred to as "*qoricha*"- drugs in the study area. The EOTC leaders support natural contraceptive methods only when it is believed necessary based on a case-by-case analysis of the economic status of the parents in question, whereas Islam leaders are essentially against any kind of fertility control interventions. Such views and practices manifest emphasized femininity, given they seemingly favor men's interest of having many children, but they play limited roles or no roles at all in preventing unwanted pregnancy. However, it is important to separately examine the agentic positions of the religious leaders from the dominant normative views of the respective religions, given there are differences in their expressions when they speak as religious leaders and as community members. For instance, they argue that the religion does not allow using any modern contraceptive method and they believe in that yet they leave some rooms for couples to decide whether they want to use modern contraceptive while their reaction to unmarried young people remain disapproval.

Although the dominant norms strongly disapprove premarital sex and premarital pregnancy, young people's experiences, on the other hand, reveal that premarital pregnancy has been frequently occurring regardless of the prohibitive views. In this study area, young men refusal to use condoms as a pregnancy prevention method is a typical feature of emphasized femininity and manhood acts.

Injunctive norms disapproving premarital sex and premarital pregnancy are expressed as "*aadaa balleessuu"* (eliminating culture), "*safuu cabsuu"* (violating norms) and "*seera amantaa diguu"* (ruining religious rules). Community members see young women walking around for fun as wanderers and those who visit men's home as shameless. They also think that parents are partly responsible for their children's misconduct which is commonly expressed as "*guddis-baddee"* (improperly raised up). Yet, they suggest that young women should use contraceptives if they failed to avoid premarital sex saying "*qoricha fayyadamuu"* (using drugs) or "*isuma barri fide fayyadamuu"* (using what the time has brought) to prevent premarital pregnancy. Therefore, getting pregnant is considered as more unacceptable than using contraceptives to avoid the shame the pregnancy would bring to the girls and their families. The finding is similar with other studies from other African countries (Cannon et al., 2022).

In terms of descriptive norms (what people think others do), findings from Zambia and this study from Ethiopia are at odd to each other. In Zambia, participants reported that it was not common for girls to have a boyfriend whereas those in Ethiopia people think that it has become common although it is not acceptable. Young people in particular think lack of girlfriend or boyfriend as an exception although some young men interviewed in this study explained that they have no any. In Zambia, young people keep having boyfriend or girlfriend secrete and those in relationships are not well known among their peers which is again in contrast to Ethiopia where most young people hide having a love partner from parents but share with their friends. However, many of them seem to keep premarital sexual relations secrete although they think that others practice it. The deviation from the descriptive norms might be because of the injunctive norms that many consider that having a premarital sex is socially unacceptable and religiously a sin. In light of contradictions between descriptive and injunctive norms as reported by Svanemyr (2019), there are a double set of norms whereby each require them contradicting behavior like

one tells that girls should be sexually passive whereas the other set of norms direct to access resources which in turn force them to practice sex in exchange of economic benefits.

It is worth mentioning that ways of young men's involvement in contraceptive use as partners are diverse, and the patterns of negotiation before and after marriage vary. Hegemonic male dominance over women and men's agentic roles are manifested in the same community. The strong opposition against women's contraceptive use or the total refusal by husbands could be understood as patriarchal manifestation of masculinity because husbands are dominant decision makers on matters that concern both or matters that concern wives even more as the pregnancy could risk their lives. Emphasized femininity and manhood acts also lead young men to make undesired decisions like denial of responsibility and running away from the area as we observed in the stories whose cases were presented to court and elders.

The involvement of men in the adoption of family planning as users and as supporters of their partners is found to be low also in a study from Tanzania, which is similar to the findings of this study. That is, the involvement of young men in contraception both as users and partners is low or unfavorable. Msovela et al. (2020) identified knowledge about family planning methods and number of children as major factors affecting the involvement of men in family planning services. This study from Tanzania also revealed that lack of education and failure to use contraceptive methods increase the chance of premarital pregnancy. It moreover showed that high school students from rural backgrounds are more vulnerable to premarital pregnancy as they are easily deceived by urban-based men and their limited use of contraceptives. The study participants had serious concerns that students, particularly those who come from rural areas to small towns for high school education, are more susceptible to premarital pregnancy and its consequences. Lack of parental supervision and control exposes them to premarital sex as they have limited awareness about its risks compared to young women of similar age living with their parents.

However, the above mentioned disapproval norms are not intact as some changes are in the making. Economic factors are resulting in critical views against high fertility rate or population growth in general. Difficulty to access land, increasing youth unemployment, and increasing cost of child bearing and rearing, among others, are reasons for emerging critical views about fertility or number of children to be born per family. People hold that the number of children or family

size needs to balance to the household income or economic capacity to support children. There is disapproval of bearing more children against 'poor families'. There is no clear suggestion of how to avoid of 'unnecessary birth' but use of contraceptives has become as part of discourses. Expressions like "*Isuma barri fide fayyadamuu*" (using what the time has brought) referring contraceptive use and "*Hakimii gaafachuu*" (consulting healthcare worker) implying seeking contraceptive use at health facilities.

Tolerance of young women's reverting to contraceptive use rather than getting pregnant in many African countries (Cannon et al., 2022) is a window of opportunity for the increasing acceptance of modern contraceptive use. Challenging economic situations and school fees were found to be reasons to support using family planning in Nigeria (Cannon et al., 2022). Similarly, girls' sexual relationships and pregnancy are disapproved in Zambia because of the subsequent economic challenges (Svanemyr, 2019). Even if large number of children is generally valued in the present study communities, many people think that poor parents should limit their number of children to the level of their economic capacity for properly raising the children. There is a shared understanding that families with limited number of children can better feed their children, buy them clothing and send them to school. Such economic causes are some windows of opportunity for changes in favor of using contraceptives.

6.8 Conclusion

Social norms of fertility and having large number of children on the one hand and norms of that strongly disapprove premarital sexuality and premarital pregnancy shape involvement of young men in contraceptive use in a complex and seemingly paradoxical manner. Such normative dilemmas between contrasting norms are reinforced be increasing socioeconomic hardships facing young men and women in the study area and beyond. Gender norms that exclude men from contraception use and lack of male contraceptives further complicated couples' contraceptive use and limit constructive involvement of young men.

Ambivalent positions about modern contraceptive use among religious leaders contribute to women's challenges in accessing and using contraceptives. Unlike their similar consensus about other events of fertility control, Islam and EOTC leaders had basic differences in their stands of contraceptive use among their followers. While the latter recognizes use of natural contraceptive

methods when necessary, the latter unconditionally rejects the use of any form of contraceptives. Simply put, differences in positions between religious leaders of both is more consensual for induced abortion (presented in the next chapter) than contraceptive use.

Marriage remains the hegemonic factor whereby different norms of fertility control intersect in shaping the involvement of young men. Rural women bear disproportionately larger burden of undesired consequences of premarital pregnancy and unwanted birth.

Male dominance in contraception manifests itself in the behavior of men and women, in dominant cultural views, and in institutional settings. Patriarchal views, norms, and practices against contraception use are clearly evident in man-woman relations, policies, programs, and services relevant to reproduction, in general, and contraception, in particular. Emphasized femininity and manhood acts are clearly visible in men-women interpersonal relations, dominant views, and community and institutional practices. Men win over the interests and choices of their wives, taking advantage of the social status of being males and husbands, and relying on a traditional authority. Hence, hegemonic masculinity is founded in cultural resources. Male dominance in contraception seems to continue regardless of an emerging agency among some young men and women, so long as the dominance of men in other spheres of lives prevails. This also implies that the limited or improper involvement of men in reproductive lives due to hegemonic masculine attitudes, practices, and service programs negatively affects people's fertility control and outcomes of efforts made to improve individuals' or couples' control over their fertility. However, the influence of education on moving towards men's constructive engagement in reproductive relations predicts an emerging positive masculinity in the future.

CHAPTER SEVEN

CULTURAL/RELIGIOUS AND LEGAL NORMS OF ABORTION

Introduction

Per the definition of fertility control used in this study individuals and couples adopt patterns of behavior pertinent to the three domains in accordance with their cultural values, reinforced by formal or informal social pressures (Sills, 1968). In Chapter 4, we presented how gender inequality is constructed and practiced in the institutional settings of the study communities, and its implications on fertility control. Fertility norms and practices pertinent to pregnancy prevention through sexual abstinence and contraceptive use in particular were presented in Chapter 5 and Chapter 6, respectively. Now we turn to norms related to terminating pregnancy or preventing birth using abortion. Chapter 7 focuses on cultural/religious rules prevailing in the study communities, and 2005 Abortion Law of Ethiopia. The chapter is also framed around young men's views on abortion in the contexts of the social norms and the progressive Abortion Law of Ethiopia. Therefore, abortion related social/religious and gender norms, and abortion law and guidelines are investigated in the chapter based on the broader sociological conceptualization of norms as rules of behavior that exists at both the formal and informal levels (Chung & Rimal, 2016, p. 5),

In response to the international agenda of promoting gender equality (ICPD, 1994; ICHRT, 1968) and national interest of reducing maternal mortality due to unsafe abortion, Abortion Law of Ethiopia (2005) made abortion permissible on many grounds. Consequently, the Ministry of Health (MoH) developed Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia (2006). Although seeking abortion nominally remains illegal in Ethiopia, the Revised Criminal Code (FDRE, 2005) provides a more liberal approach to abortion than the law preceding it did. According to the 2005 Abortion Law of Ethiopia Article 551 (p.355-356), termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable when:

a. the pregnancy is a result of rape or incest; or
b. the continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or

c. the fetus has an incurable and serious deformity; or

d. the pregnant woman is physically or mentally unfit to bring up the child, owing to a physical or mental deficiency she suffers from or her minority status.

In societal contexts where abortion represents a deviation from social and gender norms such as notions of femininity and motherhood (Forte, 2018; Kumar et al., 2009), it is a highly stigmatized practice, and norms driving abortion stigma are manifested within the family, in male partners, in the community and in service provision (Forte, 2018). The rational of a woman to seek and access abortion services is shaped by the broader social and cultural contexts not just the legality but also accessibility, acceptability, moral/ethical, religious, ideological, and familial matters of the practice (Bajos et al., 2014).

A growing number of researchers have become interested in analyzing public views about abortion services and abortion law in Ethiopia (Blystad et.al, 2019; CSA and ICF International, 2012; Grimes et al., 2006; Kebede et al., 2012 & 2014; Prata & Summer, 2015; Singh et al., 2010). Some studies revealed that such policy shift occurred in a context where the sociocultural and religious environments were and continue to be strongly opposed to a more progressive abortion law. They also found that the implementing organizations adopted silence as a strategy in the implementation of the law to avoid potential public outrage (Tadele et al., 2019; Ewnetu et al., 2020; Foster et al., 2016). Tadele et al., (22019) analyzing strategies and dilemmas in realizing the new abortion law in Ethiopia, found that the strategy of silence had its advantages, but that simultaneously it was challenging as it prevented the dissemination of knowledge about the revised law, thereby limiting women's access to safe and legal abortion services. Blystad et al., (2019) from their comparative analysis of abortion laws of three African countries: Ethiopia, Zambia and Tanzania, found that the laws are paradoxical.

Individuals', couples' and parents' right to decide on the number and spacing of their children' is recognized globally hence men are also addressed as proper agents by implication (Coates et al., 2014; ICPD, 1994; ICHRT, 1968). Men may play supportive or antagonistic roles with regards to decisions made around abortion based on their interest and societal contexts. Thus, men's attitudes, practices, and experiences associated with abortion are of importance in any abortion context and need to be documented (Newton et al., 2020). Hence, this and the next chapters are intended to contribute to fill the knowledge gap with regard to the involvement of young men in

abortion in a rural district of Ethiopia. The above mentioned studies are policy analysis conducted at international and national levels. Building on these literature, the present study scrutinized how the norms are considered at the grass root level and identified the nuances based on evidence obtained from communities in a rural context of Ethiopia, Nadhi Gibe district of Jimma Zone in Oromia National Regional State.

7.1 Local arguments for and against induced abortion

The views of participants in this study about induced abortion and abortion services can be broadly categorized into two: a view that conditionally accepts abortion and an anti-abortion view. The categorization as presented below aims to enhance the understanding of both sides of arguments; and to show that they are not mutually exclusive. For example, some anti-abortion views recognize abortion only to save women's lives.

7.1.1 Conditional acceptance of abortion

Even though seeking abortion is negatively perceived by most study participants, both men and women, some believe that abortion may be necessary under certain conditions. There are some listed acceptable grounds of induced abortion, reasons that they think should be 'tolerable' based on medical, social, and economic justifications. While saving the mother from hurt and death is the most pronounced reason, other justifications based on economic and social concerns also emerged. The partners' economic capacity and timing of the pregnancy and motherhood were by some considered justifiable reasons for abortion, particularly among young people. Some adult key informants presume short birth-spacing and lack of income to properly support the child's upbringing as justifiable grounds for seeking abortion. This view is clearly more permissive than the religious norms pronounced by religious and opinion leaders and the majority of community members. This position is also more permissive than the Abortion Law of Ethiopia (2005) that limits legal grounds of abortion to non-economic and exclude causes of birth-spacing and limiting number of children. Although failure to feed the child or limited economic capacity are not acceptable grounds for seeking abortion services from Islamic religious leaders' points of view, a Muslim midwife nonetheless find them acceptable. She explained what she perceived to be acceptable conditions for women seeking abortion:

> *In Islam, abortion is forbidden unless it occurs as a miscarriage or if the pregnancy happens before the previous baby is old enough for another baby to follow or if the parents cannot feed the child. Some women come here and complain that they can't bear the pregnancy to full term because they do not have the economic capacity to support the baby.*

People with supportive views about induced abortion stress the importance of reducing the negative effects of bearing a child from an unwanted pregnancy or seeking an unsafe abortion due to lack of access to safe abortion services. Even those who tend to see the importance of abortion for different reasons believe that using contraceptives to prevent pregnancy is much better than induced abortion. Regardless of their supportive position for the existence of abortion services at the health facilities, most study participants see the practice as essentially conflicting with their religious norms.

7.1.2 Disapproval cultural and religious norms against abortion

Induced abortion is strongly resisted by religious and/or community opinion leaders, and most community members including some health care providers, teachers and some young men who think that abortion is an immoral act that terminate unborn life. Religious leaders do not consider social and economic reasons as acceptable grounds for seeking abortion; rather, they recognize saving the mother's life as acceptable cause. Induced abortion is strictly prohibited by both the dominant religions in the study area - Islam and EOTC. Among Muslims, induced abortion is absolutely condemned, except in situations where it can save the life of a mother when opted by the pregnant woman and confirmed by doctors. According to an Islamic leader, abortion is seen as being equivalent to homicide:

> *Abortion is prohibited in our community, and it is strictly prohibited in our religion. Abortion is the same as killing a human being. Our Sharia rule prohibits abortion and teaches us to keep everyone safe. It commands us not to practice anything that causes harm both to the fetus and the mother. But if it is confirmed that the pregnancy is harmful to the life of the mother, in Sharia rule, it is not a problem if the fetus is aborted. But doctors should confirm that keeping the fetus until birth is highly dangerous to the survival of the mother. In such cases, we can tolerate or accept induced abortion* (Male, 62 year old).

Another Islamic leader rejects abortion as follows:

> *Once women get pregnant, knowingly or unknowingly, we never support induced abortion. Whether a woman conceives in marriage or outside marriage, even if*

> *she is not ready to give birth to the child, she is not allowed to seek abortion in our religion. It is a sin equivalent to killing a human being* (Male, 53 year old).

The quote from the study participant reveals a contradiction that getting pregnancy outside wedlock is more tolerable than seeking abortion although both practices are strongly disapproved culturally and religiously. Similarly, induced abortion is not permitted in EOTC except in cases where the pregnancy is life-threatening for the woman. By the same logic as in Islamic teaching, abortion is tantamount to killing a human in EOTC. A religious leader from the EOTC declares:

> *We do not allow abortion of a fetus created in a legally concluded marriage according to the teachings and procedures of the church. The church does not allow its followers, including the youth, to practice abortion unless in exceptional cases. If partners do not want to have an offspring, they can prevent the formation of a pregnancy using natural fertility control mechanisms. However, if a woman has conceived, intentionally or unintentionally, she cannot abort the fetus, according to the teachings of our church. Even if a pregnancy is unexpectedly created while a woman is using natural contraceptive methods, induced abortion is not allowed. However, if the conceived fetus is proved to be harmful to the life of a mother, it is possible to abort the fetus in consultation with religious leaders and health professionals to save the life of the mother* (Male, 52 year old).

