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**ISOLATING WOMEN AT TIMES OF LABOUR AND
REPRODUCTIVE HEALTH OUTCOMES: THE CASE OF
MANDURA, NORTH WEST ETHIOPIA**

BY

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DEDICATION

**TO ALL ETHIOPIAN WOMEN ACROSS ETHNIC GROUPS WHO ARE
VICTIMS TO HARMFULL TRADITIONAL PRACTICES**

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Acronyms

AU: African Union

CEDAW: Convention on the Elimination of Discrimination Against Women

CSA: Central Statistical Agency (Ethiopia)

ECA: Economic Commission for Africa

EGLDAM: Ye Ethiopia Goji Limadawi Dirigitoch Aswegage Mahiber (Ethiopians Association for the Eradication of Harmful Traditional practices)

EWLA: Ethiopian Women Lawyers Association

HTP: Harmful Traditional Practices

ICPD: International Conference for Population and Development

MDG: Millennium Development Goal

MMR: Maternal Mortality Ratio

MoH: Ministry of Health (Ethiopia)

UN: United Nations

UNFPA: United Nations Fund for Population Activities

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Abstract

Studies pertaining to the influence of culture on reproductive health in Ethiopia are limited. This study explores the practice of isolating women at times of labour and its reproductive health outcomes. The study is also concerned about identifying the social position of women in Gumuz society due to its importance to identify the health status of women and why the practice is sustained in the society. In order to attain the study objective, exploratory qualitative case study design of inquiry was applied using in-depth interview with women participants and key informants. Documentary films and document analysis are also used as instruments of data collection. The finding of the study revealed that Gumuz mothers deliver outside home without any midwives in bushes, pinches or near rivers. Some of the behind reasons for the sustenance of the practice are it is believed that if women deliver at home, the blood drop may call the anger of Musa (Supreme God of the people) and the cultural belief advised mothers to manage delivery by them to be a strong mother who can capably accomplish a women's role. From this study the following conclusions are developed. Gumuz mother's isolation at the time of delivery usually followed by morbidity, mortality. It is also a cause to infant mortality. Their access to health care services particularly during labour and delivery is highly constrained by the traditional belief the people have towards pregnancy and child birth as well as the long established usage of herbal medication system and scarcity of health care posts in the study area. Accordingly the researcher recommended awareness creation works on the recognition of women's rights as human rights. Designing a distinguished maternal health policy for the country, women's economic empowerment, domesticating international human rights in the local contexts up to the extent of illegalizing the practice, and working on the expansion of schools.

CHAPTER ONE

Introduction

1.1 Background

Reproduction is at the centre of women's life. However it is highly characterized by women's oppression and limited potentials to determine the course of their own lives. Since the declaration of article twenty fifth of the 1948 Universal Declaration of Human Rights, where motherhood and childhood are entitled to special care and assistance, many international conventions and conferences have affirmed and reaffirmed safe motherhood as a right and identified the central role of motherhood interventions.

In 1979, the United Nations General Assembly adopted the Convention on the Elimination of all forms of Discrimination against Women (CEDAW). This document clearly affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations (Disch, 2009).

By July 2003, after the fourth world women's conference held in Beijing, African heads of states adopted the Maputo protocol on the rights of women in Africa. The protocol primarily complements the African charter and goals to grant women's rights. It further domesticates CEDAW and the Beijing platform in the African context (Pambazuka, 2004). The Maputo protocol primarily incorporates the fight against traditional practices harmful to the health of women.

Reduction of maternal mortality ratio by 2/3 is also an international development goal expected to be achieved by 2015 with unrestricted access to high quality emergency obstetric care services promoted towards the attainment of the goal (World Health Organization [WHO], 2009). However, most of the legislative

reforms undertaken in the post world war period have not achieved significant degree of success in the reduction of maternal mortality.

The situation is very bad in the developing nations than the developed ones. According to WHO's (2009:19) statistical estimates, throughout the world, 536,000 women die of complications during pregnancy and child birth. Of the above mentioned number of women's death, 99% of them occur in developing countries. This highest level of maternal death can be prevented through different mechanisms of expanding resources and services. More than 80% maternal mortality could be prevented or avoided through actions that are proven to be effective and affordable even in the poorest countries of the world (Greer, Piercy and Walters 2007:2). Women in developing nations are not only exposed to maternal mortality, they are also vulnerable to maternal morbidity.

Contemporary development explanations assert that, harmful traditional practices like early marriage, female genital mutilation etc are risk factors in maximizing maternal morbidity and mortality. The cultural diversity of Ethiopia and the unequal gender power relationship clearly affects Ethiopian women's reproductive health through different harmful traditional practices. In Ethiopia, many women convinced themselves that, they are less capable of men to determine their own life options that mean they left every decision making either to men or to the society (Ethiopians Association for the Eradication of Harmful Traditional practices) [EGLDAM], 2008).

Women among the Gumuz of Ethiopia are totally isolated at times of labour without any birth attendant outside home as a result of a harmful traditional belief which is possibly followed by maternal morbidity and mortality. In this perspective, Bohmer (1995) asserts that, in Ethiopia there are many harmful traditional practices creating barriers in accessing reproductive health services because some of them are based on superstitions and traditions by continuing to

have a strong grip on the human mind and regulating behaviour. Lack of adequate access to health care services also aggravated the problem. According to WHO, UNICEF, UNFPA (2004) reports, in Ethiopia, health services are limited in scope and geographic coverage and most of the reproductive health services are concentrated in major towns.

A study conducted by Educational Development Research Institute of Ethiopia (2009), indicates that Benishangul Gumuz Regional State has disproportionately low health infrastructures compared to most other Ethiopian regions. For instance, in Benishangul Gumuz regional administrative region, 80.7% of all births do not receive any professional health care assistance (Central Statistics Agency [CSA] 2005:117).

According to CSA (2005:118) Demographic Health Survey report, in Benishangul Gumuz Regional Administrative Region, 74.3% of all mothers have not received antenatal care from all expected pregnancies in the regional state. Many medical health care books on maternal health confirm that, a large proportion of maternal and neonatal deaths occur during the 48 hours after delivery which is a post natal period. However, the post natal health care coverage of the region is still very low. Nine mothers from ten did not receive post natal care while only 2% of all mothers receive post natal care within the critical first two days after delivery (CSA, 2005:119).

A very recent report prepared by Ethiopian Ministry of Health (MoH) also informed, in Benishangul Gumuz regional state of Ethiopia, only 5.7% of all deliveries are assisted by health care professionals which is the lowest compared with other regional administrations of the country (MoH, 2010:39). This shows the very limited health care access of women in the region. The suffering of Gumuz women in the reproductive health arena, which is the main research problem of this study, is also accelerated by lack of access to health care services caused by

health care inequality problem associated mainly with the historical legacy of the people's exclusion from development infrastructures.

1.2 Statement of the Problem

There are traditional beliefs in all areas of life. Societies hand down traditions, from generation to generation by teaching certain attitudes, practices, beliefs, legends, customs, habits and all these affect the overall development of a country. A report organized by WHO, UNICEF and UNFPA (2004) indicates that the majority of Ethiopian people remain with their traditional health attitudes and values caused by lack of essential and other relevant messages.

In all over Ethiopia, it is only 16% of all births are attended by skilled personnel and the Maternal Mortality Ratio of the country is 470 deaths from 100,000 live births (MoH, 2010: 37-40). This is a confirmation to the fact that, women in developing nations like Ethiopia are unable to make use of care that is theoretically "accessible" to them for many reasons, the strength of traditional beliefs and practices regarding pregnancy and delivery is the primary one.

In most patriarchal societies like Ethiopians, there are certain beliefs and harmful traditional practices which deliberately underestimate the position of women. One of these situations is expressed by Shalala as follows:

Rituals and beliefs suggesting that, women's anatomical parts or physiological processes are polluting have been found to be extremely wide spread. Women in many cultures are secluded during and after child birth and during menstruation after which we must undergo a purification ritual lest we contaminate men (1995:28).

According to EGLDAM (2008) assertion, women in some cultures of Ethiopia, are isolated during labour, after child birth and at times of menstruation unattended and remained in a hut built for the purpose.

In some parts of the country, a woman in her menstrual period is kept isolated from every male including her own children. It is believed that they will die if she dares to look them in the eye. Many women deliver their babies unattended in an isolated hut built for the

purpose. These practices affect their own self-esteem and could have fatal consequences (2008:48).

Among the Gumuz of Ethiopia, when a woman approaches her time of giving birth, she leaves the living home, often to bush areas there; she gives birth by herself without the help of a midwife which is a high risk of maternal morbidity and mortality. This is the main research problem which inspired me to propose this study.

Scientific explanations confirmed the necessity of births attended by skilled birth attendants. Balado (2006) discussed that a women should not be left unattended for any significant length of time throughout the labour and delivery process because labour is possibly followed by labour dystocia which is complicated or obstructed labour. It may be followed by rupture of membranes, rupture of uterus, infection, post partum haemorrhage, umbilical cord prolapse, eclampsia etc.

If there is cephalo-pelvic disproportion which is a disparity between the sizes or shape of maternal pelvis and the fetal head, vaginal delivery is impossible and it exposes women to obstetric fistula, foot drop, vaginal scarring, uterine prolapse, haemorrhage, anaemia, infection, infertility, eclampsia etc (Balado, 2006). A higher level care is also necessary in complicated delivery process that is, after certain procedures operative delivery must be followed (Gabbe, Niebyl and Simpson 2007).