Hence, induced abortion is severely condemned in EOTC as it is the case in Islam, and the reasons are nearly the same; that is, abortion is perceived to be homicide – it is the most serious crime against a human being and it is a sinful act as well. Getting pregnant outside marriage is also considered better than seeking abortion. In the teachings of the church, modern contraceptive use is perceived as an interruption of fertility, whereas abortion is killing a human being. Therefore, in EOTC, induced abortion is viewed as a more heinous criminal act than contraceptive use. The words of the church leader mentioned above read as follows:

> *In principle, the church does not support modern contraceptive use and induced abortion. Abortion of a fetus is viewed as killing a human being. There is even a verse in the Bible that condemns induced abortion. The practice is totally condemned according to the teachings of the church. Concerning the use of contraceptive drugs, the church believes that it has the same effect as that of abortion by interrupting the natural process of human reproduction. Using drugs is interfering with the process of nature. For this reason, women are advised to prevent the occurrence of pregnancy through natural contraceptive methods instead of using modern drugs or induced abortion.*

A community member who is experienced in promoting reproductive health services for NGOs shared his observation of people's views that echo arguments of the religious leaders on induced abortion as follows:

> *Those who oppose induced abortion relate their arguments to Sharia as it does not allow the practice. They may say, 'It is God that allows life; why do you interfere?" When we consulted religious leaders on this issue, some told us that it is okay if the medicine* [refers to contraception] *is used before the pregnancy occurs. However, they warned us that it would be considered a sin if the medicine was given after the pregnancy has already occurred* (Male, 32 years old).

Participants of this study hold contradicting views whereby some have a firm objection against abortion whereas others' position is not clear. An example of opposition against abortion services by healthcare providers emerged in the account of a midwife, who was principally against abortion care, but was still engaged in providing abortion care. She presented the story in the following way:

> *I suddenly got into the business of giving abortion care at this health center. When I first came here as a new staff, the health center sent me for a training on abortion when I still didn't know much about it. At that time, I didn't even understand the topic of the training. After the training, I was forced to give abortion and post-abortion care at the health center. This is how I started giving abortion services in this health center, but many health professionals in our district refused to attend the training. I was fresh staff to refuse the training. However, if you ask me about my stance on abortion, I would say it is a sinful act. Women should not consider abortion. In my view, it is a great sin. I strongly oppose the act because religious teachings strictly prohibit induced abortion. But in cases of attempted abortion, I could freely help the care seekers by cleaning the mothers' womb because it has already been aborted. Otherwise, I am firmly against induced abortion.*

Regardless of the strong religious-oriented arguments against induced abortion, it is practiced in the study communities. An EOTC leader shared his observation that women are experiencing abortion even more frequently, stating:

> *I know a young woman who has undertaken abortion three times in three years. She is a government employee and has a sexual partner. She repeatedly sought abortion care because she does not trust her partner to be a reliable husband and father.*

This is an unusual case given, she as an educated government employee, knows about contraception. An action taken by a father whose daughter experienced premarital pregnancy is another indication that girls and women themselves seek abortion services in the area. His action also to have opened up discussions on the issue of induced abortion in the community. A young man from Dimtu narrated the agentic responses of a young woman and her father as follows:

> *The father of a Grade 6 pregnant girl asked his daughter who the father of the fetus was, and attempted to make her boyfriend responsible for that and compel him to marry her. However, the boy ran away before he was forced to marry her. Then, the father took her to hospital and got the fetus aborted* (18 year old, Grade 11).

Two points are worth noting from this story. First, the way that this father dealt with his daughter's premarital pregnancy seemed to be rather exceptional. He discussed the matter with his daughter that most fathers may totally have avoided, and he attempted to make the boy responsible for his action. Second, he sought abortion for his daughter at hospital, incurring both economic (transport cost) and social costs (stigma). According to the interviewee, both the girl and her father were stigmatized for seeking abortion care. Neighbors were disappointed with the action of this father, considering it as a practice against God's will and the community's norms of fertility. He presents the community's reaction to the event saying:

> *Members of the community were not happy with that because the action is against their religious rules and they consider it as killing a soul created by God. They also suggested that the man would only benefit from raising the child as he/she would become an additional human labor for the family when grown up.*

After the abortion was carried out, the girl returned to school even though her experience of abortion was known to the public, which also indicates the resilience of the girl and her father, and how they had to withstand the strong social disapproval by the community. The father also challenged the convention by not rejecting his daughter who disgraced the family by a premarital pregnancy, as other fathers in the community may have done. The above quoted young man expressed that is not easy for the girl to disregard the social disapproval she encountered by the community. He explained that she felt guilty and suffered from being rejected by the people:

> *That is obvious because she violated the custom of the society. She felt inferior to her friends. She spent most of her time alone at home because she was afraid to meet people. People did not even greet her as she had broken the norms of the*

> *society. It was after she came back to school that she began to interact with people again to some extent* (18, Grade 11 student, Dmitu, Gura Bidaru)

It could be understood from the quotation that her feelings of guilt resulted from the social stigma and discrimination she faced in the neighborhood and at school. A young man among FGD participants explained: "*I don't think abortion is necessary at all as young women can prevent pregnancy with contraceptives."* A young widower from Busa stated that he would accept induced abortion only if the pregnancy is potentially dangerous to the mother or the fetus. Otherwise, he considers the practice as a sinful act. Young men who are not in favor of induced abortion consider marriage as a solution to unwanted pregnancy. But at times, there seem to be contradictions between what people's anti-abortion views and their actual practices of seeking or providing the services. For example, a 23-year-old young man, who was the only person to disclose his own experience of seeking abortion, disapproves abortion in principle but he still made his girlfriend undergo an abortion:

> *If pregnancy happens by chance, you should willingly accept what God has given you. I think abortion has its own problems. First, it is a human being that is dying. Second, it could hurt the woman. The woman may be affected by the use of unnecessary medicine. But it happened to me once. I made my girlfriend had an abortion because I was not ready to have a child.*

This quote is a typical example of how descriptive norms differ from injunctive norms in a sense that his normative view is quite different from his practice. This young man further disclosed in the interview that his girlfriend was not interested in seeking abortion because he did not decide to marry her. He was also afraid of the ensuing gossip in the community and the shaming he would be subjected to if he became a father outside wedlock. He believes that she wanted to use the pregnancy as a cause to enter into marriage which is considered a common practice in the area. That is young women knowingly get pregnant to secure marriage with someone they keen to marry. The young man encouraged his girlfriend to have an abortion but she rejected the proposal but he insisted that she should go for abortion. He told her to visit a private clinic at the nearest town and he provided the money for the abortion costs but he did not accompany her to the clinic because he was afraid to show up with her. However, as he stated, his girlfriend never sought the abortion service but lied to him pretending as if she had with the intention of using the pregnancy as a precondition to get married to him. Rather, she reportedly bought a mobile phone with the money he gave her for abortion costs. Noticing she deceived him, he persuaded her

again to seek abortion and provided the money for second time, and she eventually agreed and sought abortion.

7.2 Unspeakable but known and practiced: Dilemmas about abortion

This subsection presents two sets of dilemmas about abortion in the study area: Norms of silence and sources of information about abortion services. It entails dilemmas because the topic is not discussed in public but people know, seek and practice it. Moreover, both terminating the fetus and giving birth to a child in unwed relations are highly condemned culturally and religiously.

7.2.1 Norms of silence: Abortion, a subject not discussed in public

Many study participants cut abortion-related conversations short with a usual answer "*I don't know much about it*". A 32-year-old key informant from Dacha Gibe/Gabara who has experience of working with the people on sexual and reproductive issues explained people's avoidance of the topic in the following way: "*People rarely discuss abortion; they don't like talking about it. In our culture, abortion is considered too bad to be discussed in public."*

Controversies about availability of abortion services

In line with the general secrecy about abortion related matters, abortion service is available in the district but availability of the service is not announced in public. Both social norms and abortion law support silence about abortion but for different causes. While the former implies publicizing abortion services is considered as encouraging young people to practice it, the latter adopted silence as a strategy to avoid public resistance against the services. Most community members also hold a view that abortion is an illegal and sinful act hence the topic is not freely discussed in public. Abortion is thus not a subject of discussion in public sexual and reproductive health education in health facilities, schools, or the community. When it is addressed, particularly by religious leaders, the messages communicated tend to disapprove or condemn seeking abortion. Healthcare providers at health centers implement awareness creation programs for the youth focusing on contraceptive use, but abortion service is not included, and they express that they are afraid of explicitly publicizing the existence of abortion care services in public gatherings. The scenario is explicitly described as follows by a midwife:

> *We have regular programs of teaching the community on family planning, pregnant women's delivery services, and other reproductive health-related issues.*

> *But we do not teach about abortion. I have never heard anyone teaching about abortion so far. Teaching the people, including young people, about abortion may instigate the people to practice it even more. Besides, we provide no information in public about abortion services we offer at our health centers* (Female, Dimtu HC).

A previous employee of Packard Foundation also told that abortion was not part of their promotion of sexual and reproductive health programs. Hence, they had not addressed seeking abortion in their training and other promotion activities. The same midwife told me that although they have not taught or informed them, the people have some information about abortion services. She says:

> *Even though I have no clear understanding of their sources of information, many women who come for abortion services have information about the services. I think people who previously used the services may have shared the information to others.*

It seems that there is limited access to information about abortion services partly because three of the five health centers in the district do not provide abortion care as per the decision of the district health office managers. That is, people within the catchment area of those health centers have no formal means of access to information about abortion care services. Many community members thus have no clear information that induced abortion care service is provided at health centers and hospitals. Besides, due to lack of open discussions on abortion among community members, abortion seekers remain publicly unnoticed.

There is a wide difference between community members and health care providers regarding community awareness about abortion. The healthcare providers think that the community is aware of the availability of abortion services at health centers even if they have not been publicly announced, as they see that women seek the service. In contrast, many community members responded they have no information about it. In addition, while community members think that abortion is rarely practiced in the community, healthcare workers report that the number of abortion care seekers is significant and growing regardless of the strong culturally embedded anti-abortion views. They present this as an indicator of their claim that community members have information about the availability of abortion services. It was also explained that female students experience induced abortion, dropout from school for sometime as a result of abortion experience and come back after a sick leave. Healthcare providers also see that abortion

becomes more tolerable and it becomes more visible as it is carried out at health facilities. They also imply fewer unsafe abortions and fewer maternal deaths.

Misunderstanding about legality of abortion

The key informant who was a promoter of contraceptive use for Packard Foundation responded to the question “Did you cover the issue of seeking abortion in the health education program under the Packard Foundation project?” in the following manner:

> *Given abortion is forbidden, we advise women to use contraceptives, not abortion services. Women have to take pills to prevent pregnancy. After pregnancy occurs, they don’t need to take actions. Healthcare workers check their pregnancy status and give them contraception only if they are not pregnant. But we advise them that the traditional medicine used for fetus termination could be dangerous* (Male, 32 years old, KII and Parent, Dacha Gibe/Gabara).

A high school Civic and Ethical Education teacher from Gabara, who teaches adolescent sexual and reproductive behavior as part of the subject, similarly underscored that he never teaches about abortion as a means of avoiding unwanted pregnancy and birth, and he also holds that it is illegal. He stated that:

> *Teaching how to terminate pregnancy is religiously considered a sin, and it is a crime according to the law of this country. Thus, it is better to prevent pregnancy using condoms or other contraceptives. Or else, it is better to arrange for them to get married if a premarital pregnancy occurs.*

Accordingly, study participants label teaching about seeking abortion as both sinful and illegal act. As recurrently seen, they promote contraceptive use or marriage as preventive mechanism which is an indication of improving tolerance for contraceptive use. Many other people also have limited awareness about the legal status of induced abortion as observed from the discussions of some key community members. For example, a police officer argued that seeking abortion and providing the services are criminal acts, regardless of the ground for abortion. Variation is also observed among healthcare providers in accurately understanding the legal grounds of abortion, and the procedures for seeking and providing the services although most of them are aware that abortion is legal under certain conditions. In summary, misunderstandings prevail in the community with regards to the availability and legality of abortion services.

7.2.2 Informal sources of information on abortion services

In the previous discussion, we found that the existence of abortion services is not publicly discussed, and yet women seeking the service have information about it. This implies that there are informal sources that circulate information about abortion services. Next we will discuss how health workers of formal health facilities informally disseminate information about abortion services whereas they are reserved from sharing the information through formal means.

Health center workers as informal sources of information

Due to lack of formal and public discussion on abortion services, people's main source of information on abortion appears to be informal communications and networks. Among others, healthcare workers informally share information about availability of abortion care services during their contact in personal relations with their clients. This may be informed by the following conversation with a healthcare provider in a health center:

Interviewer: You told me that sexual and reproductive education is provided for young people.

Informant: Yes, that is true.

Interviewer: Do you gather young people for the purpose of educating them about sexual and reproductive issues? If you do that, where do you gather them?

Informant: They are not gathered for this specific purpose alone. When there is a vaccination campaign, we integrate the message with the ongoing campaign. Our staff also give advice on sexual and reproductive issues during their visit to schools for other purposes.

Interviewer: Does the content you teach include induced abortion?

Informant: We focus on pregnancy prevention but sometimes we tell them that they can consider induced abortion if unwanted pregnancy happens.

Interviewer: Do you tell them this in public?

Informant: No.We talk this only to care-seekers visiting us at the health center.

Interviewer: Do you mean you secretly do that only when they come to the health center seeking services?

Informant: Yes.

Unidentified sources of information

A dialogue with a pregnant young woman held at Dimtu health center clarifies about women's access to casual abortion-related information from unidentified community members:

Interviewer: Do you have information about abortion services from public sources?

Participant: No

Interviewer: Do you know about the existence of abortion services at this health center?

Participant: Yes, I do.

Interviewer: How did you know that?

Participant: I heard while people talk but I don't have detailed information about it.

Health Extension Workers (HEWs): The main informal sources

HEWs maintain that they are the main informal sources of information about abortion care. They share the evidence during their interpersonal interaction with women during the home-to-home visits and at health posts. It is well recognized that HEWs are very close to women and they are the main providers of health-related information for women. Above all, HEWs are in charge of ensuring the realization of the family planning program by overseeing that women in their catchment area are birth spacing, be it by improving contraceptive use or seeking abortion. That is, HEWs are told to follow up on the family planning program in a manner where also abortion is informally promoted. HEWs also have knowledge about abortion care, but they are not officially mandated by the healthcare system to give the services at their health facilities; they can only link the care seekers to health centers.

It thus seems like HEWs inform and encourage women experiencing unwanted pregnancy to seek abortion services. Even though HEWs are afraid of disclosing this information for the fear of potential negative reactions from the community, two of them during interview confirmed that they are the main source of information about abortion care services. This seems to add to the pattern where HEWs emerge as the main informal sources of information about abortion services. Actually, none of the women who participated in the study disclosed to have had an abortion experience. The observed increment, according to HEWs, in the number of women who

come to health centers for post-abortion care might also be associated with HEWs' involvement in giving abortion advice. Some of the HEWs moreover expressed they would readily provide first-trimester abortion services if they are permitted to do so. Such and other seeming agentic roles of HEWs in changing women's reproductive opportunities in rural areas are worthy of further analysis.

7.3 "The fetus would have to be aborted before it is too late": Young men's views about abortion

Young men who participated in the study are aware that induced abortion is practiced in their communities. They know - or at least have heard rumors about someone who has sought abortion. Young men are also aware that some female students drop out of school because of premarital pregnancy and abortion and that others indeed commit infanticide to avoid the shame of having a child out of wedlock. A male student shared his observation in the following manner: "*For example, I know a girl who got pregnant, gave birth, and threw away the child. She came to the town from a rural area for education and lived in a rented house.*" It was evident from informal discussions with young people, healthcare workers, and other community members that the use of 'modern drugs' (misoprostol) for abortion is practiced in remote rural areas. A story in which a mother assisted her daughter in seeking abortion after her daughter became pregnant instantly reached every one's ears in the community.

Young men are well aware that having a child out of wedlock disproportionately affects women's emotional, social, and economic well-being, and that the consequences could be devastating; it may cause ill-health and it may even claim their lives. Young men reported that a woman who gives birth to a child in unwed relations experience substantial disrespect from her family, and they believe that such women receive inappropriate treatment from their future husbands if married. Moreover, if the mother is married to a man other than the father of the child, the child is forced to grow up with a stepfather, which is considered as a source of marital disputes. Hence, they believe that terminating unwanted pregnancy reduces potential suffering of young mothers and their children. A young man narrated a story as follows:

> *She was a student, too. One day, electric power was off and there was no tap water in this town. It was early in the morning. I was going to fetch water from a river. Dogs were barking and fighting along my road to the river. I saw a girl I*

> *knew coming out of a forest. As I went past her, I observed blood on the route she headed and noticed it could be coming out of her. I followed the blood sign to the end, and I found body of a dead baby in the midst of eucalyptus trees. Dogs were eating the body. I thought she might have killed it. I cried sitting there. I could have picked up the baby had it been alive. I didn't fetch the water. I took the empty jar back home. I took my brother to the place and showed him what I had seen. He took pictures of it. Failure to use a scientific method during sexual intercourse could result in such disasters. I have never seen her again after that day* (26 year old, unmarried).

As could be understood from this story as well as from further discussion about this event during and after the interview, the young man strongly supported contraceptive use as well as safe abortion services. He suggests that using scientific contraceptive methods could reduce young women's suffering, instances of death, and infanticide. Some of the young men thought that induced abortion services should be made available to save pregnant young women from multiple risks and problems associated with premarital pregnancy and unwanted birth. A young man emphasized:

> *Abortion services should be given at health centers, because pregnancy happens unknowingly, and parents may not allow unmarried young mothers to live with them. Therefore, the presence of abortion services reduces problems related to premarital pregnancy (26 year old, married).*

Many young men who participated in the FGDs were similarly in favor of abortion as a better solution than giving birth to and living with a child born out of wedlock. A 24-year-old unmarried young man from Ako, who had a girlfriend, stated that an unwanted pregnancy should be terminated sooner rather than later, i.e. before it becomes visible to the public, particularly to the family. Another 24-year-old married educated young man from Dimtu (his case was discussed in a previous chapter), whose wife is a teacher attending college education in summer program, mentioned that his wife had not experienced unwanted pregnancy, but if it happened before she completes her studies, he would opt for seeking abortion. He explained that they had decided to postpone the first pregnancy by using contraceptives. Similarly, a 22-year-old Grade 10 complete unmarried young man from Busa stated that his partner, who was studying at a college at the time of the interview, had not experienced premarital pregnancy, but if it happened, he would help her to seek abortion care services wherever it is available. He said:

> *The fetus would have to be aborted before it is too late for a safer procedure and before her parents find out because they will get angry at her; she will drop out of*

> *school; her parents may curse her, and finally she will be mad at me. The abortion can take place in Jimma city*.

The young study participants were highly aware that there are both safe and unsafe abortion care alternatives for abortion seeking women. A young man responded to the question of whether and where abortion service is available, saying: "*Abortion seekers can go to public health centers or to private clinics. Besides, they may also use traditional medicine in rural areas.*" With regard to women's practice of seeking abortion, some young men also had the understanding that pregnant girls may use drugs other than the abortion pills. Many young men believed that abortion is safe until the fetus is four months old and that it becomes a live infant at that time; hence, seeking abortion after four months was considered as both risky and sinful. A participant said:

> *I think science approves that the conception starts to have life within four months; doesn't it? Healthcare providers also advise us that if a pregnant woman takes medicine (*abortion drugs*) after four months, it could hurt the mother* (Unmarried young man, 23, student at Ako High School, Bidaru).

Some young men who believed in the importance of abortion also stressed that people should use contraceptives carefully and effectively to prevent unwanted pregnancy, rather than opting for termination of the fetus through abortion. FGD participants also agreed that young men should help their sexual partners to abort in time rather than running away leaving them alone with the pregnancy and child. The desired active position of young men is grasped from the statements of one of the FGD participants in his response to the question: 'Should young men participate in the prevention of unwanted pregnancy and seeking abortion care?'

> *Young men should share the responsibility when pregnancy occurs. Hence, they should take part in saving their partners from the risks of social isolation and other problems. If a young woman gives birth to a child, her partner should not run away; rather, he should inform his family and get married to the young woman so that she will not experience hatred and discrimination from her family and the community.*

Even though young men prioritize proper and careful contraception use over induced abortion, their agency of supporting abortion as a solution for unwanted pregnancy among unmarried young women boldly manifest as an emerging element of youth subculture. Some young men participated in this study, as presented above, justify the need of abortion even beyond the extended legal grounds permitted in the Abortion Law of Ethiopia. Their supportive arguments in favor of induced abortion are based on the negative emotional, social, and economic

consequences of premarital pregnancy and birth. They think that abortion reduces the potential suffering of young mothers and their children. The specific multiple negative consequences they pinpoint include dropping out schools, disrespect from the family, being cursed and stigmatized in the community, ill-health, loss of lives, and receiving inappropriate treatment from the future husband when married.

They boldly argue that abortion is a solution for girls experiencing premarital pregnancy when entering into marriage with partners impregnating them is not feasible. As a result, their agency manifest in the following ways. Firstly, they accessed basic information about abortion practices in the community and availability of abortion services in the rural context where access to such information is limited. Secondly, they boldly support the women's need of abortion in some specific circumstances and strongly demanded improved access to abortion care for unmarried pregnant young women. Thirdly, they sympathized abortion-seeking women who are disproportionately affected by the consequences of unwanted pregnancy and birth. Yet, they continue considering abortion to be sinful and risky for fetus beyond four months by adopting the proclaimed scientific evidence.

In practice, however, many young men usually do not accompany their abortion seeking partners to health centers. A midwife attests to this tendency saying: "*Male partners hardly come to health centers together with their female partners for abortion services for unmarried partners in particular. Most young women come alone and many of them are students.*" Detailed accounts about young men's involvement in abortion seeking when their partners experience unwanted pregnancy are presented in Chapter Eight.

7.4 Discussion

The Ethiopian Abortion Law (FDRE, 2005) in general and the Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia in particular (Ministry of Health, 2014), have ensured progressive provisions of safe abortion care. The present abortion law has removed the severe restrictions of the 1957 Criminal Code to access abortion and paved ways for a more rights-oriented abortion care. The law and the guidelines have extended legal grounds for abortion-seeking women to access abortion services (Article 551 sub-articles 1A-1D, p.356). The policy shift on abortion in Ethiopia took place in response to the global agenda of maternal

mortality reduction. The law was influenced by MDGs and the 1994 ICPD, which both implied an ideological shift towards viewing people as agents with "reproductive rights", rather than objects whose fertility is subject to external control. The policy shift was also influenced by the strong desire of the Ethiopian Government to reduce the country's high maternal mortality rate.

Three forms of contradiction about induced abortion and their implications for young men's involvement in abortion seeking are identified in this chapter. First, there is a lack of public discussion and public sources of information about abortion, while community members nonetheless know about abortion services and utilize them. Second, arguments for and against induced abortion are identified with conditional acceptance and rejection of the practice, respectively. Women's social status (e.g. being young, a student, or unmarried) and health risks are reasons for those who argue for abortion. In contrast, the opposing arguments are dominantly religious-oriented. Yet, there are overlapping and shared features between the two positions. Finally, contradictions are observed in young men's views and practices with regard to their involvement in abortion, which is a reflection of the other two forms of contradictions. Accordingly, there are diverse views and practices among young men about induced abortion. Some tend to conditionally accept the practice, whereas others reject it in favor of prioritizing contraception or marriage.

There were clear differences among community members in terms of their awareness about abortion. This must be at least partly related to the limited access to formal sources of information and lack of public discussion about the topic (Tadele et al., 2019). Lack of public discussion about abortion is partly because it is culturally considered as openly unspeakable and partly it is considered as illegal act. Rather, disapproving messages are communicated by religious leaders, by school teachers and even by reproductive healthcare service promoters and providers. A reason for the public silence around abortion is the fact that open discussion would lead to a further normalization of the practice on the one side and due to a fear that it will lead to opposition against the prevailing abortion law on the other. This finding is similar to that of Purcell's (2015) finding that found abortion is only partially represented in the media news. The success of the Ethiopian abortion policy partly seems to be related to public silence combined with numerous informal information sources as identified by Tadele et al., (2019).

The discrepancy between lack of formal sources of information, open public discussion, and personal interest to discuss induced abortion, as well as the strong disapproval norms against the practice are best explained by Purcell's (2015) argument that abortion is framed in abstract terms, and debates about it as a moral and ethical issue are removed from women's lived experiences. The strong disapproval of safe/legal abortion seems to be insensitive to women's rights, choices, and needs. Moreover, it overlooks the negative consequences of women seeking for illegal/unsafe abortion care due to the lack of access to safe/legal abortion services. People's understanding about the legal status of seeking abortion is nonetheless very limited, even among some school teachers, justice officers and healthcare providers. This could possibly be a reflection of the ambivalent legal definition of abortion in Ethiopia. In broader terms, abortion is a criminal behavior as defined in Criminal Code of Ethiopia (2004) except for some grounds as presented in the 2005 Abortion Law of Ethiopia.

Views that tend to recognize seeking abortion care to secure women's health are emerging more commonly among young and educated people whereas choice and rights-based arguments are rare (Tadele et al., 2019). Opposing views however prevail among religious leaders and adults. Positions of healthcare providers, men, and women vary depending on the different situations of abortion-seeking women. Critical viewpoints that tend to judge the necessity of induced abortion as an exception, not as a rule, are based on a case-by-case justification. Such views are held by a few people and healthcare workers. People whose views fall in this category emphasize that prevention through contraceptive use should be given priority and abortion should be a last resort only when it is unavoidable for different reasons. Induced abortion is strictly prohibited from cultural points of view as well in the study community, as is the case found in numerable societies elsewhere (Lerner et al., 2006), and seeking it symbolizes moral inadequacy of the involving individuals and their families (Kebede et al., 2012). Some individuals from different social categories tend to find induced abortion to be intolerable and leave no room for the possibility of legally acceptable grounds except for saving the life of the mother.

Strong disapproving stances against induced abortion are manifested mainly among religious leaders who consider abortion the same as killing a human being. According to EOTC leaders, however, when things beyond the couples' control (e.g. serious health issues) force them to prevent pregnancy or terminate it with induced abortion, they can exceptionally be permitted to

consider the alternatives. Yet, the decision has to be made in consultation with the religious leaders. Involvement of young men is largely influenced by the disapproval social norms of the local community and the abortion law of Ethiopia through the silencing effects of both systems but for different causes. The young man impregnating a young woman and his parents are also strongly condemned in the present study area. The 2005 Abortion Law of Ethiopia disregards men as role players in abortion seeking processes.

In Ethiopia, the process of decision making on abortion is challenging among young women in particular (Singh et al., 2010). Kebede et al. (2014) found that women have difficulty in engaging in open dialogues about their sexual experience, partly due to discouraging gendered moral discourses about female sexuality. Similarly, our study reveals silence on abortion matters. Those who disapprove seeking abortion except for saving a mother's life suggest marriage as a better solution to avoid abortion and escape from the negative consequences of unwanted pregnancy.

The study findings also confirm the existence of incompatibility between restrictive moral/social rules and young people's sexual and reproductive behavior as shown by studies from the sub-Saharan Africa (UNESCO, 2013). For example, educated women in south Cameroon condemn abortion, and yet they practice it regularly to manage timing and entry into a socially recognized motherhood (Johonson-Hanks, 2002). In Ethiopia, a discrepancy between the moral standards that condemn premarital sexuality, adolescent pregnancy and induced abortion, and young people's actual practice has been empirically established (Berhane et al., 2014; Kebede et al., 2012 and 2014; Seifu et al., 2006). In the study area, like in southern Cameroon, for a young school girl, bearing a child is strongly linked to ending her school career (Johonson-Hanks, 2002). Studies show that, regardless of clear moral sanctions, an increasing number of young women in Ethiopia seek abortion (Kebede et al., 2012). In the present study, abortion seekers do not have authentic public sources of knowledge about the legal status, grounds of abortion, and availability of services. Some young men disapprove induced abortion while others consider it as a solution for unavoidable unwanted pregnancy to revert its undesired consequences. Those who support manifest features of youth subculture and exercise agency.

7.5 Conclusion

Induced abortion remains a debatable topic and is highly contested in the study area. Norms of silence, disapproval religious/cultural norms and the abortion law of Ethiopia uncomfortably coexist. Dilemmas about abortion that it is unspeakable but known and practiced in the study communities emanate from the norms of silence and lack of official sources of information about the phenomena. The categorization of approval or disapproval views about abortion is a matter of continuum given one side is not exclusive from the other rather contains virtues of the other. That is, those who largely disapprove the practice partly approve it on exceptional grounds whereas those who tend to approve do not do it unconditionally. Those positions are constructed based on competing and hierarchical norms of fertility and social values. Generally, however, there is a growing tendency towards increasingly tolerating abortion given the undesired consequences of unwanted pregnancy including unavoidable women's seeking for unsafe abortion, when denied access to safe abortion, that likely claims their lives. More specifically, the young men and educated people are challenging the status quo of uncritically disapproving women's seeking abortion in favor of supporting abortion based on practical and justifiable needs of abortion-seeking women. Systemic and public silence about induced abortion does not fully prevent abortion seekers from having access to information about the availability of abortion services; nor does the strong community disapproval of abortion stop women from having pregnancies terminated. Given that the legal frameworks are national and that the powerful culturally/religiously-embedded anti-abortion norms and sentiments are found throughout Ethiopia, it is likely that the findings of the present study are relevant also to other settings in rural or even in urban Ethiopia.

CHAPTER EIGHT

RESTRICTED ACCESS TO ABORTION ALBEIT PROGRESSIVE ABORTION LAW

Introduction

Chapter Seven presented formal (abortion law and guideline) and informal (cultural and religious) norms related to abortion. Young men's views about abortion in the contexts of those norms were also explored. As an extension from Chapter Seven, this chapter deals with abortion-seeking women's access to abortion care services in the presence of the progressive abortion law and disapproval cultural/religious norms. More specifically, Chapter Eight examines how the progressive 2005 Abortion Law of Ethiopia, the disapproval cultural/religious norms and healthcare practices at the grass root level influence abortion-seeking women's access to abortion care services. Systemic barriers and healthcare workers' use of discretion in providing abortion care, their implications on abortion-seeking women's access to the service and involvement of young men in handling their partners' unwanted pregnancy are examined in the chapter.

Women's access to and utilization of abortion services have attracted attention of researchers and policy makers (EDHS, 2011; Ipas, 2010; Jones et al, 2014; Rominski et al., 2015; UNESCO, 2013; UNFPA, 2012; Zenebe and Haukanes, 2019). Scholars in the field agree that the broader sociocultural contexts in which abortion take place such as the legality, accessibility, and acceptability of the practice influence women's decision to seek for abortion care (Bajos et al., 2014, p. e91539; Purcell, 2015). Although it is established that policy and legal frameworks are important instruments to ensure the right to abortion services, access to legal abortion care is not guaranteed by a mere presence of permissive policies and laws. The access is influenced by a number of structural and relational factors that regulate women's sexuality and pregnancy decisions (Forte 2018, p.7).

Therefore, reducing unsafe abortion and its consequences is mediated by social, economic, and political factors that influence implementation of the laws (Berer, 2017; Blystad et al., 2020; Moland et al., 2017). Blystad et al (2019), Getnet et al., (2019) and Zenebe and Haukanes (2019) have also examined abortion policy and services in Ethiopia. Abortion related knowledge and practices, service conditions, women's negotiation and decision making are also well documented by many scholars (Getnet et al., 2019 and Kebede et al., 2012 and Kebede et al.,

2014). Among others, Blystad et al., (2019) argue that regardless of the legal statuses of abortion in Ethiopia, Tanzania and Zambia, access to legal abortion services are restricted in one way or another hence women seek unsafe abortion.

As stated in the preceding chapter, abortion by a recognized medical institution within the permitted period is allowed if: the pregnancy is a result of rape or incest or the continuation of the pregnancy endangers the life and health of the mother or the child; the fetus has an incurable and serious deformity or the pregnant woman is physically or mentally unfit to bring up the child. According to the Procedural and Technical Guidelines of Safe Abortion Care Services in Ethiopia (MoH, 2014), all health centers are supposed to provide first-trimester abortion and post-abortion care, but refer women who seek second-trimester abortion care to hospitals. An important additional condition stated in the law (Article 551 sub-article 1A p. 8) is that abortion-seeking women are not required to justify or verify the reason for seeking abortion – a mere statement based on the four legal grounds for abortion is sufficient for gaining access to the service. In the guidelines it is specified as follows:

> *Termination of pregnancy shall be carried out based on the request and the disclosure of the woman that the pregnancy is the result of rape or incest. This fact will be noted in the medical record of the woman. Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion service* (Section IV, No 1, p.9).