A skilled team is also very important to monitor the pulse, blood pressure, respiratory rate, temperature, urine output and flude intake throughout the course of the complicated labour (Balado, 2006). However, Ethiopian Gumuz women face complicated delivery without medical assistance and even without any traditional birth attendant as a result of a harmful traditional practice which obliged them to give birth by themselves without assistance even outside the living home.

Despite enhanced interest in the issue of women's health in the past decade, research in this area is still scanty, especially in the developing countries

(Kyomuhendo, 2005). Similarly, in Ethiopia, health related researches are scanty and the majority of them are conducted in the central part of the country. As a result, little is known about the reproductive health of women in communities like the Gumuz who have distinct socio-cultural set up compared to the agrarian high land population of Ethiopia.

As the prior knowledge of the researcher, the practice of isolating women at times of labour and delivery is not studied in previous research undertakings. The study is highly indebted in providing a place to the voice of women who are victims of the practice.

1.3 Research Questions

- How the practice of isolating women at times of labour is exercised in Gumuz society?
- How the social position of Gumuz women contributes to the practice of isolating women at times of labour?
- How do women themselves perceive the practice of being isolated at times of their labour and delivery?
- How the practice of isolating women at times of labour does affect the reproductive health of women?
- Why the practice of isolating women at times of labour is exercised among the Gumuz people?

1.4 Objectives of the Study

1.4.1 The General Objective

Basically the study uses the feminist perspective, that is, the focus is on mothers' experiences because this perspective facilitates breaking through the silence surrounding marginalized lives. The study is highly concerned about mother's memories and experiences at times of their labour and delivery. The general objective of the study is to explore how the practice of isolating women at times of

labour affects the reproductive health of women and the study develops explanations as to how and why mothers are isolated in Gumuz society of Mandura wereda.

1.4.2 Specific Objectives

- Explore how women are isolated at times of labour among the Gumuz society.
- Identify how the social position of Gumuz women contributes to the practice of isolating women at times of labour.
- Explore participants' perceptions about their own isolation at times of their labour and delivery.
- Find out how the practice of isolating women at times of labour affects the reproductive health of women.
- Explore why the practice of isolating women at times of labour is exercised among the Gumuz.

1.5. Delimitation of the Study

Mandura wereda, Benishangul-Gumuz regional administration of Ethiopia is the site of this study. Due to the wide coverage of Gumuz people, it is difficult to find concrete and feasible finding applicable to the Gumuz people as a whole within very limited time, energy and money. Moreover, the study is delimited on individual case experiences of women and key informants information about the practice of isolating women at times of labour in the society.

1.6. Limitation of the Study

Research undertakings were not adequate in Ethiopian political periphery until recently; this applies to particular border land people such as the Gumuz about who very little is known (Berihun, 2004). This is the main limitation the researcher encountered. Specifically, the problem of accessing adequate documents not only on the practice of isolating women at times of labour, but also about the Gumuz in general was the main limitation I encountered. The finding may not be general to

all areas inhabited by Gumuz people. Barriers of language and shortage of time and money were also causes that forced me to limit the scope of the study.

1.7. Significance of the Study

Health problems are series problems that hinder the development of a country. Women's poor health affects the welfare and productivity of their household, communities as well as their country. It is difficult to find detailed individual case experience which makes women's voice out to show the effects of women's isolation at times of their labour in Gumuz society. The study will stimulate the socio-political interventions required to address the reproductive health problems of Gumuz women and it will help health policy makers, people and institutions work against harmful traditional practices. Generally speaking, the study has a significant contribution to the promotion of safe motherhood and to the improvement of Gumuz women's social position.

1.8. Organization of the Study

This study has five chapters. The first chapter gives an overview of the background, statement of the problem, research questions, research objectives, limitations, delimitations, significance of the study and operational definitions of terms. The second chapter reviews three feminist theories and works deals with culture, reproductive health, social position etc. The third chapter focuses on the methodology of the study. The findings and discussions of the study incorporated in the forth chapter. The final chapter shows conclusions and recommendations.

1.9. Definition of Terms

Labour: Is a clinical diagnosis defined as uterine contractions resulting in progressive cervical effacement and dilation, often accompanied by a bloody discharge referred to as bloody show which results in birth of the baby (Gabbe *et al.* 2007).

Labour Dystocia: Prolonged labour associated with an increased incidence of several common obstetrical and neonatal complications (Balado, 2006).

Cephalo-pelvic disproportion: A disparity between the size or shape of maternal pelvis and the fetal head (Balado, 2006).

Maternal Mortality Ratio:-The number of maternal deaths that results from the reproductive process per 100,000 live births (Twickler and Wendle 2010).

Post partum: It is also called puerperium, lasts from delivery of the placenta until 6-12 weeks after delivery (Gabbe *et al.*2007).

Post partum haemorrhage: An enormous blood loss after child and placental delivery caused by bleeding from placental implantations (remaining piece of placenta) trauma to the genital tract and adjacent structures or both etc (Twickler and Wendle 2010).

Post partum Anaemia: Is a problem caused by post partum haemorrhage or heavy delayed bleeding (Gabbe *et al.*2007).

Post partum infection: A life threaten complication and a series cause of maternal morbidity after delivery, it can be viral or bacterial (Gabbe *et al.* 2007).

Eclampsia: A life threatening complication of pregnancy, resulted when previously diagnosed with pre eclampsia which is high blood pressure and protein in the urine, develops seizures of coma (<http://www.Emedicine health.com/ eclampsia/ 2010/article-em htm>).

CHAPTER TWO

Theoretical Framework and Review of Related Literature

This chapter deals with the theoretical framework of the study and the review of related literature. The theoretical framework incorporated three feminist theories served as both as methodological construction and analytical framework. Topics and sub topics of the review of related literature part included different explanations that are linked with the main problem of the study. Some of them are culture and how it is justified by relativists' justifications and how it affects the human rights of women. How religions are contributed to the violations of women's rights is also discussed. The reproductive health status of Ethiopian women, the maternal mortality ratio and the social position of Ethiopian women are also parts of the review of related literature section.

2.1 Theoretical Frame Work of the Study

Every qualitative research is expected to reflect particular paradigms, stances, philosophical assumptions, epistemologies and ontology's. Particularly if the research fundamentally involves issues of power, class, gender and if the research is about the oppressed and marginalized people, using a theoretical lens or stance is very important (Creswell, 2007). This study used three feminist theories as a theoretical triangulation and to look at different perspectives and dimensions in attaining the study objectives. The entire methodology and analysis of the emerging design of the study used these three feminist theories. These theories highly helped in making the study a feminist one relayed more on women's issues and they are modified and applied in the Ethiopian women context and experiences.

2.1.1 Feminist Stand Point Theory

The very principle of feminist researchers is experience is knowledge. This is the basic philosophical assumption of feminist stand point theory. Both the methodology and the analysis of this research are founded on feminist stand point theory basically by taking the *Experience* of the participants of the study. As Smith (1987) asserts, it is important to start thought from marginalized lives and take everyday life as problematic.

For feminist researchers, gender power relation is a lens on which everything revolves or feminist researchers see gender as a basic organizing principle that shapes women's life. They are also basically believed that it is on the bases of this principle transformative research can be done. In addition, stand point theory used gender difference as a resource to scientific research because it leads us to ask questions about nature and social relations from the perspectives of devalued and neglected lives (Harding, 1991).

Knowledge is socially situated is the core value of stand point theory. Harding (1991) asserts that for stand point theorists, knowledge is quiet situated. The reason why stand point theorists take experience and socially situated knowledge in research is to expose silenced voices of the marginalized because women in many social groups of the world are considered as the others in their own society (Harding, 2004). Taking women's experience as the main source of knowledge in research undertakings is to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position.

This study in its all aspects used feminist stand point theory as a primary constructing foundation of the study. The study is done by taking individual women's experience as a primary source of data and the entire data is analyzed by focusing on the perspectives of the participants.

2.1.2 Radical Feminist Theory

The radical feminist's definition of patriarchy can be applied for patriarchal societies like Ethiopians because patriarchy exists in all times and all places of the world. The radical feminists' analysis of patriarchy applies to most societies we know of and can't distinguish among them (Hartman, 1981). She defined patriarchy as a set of social relations which has a material base and in which there are hierarchical relations between men and solidarity among them which enable them in turn to dominate women.

Radical feminist theory uses the term *patriarchy* to refer to a social system characterized by male's domination over women. Hartman (1981) explained that, for radical feminists, "*the personal is political*" means, the original and basic class division is between the sexes and that the motive force in history is striving of men for power domination over women.

Radical feminism asserted that, sexuality and reproduction of women is controlled by men. The men's control over women's bodies and the sexual oppression of women is the original coercive power (Beasley, 1999). Weedon (1999) also states that, patriarchy encompassed all set of power relations aimed at securing men's control of women's bodies, sexuality and procreative power and labour. The material base up on which patriarchy lies most fundamentally in men's control over women's labour power and men maintain this control by excluding women from access to some essential productive resources and by restricting women's sexuality (Hartman, 1981). She also further explained, controlling women's access to resources and their sexuality in turn allows men to control women's labour power, both for the purpose of serving men and rearing children.

This study used radical feminism mainly because; the study participants are living in a system of patriarchy where women have no power in all their life aspects. In

addition, the radical feminists theoretical frame work supported this study to look at how patriarchy works and intertwined with culture and religion in maximizing women's oppression. It is because as Daly (1979) states patriarchal practices work unambiguously in the interest of men. The control of female's freedom is practiced in many cultures especially by religious one's and those that look to the past revered traditions as guidelines and rules about how to live in the contemporary world (Cohen, Howard and Nussbaum,1999). The continuing and rising influence of cultural and religious justifications for women's inequality is one important reason why it is so significant for women's rights to be recognized as human rights (Narayan and Harding, 1999).

The present study examined the social position of Gumuz women where, patriarchy which is embedded and manifested in the name of religion and culture, deprived women the right to decide on their own reproductive wellbeing through unequal power relationship and by depriving women the right to health, education and control over resources.

2.1.3 Multi-Cultural Feminist Theory

Many recent works show the fact that, gender links with other forms of dominations like race, class, culture, religion, ethnicity etc. The triple oppression of women is the organizing principle of multi-cultural feminism or intersectionality. Patricia Hill Collins (1990) explained it as "*a matrix of domination*" where several fundamental systems work with and through each other.

This study participants' possessed a very low socio-economic status, particularly caused by the historical legacy of ethnic and class oppressions as well as the existing gender, cultural and religious oppressions. This directly and indirectly affects Gumuz women's reproductive health. The study in particular shows how the intersectionality between gender, culture, religion, class and ethnicity affects the lives of Gumuz women in the reproductive health arena.

2.2 Culture

Culture is specific for a given society in different contexts. As a result, one can conclude; there is no one workable definition of culture. Hirut (2000) similarly states, the definition of culture is varying depending on the context which they are defined because there is no one homogeneous culture. Anthropologist Clifford Geertz defined culture as, historically transmitted pattern of meanings embedded in symbols and a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about and towards life (cited in Griswold,2004). This Geertz's definition of culture captures what sociologists currently mean when they use the term culture (Griswold, 2004). Though his definition suffered from andro-centric bias which neglected the very existence of women, I preferred to use his definition because he perceived culture as empirical and can be studied like anything else.

Tradition on the other hand implies specific patterns of behaviour shared by members of a given society and when the term harmful is added, it directly implies negative health, social, psychological, and sexual impacts. The African women's protocol defined harmful traditional practices to mean all behaviour, attitudes, and/or practice that negatively affect the fundamental rights of women and girls such as, their right to life, health, dignity, education and physical integrity (Westhuizen,2005). MacLean defined tradition as values inherited from generation to generation.

Tradition means what appears significant for human life. It is what has been seen through time and human experience to be deeply true and necessary for human life. It contains the value to which our forbearers first freely gave their passionate, commitment in specific historical circumstances and then constantly reviewed, rectified and progressively passed on generation after generation (1999:30).

Certain practices purposefully inflict pain. Wronka (2008) states this fact that, humans are obviously embedded in cultures which at times themselves inimical to fundamental human rights principles. If we take access to health care as an example, it is a fundamental human right which must be attained by every one without discrimination based on culture, ethnicity or religion. However, harmful traditional practices like the practice of isolating women at times of labour and child birth, deprived women's access to healthcare services.

In many countries of the world, there are many harmful traditional practices conducted against the reproductive health of women. Harmful traditional practices are formidable barriers to the application of universal human rights of women. Griswold (2004) states that, some practices are clearly wrong and need fixing because any society produces conditions that are pathological, dysfunctional, cruel, and shameful may be even evil.

All human beings are equal in worth and dignity, regardless of gender, religion, race or ethnicity. However, cultural relativists stood in contradiction to this principle. Corradetti (2009) stated that, normative relativists claimed, moral requirements are applied to different moral agents or groups of agents since they are relative to the internal principles of such agents and groups. He also explained that, this idea tends to reduce what is morally required to what is morally acceptable as a motivation to action and relativists justification that is what is morally right is culturally context dependant. Therefore, one should act in accordance with his or her own cultural context since cultures are the moral sources of actions.

However, the relativists' justification that is, one should act in accordance with his or her own context, which is cultural relativism, directly leads to the violation of human rights because we are living in a world where, many painful practices exist in the name of culture. Anderson and Hill Collins (2010:499) stated that, "*Cultural beliefs, attitudes and values have often been used to justify the oppression of women.*

Justifications such as this is how we do things, this is part of our culture negate the fact that cultures are dynamic entities, that what is acceptable today is different from what was acceptable hundred years ago."

Tradition in general and traditional religions in particular can be factors negatively affecting out common in HTP interventions .What people have done over a long period of time has the aura of seemingly having proved its worth overtime and it is therefore taken as granted. It is difficult for a tradition bound people to accept change to face the uncertainties they imply. (EGLDAM, 2008:15).

EGLDAM's explanation also explained the existence to the idea of perceiving culture as static and unchanged. Explanations associated with cultural relativism and traditions are fundamental causes for the denial of women's reproductive and human rights. According to Westhuizen (2005) explanation, the disparities between the interests advanced in the discourse on women's multiple identities and the discourse on cultural relativism have resulted in an unclear language. There is a bigger lack of clarity on what needs to be done when women's human rights are inconsistent with group claims. The cultural relativists critique is a major threat to the legitimacy and universality of human rights. This is because there is a bigger dichotomy of ideas between cultural relativism and universal human rights (Henry, Aliston and Goodman, 2007).

In order to reconcile the two dichotomies, Rehman and Breau (2007) suggested that, culture and human rights dichotomy engages in analysis of the roots of religion, philosophy and culture itself so that, all shared a common basis of the essential worth and dignity of human beings. Studying and digging out the ideas of human rights from a specific historical, cultural and religious traditions in rigorous evaluation may help to reconcile the problem.

Feminists believe that, transformative change in cultural relativism and cultural oppressions could be achieved through feminism because feminism is a movement that gives mechanisms of liberating oppressed women in the system of patriarchy.

Feminism is a feature of life in the twenty first century. They are sometimes considered to be ground breaking, sometimes dangerous but whatever the perspective taken on the value and effectiveness of feminism there is persistence in their varied and often troubled presence weather they are accepted, disputed, feminism can be seen to inform many different aspects and contexts of human living (Pears 2004:1).

Pears's expression shows how feminism is important to look at different aspects of human life and to alleviate women's oppression existed in different cultural contexts. Many feminists throughout the world claim women's liberations from oppressive cultural practices. As Hill Collins and Anderson (2010:499) asserted, *"we can't give up and accept practices that deny women's basic human rights."*

2.2.1 The Practice of Isolating Women at Times of Labour and Child Birth

In many cultural groups of the world, women's blood is treated as polluting and dangerous. It is also one of the means used by many societies to justify women inferiority and gender based discriminations. Similarly in many religions, women's blood is perceived as pollution to rituals and men. Shalala (1995) pointed out that, women in many cultures are secluded during and after child birth.

The same situation is explained by EGLDAM (2008) that is, in some parts of Ethiopia, a woman in her menstrual period is kept isolated from every man including her own children. It is believed that they will die if she dares to look them in the eye. The same is also applied for child birth period. As a result; many women deliver their babies unattended in an isolated hut built for the purpose which clearly affects their reproductive health.

The Gumuz people in Ethiopia practiced a similar seclusion of women during delivery and at times of menstruation. Wolde Selassie (2002) in his work entitles Gumuz's and highland settlers' different strategies of livelihood and ethnic relations in Metekel, North west Ethiopia mentioned that, women leave their home and stay a certain distance away during delivery. At night, the husband guards her from wild animals at a distance. The labouring woman delivers without anyone's assistance, except those women at their first delivery who need help. He also mentioned that among the people, it is believed that, dropping menstruation and delivery blood at home is polluting, and the anger of Missa (Sprit) will cause serious consequences and retribution.

Before Christianity and Islam, isolating menstruating women and women after child birth was a long tradition of Jews people. The bible of the Jews in Leviticus, (12:1-8) explains that a woman who becomes pregnant and gives birth will be ceremonially unclean for seven days just like she is unclean during her monthly period.

If we look at historical evidences to women's isolation at times of menstruation and child birth, early twentieth century informants and ethnologists referred to, "a house," "a seclusion lodge," "a separate tent," and a small house near spring or stream for menstrual and child birth seclusion among southeast North American Indians(John Swanton, cited in Brettell and Sargent,2005).

Though Swanton's sources about menstrual and child birth lodges are mostly limited to the tortuitous testimonies of eighteenth century male European missionaries, colonialists and ethnologists of his own time, he confirmed the existence of a seclusion lodge for menstruation and child birth seclusion among southeast North American Indians (Brettell and Sargent 2005).They also further discussed that though no menstrual hut was found in archaeological excavations of today's southeast north America, Art factual evidences like pottery, vessels, statuettes, pipes and particularly, Ramey ceramics perhaps used to obtain cooked

foods destined for women in menstrual or childbirth seclusion huts were found in excavation sites.

Ramey ceramics which are decorated ceramics, in particular are believed to be associated with menstrual and child birth seclusion because, they are decorated to ensure their recognition and avoidance by others and they are used in the women's house because pollution restrictions would keep them there, where they would likely to be found distant from living area in fields or forests. The location might be selected for its nearness to running water or may be because of its requirement for ritual cleansing (Brettell and Sargent 2005).

The above explanation shows pre-historic archaeological evidences and early twentieth century ethnographic literatures of southeast North America. But in the twenty first century Ethiopia, According to EGLDAM (2008) assertion, women in some Ethiopian cultures are isolated during labour, after child birth and at times of menstruation unattended and remained in a hut built for the purpose.

A similar situation among the Kung people of Botswana in northern part of the Kalahari Desert of Southern Africa is discussed by Anthropologist Marjorie Shostack (1981). Among the Kung, solitary child birth and child birth with minimal assistance is a stated cultural ideal. As a result, pregnant women face child birth with no medical facilities and with no traditional mid wives or other birth specialists to call up on except in some cases of first child birth.