Accordingly, abortion-seeking women and healthcare providers are to make informed decision on abortion care with no pressure and interference from a third party. In the pre-abortion care counselling, accurate and sufficient information needs to be provided with regard to the methods of pregnancy termination, including advantages, disadvantages and comparative risks of both continuing the pregnancy and terminating it. Overall, the guideline favors abortion seeking women to access the services (Article 551 sub-articles 1A-1D, p.356).

Studies from various countries demonstrated that healthcare workers find the criteria for legal abortion services frustrating (Foster et al., 2016; McLean et al., 2019). The use of rape and incest as reasons for seeking abortion is both common and contentious (Evans et al., 2023). A study from Brazil showed that healthcare workers were particularly grappling with the provisions or

the clauses that provide the word of abortion-seeking women to be taken-for-granted, which allegedly lead many women to use rape as a "cover" for seeking abortion (Diniz et al., 2014).

Mclean et al. in a study of abortion service providers in Addis Ababa, Ethiopia, found that healthcare workers' discretion in deciding who gets access to safe abortion entails considerable ethical dilemmas (Lipsky, 1969). The dilemmas arise when the professionals interpret and implement the law in a bid to balance between their religious faith and values and their strong professional obligations and concerns for women's health. Ewunetu et al. found that religious distress and the stigma associated with providing abortion influenced the healthcare workers' view of the law and abortion practices, and it even caused some to experience severe frustration and burnout (Ewnetu et al., 2020). The same authors in a related article argue that, although Ethiopia's 2005 abortion law improved access to legal abortion services and women's freedom to choose, healthcare workers were confronted with new moral dilemmas and challenges (Ewnetu et al., 2022). The authors state that "the law appears to have opened a large space for professionals' individual interpretation and discretion concerning whether criteria for abortion are met or not" (p.1).

Syvertsen, in a study from Jimma town in Ethiopia, argues that healthcare workers complain that some women do not use words that fit with the legal grounds for safe abortion care, which does not make them eligible for the service (Lans Syvertsen, 2021). In cases when women do not have reasons recognized by the law but still insist on getting the service, Syvertsen (Lans Syvertsen, 2021) found that professionals nonetheless often provide the service by recording the reason for seeking abortion as '*She was raped'*. According to Syversten, claims of rape or incest were found to be the most common reasons that women stated to gain access to the service.

Most previous studies on the abortion law have been undertaken in urban areas mainly in Addis Ababa (Blystad et al., 2020; Ewnetu et al., 2022; Lans Syvertsen, 2021) while only a few studies have been conducted in regional cities like Jimma (Lans Syvertsen, 2021). Overall, healthcare workers' perspectives on abortion laws in rural Ethiopia are not well studied. Exploring how healthcare workers perceive, interpret and implement the abortion law in rural contexts where abortion is often strongly disapproved, is important to understand both the abortion-seeking women's actual access to the services at the grass-roots level and the potential implications of

the findings for policy (Ewnetu et al., 2022; McLean et al., 2023). The next sections will present the results of the study organized into two major themes: systemic barriers and healthcare workers' discretion.

8.1 Systemic restrictions to abortion care

This section presents systemic restrictions to women's access to abortion care at the grass root level. Anti-abortion or disapproval dominant cultural and religious norms, and limiting healthcare services management systems including lack of abortion care training, limiting the number of health centers that provide abortion care and challenging referral system constitute the systemic restricting factors.

8.1.1 Abortion care training as a tool of restriction and avoidance

One systemic factor restricting access to abortion care is lack of access to abortion care training. In the first place, providing abortion care is not legally mandatory for a healthcare provider unlike post-abortion care hence receiving the training is also voluntary. Secondly, there is no such training program implemented by the healthcare system after Ipas, an international NGO, provided sample training. As a result, only a few health workers in the district had taken the training and Ipas was not providing the training during this fieldwork nor the healthcare system. A midwife questions the reasons why their health center does not provide abortion care services while it is supposed to serve according to the abortion guidelines. She states the points as follows:

> *I don't understand what prohibits us from giving the services. Actually, there is no rule that prohibits abortion from being administered in this health center by the existing staff. They say 'abortion care is carried out by a trained person so taking the training is required.' However, nobody has been invited to take the training since I came here. The district health office also knows that we are not providing the services because we have not taken the training.*

The midwife points out that provisions of the guidelines are overlooked by unnecessarily adding taking the training as mandatory criterion to provide abortion care. As the study participant pointed out, the guideline presupposes that health center staff can provide at least first-trimester abortion care with their basic training as BSc nurses, midwives, or public health officers even though it prescribes specific on-job

training for second-trimester abortion to better perform the procedures. The guideline gives the specifics as follows:

> *The following health workers are authorized to perform abortion procedures for first-trimester pregnancy using medical abortion and/or MVA: clinical nurses, midwives, health officers, GMPs, and those that have higher qualifications than these. GMPs and health officers with additional training on the specific skills needed for second-trimester abortion and specialists in obstetrics and gynecology are authorized to perform second-trimester abortion procedures (p.18).*

To the training point, some health workers and district health administrators think that training is demanded whereas some other health workers argue that the training is not mandatory to provide abortion care but only experiences for healthcare workers authorized in the guideline to provide the care. A contrasting view that supports the necessity of special training as a precondition to provide abortion care is given by another healthcare worker:

> *Only trained professionals in safe abortion care can provide the services because it needs special training. Therefore, healthcare workers who are interested in providing safe abortion care can take the training on how to deliver the services.*

However, the same healthcare worker further hinted that special training may not be mandatory to provide abortion care:

> *I have taken training on mothers and child health care (MCHC) to work in women and children's ward. All staffs working in women and children's health care unit have taken MCHC training which focuses on delivery, abortion, and pregnancy care.*

It seems that healthcare workers have different opinions on whether taking special training in administering legal abortion should be mandatory based on their personal positions, beliefs, or interests. The difference may also emanate from their level of understanding about the abortion law and abortion care guideline.

Evidences obtained from interviews also reveal that some healthcare workers are against abortion care for cultural and religious causes hence they are not willing to receive the training. They also discourage their fellow workers from attending the training or they even further stigmatize those who provide the service.

District health office administrators take the position that the training is a necessary criterion and they allow health centers to provide the service only if they have at least a trained healthcare worker. The implication is that if those trained health workers leave the health centers, they cease to provide the service because there is no training opportunity for other workers to replace the missing staff. However, healthcare workers are not obliged to provide abortion care unless they have taken training on the management of abortion care. Taking the training is also not mandatory, which implies that if no one is interested in the training, a health center does not provide the service at all.

8.1.2 Only two of five health centers provide abortion services

Comprehensive abortion care is not provided at health posts where rural women can easily come in contact with healthcare facilities. A Health Post (HP) is the lowest level healthcare facility and the closet community-based tier in the primary healthcare system where health extension workers (HEWs) provide four components and 16 packages of the health extension program (HEP). At health posts health extension workers can only identify symptoms, provide counseling and refer cases to health centers. Moreover, only two of the five health centers in the district, namely Dimtu and Ako, provide abortion care fifteen years after the enactment of the progressive abortion law and the abortion care guideline as evidence obtained from the district health office and the five health centers indicates. As discussed in the preceding subsection, the service is lacking in the health centers by a pretext for lack of trained health worker in abortion care. In principle, however, all health centers were supposed to provide first-trimester abortion and post-abortion care as per the Procedural and Technical Guidelines of Safe Abortion Care Services in Ethiopia (MoH, 2013, 2006). The other three health centers: Raga, Busa, and Dacha Gibe, were not providing the service. A mid wife stated that:

> *A comprehensive abortion care is not provided in our health center. But pregnant girls come to us seeking pregnancy check-up and abortion care. When a pregnancy test shows a positive result, they want to get it terminated, but we tell them that we do not do that.*

No formal direction is set by the district health office as to what the healthcare providers and abortion seeking women should do in the absence of abortion care at health centers. As a result, abortion care seekers are differently treated and receive inadequate responses from healthcare providers at the respective health centers. Some are referred to other health centers or hospitals to seek abortion care or advised to go home and keep the pregnancy to full term. Advising the

women to go home or to keep the pregnancy to full term, or just ignoring their concern is against the provisions of the guidelines, which state:

> *All health personnel involved in the care of the woman have an ethical responsibility to direct her to appropriate services at any time. Refer a woman if the type of care that she needs is beyond the capacity of your institution (MoH, 2006: p.15)*

Evidence also shows that some young women from the Gabara area visit Ako or Dimtu health centers for abortion care.

Some healthcare workers of the three health centers complain about the decision and the differential treatment of the district health office. Health centers are designated into abortion care 'providers' and 'non-providers' based on availability of trained staff in abortion care procedure. The training had not been given anymore after the Ipas pilot project and the healthcare system was not giving such a training. Therefore, it is paradoxical that the system has no training program for abortion care but the heath service managers at the district level use the training as a criteria for healthcare workers and health centers in order to provide the services. In this view, Ako and Dimtu health centers were given the chance to take training on the management of abortion care and were consequently allowed to provide the service but the remaining three health centers were reportedly denied the chance. Ipas provided a limited quota for training given to health centers in the zone and the government had not scaled up the training by the time this data was collected in 2020.

The tone of the interviewees from the health centers that do not provide abortion care indicates that the absence of the first-trimester abortion care services in the health centers is a deficiency of the district healthcare system and the leadership as they were supposed to provide the services as per the abortion care guidelines and healthcare standards for health facilities. A midwife at Dimtu health center also reflected that the gap in abortion care providers should be filled to increase women's access to the care in the district: "*Many women come to our health center (*Dimtu*) for abortion care outside from our cluster. This should not have been the case. All health centers should be empowered to give abortion care."*

8.1.3 Challenges of abortion related referrals

Another systemic restriction built into the local health care system is the lack of clear direction on what the three health centers that are not providing abortion care should do for the abortion-seeking women visiting them. As all health centers are supposed to provide first-trimester abortion care with a similar standard, some healthcare providers believe that a health center is not supposed to refer abortion care seekers to another health center. Healthcare providers at one of the three health centers that do not provide abortion care reported a case of a premarital pregnant young woman who sought abortion care, but they could not help her because of the restriction. Here is an example of a case where the service was denied:

> *Our responsibility is to refer abortion care seekers with above four months of pregnancy to hospitals because there could be bleeding in such cases. Otherwise, we never refer first-trimester abortion cases to other health centers and do not carry it out at this health centre.*

Probing questions were posed for further elaboration of the reasons why some healthcare providers refrain from referring abortion-seeking women to where the service seekers can find it. The questions include: "Is there any rule that prohibits you from giving the referral order to visit another health facility?", "Why do you just tell them that they can't get it with you while you can correctly refer them where they can find the services?" A midwife elaborates the issue:

> *We tell them. We say, 'We do not give the service here; you can get it in another district. There are other health centers even in this district itself where you can get the service, but we cannot do it here.' We also tell them: 'When you abort, you may face this and that problems. But you can go to these health centers if you want.' Then, they go home. We never formally refer them to other health centers.*

The conversation with this midwife and my observation of her facial expressions give hints that she is not convinced by the decision that restricts them from providing the abortion care and she has interest to provide the services. She sees district health leaders' decision of allowing some health centers to provide the service and refusing others from doing the same as discriminatory because she does not recognize taking abortion care services as appropriate criteria to provide the service. She, like some other health workers, argues that her lack of interest to support first-trimester abortion seekers on how and where to access the services is associated with this

disappointment. Her rationale that "*referring abortion seekers from one health center to another is not appropriate because all health centers give similar services in principle"*.

It is worthy of note that regardless of other factors, including conflict of interests, the guideline presupposes a healthcare provider to arrange referral links to wherever the service is available if one cannot provide it. Even though a healthcare provider in a health center not providing the service is logically expected to refer cases to other health centers where the service is available, some refuse to do so.

Referral linkage is very important for access to safe abortion services particularly for the second-trimester abortion as stated in the guideline. The need for referrals for 'normal' first trimester abortions is odd given all health centres are assumed to offer the service. However, referral from health centers that do not provide the services to another on their status of providing abortion care is practically needed due to a lack of clarity on the guideline that states, in theory, all health centres should offer the service. As presented in the case of healthcare workers' response to opportunities of abortion care training, this loophole is used by some healthcare workers to deny women access by not referring them to health facilities where the services are offered. One of the health workers' discretion is related to lack of referrals that is manifested by telling them to go home. In the next section, we will discuss in further details about health workers' discretion in providing the services. As it goes without saying that if you do not offer a service that women have the right to use, then a patient needs to be referred.

8.2 "We need to confirm at least from two or three": Healthcare workers' use of negative discretion

The findings reveal that healthcare workers often use discretion in their interactions with abortion-seeking women in a manner that impedes women's access to abortion care. However, we also find a few examples of healthcare workers who use discretion to meet the needs of abortion-seeking women. The identified negative discretionary performance of healthcare providers will be presented in the following three sub-sections: 1) making a decision on behalf of the abortion-seeking women, 2) involving third parties in making decisions about the abortion-seeking women, and 3) using additional/alternative criteria that are not part of the law/guidelines

as preconditions for accessing abortion service. Negative discretion generally means that the providers are not implementing the law as intended.

8.2.1 Making decisions on behalf of the abortion-seeking women

During the course of the fieldwork, it became clear that many healthcare providers make decisions on behalf of the abortion-seeking girls/women and challenge them to take a different stance and to change their minds, rather than giving them balanced and legal- and policy-based pre-abortion counseling. A midwife who complained to have been forced to provide abortion care tried to convince her clients to keep the pregnancy to full term unless the clients insisted on getting an abortion. She asserted her view saying:

> *Giving abortion care is a very difficult task. I got into abortion care giving unknowingly. It was against my personal interest. Hence, before giving them the abortion care services, I try to convince abortion-care-seeking women to keep their pregnancy. I advise and encourage them to avoid seeking abortion. I don't rush to give abortion care; rather, I focus on educating them not to abort, and I also counsel them about the disadvantages of abortion. As long as a pregnant mother has no serious health problem, we recommend that she should keep the pregnancy instead of aborting it. That is, we mainly try to counsel pregnant women not to abort. This is all we do with abortion care. So abortion care is the last resort. When a woman totally refuses to carry her baby to the full term, I give abortion care.*

The quote shows that the healthcare worker is more preoccupied with making the woman change her mind than establishing the legal reason for the abortion. A HEW similarly reported her proxy decision making on behalf of an abortion-seeking woman as follows: "… *For instance, a woman came to me and asked me for abortion care services. However, I told her to give birth because she was married."* Another HEW said, "*I told her* [the abortion-seeking woman] *it was difficult to abort a six-month pregnancy, provided her with counseling services, and accompanied her to her home*."