In her Anthropological field work, (Shostak, 1981) also discussed that, among the Kung, fear of child birth is thought to be dangerous causing tension that makes delivery more difficult. God interpreting a woman's apprehension as indicating that the child is not wanted, so that God may kill the child and take it back to the spirit world in such cases, the mother may also be taken away. As a result, child birth is a woman's work to be accomplished by herself quietly and bravely without cries and afraid of the labour pain.

Another similar practice is also existed among the Kwaio people who lived in Malita Island, one of the Solomonian islands in the Pacific. (Roger Keesing, cited in Jaan Valisiner 2000), reported a highly ritualized seclusion among the Kwaio. For the people, child birth is a strictly women's affair. For the purpose of child birth, a special "birthing hut" which has two sections is erected in the vicinity of the "menstrual hut". The building process is done by the pregnant woman and her birth attendant (Valisiner, 2000). One of the reasons that make Kwaio child birth different from the Kung is, though seclusion during child birth is a must, the mother is allowed to have one birth attendant with her in the whole times of child birth isolation. From the beginning of entering in to the labour, the mother and her assistant are separated from the community. The mother and the baby as well as her assistant stayed in the "birthing hut" and nobody else is allowed to interact with the new mother for ten days except her assistant (Valisiner, 2000).

The post partum seclusion period of the Kwaio includes the maximum separation of the mother and her baby from 17-18 days. At the end of the first ten days, the mother washes herself and the baby, her assistant shaves the mother's head, then the mother destroys her part of the child birth hut and the birth attendant also destroys her part of the hut (Valisiner, 2000). He further explained that, it is important that a pile of stones is placed on the place where the after child birth is buried so that the forgoing pigs can't dig it up. At the end of dismantling the child birth hut, the mother and her baby remain in a menstrual hut for additional five days and finally the baby and the mother leave the menstrual hut and back to the village led by the assistant.

2.2.2 Religion

"Religious traditions may impinge on human rights and religious leaders may assert the primacy of those traditions over rights" (Henry, Aliston and Goodman, 2007:569).

Though patriarchal religious traditions shape the lives of women in an oppressive and non liberal ways, the relationship between feminism and religious traditions remained relatively unexplored even in the feminist scholarship. However as, Cooley, Eakin and Daniel (1991) discussed, the most oppressive patriarchal religions have sometimes been transcended by making a humane use of them; such events are to be honoured and are a source of meaning beneath and beyond difficulties.

One can easily say that, many world religions are founded on patriarchal thoughts and the roots of patriarchy itself lie in the myths of creation and the religious world. *“Patriarchy has an insidious partnership with religion and all of the so called religions legitimating patriarchy ... from Buddhism and Hinduism to Islam, Judaism, Christianity, to secure derivatives... are infrastructures of the edifice of patriarchy”* (Kamitsuka,2007:5). The most paradoxical thing is that, men constructed religions and women believe in them or women have found religions a place to try and be, in a world that says women have no place (Cooley *et al.*1991).

Though religions are not still adequately explored in feminist scholarship, most feminist works on religious analysis viewed religion as oppressive to the rights of women. Pears (2004) discussed that, feminist analysis constantly viewed religion with suspicion and sometimes outright hostility and feminist critique of religion has often focused on the claim that stereotypical and derogatory understandings of women are legitimized in most religious doctrines of the world.

Religions do not solely show spiritual matters they are also the main instruments embedded the cultural practices, beliefs and norms of a given society. Religious symbols are socially constructed and they reflect the cultural values of the times and places in which they are constructed (Essed, Goldberg and Kobayashi, 2009).

If we take isolating menstruating women, which was a religious tradition among the Jews, it also incorporates the lower social position of women in patriarchal cultures. If we look at most religious traditions from a feminist perspective, they

often see men as closer to God and whatever considered most important and women to that which is of lesser value, sometimes even problematic (Essed *et al.*2009). There is also a clear contradiction between religious freedom and the claims of women's rights.

The co-existence of the rights to freedom of religion and the prohibition of discrimination on the basis of religion with that on the basis of sex has led to contestation and struggle, where by claims for women's equality and empowerment are set against the requirements of religion. The human rights frame work does not set out any hierarchy nor any mechanism for resolution of conflicting claims leaving it open for protagonists and decision makers to determine their own priorities. (Rehman and Breau 2007:56)

Making religion exposed for change is the most difficult task feminism encountered. If we see culture, it is theoretically evolving and subject to change than religion. According to Rehman and Breau (2007) explanation, the basis of religious doctrine in sacred texts imposes restraints on the outer limits of change and reform.

The subordination of women in cultural and religious practices manifests itself through different ways. Women's economic status, discriminatory laws that justify exclusion from owning or accessing property and restrictive personal laws and the claim of religions to control women's bodies, sexuality and reproduction through many devices, directly lead to the violation of women's human rights(Rehman and Breau,2007).

A study conducted by Ethiopian Ministry of Health, (2006) states that, Ethiopia is a composite of ethno-religious groups and certain groups retain distinct traditions and practices and everything in each ethnic group, have divine interpretations. Maternal mortality, morbidity, and all health problems are associated with divine beings and religions may offer the principal source of explanation or hope.

It is obvious that, women's equality rights clearly violated in religious doctrines should not be left as normal and correct. Rehman and Breau (2007) have asked

questions like, who is making the particular argument? For what reason? In what context and with what objectives? Are claims based on religion being used as a justification for maintaining existing power structures? Are women's voices heard when such claims determined? Or is it the voice of male religious leaders that predominate? Does a majority community essential's minority communities by taking account of the views only of its male members there by silencing other voices, including those of women?

If we take the practice of isolating women at times of labour and child birth, one of the explanations for the practice is religious. Asking questions posed by Rehman and Breau (2007) will be helpful to critically look at the practice of isolating women at times of labour and even searching mechanisms of alleviating the problem is possibly embedded in it. Generally speaking, though the politicization of religion is very much contesting to attain the rights of women, asking such claims and questions is important to women's liberation which is constantly violated and justified using religious explanations.

2.3 Reproductive Health

Reproductive Health is at the centre of everybody's wellbeing incorporating physical, emotional and social needs of people. WHO (2003) has offered a definition of health that goes beyond the biomedical model and argument that is, health is a state of complete social, psychological, and physical wellbeing not merely the absence of diseases. So that, Reproductive health is directly associated with the social, psychological and physical well-beings of people.

Reproductive Health is a relatively new concept that comprehensively addresses all the health issues regarding reproduction. According to Reichenbach and Rosman's (2009) explanation, Reproductive health was not newly minted at the International Conference on Population and Development (ICPD). The term was first coined by Dr Mahmoud Fathalla when he was working at the human reproduction program of WHO. He laid the foundation for ICPD's definition of

Reproductive health that is, Reproductive health means people have the ability to regulate their fertility; that women are able to go safely through pregnancy and child birth and that reproduction is carried to a successful outcome through infant and child survival and wellbeing.

Reproductive health is also emerged out of the women's health and rights movement. Correa and Riechmann, (cited in Reichenbacch and Rosman, 2009) stated that, Reproductive health was a bigger agenda raised during the movement of women's health and rights preceded ICPD at list by two decades. In 1994, ICPD declared Reproductive Health as it implies people having satisfying sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so ([http://www.Population.org Publications/Reports/A world of difference/ICPD definitions and Goals.html](http://www.Population.org/Publications/Reports/A_world_of_difference/ICPD_definitions_and_Goals.html)).

Population and development for a long, was associated with fertility regulation issues. It was only in the Cairo conference that, incorporating the reproductive health dimension of population and development was started. Reichenback and Roseman (2009) stated that, the Cairo paradigm transformed population and development in to reproductive health. It was beginning from the 1994 Cairo conference that reproductive health is started to be seriously taken as one of a bigger human development indicator and not merely a fertility control issue.

2.3.1 Women and Reproductive Health

Women have a wider range of reproductive health needs than men because there are so many issues associated with women's reproductive health. Some of them are safe motherhood, maternal morbidity, maternal mortality, the necessity of birth attendants, family planning and safe abortion. However, in many cultures, women are not allowed to fully participate in the decision making process which directly affects their reproductive health status. Smyke (1995) asserts that, most women do not have the power to decide on their own reproductive health life.

The 1995, Beijing platform for action approved a common vision that recognises Reproductive health as an essential element of Human welfare and development. However, the overall socio economic status of women, poverty, harmful traditional practices and gender inequality in sharing power and decision making at all levels affects women's Reproductive health. On the other hand, international conventions declared to promote women's reproductive health are not effectively implemented.

It seems though that in practice over and over again and again the universality of human rights is particularly challenged when applied to women. The resistance to women's rights often takes a form of adopting cultural relativism view point and claiming that women's position in the private sphere leaves women outside the human rights framework (Disich, 2009:661).

This shows how the reason that is cultural relativism, kept the suffering of women in the reproductive health arena. Disich (2009) also mentions that, recognizing women's rights are human rights is an ongoing and arduous process and an agenda for struggle.

"Throughout the world, there are practices violent towards women and harmful to their health but have avoided national and international scrutiny because they are seen as cultural practices that deserve tolerance and respect...cultural relativism is therefore often used as an excuse to allow for inhumane and discriminatory practice against women in the community..." (Henry, Aliston and Goodman, 2007:568).

On the other hand, understanding the social construction of gender and gender power relationship is central to identify measures to be taken against harmful traditional practices and health care service provision inequality. Women's subjectivity in all life aspects is often framed by the social construction of gender and its power paradigm. Hirut (2000) stated that, all societies have devised different methods of the repression of female sexuality. It is also similar if we look at female reproduction, because female reproduction like female's sexuality is controlled and shaped by the social construction of gender and gender power paradigm.

Gender is a socially constructed idea of femininity and masculinity i.e. what women and men can or cannot do (Mulumebet, 2006). If we look at the ideas and meanings given to femininity and masculinity which is usually manifested through categorizing what women and men can do or cannot do, it clearly victimized women to the unequal gender division of labour and restricted women from accessing resources and education which at the same time, restricted them from investing on their own health. If we also take the gendered nature of women's daily life and reproductive roles, it directly or indirectly contributes to women's poor health.

The inequitable power relationship between men and women have over the years created a kind of cage around women which restrains their mobility, their control over their own fertility and their participation in and benefit from development (EGLDAM, 2008). This problem indicated that, health inequality highly demands gender equality too. *“ If we are to achieve greater social and health equality, we must better understand the social, cultural and political process that produce disparities in health, only then we will be able to act effectively to revise or mitigate those processes (Anderson and Hill Collins,2010:499)”*.

Harmful traditional practices are not the only problems women encounter in relation to reproductive health. Lack of adequate health care services is also the major problem so many women suffer and die in developing countries. (Kristof and Wudunn, 2009) stated the presence of health care deficiency not only for women but also for men in developing countries. Particularly in sub Saharan Africa, where, 11% of world inhabitants live, people suffer 24% of world's diseases burden, which is addressed with less than 1% of the world's health care spending and maternal health care is particularly neglected never receiving adequate funding.

2.3.2 The Reproductive Health of Ethiopian Women

Most of the reproductive health problems of Ethiopian women are associated with cultural and religious beliefs, norms, traditions and lack of adequate health care services. According to EGLDAM's (2008) assertion, Ethiopian women are suffering from many harmful traditional practices and beliefs. Some of them are, female genital cutting, early marriage, marriage by abduction, shaking a woman after delivery, food discrimination, massaging the abdomen in labour, drastic measures to enhance expulsion of placenta, isolating and perceiving women unclean during menstruation and child birth etc are some of the harmful traditional practices conducted against the reproductive health of Ethiopian women.

The lower social position of women which is highly related with the unequal gender power relationship, contributed a lot to the existence of these harmful traditional practices which directly caused ill reproductive health of women. Due to their inferior socio economic and cultural status, most women in the country do not have alternatives to lead their own life choices except accepting and being part of traditions and practices that are constructed against their reproductive health (EGLDAM, 2008). The same report also confirmed that, Ethiopian women's suffering caused by harmful traditional practices is perpetuated by women themselves because it is their only way for survival in an environment where the economic dependency on their husband is their only choice in life (EGLDAM, 2008).

Some Ethiopian women also faces additional disadvantages in health due to intertwined influence of historical ethnic, class and different problems like geo political status. As (Gatti and Bagio, 2009) stated, gender interlinked with other influences like race, class, ethnicity and geo-political status. The health policy of the country is still dependant on the provision of primary health care services.

2.4 Safe Motherhood and Development

Safe motherhood implies women's ability to have a safe and healthy pregnancy and delivery. In the second UN's decade for women, which was from 1985-1996, WHO launched Safe motherhood at the Nairobi conference of 1987. Safe motherhood is also one of the Millennium development goals of the world expected to be attained by all countries in 2015 (ECA, 2009).

Safe motherhood incorporates: ensuring access to safe water, providing tetanus immunization after delivery, providing access to appropriate maternity care, ensuring the availability of trained birth attendants, providing a clean environment for the birth, ensuring ease of referral to specialist care, remaining watchful for indicators of complications in all women, providing readily available emergency obstetric care, educating and informing women about their pregnancy and child birth and warning signs of emergencies, providing easy access to family planning services, setting protocols or guide lines to be followed for dealing with problems such as haemorrhage or eclampsia (WHO,2003).

Health is a fundamental human right indispensable for the exercise of other human rights; every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Measures must be put in place to improve child and maternal health, sexual and reproductive health services including access to family planning, pre and post natal care, emergency obstetric services and access to information as well as to resources necessary to act on that information (ECA, 2009). .

The above explanation asserted the existence of international consensus on the importance of maternal health. International conference for population and development also asserted the necessity of expanding the provision of maternal health services in the context of primary health care. These services should offer prenatal care and counselling with special emphasis on detecting and managing high risk pregnancies. ICPD, twenty first special session agenda item 8:64 also

stated a program that is, all countries should continue their efforts so that, globally by 2005, at least 80% of all births should be assisted by skilled attendants, by 2010, 85% and by 2015, 90% (ECA,2009:115).

Traditionally development meant the capacity of a national economy that is the growth of income per capita to take in to account the ability of a nation to expand its output at a rate faster than the growth rate of its population, which is a very narrow definition of development (Torado and Smith, 2009).

The new development perspective is established by the 1998, Nobel Laureate in economics, Amartya Sen that is, *Capability to function* fundamentally expressed development as Human's wellbeing means being well in basic sense of being healthy, well nourished, or highly literate and more broadly, having freedom of choice in what one can become and can do (Torado and Smith,2009).

The new perspective of development emphasised on the need to health wellbeing of individuals including safe motherhood. Torado and Smith (2009) confirmed that, health is a vital component, a prerequisite and indispensable contributor to development. WHO's (2003) report similarly stated that improvement in health is not only important in its own right, but also better health is a prerequisite for economic growth and social cohesion. It is these complexes enter relationship of health and development that makes health a bigger agenda and one of MDG's of the world.

The new development point of view clearly emphasized on human capital particularly, on health and education. It is because they are prerequisites to development. It is clear that, women must be healthy enough to contribute to the process of development. In women's contribution to development, at any social level the importance of health is very big because it is only when women are healthy that they can cope with their productive roles (Kyomuhendo, 2005).

If we look at Ethiopian women from the point of the new development perspective, women are deprived in health, education and freedom in all its forms basically due to socially constructed practice and explanations imposed and denied women's equal opportunities in many of their life aspects. EGLDAM (2008) national survey on HTP's confirmed that Ethiopian women lagged behind men in all areas of life due to many harmful practices performed against their rights.

The new development perspective is a path way to work on the attainment of safe motherhood. Torado and Smith (2009) discussed that; human capital must be given direct attention in its own right. Even in economies that are growing rapidly health and education may be distributed very unequally just as income and wealth are. But improved health and education help families escape from some of the vicious circles of poverty in which they are trapped.

2.5 Maternal Mortality

A maternal death is defined as the death of women while pregnant or within forty two days of termination of pregnancy from any cause related to or aggravated by pregnancy and its management (Greer *et al.*2007). Maternal mortality rate is the most widely used indicators of the health of a nation. WHO suggested that maternal deaths could be prevented through actions that have been proven to be effective and affordable even in developing countries. However, maternal mortality rate of developing nations is very high.

The 2009, ECA report explained that, the major factor for high maternal mortality ratio in Africa is lack of access to adequate medical care and even when access is available it is often inequitable. Lack of adequate medical care is not the only reason for high maternal mortality in developing countries, harmful traditional practices, beliefs and norms are also causes for high maternal mortality. This is despite the fact that, maternal health care service incorporated the presence of trained birth attendants, aseptic birth environment, identification of maternal, fetal,

neonatal, complications and transport to higher level care when indicated (Gabbe *et al.*2008).

Four, five, and six of MDG's are towards health progress. These goals are series challenges for Africa particularly in child and maternal mortality rate. The continent is making steady progress on few goals but less so on others. The same report also discussed the absence of convergence either in levels or rates of progress across sub regions (ECA, AU and ADB, 2009).

A maternal death might be direct or indirect. Direct maternal death is resulted from delivery complications during delivery and indirect deaths are associated with previously existing disease which deteriorates because of pregnancy and child birth (Chamberlain and Simpikins, 2000). Eighty percent of maternal deaths in developing countries occurred as a result of direct obstetrical complications during delivery usually arise in the form of haemorrhage, infection and eclampsia (Greer *et al.*2007:2).

2.5.1 Maternal Mortality in Ethiopia

Lack of vital registrations, longitudinal studies on pregnant women and absence of repeated household demographic health survey are problems of estimating maternal mortality rate in Ethiopia (MoH, 2007). It was only by 2000, the first ever demographic health survey was conducted in the population based national survey of the country.

The maternal mortality ratio of Ethiopia, for the period 1998-2004, was 673 deaths per 100,000 live births (CSA, 2005:233). By 2010, it is reduced to 470 deaths per 100,000 live births (MoH, 2010:37). This is still the highest number in Africa.

Since, maternal mortality is a bigger indicator of human development, the highest MMR of Ethiopian women shows the overall inferior status of women in socio-economic, cultural as well as political affairs of the country. Ethiopian mothers are dying of complications arising from pregnancy and child birth particularly in the rural settings of the country. I found the following explanation, proper in

expressing the suffering of Ethiopian women in the Reproductive health arena. *“On a more fundamental level women are dying because they are poor, malnourished, lack of education, have lower social status than the decision makers in their families and communities, have no voice and many lives in societies that to date have not invested in maternal health”*(Greer *et al.* 2007:2).

The above explanation is the everyday experience of Ethiopian women. Contrary to this reality, Article 35, of the 1995 Ethiopian constitution stated women’s right that is; women have the right to be protected from any harm arising from pregnancy and child birth. However, the majority of Ethiopian women do not have adequate access to maternal health care services, caused by different socio-economic and cultural factors.