According to the abortion care procedural guidelines, this latter HEW should have referred the case to a health center, but she did not do this as she believed that being married and having moved far into the pregnancy were against the acceptable norms in terms of gaining access to abortion services. Her decision on behalf of the pregnant woman thus contradicted the norms of the service provision, which tells healthcare workers to counsel abortion-seeking women by

explaining both the advantages and disadvantages of abortion and encourage them to seek abortion based on legal grounds (Article 551 sub-articles 1A-1D, p.356). Most importantly, when legal requirements are met the choice should be left to the abortion-seeking woman. The healthcare providers are then expected to provide abortion care or refer the woman to a place where she can obtain the service. However, staff in health centers which do not provide abortion care may not give the women proper advise. As a result, the abortion-seeking women are left in circumstances where they find it difficult to access the safe abortion services. For instance, a midwife working at a health center that did not provide abortion services said, "*We tell them the disadvantages of undergoing abortion. Then, they may go to other districts for abortion care, but I don't know much about that."*

8.2.2 Involving third party: endangered anonymity

The findings revealed that in their encounters with abortion-seeking women, healthcare workers involve third parties like parents, partners, local leaders, health extension workers, friends and even the rapist in the decision making regarding abortion care. For instance, a midwife said, *"I first consulted her mother; I also informed the father*." They were found to commonly require abortion-seeking women to bring any of these third parties to justify the abortion and endorse the abortion-seeking women's decision. A story shared by a HEW is a typical example that reveals the involvement of third parties in the decision-making process. She narrates the story as follows:

> *One day, a six-month-pregnant young girl came to my office seeking abortion care. I first consulted her mother and told her that premarital pregnancy could happen among girls. I informed her that her daughter got pregnant and advised her that once the pregnancy occurred, her daughter should not be exposed to different health risks. In the beginning, the mother was shocked. However, gradually I persuaded her, and she accepted my advice. In consultation with the mother, I also informed the father. Like the mother, the father was shocked in the beginning. Nevertheless, I helped him calm down and control his emotions. In this way, I resolved the problem. As a result, the young woman adjusted herself to the situation, and her parents provided her with the necessary support. I also continuously visited and supported her at home or offered her to visit me at the health post any time. When the pregnancy period was due, I took her to the health center for the delivery service and she safely delivered there. After recovery, her parents took her back home. After staying with her family for some time, she went*

> *to Finfinnee (*Addis Ababa*). She dropped out of school due to the unwanted pregnancy and birth.*

The story demonstrates that the measures taken by the HEW are not in line with the abortion law and abortion care procedural guidelines. The guidelines stipulate that an abortion-seeking woman should be referred to a health center (for potential further referral) or to a hospital. Referring the case directly to a hospital, if that is practically more appropriate, is also possible, as observed during the data collection. In fact, due to geographical proximity and accessibility, sending clients directly to hospitals may at times be easier and more useful than referring women to the health center of the catchment area, which may or may not offer abortion services. The story also involves elements of the kind of proxy decision making discussed above. In this case, instead of providing the abortion seeker with the counselling service about her options, her parents were consulted without the consent of the girl.

Healthcare workers' decision to involve the abortion seekers' partners in the decision making demands particular attention, as this was commonly encountered. In the process of making decisions about the fate of the pregnancy, it was found that healthcare workers would involve the partner without the consent of abortion-seeking women. This practice contrasts with the principle of ensuring the abortion-seeking woman's privacy, and the fact that the abortion seeker is the primary decision maker about whether or not she wants to keep the pregnancy. In such cases, the anonymity of the abortion-seeking woman is not kept, as is the case in the following example:

> *If two partners disagree on whether abortion should be sought, we involve the HEWs and the 'kebele' manager who go to the partners' home to resolve the issue through negotiation. If they fail to agree, we take the case to religious leaders. If the husband still refuses to accept the religious leaders' decisions, we have nothing else to do but apply the abortion law of the country. That is, as the law supports us, we administer abortion care for the woman who seeks it* (Healthcare provider at a health center).

Another healthcare worker had a similar stand on the importance of consulting and getting confirmation from a third party:

> *We need to confirm at least from two or three of the young woman's friends. It is then that we should help. I know a case around Gibe where a family went to visit relatives, leaving at home a young woman and a young man who had blood relations. The young man and the young woman were sleeping together, sharing a bed, whereby the young man raped the girl. After some time, she came and told us*

that her menstrual cycle had stopped. When she was tested for pregnancy, the result was positive. She told us that her uncle raped her and that she was going to take the Grade 8 national examination. Then, we asked her to call the man, but when he heard this, he disappeared, dropping out of school. When we asked her to bring someone who could confirm this, she told us to call her mother. Her mother came and her father was also informed. After confirming the cause, we referred the case to Sokoru health center in an adjacent district where the fetus was aborted in a private clinic.

Providing abortion care without the consent of the husband indeed seems to be an exception in the study area. Of note is a midwife's assertion:

But sometimes, when a married woman complains that her husband is not providing the necessary care and support for his children, we give abortion care after she signs the abortion agreement form without the consent of her husband. However, as much as possible, we urge couples to reach an agreement on abortion care. If not, it could lead to a conflict between the couples, and may even cause divorce.

8.2.3 Using extra-legal criteria as preconditions for abortion

In addition to healthcare workers' discretion discussed in the preceding sections, we also found that some healthcare workers use additional, but not legally endorsed, criteria to either provide or deny access to safe abortion care services to girls and women. Such criteria included, for example, using incorrect time reference for the pregnancy, checking the marital status of abortion-seeking women, verification of reasons for seeking abortion, and making family planning a precondition for providing the abortion service as discussed below.

Misconceptions about timing of pregnancy and seeking abortion

The following quote reveals that some HEWs would refrain from referring abortion-seeking women to hospitals or clinics based on the timing of their pregnancy, albeit not in accordance with the timing established in the abortion care guidelines. A HEW stated:

We have been told as part of our health education that if a mother aborts a fetus that is more than three months, it causes serious health damage to the mother. Since it is highly risky for the life of the mother, we do not encourage undergoing abortion after three months of pregnancy. It is better for her to give birth to the child. I think, if the fetus is less than three months old, abortion is acceptable because it does not cause any harm to the mother.

The quote implies that either the HEW misunderstood the provisions about time limits detailed in the guidelines or was not willing to apply them. It also seems that her assumptions about the consequences of seeking abortion are misleading, given that she states potential harms that are not presented in the guidelines. A similar confusion was observed among other HEWs and some other healthcare workers at health centers. For example, as noted across many interviews, there was a strong tendency of rejecting second trimester abortions under the pretext "*It is difficult*". As a result, referrals of second-trimester cases to hospitals were rarely reported by the healthcare workers. The guidelines, however, clearly state that, while first-trimester abortion care should be provided at health centers by relevant health personnel, cases of second-trimester abortions should be referred to a hospital to be safely managed by trained physicians.

Marital status as a precondition to access abortion care

Systematic checking of marital status as part of the decision-making process for abortion care is another example of extra-legal demands from the healthcare workers. A healthcare worker asserted, "*We always check whether a woman has a husband before giving abortion care.*" Although attempts to know about the marital status of an abortion-seeking woman is not a problem in itself, forcing the woman to ensure the consent of her husband for seeking abortion care, which happened in cases of abortion-seeking women in the study area, is not in line with the stated provisions. Another healthcare worker, who had experience of quarreling with a husband when he (the health worker) administered a contraceptive to the wife, argued that he would not provide abortion care without the consent of husbands. He explained:

> *For married couples, we do not provide abortion care if a woman comes alone or if her husband has not given his consent. Thus, we insist that she should persuade her husband and bring him to the health center.*

"If a woman refuses family planning, we don't give abortion care"

Requiring that an abortion-seeking woman should use contraceptives as a precondition to get access to abortion care was another unofficial requirement encountered. This goes against the principle of the safe abortion guideline that reads: "*Family planning services are based on a free and informed choice and the availability of methods*" (P.8). The abortion care guidelines highly encourage abortion care providers to integrate pregnancy termination with family planning

services, including contraception, to prevent unwanted pregnancies in the future. That is, while giving abortion care, healthcare providers are expected to encourage or counsel abortion-seeking women to use contraceptives, but they are not to make contraception use a precondition to access abortion care. However, we found that some healthcare providers made contraceptive use mandatory to access abortion care. One of them said:

> *We also give counseling to abortion-seeking women on how to use family planning services to prevent unwanted pregnancy in the future. Thus, we try to convince abortion-seeking women to use the services before giving them abortion care. If an abortion-seeking woman refuses to use family planning, we do not give her abortion care because she will make the same mistake in the future.*

This quote again demonstrates healthcare workers' discretion in giving access to women or preventing them from gaining abortion services, in this case based on contraceptive compliance.

Health providers' discretion that often worked in disfavor of the abortion seeking women, needs to be understood in a context where health workers operate in the broader normative contexts of the rural communities, - where they live their lives not only as health workers, but also as daughters, mothers, wives, aunts etc. which influence the ways they operate professionally. The anti-abortion sentiments and norms highly prevalent in the communities is thus highly likely to constrain their professional conduct. Knowledge obtained in other arenas of the fieldwork suggests the presence of religious and cultural norms which are highly disapproving of abortion. The fact that only two of the five health centers in the district provide abortion care, and the lack of referrals from the health centers to health facilities that do provide care moreover speak to health workers who operate outside of the legal framework.. What is more, few of the healthcare providers had received abortion care training that is considered a precondition to provide the service. As the training is not made mandatory for health center staff, many are not willing to attend the training due to their religious and cultural convictions against abortion.

8.3 Healthcare workers' discretion to meet the women's needs

This subsection presents practices of healthcare workers who do not use negative discretion but rather interpret the law and the guidelines in a way that helps women access abortion services. Some of the healthcare workers interviewed tend to carefully abide by the law and the guidelines

as far as their level of understanding allowed. Good knowledge about the legal provisions is expressed by the following healthcare worker, who said:

> *There is a guideline that clearly states the rules of abortion care. According to the guideline, we give abortion care if the fetus is highly dangerous for the mother's life due to illness or other related health concerns. Also, we give abortion care if the mother cannot care for the child due to health, age, disability or other risk factors that may hamper her capacity.*

There were also other healthcare workers who were willing to give the services to the needy clients and who wanted to interpret the laws in favor of the abortion-seeking women or girls. A healthcare provider at a health center, for example, revealed her readiness to provide the service:

> *We give priority to the women's preference, health and life. We do not require abortion-seeking women to produce evidence for their claims or to prove their marital statuses as long as they mention one of the four criteria for legal abortion. Healthcare provision demands keeping secrets of a patient so that her words are respected, and saving her life is our primary concern. We give abortion care services for a woman who claims she has no husband even if we suspect that she does.*

This healthcare worker interpreted the law in line with its intention; that is, meeting the woman's health and survival needs while observing professional ethics of retaining the anonymity of the patient. Yet, in the same example, it is simultaneously observed that the healthcare worker wrongly understood marital status as a criterion for seeking abortion. This indicates that healthcare workers may partly abide by the law, and partly use discretion based on their level of understanding of the legal and policy basis. One of the healthcare providers articulated the concern that emanated from such sympathy with the life conditions of the abortion seeker as follows:

> *People in this area are very poor and life is very difficult here. It is difficult for families to raise two children, let alone five or six. We see their economic conditions during delivery. We know the food they bring for mothers who give birth here. If we refer abortion-seeking women to other health facilities, they may not be able to go there for economic reasons. In this area, it is very difficult even to get their children treated when they get sick because of the limited resources they have. They are worried even about transportation. If we give the services here at local health facilities, we could do it in an affordable manner. That is, we give her abortion care if we believe that she is unable to raise the child. Furthermore, we give abortion care for girls attending schools in primary or secondary levels. For female students who experience unwanted and teenage*

> *pregnancy, we give abortion care and advise her to use contraceptives for the future. If a young woman is less than 18 years old and has no husband, we give her abortion care. We also give abortion care when a lactating mother faces an unintended pregnancy. Furthermore, we give abortion care if pregnancy results from incest, which is morally and socially unacceptable in our community. These are the ways the abortion care guidelines dictate us in giving the care.*

This healthcare worker followed a mix of legal and extra-legal criteria in providing abortion service with the good intention of assisting the abortion-seeking women in situations of life not compatible with motherhood. The healthcare worker correctly cites some of the legal grounds of abortion, including incest, being a minor, life and health threats as reasons to access abortion, but he/she mistakenly or deliberately considers abortion-seeking women being student regardless of age, their having many children, and their not having a husband as justifications for providing the service. Another healthcare provider expressed a combination of supportive and legal views related to abortion-seeking women as follows:

> *When a woman reports experiencing rape, we check for pregnancy and HIV. If the pregnancy test is positive, we (*health center staff*) refer her to health facilities where she can get the service and contribute money for her expenses of the abortion care services. If the test is negative in both cases, we advise and counsel the woman how to protect herself in the future. We advise her to use different options if such a thing happens again. After the advice, we give her an implant, telling her that the rape and unwanted pregnancy could happen in the future. We also give her condoms if she is willing.*

8.4 Young men's strategies in handling their partners' unwanted pregnancy

Young men use different strategies in handling their partners' pregnancy as shaped by the socio-cultural and economic conditions of the study context. The strategies that men use in handling their sexual partners can be broadly categorized into two based on their intentions: strategies for supporting their partners and those for escaping from responsibilities.

8.4.1 Supportive strategies

Providing money and getting married constitute supportive strategies that young men use in the study area.

Providing abortion costs

Many young men expressed that managing unwanted pregnancy is a shared responsibility of both partners hence induced abortion should be a concern of young men as well as the pregnant girls or women. Some think that young men identify and suggest where the young women can go to seek abortion care. This notion extends from the assumed responsibility of young men in the prevention of unwanted pregnancy (presented in Chapter Five). Providing money to cover the costs related to the abortion care services is recurrently pointed out by the study participants, and it is considered as the main responsibility of young men.

Getting married

Another strategy that young men use in dealing with their partners' unwanted pregnancy is getting married to avoid induced abortion and the consequences of giving birth to a child outside the wedlock, conforming to the socially acceptable solution. Some young men admit having had sexual relations and decide to marry their partners. Readiness of both partners for marriage and the will of their parents and their religious leaders are among factors leading to such a decision. That is, partners marry each other quickly to hide their premarital sexual relationships and the unwanted pregnancy. Here is a point a young man made:

> *A young man should protect his girlfriend from danger and honor his name by preventing unwanted pregnancy and birth. I think a young man should buy the drugs to prevent pregnancy but abortion should not be used. And once pregnancy happens, a young man should marry his partner rather than going for abortion. Since both of them will be defamed because of the premarital pregnancy and unwanted birth, getting married is a good choice. Abortion has negative impact on young women (26 year old, unmarried, Busa).*

Some young men consider getting married as the safer and morally better response to premarital pregnancy than seeking abortion. They recommended this especially for premarital pregnancies identified late. Some young women hide their pregnancy even from their sexual partners until the pregnancy matures. In this regard, a high school teacher from Gabara pointed out that whenever

premarital pregnancy occurs, the community expects the partners to get married. Hence, families try to quickly arrange for the marriage to happen either before or after the birth, mostly the former. He explained that "*It is better to prevent pregnancy using condoms or other contraceptives. Or else, it is better to arrange for them to get married if a premarital pregnancy occurs*".

8.4.2 Strategies for escaping from responsibility

Forcing pregnant partners to seek abortion, denial and abandoning are the major identified strategies that young men use to escape from responsibility of impregnating girls.

Forcing partners

Evidence from the ethnographic informal conversations, interviews, and FGDs reveal that many young men influence their girlfriends to terminate an unwanted pregnancy. Unmarried men push their partners to abort. Some unmarried young men tend to compel their girlfriends to seek abortion when unintended pregnancy occurs even if the young women would rather keep the pregnancy. The young man presented earlier who put pressure on his partner to seek abortion services and eventually succeeded is an example. A HEW also noted:

> *Most married women do not seek abortion services, and those who seek it prefer to get the services in secret at health centers. For the out-of-wedlock pregnancy, young men mostly prefer induced abortion, and they push their girlfriends to abort. Men do not want to be the subject of community discussion arising from unwanted pregnancy and birth. In addition, young men do not want to bear the responsibility of caring for children born out of wedlock.*

Denial of fatherhood

Another strategy that young men use to escape from the responsibility of unwanted pregnancy is denial. Although some young men suggest that young men should share responsibility for the occurrence of premarital pregnancy and should be part of the solution, including getting married, they admit that the reality on the ground is different as many young men run away to escape from the responsibility and very few are determined to get married. Young men's denial of the relationship when pregnancy happens is manifested in two ways. First, a young man simply denies having had sexual contact with a young woman. Second, he admits that they had sexual

contact but he denies being the father. In this case, a usual pretext presented by the young men is that the young women also had sexual contact with other men.

The court and/or elders get involved to settle the matter when the case is brought to their attention by the partners or their families as presented in two cases in Chapter Six. The young men may deny having been the culprits before the local elders and the formal state courts in reaction to the young women's or their parents' complaints, as evidence obtained from the district Justice and Women's and Children's offices indicates. A DNA test is not possible in this context to determine the paternity of the young men. Consequently, in the absence of witnesses or evidence, it is difficult for the court to prove whether a defendant is a biological father of a child or not. In such cases, the court, in collaboration with the Women's and Children's Affairs Office refers the parties to the community elders to settle the matter in customary ways. This is the case because dealing with the matter is perceived to be easier for the elders than it is for the court, because they use informal mechanisms to gather evidence about the relationships of the two parties. They also make the young man swear as a proof of not having had sexual contact with the young woman or not having made her pregnant. Many young men are afraid to swear in front of elders because they believe that they will be punished by God for that. But they will also be afraid to confess that they had sexual relations with the young women because they will be forced by the elders to marry the girl, as this is the culturally acceptable way of solving the issue.