2.5.2 Delivery Complication

Labour dystocia literally *difficult labour or child birth* resulted when anatomic or functional abnormalities of the foetus, the maternal bony pelvis, the uterus and cervix and a combination of these interfere with the normal course of labour and delivery (Balado, 2006).

Pregnancy and child birth are natural events or physiological processes in which no harm comes either to the baby or the mother (Chamberlain and Simpikins, 2000). However problems can arise for this reason a skilled team should be available to assist the mother. Monitoring of maternal conditions including pulse, blood pressure, respiratory rate, temperature, urine output and fluid intake should be performed periodically throughout the course of labour (Balado, 2006). If the foetus is with a non reassuring fetal heart rate pattern, operative delivery is a must to avoid further deterioration (Gabbe *et al.*2008). However in developing countries the usual factor behind most delivery complications is lack of adequate pre natal, delivery and post natal care services.

In developing countries, where access to health care services is very limited, delivery complication or obstructed labour is usually concluded with maternal mortality, chronic anaemia, obstetric fistula, urinary incontinence, foot drop, pelvic inflammatory diseases (Greer *et al.*2007). A report prepared by Ethiopian Ministry of Health (2006) on safe motherhood and community based survey, estimated 80 obstetric fistula cases per 100,000 mainly caused by prolonged and obstructed labour.

2.6 Social Position and Health

Since the 1980's, the new approach of public health education started to recognize different social determinants of health. From among these, social position or status is the biggest one. Bird and Rieker (2008) stated social status and unequal social and economic resources distributions as *fundamental causes of health disparities*. Women's reproductive health wellbeing is significantly important in showing women's social position in a given society. The wellbeing of women during child birth is particularly a clear signal of women's status. Similarly Gatti and Bagio (2009) discussed the importance of societal values in health that is; there is increasing recognition that the health of individual is a product not just of biology. It is also individual's practices and the conditions of their environment that determine their health. This explanation clearly shows the fact that, problems of health goes beyond biological causes and exacerbated by conditions in a society.

All societies have rankings because individuals are unequal in a variety of ways: but not all societies have the same gradients in health. What matters is the degree to which inequalities in ranking lead to inequalities in capabilities. The lower in the hierarchy you are the less likely it is that you will have control over life opportunities for full social participation, autonomy and full social participation are so important for health that their lack leads to deterioration in health.(Michael Marmot, cited in White, 2009:55)

The explanation confirmed how social status matters a lot on individual's health. The influence of inferior social status on health is directly applied to most women

throughout the world as a result of the social construction of their gender inequality in many of their life aspects.

2.6.1 The Social Position of Ethiopian Women

Women's health is profoundly affected by who they are and where they live (Essed *et al.*2009). Who they are is associated with women's social position in their own society. In most patriarchal societies, females are regarded as the inferior of the species. Similarly in Ethiopia, women are considered as inferior to men and should therefore be under the control of men (Tesfu, 1996).

Women's lower social position particularly existed in societies where their economic contribution is unrecognized. A study conducted by Habtamu, Hirut, Yusuf and Konjit (2004) state similar situation that women often have a low social status because their work in the household and in the informal sector goes unrecognized though their contribution is vital to the wellbeing of households as well as to the country. The same study also confirmed the existence of lower social position of women in the country.

Though women contribute much to the productive sector, many Ethiopian societies do not recognize it as an important contribution. For instance, if we take the case of Gumuz women, Gebre (2001) stated that, women are engaged in all agricultural and routine laborious works for about eighteen hours a day. He also explained, in the society, divorced women take no property with her except for those goods recognized as her personal belongings like clothing but the husband has a right to retain the common property of the household. This situation shows the very lower social position of women in the society which at the same time has a bigger contribution to the poor health of women.

In some cases of Ethiopian societies, the inferior social position of women is intertwined with the historical legacy of ethnic and class as well as with the existing cultural and religious oppressions. It is like what Brid and Rieker (2008) states that, Models of inequality can explain many if not all observed gender

differences in health, that is racial, ethnic and socio-economic health disparities contribute to and interact with the gender difference. Gender based inequalities interact with inequalities of social, class, race, ethnicity etc (Gatti and Bagio, 2009). So that, women faced additional disadvantages compared to men even in the same social group. This reality is also experienced by many Ethiopian women.

CHAPTER THREE

Methodology of the Study

3.1 Research Design

This study involved a philosophical assumption, a research design, research methods and procedures. The philosophical assumption of this study is based on the social constructionists' views which direct the entire goal of this study to relay on the participants views of the situation being studied. According to the social constructionists' philosophical assumption or world view, the meanings of the participants life is formed through interaction and the researcher intent is to make sense or to interpret the meanings others have about the world (Creswell, 2009). This philosophical assumption directly leads an inquirer to relay more on qualitative research design because qualitative research is about participant's meanings of life.

Qualitative research is important to explore new issues. The research problem of this study is a social problem that is not studied in research undertakings. To this end, exploring the practice of women's isolation at times of labour is better attained through qualitative design. Creswell (2009) stated that, one of the chief reasons of conducting a qualitative research is its importance to investigate new phenomena that do not possess adequate documents.

In addition, the study is highly indebted to air the voice of women participants who are living in the practice. Qualitative research is useful to promote dialogue, emancipate the oppressed and empower the weak which is the main purpose of social research (Seal, Pietro and Jaber 2004).

Different scholars identified different strategies of qualitative inquiry. Creswell (2007) recommended five traditions of qualitative research namely, narrative, phenomenology, ethnography, case study and grounded theory. Creswell further

pointed out his reason of stating these five approaches and of their usefulness and popularity in social and health sciences of today.

3.1.1 Case Study

Case study research method has a long distinguished history across many disciplines (Creswell, 2009). He called case study as a methodology and a type of design in qualitative research in which the investigator explores a bounded system *a case* or multiple bounded system *cases* over time through detailed and in-depth data collection involving multiple sources of information.

The main reasons why this study used case study method are first, Yin (2003) recommended a case study approach when the type of research questions are typically concerned to answer how and why issues. How the practice of isolating women at times of labour is exercised among the Gumuz of Ethiopia? How the social position of Gumuz women contributes to the practice of isolating women at times of labour? How women themselves perceived it? How the practice affects the reproductive health of women? Why the practice of isolating women at times of labour is exercised among the Gumuz of Ethiopia? Are the Basic research questions of this study.

The research problem of the study is also a primary investigation which demanded real life individual and context based in-depth investigation which is better attained through case study research approach. The method of case study is also very conducive for feminist researchers because it is largely the method of disciplining personal and particularized experiences. This is the main reason why feminists are very much interested in case study approaches that is, as a result of their interest in exposing the voice of marginalized women. It is particularly to make social reforms easier. Feminist interest in case studies stems from the desire to document aspects of women's lives and achievements for future analysis and future action on behalf of women(Renharz,1992).

According to Denzin and Lincon (2005) there are three types of case study designs namely intrinsic, which is undertaken to get better understanding of a particular case, instrumental, which examined a case to redraw generalization and the last one is multiple case study design, which gives emphasis to a number of cases studied jointly in order to investigate a phenomena.

Multiple case study design is the specific approach of this inquiry due to its usefulness to look at different perspectives and the complexity of the problem that further helps to bring adequate answers to the research questions through in-depth investigation of individual, personal and cultural experiences of people.

A case study is a good approach when the inquirer has clearly identifiable cases with boundaries and seeks to provide an in-depth understanding of the cases or a comparison of several cases (Creswell, 2007). Furthermore the same author argues when an inquirer chooses multiple cases, there is no a set number of cases but having enough information to present an in-depth picture of the case limits the case number but he suggested 4-5 people to be involved as cases. On the other hand, Strauss and Corbin (1998) introduced a principle called, theoretical sampling method which is a process of sampling individuals by the researcher to select additional cases to be studied according to the potential in developing new insights or expanding and refining those already gained. Based on the principle of theoretical sampling method, I used additional cases that are more than five participants due to their importance to develop new insights and information's helpful to answer the research questions of this study.

Seven women participants who experienced solitary child birth and seven elderly key informants (women and men) who have knowledge and experience about the practice of solitary child birth were involved in the study. These fourteen participants are distinguished as different cases. Women participants are distinguished based on their last child birth stage. Women who gave birth to, their first, second, third, fourth, fifth, six and seventh child were included because

giving birth to first and seventh child may not give them similar experiences. In addition, they are also distinguished as cases because they are recruited from different villages.

From seven elderly key informants, one of them is elderly woman key informant and five of them are very old people perceived as community leaders of the society. In addition, one of the study key informants is a government worker in Mandura wereda administrative office because; I want to look at the works and the responses of the administrative office towards the issue of this study. All this study participants are different individual cases and they are from Gumuz people in the study area.

3.1.2 The Site and the People of the Study

Benishangul Gumuz is one of the nine regional states of Ethiopia established in 1994, by the new constitution of the country that created a federal system of governance. According to the 2007, population and census of Ethiopia, Benishangul Gumuz is inhabited by 784, 345 people where 385,690 females and 398,655 male inhabited in the regional state (CSA, 2010).

The regional capital Asosa is at a distance of 687 km west of Addis Ababa. According to the current administrative structure, Benishangul Gumuz is divided in to twenty weredas with special weredas, which are structured under three administrative zones. The three zones are Metekel, kemashi and Asosa where as the special weredas are Pawe and Mao-Komo.

Metekel zone is one of the zones in the region located in northwest part of Ethiopia. It is a vast territory used to be one of the provinces of Gojjam until 1989 when it is upgraded into the status of administrative zone. The capital of the zone is Giligel Beles, which is situated at 555kms from Addis Ababa in the Northwest direction. The zone is bounded by national and international boundaries. It is bounded by Amhara national regional state in the north and north east, it is bounded by Oromiya national regional state in the southeast and east, by

Gambella national regional state in the south and the Republic of Sudan in the west.