Abandoning

Study participants emphasize that many young men impregnating their girlfriends abandon their partners and hide themselves from the public. Abandoning responsibilities when unwanted pregnancy occurs is a known practice used by young men in the study area. This is the most commonly reported accusation against young men and evidences show that they flee the area when they know that their girlfriend get pregnant before the case is presented to the court or the elders rather than sharing responsibility. Among others, they abandon to escape from entering into marriage with their pregnant girlfriends for different reasons. First, most young men are economically dependent on their parents; hence, they cannot support the child. Second, their parents would prefer them to focus on their education or agriculture or trade before turning to marriage. Third, parents of the young man or the young woman may not be willing to have a

marriage relationship with that particular family due to differences in social status or other factors.

8.5 Masculine manifestations in abortion care services

Some healthcare providers require the approval of men as a precondition for abortion care. This position of healthcare providers is against the rules of abortion care procedures, which tend to give priority to women's choice so long as one of the legally acceptable grounds of seeking abortion is fulfilled on the abortion seeking women's side. One male abortion care provider declared that "*… an abortion seeking woman has to come with her partner who is expected to sign because abortion care involves risks during and after the procedure. Otherwise, I do not perform the abortion care.*" Even though medical procedures require the patients' partners to sign on their behalf, it seems that this is often exempted for abortion care to ensure privacy and meet the rights of the abortion seeking-women. Moreover, disagreement between couples on seeking abortion care is commonly resolved in favor of the husband. Given that seeking abortion is socially and religiously disapproved, willingness of the husband is a central factor to access abortion care whereas women's decision-making power is much compromised. The following case was shared by a midwife at a health center:

> *A woman came to our office seeking abortion care. We told her to bring her husband. When she brought her husband, we asked him if he was willing for his wife to receive the abortion care. However, the husband strongly resisted the abortion care. Then, we sent them back home to discuss together on how to raise their child or to come back for the abortion care if they reached an agreement. But they did not come back. There are such partners who disagree on abortion care.*

In this case, the decision was made in favor of the husband's right to have a child but at the cost of his wife's right not to get pregnant and have the child. The midwife was asked how they as health workers could reconcile the 'choices and rights' of their clients. The response of the midwife implies that the decision against the choice and right of the pregnant woman was made because the pregnancy had no life-threatening risk to the mother. She personally believes that priority in principle should be given to the women, but that decisions are made based on a contextualized case analysis. Arguing in favor of the husband, she said:

> *In my view, both the husband and the wife have the right to have a child. However, the mother is the victim of pregnancy more than the father. So, if the fetus is a threat to the life of the mother, we give priority to her. If we believe that the pregnancy could have an unbearable consequence to the mother, we give abortion care.*

Accordingly, when there is disagreement between couples with regard to seeking abortion, the health workers do not provide the abortion care unless the pregnancy is a threat to the mother's life, which used to be the criterion before the revision of the Criminal Code of Ethiopia in a way safe abortion is legalized on many grounds. The conversation with a midwife at Dimtu health center added to the understanding of the issue of couples' rights when a request is made by the mother for abortion care.

Interviewer: How do you assure the husband's consent when a wife seeks abortion care?

Informant: For married partners, we consult both of them. We bring the spouses together to the health center and counsel them about abortion care – its advantages and disadvantages – and if both settle for abortion care, we will proceed with it.

Interviewer: What if the husband refuses to cooperate or is not willing to show up for consultation about the abortion care?

Informant: For married couples, we do not provide abortion care if a woman comes alone or if her husband has not given his consent. Thus, we insist that she should persuade her husband and bring him to the health center.

Interviewer: Does the abortion care guideline state it this way or is it your own opinion?

Informant: Yes, it does. For married partners, the consent of both partners is mandatory to give abortion care.

Interviewer: How do you entertain the issue from a rights perspective? A woman is much more at risk of pregnancy-related problems. If she seeks abortion care but her husband refuses, how do you see it from point of view of her rights?

Informant: This is a very difficult question; yet, we must convince either the wife or the husband. Otherwise, it will lead to marital disputes.

Interviewer: When you say 'to convince', do you mean persuading the woman to keep the fetus to the full term?

Informant: Yes. I try to convince her to give birth to the child because her husband wants it. But for the future, we counsel the couples to use long-term family planning.

Interviewer: How do you see it in the lens of gender equality?

Informant: Hahaha! It is a very difficult question again. However, it is really difficult to make decisions unless both partners agree on abortion care. If partners could not reach an agreement, we do not give the service.

Interviewer: What do the abortion care guidelines say about this? What should be the decision if disagreement occurs between couples on abortion care; what do the laws say?

Informant: For a legal marriage, the consent of the husband is mandatory to giving abortion care. If he refuses, we don't provide the care.

Interviewer: I mean, who has the 'veto power' when they disagree on abortion care, the husband or the wife? Who is going to be heard more? Whose voice or stance is going to be given priority? How do you reconcile the rights issues?

Informant: In real work circumstances, most often the couples come to an agreement on either to abort or not after they receive counseling services on the issue. One of them convinces the other. Mostly, women submit to their husbands' decisions.

Arguably, the conversation shows that the healthcare worker either does not have a full grasp of the law and the guideline, as she wrongly argues that the laws require a husband's consent to access abortion care, or she ignores them. This particular health worker is against abortion as she declared during this interview, and she strives to convince pregnant women not to seek abortion care. The Abortion Law of Ethiopia (2005) and the Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia (2006) are silent about family (and parental) concerns in dealing with abortion care and the involvement of men in seeking the services. It seems that the provisions consider the matter as "a woman's domain" given men's roles are not clearly indicated in the process of seeking abortion and what should be done when disagreement occurs between men and women whereas the healthcare providers rely on men's decision. The willingness of a couple to use contraceptives is also used by some healthcare workers as a precondition for a woman to have the abortion care, which is a serious violation of women's interests, choices, and rights, and indeed is against any of the terms spelled out in the Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia (2006). In the guidelines, counseling abortion-seeking women to use a contraceptive is indicated as a central part of the abortion care service, but it is not presented as a precondition for access to the service.

8.6 Discussion

This chapter accounts how the abortion services are rolled out, perceived and related to abortion law of the country in the local study context. It focuses on systemic barriers and the healthcare workers' extensive use of discretion that restrict abortion-seeking women's access to legal abortion. It also emphasizes how young men involvement in induced abortion is shaped and play out in the study communities. A number of healthcare system induced systemic restrictions against access to abortion care in-built in the healthcare system are identified. These include: limited health facilities provide abortion care services; lack of on-job training on abortion care and its use as a pretext to restrict access to abortion care; and absence of clear referral system and uniform practices among the health facilities. Use of training as a pretext to provide abortion care severely restrict abortion-seeking women from access to the services because the said training is not always offered and some workers are not ready to receive it. The abortion guideline also does not demand such training for first-trimester abortion. Arguments and practices related to the training also reveal healthcare bureaucrats and healthcare workers' discretion related to abortion care. It seems that abortion care is not demanded for many cadres of healthcare workers although having experience would be important, not necessarily the training, in order to carryout abortions. The fact that the training is not always offered has to do with healthcare workers' discretion given holding back training serves as a way to avoid the provision of abortion services.

In contrast to the abortion law and abortion care guidelines, the local institutional arrangement and the service providers' approaches and responses to the provisions hinder the translation of the provisions of these frameworks into practice. Only two of the five health centers provide abortion care services and the decision is subject to debate for its correctness among the key actors. The restriction of the abortion care services to only two health centers and the limited access to on-job training that is considered as a qualifying criterion to provide abortion care is strongly objected by pro-abortion healthcare providers.

There is also a paradox in the way professionals in the health centers provide services for abortion-seeking women. They refer second-trimester abortion seekers to hospitals, but for no medical reasons, some healthcare providers do not give abortion care for first-trimester abortion seekers. Nor do they refer them to places where they could get the service. This disrupts the

service referral linkage and leaves the service seekers in a dilemma about what to do next and where to find the service. Previous studies also found that negative attitudes of healthcare professionals towards the service and a slow and unclear referral system negatively impact women's experiences and can lead to delays in their treatment (Purcell, 2015; Ping and Smith, 1995). The healthcare workers use the non-compulsory nature of the service provision or lack of on-job training as a window to refuse abortion-seeking women whereby the latter nearly cannot find the service otherwise. Besides, those working at the health centers where abortion care is not given but have interest to provide the service refuse to refer the abortion seekers to other health centers where the service is available. That is, they use negative discretion as a means of resisting against administrative injustice.

The healthcare workers' discretion often comes in conflict with the provisions of the 2005 Abortion Law and the Technical and Procedural Guidelines for Safe Abortion Care Services in Ethiopia (MoH, 2013), as detailed above. In the sections below, we discuss the findings with reference to Lipsky's street-level bureaucracy as well as in relation to other relevant studies (Berer, 2017; Maynard, n.d.; Tadele et al., 2019). The findings of this study show that the progressive abortion policy and legal frameworks of Ethiopia are often not known, are misunderstood, or are ignored and challenged by the healthcare workers. I found that healthcare workers' discretion interpreted and often distorted the abortion law and guidelines as they saw fit. Based on the study findings, I argue that in the study area the abortion regulatory framework is not sufficiently binding and is only partly attended to. This has severe implications for women's actual access to abortion services and thus for their health and lives as women who are denied the service are likely to seek unsafe abortion measures. The challenge is at a more fundamental level embedded in the negative sentiments to abortion in the community. This prevents knowledge about the abortion law and guidelines to be openly spread, even among the health workers who are to implement the policies in their day-to-day clinical work. The strategy of silence adopted by the implementing organizations has also prevented the dissemination of knowledge about the abortion law and services (Foster et al., 2016).

Mclean et al., (2019) in their study from Addis Ababa, state that "where the law makes the door slightly open, healthcare workers become important in deciding who gets access to safe services and who doesn't, thus creating considerable ethical dilemmas" (p.1). Similarly, this study, in a

typical rural setting of Ethiopia, reveals that healthcare workers play an even more invasive role in deciding women's access to safe abortion. As there were few attempts by the healthcare workers to hide the lack of adherence to the guidelines, it is clear that there was a fundamental lack of knowledge about their content. It also suggests that few or no attempts were made to follow up on practices not in line with the stated policy. Non-adherence to the policy thus seemed to have no negative repercussions for the healthcare workers themselves. Rather, they seemed to follow up on the abortion requests in a manner expected of and respected by their communities.

I found that health workers breach women's confidentiality and involve external individuals, including partners, in the decision making. I also found that healthcare workers show signs of a paternalistic attitude towards their clients and act as proxy decision makers in abortion-related clinical decision making. That is, healthcare workers' decision on behalf of and against the interests of abortion-seeking women seems to emanate from healthcare workers' paternalistic thinking, indicating that abortion-seeking women do not have adequate understanding of the negative consequences of seeking abortion. Abortion-seeking women's limited voice in making decisions about their experiences of pregnancy reveals healthcare workers' discretionary power and women's limited potential or agency to control their fertility.

In line with previous studies, the findings of this paper indicate that women have severely limited access to legal abortion care services which implies that the existence of enabling policies, laws, and implementation guidelines on abortion care does not guarantee access to the services (Berer, 2017; Blystad et al., 2020). Indeed, the findings from this study reveal that access to abortion care is largely constrained by care providers' use of extra-legal discretion in their interaction with abortion-seeking women. This emerges as a prime example of street-level bureaucrats' engagement in giving their own interpretations of key policy documents to the detriment of the women who were to benefit from them. In many of the examples presented above, the women's health and futures are determined not by the rights entailed in the law and guidelines but by personal assessment of healthcare workers who, either willfully or out of lack of knowledge or misinterpretation, stop them from benefiting from policies and laws.

Many healthcare workers believe that seeking abortion overall is riskier than lack of access to the services. As a result, they use negative discretion against abortion-seeking women as a measure

of safeguarding them from dangers of experiencing abortion, even in cases where the quest for abortion is made on legal grounds. A position emerges where many healthcare workers find that abortion should be avoided on almost all grounds, as demonstrated by their intense attempts to advise and encourage women to refrain from seeking abortion. The findings reveal that the encouragement given to women and girls not to seek abortion care often disregards the legal grounds for abortion. This indicates a street-level bureaucratic approach, where the law and guidelines are set aside due to contextual concerns, for example the fear of being confronted by an angry spouse.

Using additional and inappropriate criteria as preconditions for restraining abortion-seeking women's access to the services seems to be based on two grounds. Either the healthcare workers have not fully grasped the law and the practical procedural guidelines or they systematically challenge the implementation of the abortion care framework and policy based on their personal, social and religious convictions (Ewnetu et al., 2022; McLean et al., 2019). It is important to reflect on the fact that healthcare workers who took part in the study may not have been as open about their discretion if they knew that they were disclosing acts against established law and regulation. In this context, it is vital to consider that the kind of discretion described in this paper takes place among healthcare workers who serve in a cultural and religious setting with strong anti-abortion normative patterns (Tadele et al., 2019)**.** This context is likely to underlie the dynamics of street-level bureaucratic maneuvering among the healthcare providers.

Alden's (2015) concerns related to having little information about the policy is highly relevant in this context. Vedung (2015) and Lipsky (1971) contend that street-level bureaucrats deliberately develop mechanisms of discretion to cope with psychological threats and conflicting, ambiguous, contradictory and unattainable role expectations that other authors also found similar findings (Moland et al., 2017; Tadele et al., 2019). This point resonates strongly with the interpretation of this study findings; it is likely that the healthcare workers operate under conditions of severe pressure to avoid supporting or performing acts that are perceived by community members as illicit.

The substantial power healthcare workers enjoy and their extensive impact on abortion-seeking women's lives and futures speak to the immense impact implied in their roles as street-level bureaucrats. It is also important to note that there are healthcare workers who attempt to abide by

provisions of the laws and guidelines and/or use their discretionary power in favor of the abortion-seeking women. Yet, those who use positive discretion are not always law-abiding. Their use of positive discretion reveals that they strive to make adjustments to the policy provisions to fit the rural context and the needs of abortion-seeking women in line with the study conducted by Tummers and Bekkers (2012).

Understanding people's views and experiences about abortion also requires looking into gender dimensions (Purcell, 2015; Izugbara et al., 2009). Abortion services have also been noted to be provided for women seeking it without requiring them to prove reasons for their claims. In contrast, forcing women to seek abortion, denial of fatherhood and running away from partners when they get pregnant are among the strategies that young men employ in handling premarital pregnancies. Young men's denial and abandonment are among escaping strategies that young men use whereas providing abortion costs and arranging marriage are among supportive strategies they use when pregnancy occurs. Finally, the abortion care service provision approach and practice are gendered and manifest features of hegemonic masculinity. Gender dimensions and implications of abortion are easily overlooked because abortion is considered as a taken-for-grant domain of women, regardless of the practical involvement of men with potentially significant influence in the process of decision making surrounding abortion.

8.7 Conclusion

This chapter explores the systemic barriers, and perspectives of the healthcare providers: their understandings of the law and guidelines and their narratives of clinical encounters with abortion-seeking women in a rural context of Ethiopia in a bid to complement previous studies. It aims to examine how the 2005 abortion law of Ethiopia and the procedural guideline of abortion services are implemented at the grass root level.

The study fills an evidence gap on rural women's access to abortion care in the context of a relatively permissive abortion law.The findings of this study indicate that there are substantial barriers to Ethiopian abortion-seeking women's possibility of gaining access to legal abortion services, despite the presence of a progressive legal framework and operational guidelines. According to the legal provisions, abortion care providers are expected to accept abortion-seeking women's reasons for seeking abortion at face value as far as the claims fall within the

legal grounds to access abortion care. However, there are diverse structural arrangements such as lack of training, absence of abortion care at health centers, and lack of referral arrangement, and interactional responses among healthcare providers that hinder access to abortion care services.

Although laws supporting the services on some legal grounds are laid out, the majority abortion-seeking women do not have access to the provisions given the disapproval cultural norms and religious views against abortion influence healthcare practices at the grass-roots level. Access to abortion care is partly constrained by care providers' tendency to promote masculine hegemonic manifestations, given that some of them do not provide the service until the male partner gives his consent. Their approach of favoring men in settling marital disputes over seeking abortion care is another indicator. Some healthcare providers require the agreement of male partners for abortion care-seeking women to get the services. That is, the healthcare providers do not directly administer abortion care until disagreements between a wife and a husband are resolved in favor of the women's interests to abort the fetus.

Although there are clues observed from the overall situation that access to abortion care service to young partners is challenging, pinpointing the special features among young people is important and requires special consideration. For example, demanding the approval of sexual partners as a precondition to getting abortion care by some health workers strengthens the view that sexual and reproductive health services are in most cases designed for the married population, and not specifically for young people (UNESCO, 2013). Young women who live in remote areas in the district have difficulty in accessing information about abortion care services. Zenebe and Haukanes (2019) documented that abortion is not within reach for young women in general and it is much more inaccessible to those with rural backgrounds. This study found that abortion services are provided in strict confidentiality even in public health centers. In such settings, young people are poorly addressed; young women are compelled to seek unsafe abortion. A study in Ethiopia, Tanzania, and Zambia reported similar findings (Moland et al., 2017).

Overlooking men's roles, interests, and influences in the abortion care seeking process is a manifestation of hegemonic masculinity of the law and the guidelines. Men are actually the ultimate decision makers on family matters including abortion care for their partners. In the study context, the interest and choice of a husband determines the decision about abortion care.

Limited emotional and financial support from partners in seeking safe abortion services put women at risk of seeking unsafe abortion. Structural and agentic factors to abortion care severely challenge young women's access to abortion care and young men's constructive engagement or positive masculinity in abortion seeking and decision making processes.

The study findings demonstrate that a few healthcare workers use positive discretion to meet the needs of abortion-seeking women. However, it is evident that healthcare workers commonly use their power of discretion to prevent women from having abortion, either out of lack of knowledge or misunderstanding of the established legal and policy frames, or knowingly, with the purpose of preventing legal abortions from being conducted in the context of strong anti-abortion norms. The discretion clearly poses challenges to the aims of the progressive legal grounds for abortion in Ethiopia. The findings alert us to the fact that a well-intended permissive abortion policy will have no impact on women having access to safe abortion services if its content is not known and properly enforced or adhered to by health care providers. Making sure that healthcare workers learn more about the abortion law and guidelines as well as the potential consequences of unsafe abortion on women seeking the service is crucial to improve the situation. A prime recommendation is thus to ensure continuous training of abortion providers in the content of the policy and enforcing its proper implementation. This seems particularly urgent in rural areas of the country where health workers may be particularly prone to be influenced by community norms and expectations.

The strategies that young men use in handling pregnancy of their female partners results from sociocultural conditions that shape involvement of young men in fertility control and manifest hegemonic masculinity. Even though anonymity concerns limited us from directly observing the provider-client interactions in abortion clinics and obtaining abortion-seeking women's first-hand experiences, we believe that this study has significance in filling the knowledge gaps about access to abortion in the rural context of Ethiopia.

CHAPTER NINE
GENERAL DISCUSSION, CONCLUSION AND RECOMMENDATIONS

9.1 Discussion

9.1.1 Norms and practices of fertility control in the study context

This study found that the dominant cultural and religious norms largely disapprove intentional fertility control as far as they occur within acceptable institutional contexts, that is, marriage and the family. Fertility norms including expectation for early first birth after marriage and having many children per woman or family, religion-based discouragement of contraceptive use and strong rejection of induced abortion by the religious leaders and among the general public are against the notion of intended fertility control. Cultural values of large number of children generally and sons in particular as a blessing, source of social pride and power are still strong in the study communities. Religious norms in particular tend to conclude that fertility control is not within a domain of human decision and action rather it is a divine will. Religious leaders' argument that conception can occur even while using contraceptive methods is an extreme view of the position. Disapproval norms of premarital pregnancy and pregnancy without marriage are among the exceptions because of the existence of other competing norms and associated parallel arguments. Fertility in such conditions is rejected because of strong norms that dictate sexuality and pregnancy are acceptable only in marriage and family institutions.

Most community norms, practices, programs and institutions are gendered that discourage involvement of young men in fertility control in general, and in sexual restriction, contraceptive use and seeking abortion in particular. As a result, involvement of young men in fertility control is masculine hegemonic in a multifaceted ways. Men nearly do not use contraceptives as partners mainly because of lack of male contraceptives and rejection of condoms use due to associated stigma of using them.

However, there are emerging norms contrasting to the dominant pro-fertility views that imply the possibility and necessity of fertility control. For instance, appreciation for balancing the number of children born to a mother or a family with the economic capacity of the respective family is emerging as a new norm in the study area. Male and female community members with particular

reference to the young, employed and educated people have increasingly become pro-child spacing and limited number of children in the changing socioeconomic conditions like increasing living and child rearing costs, and improved women's engagement in education, economic and public service activities. Moreover, many practices of men and women, service programs and political will are in favor of fertility control. Therefore, one can fairly conclude that norms and practices are changing or emerging in line of a position that promote fertility control as a necessity and possibility.

9.1.2 Gendered institutional norms and involvement of young men in fertility control

The study findings reveal that the major social institutional settings are gendered and manifest hegemonic masculinity in men-women interaction in general that are pertinent to involvement of young men in fertility control. While the family and religion are explored in more details, other social institutions like education, health, economy and politics are selectively addressed based on their relative relevance for the subject matter. Discourses about gender equality at the interface of culture and religion are thoroughly explained given their strong influences on other institutions. However, other institutions such as the media, creative arts like sports and entertainment were not entertained in the interest of limited space to cover all institutions.

How do religious norms and practices perpetuate gender inequality? In what ways culture and religion intersect in shaping gender inequality? We found that religion and culture reinforce each other towards promoting gender bias through their shared values like discouraging women from taking leadership roles and talking in public. While the gender bias is directly linked to patriarchal rules from the cultural perspective, religious leaders see them as divine rules not allowed in the Holy Quran/Holy Bible implying that it is unlikely to change. Practically, both promote women's caring roles and passive representation in public, and men's active public leading roles. Such arguments sound to be less flexible given the religious leaders and the lay people lack courage to question or challenge those biased religious-based assumptions, values, and practices. The religious leaders are reactive to views that condemn the religious practices to be discriminatory and try to discredit the condemnation.

Moreover, an ambiguity is revealed in that the study participants rhetorically favor gender equality but practically manifest pro-men behaviors to some extent. Young men selectively adhere to dominant views and cultural norms of hegemonic masculinity throughout different

phases of fertility control events, starting from establishing love relations to seeking induced abortion. But the study also revealed a number of indications of gendered transformation.

Norms of the *michu* cultural practice, which permits premarital love but strongly opposes premarital sex among young men and women, is an ideal type of love, marriage, and sexual relations in the study area. Like the religious norms and practices in the area, *michu* encompasses several features of hegemonic masculinity. The cultural and religious norms of remaining chaste until marriage are however stretched due to the introduction of modern education and economic and technological advancement into the rural areas. Young men maintain their dominance over women in love, sex, and marriage relations as per the institutionalized norms, but they increasingly break the rules and engage in premarital sex. In response, modified forms of marriage arrangement that deviate from the ideal types of marriage and that tend to tolerate premarital sex are practiced both culturally and religiously. Yet, some of these modifications also take into account women's wishes of extended education and of using contraception for an extended period of time. There are also signs that women emerge in a stronger position than earlier.

Young men's dominance over women takes several forms when it comes to contraception. Avoidance of using the available male contraceptive method to prevent unwanted pregnancy typically represents views that reproductive roles are exclusive domain of women, and yet men make the decision. The study found that variations in the involvement of young men as partners in women's use of contraception vis-à-vis the degree of support or refusal they may demonstrate, range from strong support by a few young men to serious opposition by many. Such variations and evolving patterns of negotiation among young men and women over contraceptive use are mediated by marital status and the number of children born to a woman. Nevertheless, men are the primary decision makers, while women disproportionately bear the negative consequences of infertility, premarital pregnancy and giving birth to larger number of children. Such dominance of men over women on matters that affect the latter more is supported by cultural ideals of fertility, social expectations of being a man, and prohibitive religious rules of modern contraceptive use. Male dominance extends to influencing healthcare providers' provision of contraceptive service. In spite of the disapproving cultural and religious stances and men's refusal of contraception use, women's use of contraceptives becomes more visible. The overall

implication of the limited and dominating involvement of young men in contraception use is that couples have limited ability to control their fertility.

Induced abortion involves several contradictions that shape young men's involvement in the activity. The topic is not discussed in the general public but basic information about it informally circulates among the community members. Regardless of the silence about induced abortion, women undergo unsafe or safe abortion. There are contradicting arguments about induced abortion among social interest groups. Some study participants, men and women, tend to tolerate induced abortion as they believe it plays a role in overcoming socioeconomic challenges and mitigating medical problems whereas others condemn the practice unless it is for saving a woman's life. Arguments against induced abortion are mainly religious-based. Contradictions about induced abortion are manifested in young men's involvement in practice where most of them tolerate abortion as an alternative solution to unwanted pregnancy and others conditionally accept or reject the practice. On top of the aforementioned contradictions, young men's involvement in induced abortion is further influenced by norms against premarital pregnancy and by hegemonic masculine expectations. The involvement of young men is limited to providing money for abortion services. Otherwise, they either deny their responsibility of impregnating the young women or they abandon their partners when premarital pregnancy occurs.

Ethiopia has a more permissive abortion law than it was before 2005 but evidences reveal that women's access to abortion services is still limited because of different structural barriers and factors influencing women's interaction with other actors. Among others, not all health facilities that are supposed to provide the services are doing so. Moreover, the dominance of men over women in deciding on the matter, women's lack of formal sources of information and their inability to reach where the service is available, and the negative attitudes of some healthcare providers towards abortion make it less accessible to women in the study area. It is found that some healthcare providers wrongly apply the abortion law and abortion care guidelines with intention of mostly to avoid the service or cooperate with the service seeking women based on illegitimate grounds. For example, they make proxy decisions on behalf of the women or refuse to provide the service in favor of the interests and positions of the male partners. In contrast, some provide abortion based on economic and legally unrecognized social factors like lack of income and having small child.

The Abortion Law of Ethiopia (2005) is permissive only in relative sense. The law is more permissive than the preceding law that used to permit abortion on narrower grounds for safe and legal abortion. While the previous law permits abortion only to save life of the mother when the fetus is proved to be life threatening, the revised one introduced additional grounds like conceiving from incest and rape, broadly defines mother's and fetus's health conditions and being a minor. However, the law still does not recognize the most important and the commonest factors that women seek abortion for. As findings of the study reveals, most abortion seeking women claim economic (lack of income), having interest of child spacing or limiting the number of children because of different reasons, and others social reasons like being unmarried or student none of which are explicitly recognized by the abortion law.

The law is aimed at reducing maternal mortality due to unsafe abortion yet the legal grounds it recognizes to access abortion have little contributions. Hence, the law is self refuting. Therefore, the law is not only substantively inadequate it is also medical, pathological or defective in approach than need-based, empowering and right-oriented in contrast to the definition of fertility control and the dominant ideals promoting safe and legal abortion. The definition of fertility control used in this study characterizes it as patterns of human behavior that individuals and couples adopt with a primary objective of preventing unwanted pregnancies and births, and reinforced by the existing norms. Proponents of permissive abortion laws also emphasize the rights of parents to make decisions about whether, when and how many children they want to bear (CEDAW, 1980; FWCW 1995; ICPD, 1995; Sills, 1968). The Abortion Law of Ethiopia recognizes the right elements in very restricted ways although it is assumed that it was developed partly in response to global pressures demanding changes in this regard. Therefore, conclusive arguments about the Abortion Law of Ethiopia (2005) as if it is radically permissive without qualifying remarks could be misleading.

Rather, the abortion law and the subsequent procedural guideline are permissive given they encourage healthcare workers to support and cooperate with abortion seeking women like relying on their words without demanding any verification for their claim. It is also imperative to note the undesired effect coming out of the mismatch between the content of the abortion law and abortion procedural guideline. This is the fact that most women seek abortion for factors other than those recognized by laws but the healthcare workers are advised to support them resulted in

providing abortion based on 'cooked causes' mostly by recording "*I am raped*" and incest or minor at times whereby the true causes for seeking abortion are obscured. Using such cooked causes because of the mismatch between the content and the procedure of the legal frameworks resulted in publications with wrongly inflated rate of raping in the country which is also gendered in itself.

9.1.3 Theoretical Reflections: Towards a positive masculinity

Masculinity is a social construction by men and women of expectations and perceptions about the role of men in society and what it means to be a man (Caulfield, 1985; Selgh, et al., 2017). It is also a configuration of practices organized in relation to the structure of gender relations (Connell and Messerschmidt, 2005). It is a set of culturally defined behaviors and languages commonly associated with males, and it does not exist except in contrast to 'femininity' (Itulua-Abumere, 2013). In its plural form –masculinities– it refers to the multiple ways manhood is expressed and the power dimensions that exist between different groups of men (Selgh, et al., 201). Therefore, there is a possibility of modifying expectations, perceptions, languages, and practices associated with masculinity, meanings attached to being a man, and effects of masculinities on fertility control. This sub-section discusses the possible ways of applying positive hegemony toward improving gender equality, in general, and improving the involvement of young men in fertility control, in particular.

According to Connell and Messerschmidt (2005), hegemonic masculinity recognizes multiple and dynamic masculinities, agency, the possibility of democratizing gender relations, abolishing power differentials, and a positive hegemony as a key strategy for efforts to reform. Hegemony may also fail. Moreover, how to signify masculine selves as boys or men and gender identities are learned (Schrock and Schwalbe, 2009). Itulua-Abumere (2013) also argues that masculinity just represents social and cultural interpretation of maleness learned through engagement and participation in the society. Accordingly, men and women can learn new ways of presenting themselves and viewing others as equal to others, defend this position, and contribute to changes toward gender equality, which in turn improves young men's involvement in fertility control. Education in general and females' education in particular have the promising roles in improving gender equality and young men's involvement in fertility control.

Similar concepts with positive masculinity now feature in contemporary versions of hegemonic masculinity which refers to what it means to be a boy/man in ways that are more positive or equal. Men and boys who exhibit positive masculinity believe and accept that they are different from but equal to girls and women. Such 'new real men' respect women and are considered strong, not weak (Labeodan, 2019, p.75). It represents shifts or progress towards the embodiment of key human strengths by males through socialization of boys and young men (Wilson, et al., 2022). *New man-ism,* which refers to men as more caring, sensitive, domesticated, and expressive (Beynon, 2002, p. 17), and *constructive men's engagement* (CME) are emerging commendable approaches to improving gender equality by involving men as clients of health services, supportive partners, and agents for social change (Robles and Aditi Krishna, 2010, p. vi). Given patriarchal rules, gendered power relations and hegemonic masculinity are socially constructed, hence subject to change; moving towards positive hegemony requires agentic involvement of young men in fertility control.

9.2 Conclusion

Formal and informal institutional settings in Ethiopia are gendered in their structures, programs, and practices, the effects of which are manifested in men-women relationships pertinent to fertility control. Male dominance over women is evident in the family, religious, leadership, school, economic and health service settings. Men are the primary decision makers in family lives, as well as sexual and reproductive relations. Men play key leading roles in religious practices and formal sectors. For example, all households, school principals and most sectors' leaders were men in the study area.

Gendered institutional settings and practices maintain gender inequality. They moreover open ways for changes towards equality tolerating young men's deviation from the norms. Some cursors of change are emerging among social institutions; education being the crucial force with more potential influence towards gender equality and pro fertility control patterns of behavior.

The huge discrepancies between discourses about gender equality and fertility related norms, and respective practices, imply that people may endorse views they do not really own. The co-existence of disapproval norms against, parallel or contrasting discourses open ways for fertility control patterns of behavior.

The agenda of gender inequality has been disoriented and mismanaged in Ethiopia, and that resulted not in gender equality but another form of gender inequality in which people rhetorically appreciate men-women equality for political correctness whereas most of them practically live up to the expectations of men's dominance over women. The dominance is clearly evident in significantly shared men-women lives, as in fertility control, particularly in contraception and abortion. Male dominance is reinforced not only through men and masculinity but also through women and femininity. The cumulative effect of over-emphasizing or under-emphasizing men or women in activities related to fertility control is male dominance.

Features of hegemonic masculinity are manifested not only in most sociocultural norms, institutional rules and practices but also in young men's and women's behavioral patterns of love, sexual and marital relations, pregnancy, contraceptive use, and seeking induced abortion. They are moreover manifested in indoctrinated religious support for masculinity and gendered power relations in teachings and rituals which justify the prevailing gender inequalities. Schools and health service facilities endorse the pro-men cultural and religious dominant views in their daily practices. Young men adapt the pro-men dominant views and practices in such a complex way that they maintain hegemonic masculinity but contravene age-specific and marriage-based sexual and reproductive norms. Young men's limited involvement in reproductive matters resulted in poorly controlled fertility.