Historically, Metekel zone in the Ethiopian administrative system was highly inaccessible to modern infrastructures. Gebre (2001) stated that, Metekel was an inaccessible remote location with few modern amenities such as schools, health centres, communication infrastructures and industrial products.

Mandura wereda is one of the weredas incorporated in Metekel zone, which is the focus site of this study. Many ethnic groups live in the wereda constituted 40,746 people where, female are 19,505 and male are 21,241 which is based on the 2007 national census of the country (CSA, 2010).

The Gumuz people are predominant and indigenous ethnic group of Mandura wereda. They are one of the Nilo-Saharan speaking people located generally along the Blue Nile and its tributaries (Christopher, 1995). Historical accounts and ethnographic data revealed that the Gumuz people experienced marginal economic and cultural relationship with their neighbours and the rest of Ethiopia (Gebre, 2001). Socially the Gumuz are organized in different clans and sub clans that consist of people who claim patrilineal descent relations. Property and power are inherited through the paternal line (Berihun, 2004). The Gumuz believed that, *Musa* is the creator and saviour of human beings and non human creatures (Gebre, 2001).

Some of the main reasons of selecting Mandura wereda or the research site of this study are firstly, it is a place where many harmful traditional practices affecting the lives of women and the practice of isolating women at times of labour is very common and this social problem is not studied on the site so far. Thus, I think it is important to research an issue that was not researched before in order to discover solutions and make reforms easier. In addition, I am very much interested to make women's voice heard.

3.1.3 Sources of Data

This study utilized both primary and secondary data's. The primary sources of data are women participants who have experienced solitary child birth and elderly key informants. Documents particularly a statistical data showing Gumuz women's access to education was included as secondary sources of information. One documentary film prepared on the life of Gumuz women and another documentary film showing the overall life styles of the Gumuz were also included as supplementary sources of information.

3.1.4 Informants of the Study

All Gumuz women who gave birth in isolation from people in Mandura wereda are possible informants of the study. Since it is difficult and not necessary to interview every one everywhere and at any time, taking sample informants is inevitable. Their significance in providing appropriate and the necessary amount of data is the fundamental reason of selecting the study participants. In qualitative research we look at the social significance of samples instead of the statistical logic (Seal *et al.* 2004).

The study used purposive sampling method because individuals are selected based on their life experiences and having cultural knowledge about the research problem. Since it is a qualitative case study and an in-depth investigation, limited numbers of samples were used in order to manage the volume of the data based on the fact that, the number of participants properly addressed the research questions of the study.

Despite the fact that, the study utilized purposive sampling method, the purposeful selection of sample participants was guided by certain criteria's. Seven women participants are selected because they are women who gave birth in isolation from people living in Mandura wereda and who are in their reproductive age. Further criteria's in selecting key informants are their age at list fifty: this is because old people are opinion leaders in many societies who could briefly explain

why certain practices are exercised in their people's culture. Both (men and women) indigenous Gumuz living in Mandura wereda and knew repository of Gumuz culture and communal life and intimate knowledge about why the Gumuz exercise the practice of solitary child birth. One key informant is also selected from government administrative office in order to look at the work and the response of the government administration towards the practice.

Generally speaking, all participants of this study purposefully recruited from Gumuz people. Fourteen individuals have contributed for the primary data, eight women and six men. From eight women participants, seven of them are in their reproductive age (15-49) because all of them gave birth in recent times and one woman is old aged key informant. From all participants, thirteen participants do not know their exact age number but six key informants associated their age with certain historical events which helped me to estimate their age. Based on the information they gave, these six key informants were above fifty years of age. The rest one key informant is tenth grader and fifty years of age.

Table 1. Women Participants' Socio-demographic Profile

Participants	Age	Educational Status	Last Child Birth	Marriage Type
I	35	No formal education	Fifth	Polygamous
II	18	"	First	Monogamous
III	20	"	Second	"
IV	23	"	Third	Polygamous
V	25	"	Fourth	"
VI	27	"	Seventh	"
VII	30	"	Sixth	"

All age numbers are estimated

Table 2: Key Informants' Socio-demographic Profile

Key Informants	Sex	Age	Education Status	Marriage Type
I	Male	60	No formal education	Polygamous
II	Female	80	"	"
III	Male	65	"	"
IV	„	75	"	Monogamous
V	„	70	"	Polygamous
VI	„	72	"	"
VII	„	50	Tenth grader	Monogamous

All age numbers are estimated except key informant seven's

3.1.5 Methods of Data Collection

In-depth one to one interviewing of a flexible research design is the primary means of data collection basically because the study followed feminist research methodology that is *“Experience is knowledge”*. Interviewing is important in offering researchers access to people's ideas, thoughts and memories in their own words that is access to experience is gained through the talk. It also increases sensitivity helps to perceive the subtle nuances and meanings of participants which help for making exploration of an issue (Renharz, 1992).

In-depth interviewing with women participants primarily focused on their own personal experiences. They were asked questions like where did you gave birth? How do you perceive the practice of being isolated at times of your labour? Do you encounter any health problem while you gave birth in isolation? Were, some of interview questions responded by women participants in the study.

Key informants of the study were asked questions like why the practice is conducted. How it is exercised? What is the place of women in the society? Are women having enough access to education, health care, resources in the society? Who shares the burden of productive works? Why? Were, some of the questions used for interviewing the key informants.

Qualitative researchers should pay careful attention to the collection and analysis of documentary realities (Silverman, 1997). This study analyzed one statistical documentary reality and from public archival records, two documentary films about the Gumuz were analyzed and interpreted.

3.1.6 Procedures of Data Collection

I spent a month at the site. When I arrived there I informed the purpose of the study both to Metekel zone and Mandura wereda administrative offices in Giligel Beles town. People who lived in Giligel Beles town whom I knew helped me to find three assistants working with me as guiders and translators of Gumuz language throughout the collection of the data. Particularly, one of my assistants was born in one of the villages I conducted the data collection. In order to access participants, usually we were walking for three hours from one village to the other usually crossing small rivers in the area.

The in-depth interviewing was conducted in three rounds. First, preliminary information about the participants were gathered. Second, the core of the interview questions were presented and lastly interview was made in order to cross check and confirm the certainty of the data given in the second round interviewing. The data were tape recorded and to reassure its existence, note taking was also done at the same time.

3.1.7 Ethical Considerations

- Respect for participants is a fundamental ethical consideration of this study.
- Informed consent was obtained before the beginning of the study with each participant.
- The purpose of the study was properly expressed to the participants.
- Participants were given their free consent to participate in the study and they were told that they have the right to with draw from being interviewed

at any time. It is based on the oral consent participants give to the researcher; the interview process was started and held.

- I identified myself and my address to the participants.
- Participants were told that, the information they provided would be used for research purpose only. They were also told their name will be kept anonymous and all their names in the research finding will be represented through pseudo names.
- Participants were told not only the purpose of the research, but also procedures to be in the data collection.
- Expected benefits and risks the research will bring were explained to the participants.
- Participant's privacy was considered particularly while they were interviewed.
- After the end of the analysis of the data, the data will be kept for reasonable period of time and will be discarded. It will not fall in to the hands of other researchers.
- I tried to provide accurate account of information in the process of data analysis and interpretation.

3.1.8 Validity of the Study

Validity in qualitative research is called by many researchers as *trustworthiness* of the study and which is highly associated with words like *credibility, authenticity, transferability, dependability, conformability* etc.

Many qualitative researchers recommended different ways of preserving trustworthiness. Creswell (2009) stated prolonged field work, reflectivity, methodological and theoretical triangulations, avoiding objectivity and emphasising on conformability, using multiple sources of data etc. Overall of these, showing thick description of the problem of the study could successfully preserve the trustworthiness of a qualitative study.

This study shows detailed description and provided diversified perspectives of the issue in each thematic categories of the study with rigorous procedures. This primarily helps to preserve the validity of the findings. In addition, thematic categories of the study are done based on the methodological and theoretical triangulations.

The study also included detailed narrative descriptions using a narrative passage to convey, the findings which are crucial to show the diverse perspectives of the participants and the problem. I also informally talked with people who are not participants of the study in the area with the intention of maximising the validity of the study.

Reflectivity is the core value of a qualitative research. Good qualitative research comments how researcher's interpretation of the findings is shaped by their background such as gender, culture, history and socio economic origin (Creswell, 2009). Since clarifying the bias the researcher brings to the study is important to qualitative validity, I acknowledge the gender bias I could be subject because the research problem is a practice directly violates the human rights of women which could make any women very sensitive and emotional. Though I tried all my best to minimize, it is difficult to eliminate at all.

The possibility of generalizing a qualitative case study is stated by Yin (2003) but he brought prerequisites like, if the qualitative researcher study additional cases and generalize findings to the new cases, which is the same as the replication logic used in experimental research that is, to repeat a case study's finding in a new setting, requires good documentation of qualitative procedures, such as a protocol for documenting the problem in detail and the development of a through case data base.

Since, this qualitative case study utilized one month for data collection and the study is a beginning exploration; I found generalization difficult rather the study emphasised on depicting the complex picture of the problem of the study. The

study will provide adequate ground for a person who wants to inquire more on the problem.