The fact that religious leaders leave no room for searching elements of gender discrimination and men dominance over women in the religious views, practices and organization implies that they tend to defend gender inequality. Yet, at times, religious leaders take ambiguous personal positions as members of the society and religious leaders.

Fertility related norms in the study communities have the following implications on involvement of young men in fertility control. First, the involvement of young men in fertility control is generally limited while the degree of men's constructive engagement decreases from love and sexual negotiation to pregnancy and contraceptive use to seeking induced abortion. Second, there are huge discrepancies between the social norms, young men's views and practices. Third, there are tendencies of change in fertility related norms and people's practices towards gender equality and constructive men's engagement though very gradual.

Involvement of young men in preventing premarital pregnancy and contraceptive use as partners tend to be supportive and increasingly progressive, respectively, whereas their involvement in seeking abortion is minimal, marginal and defective yet hegemonic. There continues to be severe restrictions on young men involvement in fertility control. However, there are a number of signs of opposition against prevailing restrictive regimes, and of young people's agency to act against these restrictive normative and practical orders. Currently, men's constructive engagement in abortion is an exception than rule. Exceptions to this are emerging views that demand young men's sharing responsibility in all events of fertility control including abortion. However, young men's involvement as change agents for fertility control seems yet to strongly emerge.

The three domains of fertility control - sexual abstinence, contraceptive use and induced abortion - are not well integrated in academic and policy endeavors. Sexual abstinence as a domain of fertility control is nearly missing hence needs of unmarried young population is unmet. This implies that delaying the first sex and the first birth among this sub-population is little controlled through programmatic interventions.

The abortion law disregards men as role players in seeking abortion. Institutional arrangement and healthcare providers' negative discretion hindered the translation of the Abortion Law of Ethiopia into practice.

In summary, social norms and involvement of young men in fertility control are not duly taken into account in programmatic interventions yet both have significant influences. As a result, men's and women's needs and interests of fertility control are highly compromised.

9.3 Recommendations

Rethinking structural and programmatic frameworks, empowering women, educating men and women, and fully involving males in gender-related matters are commendable ways of ensuring the desired gender equality and fertility control. This in turn needs to properly comprehend how gender is constructed and practiced at different levels and in different contexts.

Engaging religious leaders in promoting gender equality through reinterpretation of religious rules and practices is useful.

A due attention should be given to fertility control related norms, integrative approaches to the three domains of fertility control, and involvement of young men in research and intervention programs.

The missing link between sexual restriction and other domains of fertility control mainly for the unmarried young people should be addressed through program interventions designed to serve this purpose. Comprehensive sexuality education (CSE) that socially and legally fit to address young people's needs and interests of managing their lives including their gender and sexual relations and controlling their fertility is a commendable intervention. Government, non-governmental organizations and development partners having stakes in improving young people's lives and well being should be considerate of addressing the gap.

Understanding the power of hegemonic masculinity as an 'ideal type of masculinity' in explaining contextual men-women relations and building on emerging positive masculinity among the few educated young men are the potential means of improving the involvement of young men in fertility control. However, given masculinity in any form is socially constructed, positive masculinity comes true only along with significant social changes about gender norms whereby the involvement of men is a crucial factor.

Hegemonic masculinity remains among the most important theoretical framework in gender studies, given its superior analytical power. Yet, considering other evolving and diverse forms of masculinity as supplementary tools is unquestionably important. In this study, the theory was very useful in framing the study, analyzing the data and drawing conclusions.

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Annex: Interview/FGD Guiding Questions

This set of questions is designed to guide individual and group interviews conducted to gather information for a PhD study on *"**Fertility control in cultural and gendered normative context of rural Ethiopia, Nadhi Gibe: Implications for involvement young men**"* The questions also inform focus areas of ethnographic fieldwork (participant observation). The guiding questions are framed in six thematic areas in line with the basic research questions.

Theme I. Dominant cultural views and community practices pertinent to fertility control (FC)

1.1 Dominant cultural views: Views related to premarital sexuality, pregnancy and induced abortion

1.1.1. How premarital sexuality and outside wedlock pregnancy are culturally and religiously viewed in Nadhi Gibe?

Participants: Community opinion leaders (religious leaders and elders)

Probing: *Acceptance or tolerance level of premarital sex of young men and women. Discourse on whether sexuality and pregnancy are personal or collective concerns. Abstinence from sex of men and women until marriage. Proper age of sexuality and marriage for men and women.*

1.1.2 How far is it culturally and/or morally acceptable for men and women to intentionally control their fertility by using contraceptives or induced abortion?

Participants: Mainly community opinion leaders (religious leaders and elders) plus other key informants.

Probing: *Reproductive rights of men and women. Cultural values and religious principles related to human reproduction. Social values about number of children. Moral legitimacy of contraceptive use. Views related to induced abortion (beginning and end of life, abortion vs infanticide, acceptable and unacceptable types/conditions of abortion, and discourse on whether induced abortion is a personal or collective matter. Stories, if any.*

1.1 Dominant cultural views: Views related to masculinity and gendered power relations:

1.1.3 How the cultural and religious views of gender relations (equality and inequality) influence gendered views on human sexuality, pregnancy and induced abortion?

Participants: almost all data sources to gain information on views and practices/experiences

Probing: *Culturally defined identities of being man or woman or acceptable order of men-women relationships. Domain of patriarchal rules in sexual and reproductive lives. Traditional expectation of men's control over women. Notion of "good boy or good girl", "good husband or good wife", "good brother or good sister" and "good student or good worker." Norms of motherhood and fatherhood. Costs of masculinity for men and women. Please, share stories, if any.*

1.1.4 To what extent is involvement of men in fertility control acceptable in the community?

Participants: almost all categories of data sources relevant to gain information on views and practices/experiences

Probing: *cultural, religious, parents and men's view about men involvement in contraceptive use and seeking abortion services. Involvement of men as direct user of contraceptives or cooperation with sexual partners' fertility control. Conditions under which men involvement is appreciated or discouraged. Forms of resistance against fertility control. Men's and women's responsibility in deciding the number of children and patterns of birth spacing? Please, share stories, if any.*

1.1.5 To what extent do young people's sexual and reproductive practices match with the cultural and religious normative views/principles?

Participants: community opinion leaders, young men and young women, and healthcare providers

Probing: *how, why or why not to the response. Causal attributions for the observed discrepancies (if any) between the rules and actual life practices. Enforceability of the restrictive sexual and reproductive principles in people's lives. Stories, if any.*

1.2 Community practices

1.2.1 How do power relations between men and women in community settings shape young men's involvement in fertility control in Nadhi Gibe? Which specific practices are influencing them?

Participants: mainly to be considered for participant observation. Relevant evidences also to be drawn from interviews and FGDs with young people, parents, teachers and religious leaders.

Probing: *Why and how to the above responses. Roles of men and women in economic activities, family, religious practices and school setting. Family-based masculinities. Gender hierarchies and cultures of masculinity in schools, work places and villages. Access to means of production (mainly land). Sex-based occupational segregation. Patterns of collective men and women's economic, social and cultural practices. Features of formal and informal sanctions against premarital sexuality, pregnancy and induced abortion (social control mechanisms). Arrangement, responsiveness, accessibility and suitability of health service system pertinent to young men's involvement in fertility control.*

Theme II. Young men's experience of love, premarital sexuality and use of fertility control methods

2.1 Love and premarital sexuality

2.1.1 What does your experience of love and premarital sexuality look like? Share stories as well, if any.

Participants: Young men

Probing: *Initiation of love: at what age? How? With whom? Why? Who do/did initiate? Primary intention of love: sexual desire vs marriage establishment. Initiation of premarital sexuality: at what age? How? With whom? Why? Who do/did initiate the first sex?*

Where? How long do/did you stay in love & sexual relationship? How do/did you maintain love & sexual relationship? How do you express your love to your lover/sexual partner? Is your love/sexual relationship known or secrete? Why if it is secrete? What would happen if discovered? What is people's response if it is known? Mention in terms of response from the significant others (family members & friends) and the general public. Is virginity your criteria to establish love/sexual relation? Number of sexual partner since start? Number of current sexual partner? Do you believe that love must end in premarital sexuality? Is premarital sex morally acceptable? Explain why or why not. Does premarital sex involve risk for men? Does it for women? Is sexuality a personal right or collective issue? Explain 'hows' and 'whys'.

2.1.2 How do you view young men's experiences of love and premarital sexuality in your community? Participants: Parents

Probing: *selectively refer to probing questions raised in question number 2.1.1. Share stories and love/sexual lives of your son/s, if any.*

2.2 Experiences of young men related to young women's pregnancy (sexual or marital partner)

Participant: Young men

2.2.1 How do you perceive pregnancy?

Probing: *What is the appropriate age of pregnancy for you? What other preconditions should be fulfilled for a woman to get pregnant? Do you accept young women's pregnancy? Discuss if it is in marriage or premarital/outside marriage? Do you believe that premarital pregnancy involve risk to the woman? Mention the possible risks if any. What about to the male sexual partner? What is role of the male sexual partner to prevent occurrence of unwanted pregnancy and to terminate/abort it? Has your sexual partner got pregnant so far? Tell the story if "yes". What will you do if she gets pregnant in the future before your marriage? What do you expect her to do with the pregnancy? What do you do if her stand about the pregnancy does not match to yours? Tell stories, if any.*

2.2.2 What major experiences do you have in relation to your sexual or marital partner's pregnancy? *Please elaborate.*

2.3 Experiences of young men related to use of contraceptives

Participants: Young men

2.3.1 Do you believe that young women have to use contraceptive to avoid unwanted pregnancy? Have you ever used any contraceptive method with primary intention of preventing your sexual or marital partner/s from getting pregnant?

Probing: *Why or why not? What do you know about advantages or disadvantages of using contraceptives? Who should use contraceptive, men or women or both? What are your reasons to take this stand? Which females' contraceptive methods do you know? Mention names, how to use and for how long. How many males' contraceptive methods do you know? Mention names, how to use them. Is using contraceptive morally acceptable for you? Why or why not? Does your sexual partner use*

contraceptive? Are you in favor or against her use of it? Mention your reasons and involvement. Do you have child or children? If 'yes', tell the story. Do you want to have child if not yet? Why or why not? Are you willing or do you have future plan to use contraceptive method if you have not so far?

2.3 Use of induced abortion services

Participants: Young men

2.4.1 Do you believe that young women have to use induced abortion to terminate unwanted pregnancy? To what extent is induced abortion practiced in your community? What does your sexual or marital partner's experience of seeking induced abortion look like?

Probing: *What does abortion mean for you (induced abortion in particular? Why, how and by whom is abortion performed? Would you tell me about the safety level of different types of abortion? What risks does abortion involve? Why do women seek induced abortion? Do you have personal experience related to abortion? If yes, please, elaborate. Would you tell me a story (stories) related to induced abortion in your community or in your partner's life? Do you support induced abortion practice? Why or why not?*

Theme III. Manifestations of the dominant cultural/religious views and gender norms in young men's involvement in FC

Participants: Young men and young women, parents, community opinion leaders and teachers

3.1 Do you believe that men (have to) manifest masculine behaviors in their social and economic relations with women? If 'yes,' what are such masculine manifestations?

Probing: *masculine expressions, models and acts of manhood, violent acts against women or use of physical force in sexual relations. Men dominance in making decision on shared interests including use of contraceptives and induced abortion services. Control, verbal attack, joking and sexist talk. Men's risk and vulnerability related to masculine manifestations. Means of identifying oneself as boy and signifying masculine self. Segregation of boys and girls into different groups. Hegemonic patterns in schools, work place and family environments. Control of school spaces. Dating and harassment in neighborhood and school settings. Practicing skilled body activities like sports and physically tough occupations. Living up to the breadwinner ideals. Ability of performing sexual intercourse as source of respect from the female partner. Participation in school-based non-curricular activities. The dynamics of classroom life including patterns of resistance and bullying among boys. Dominant students over male and female students. Gender based teacher-student relationship. Features of power relationships within and across sexes in husband-wife, brother-sister and lovers relationships.*

3.2 How do those manifestations relate to involvement of young men in fertility control?

Theme IV. Continuities and processes of change in masculine gender relations, sexual and reproductive norms

Participants: Young men and young women, teachers and health care providers

a. Continuities

4.1. What features of masculine gender relations, sexual and reproductive norms and practices pertinent to involvement of young men in fertility control has been changed in Nadhi Gibe?

Probing: *Acceptance/resistance to premarital sexuality, pregnancy, contraceptive use and induced abortion. Values for number of children. Awareness about women's sexual and reproductive rights. Traditional control of men over women. Men and women's responsibilities in reproductive health. Sex-based reproductive and productive role assignment. Patterns of love and marriage establishment. Age of sexual initiation, pregnancy and marriage. Induced abortion seeking behavior. Use of force against women/sexual harassment. Role of decision making. Masculine manifestations. Sex-based segregation and marginalization in social and economic lives. Bread winner ideals.*

b. Processes of change

4.2 What features of masculine gender relations, sexual and reproductive norms and practices pertinent to involvement of young men are persisting within the processes of change in Nadhi Gibe?

Probing: *Acceptance/resistance to premarital sexuality, pregnancy, contraceptive use and induced abortion. Values for number of children. Awareness about women's sexual and reproductive rights. Traditional control of men over women. Men and women's responsibilities in reproductive health. Sex-based reproductive and productive role assignment. Patterns of love and marriage establishment. Age of sexual initiation, pregnancy and marriage. Induced abortion seeking behavior. Use of force against women/sexual harassment. Role of decision making. Masculine manifestations. Sex-based segregation and marginalization in social and economic lives. Bread winner ideals.*

Theme V. Enabling and constraining conditions for involvement of young men in fertility control as agents of change

Participants: Young men

a. Enabling conditions

5.1 What enabling conditions are there for involvement of young men in fertility control? Please, elaborate if any.

Probing: Family and parents' *supportive involvement in the reproductive lives of their children. Conducive regulatory (legal and policy) environments. Existence of and people's familiarity with sexual and reproductive health service programs. Young women's welcoming conditions. Responsive justice institutions. Accessible contraceptive and abortion services. Youth-and-male friendly contraceptive service provisions. People's familiarity with family planning services. Lessons learned from adults. Supports from sectoral offices and schools. Alternative male contraceptives (traditional or modern).*

b. Constraining conditions

5.2 What constraining conditions are there against involvement of young men in fertility control? Please, elaborate if any.

Probing: *community's disapproval of involvement of young men in fertility control.* Stigma and stereotype against contraceptive user men. Challenging perceptions against contraceptive use and seeking abortion. Young women's (spouse or partner) resistance against young men involvement in fertility control. Women's conformity to the conventional sexual and reproductive norms. Women's complicity to the patriarchal norms/gender order. Gender-based role division and socialization. Health service providers' negative attitude and handling. Emphasized femininity.

c. Possibility of agency

5.3 How do young men can play agentic roles and responsibilities in their involvement in fertility control? Would you share your personal experience, if any?

Probing: *Young men's seeking behavior of contraceptive use. Young men's resistance against prevailing sexual and reproductive norms, and men's domination over women. Young men's engagement in traditionally women's domain activities. Young men challenging other pro-masculine men. Young men's constructive engagement in fertility control like sharing roles and responsibilities with young women. Innovative strategies used by young men to engage in FC and reforming gendered power orders. Young men's belief in women's negotiation for love, sexuality and pregnancy. Young men's resistance to hegemonic forms of masculinity.*

Theme VI. Young women's response to young men's involvement in FC

Participants: Young women

6.1 How does your sexual or marital partner involve in fertility control as direct user of fertility control mechanism? To what extent does he cooperate with your use of fertility control methods?

Probing: *Belief in and acceptance of young men's involvement in contraceptive use and induced abortion practices. Willingness in allowing men to involve in decision making process about fertility control. Active and passive forms of resistance against young men's involvement. Evaluation of men's willingness to cooperate with women and the actual practice. Potentials for men engagement. Negotiation with partner about contraceptive use. Participatory discussion on sexual and reproductive issues. Joint decision about fertility control. Belief in the dominance of men over women. Real or potential acts of young men when involved in fertility control. Qualities of an "ideal man or sexual partner."*

6.2 What is your response to his involvement? What is your suggestion on how to ensure men's constructive involvement in fertility control?