3.1.9 Data Analysis Procedures

The study analysis is made through holistic approach and accounts. Digging and reporting multiple perspectives, identifying the many factors involved in the study and showing the larger picture and the diverse perspectives that emerges in the process of the study is the main concern of the data analysis section. Stake (1995) asserts that, case study and ethnographic research involves a detailed description of issues. As a result, valid answers to the research questions and thick descriptions of the problems are attained through content or thematic analysis method.

The first step of the analysis was made through preparing and organizing the data, by transcribing interviews, sorting and arranging data's based on sources of information. The second step was squeezing all the data into short notes to make it easier for coding and categorizing concepts. At the third step in which coding was done, firstly open coding was done in order to identify the properties and dimensions of concepts. The next coding was axial coding which is the act of relating categories to sub categories along with the lines of their properties and dimensions.

The coding process helps to develop categories stands for the phenomenon or the issue and sub categories are emphasized to answer questions like 'why?' and 'how?' At the end of categorizing concepts, themes were organized and lastly, interpretations including what does it mean to the participants and what does it mean to me are described basically with the objective of exploring individual case experiences of people about the issue of the study.

Table 3: Themes, Categories, Sub-categories and Codes as Identified from the Data

Theme	Procedures of Child Birth Seclusion			
Category	Labor and Gumuz women	Post Partum Period		
Sub-category	-	Post partum seclusion	Pollution restrictions	Purification rituals
Codes	Unattended labour. Laboring outside home and far from agricultural fields.	Protecting women isolated	Using cups and dishes reserved only for the delivered mother. Avoidance of materials.	Ritual sacrifice. Rituals after birth and at the end of post partum seclusion.

Theme	The Social Position of Gumuz Women				
Category	The place of women		Women's access to human capability potentials		
Sub-category	Inferior social position	Gender division of labour	Access to Resources	Access to health care	Access to education
Codes	"Women are created to serve men". Men are highly respected.	Disproportionately assigned. The burden of women's work.	Women are systematically excluded.	Lesser access. Traditional beliefs.	Polygamy Lesser access

Theme	Experiences and Perceptions of Women	
Category	Labour experience	Women's perceptions towards the practice
Codes	Obstructed labour. Unattended labour. Difficult Weather condition.	Striving for a birth attendant. Dislike towards the practice.

Theme	Reproductive Health Outcomes		
Category	Maternal morbidity	Maternal mortality	Infant mortality
Codes	Pelvis and waist pain. Post partum hemorrhage. Childbirth complications.	Maternal mortality caused by unattended labour.	Infant mortality resulted from unattended labour.

Theme	Justifications of Childbirth Seclusion		
Category	Religious	Cultural	Other factors
Codes	"Musa" will bring curse. Women's blood is perceived as "pollutant".	Bearing the pain of delivery. Men will be sick.	Poverty. The historical legacy of oppression. Men attendants.

Throughout the analysis process, cases were analysed for each individual case which is *within case analysis*, analysis across different cases using explanations and word table cross-case analysis, and contradictory cases were also incorporated and analysed. In applying cross-case analysis, word table depicting similarities of participants' responses was included. This is done on the basis of Yin (2003) recommendation of using alternative strategies of cross-case analysis. In his suggestion he stated that, a word table can be created to display the data from individual cases according to some uniform framework and the implication is the researcher can then look for similarities and differences among the cases.

CHAPTER FOUR

Findings and Discussion

Ethiopian women sustain dozens of harmful traditional practices and the social position of women is inferior to men basically because the culture regards men superior than women. Religion in the country also ascribes a subordinate position of women exposes them to countless harmful traditional practices which directly affect women's physical and psychological wellbeing.

Although child birth (*Impiqua*) is highly valued and perceived as accomplishing one's goal in life, it is a complicated event for Gumuz women of Ethiopia due to the cultural practice which isolates women both at the time of labour and after child birth. Women among the Gumuz of Ethiopia are forced to leave their living home and give birth isolating themselves from people and without any birth attendant because solitary child birth is the stated cultural ideal and a common practice of the people.

Gumuz women do not have enough access to education basically due to their engagement to laborious works, female exchange marriage and for their reproductive works and roles. Their access to health care is also highly constrained by traditional beliefs and practices as well as the inequitable health care provision in the area. Besides, the rigid gender division of labour is tedious and back-breaking to women and has a negative effect on women's health. All these life experiences of Gumuz women clearly show the very inferior social position of women in the society.

The findings and discussions of the study encompassed different thematic topics and sub topics. Procedures of Gumuz women's child birth seclusion including the post partum seclusion are discussed and interpreted in accordance with the theoretical framework and the review of related literature of the study.

The place of women in the society, gender division of labour, women's access to resources, health care and education services are also explained and interpreted because of their importance in identifying the social position of Gumuz women which at the same time are crucial to realize their health status and why the practice of isolating women at times of labour is sustained in the society. Each woman participant's perception about being isolated at times of their child delivery is incorporated. The people's justifications of child birth seclusion including cultural, religious and other factors are also discussed and interpreted in the chapter.

4.1 Procedures of Child Birth Seclusion among the Gumuz of Ethiopia

The Gumuz people exercise the seclusion of women during delivery. The seclusion of the delivering mother starts when a woman feels the labour pain and the isolation of the mother stays throughout the post partum period where a woman after child birth is restricted from touching growing plants, goods, preparing foods, fetching water and from making any contact with people till the stated period of time and the cleansing ritual is over.

4.1.1 Labour and Gumuz Women

During pregnancy, Gumuz women engage in laborious works. They do not refrain from carrying out their daily livelihood until the last minute of delivery. Throughout the time of pregnancy, there are many cultural taboos that force pregnant women not to eat goat meat, egg and chicken.

When the labour pain starts, a Gumuz woman prepares herself to leave home and agricultural fields till she makes herself sure that she is far from the living home, granaries and agricultural fields. When she leaves the village, if her women relatives, neighbours or co-wives see her they could follow her, in order to talk and fetch water for the delivering mother from a near distance. If nobody observes a woman in labour pain when she leaves the village, she must leave alone quickly. It

is sometimes the pace of the labour pain that determines the distance she travels away from home and agricultural fields.

When the labouring woman arrives near tree areas, pinches, bushes and near rivers, she sits down in a place she finds conducive. The task of taking the baby out from cervix, cutting the umbilical cord, wiping the new born clean, removing the placenta and burying it are all accomplished by the delivering mother. Even in the presence of women relatives, co-wives or neighbours, nobody is allowed to touch and help her except fetching her water to clean the baby and herself. In some cases of first child birth, elderly women, usually the mother-in-law is allowed to show her how she can manage the delivery for the future.

I have five children. I gave birth for two of them near Beles River where as the rest of them were born around bushes not that much far from our village because the labour did not give me enough time to travel far. I gave birth to all my children without the help of any body. I myself took them out from my genital, cut the umbilical cord, wipe them clean and bury the placenta and came back to the village carrying them and stayed outside till a reserved place in the home or a hut is prepared for me for the post partum seclusion period.(Woman participant I).

All women participants similarly confirmed that they all gave birth outside their living home and managed labour and delivery without anyone's help except one woman participant who gave birth to her first child with the help of her mother-in-law. She further described her experience of first child birth as follows:

I gave birth to my first child before four days. When I was in labour, my mother in-law was with me. She showed me how to manage it. The labour stayed for six hours and I came back to the village with my husband's mother. As you see, this hut is prepared for me to stay. People told me that I will stay here for about two weeks without any contact with anybody particularly with men.

A documentary film prepared by Walta information centre (2005) on the lives of Gumuz women shows a similar situation that when labour comes, Gumuz women are obliged to be out of sight and move to bushes, there women give birth by themselves without help." *When labour comes, even if the labour is sudden the delivering mother will run out of the living home and sit under trees possibly out of sight,*

cut the umbilical cord with a cover of a sugarcane. If there are women in a near distance, they will fetch her water for cleaning purpose. Then she holds the baby herself and back to the village'' (Key informant VII).

4.1.2 Post-partum Period

After child birth, women among the Gumuz are isolated in the living home or in an isolated '*child birthing hut*' prepared for the purpose. There are also pollution restrictions expected to be fulfilled by a woman after child birth.

4.1.2.1 Post-partum Seclusion

Most of women participants and key informants informed me that recently, preparing '*child birthing hut*' for post-partum seclusion of women is a rare case due to financial constraints, but still there are people who protected women after child birth in an isolated hut. The usual trend now a days is preparing an isolated place in the living home for the after birth seclusion. Some families also use '*menstrual hut*' for post-partum seclusion too.

The post-partum seclusion process is usually very strong during the first fifteen days. Most of the time, these huts, both *child birthing and menstrual huts* are cramped dwellings that are not properly constructed. A woman participant reported "*One day I was asleep with my new born in a child birth hut. A hyena came and shouted at me and my baby. The hut was not strong. He tried to take my child. I shouted bluntly. My husband from the living home expelled the hyena using gun shouts* (Woman participant I).

Throughout the post-partum seclusion period, women in a '*child birthing hut*' or in a reserved area of the living home, will be given food and drink by another women using goods like dishes and cups reserved and kept to be used only by a woman after child birth.

4.1.2.2 Pollution Restrictions

Women's blood among the Gumuz is perceived as highly pollutant and a cause for the anger of *Musa* (a supreme God and determinant of everything in the lives of the Gumuz). It is believed that women's blood drops in the living home will bring punishment from *Musa* on the family. Women's blood is also believed to call evil spirit to the village. Due to this belief, "women after child birth are pollutant, unclean, filthy and problematic." There are pollution restrictions and rules that must be fulfilled by women after child birth. Transgressing the rules lead to the punishment by *Musa* and other evil spirits.

The Gumuz similarly isolates menstruating woman till the physiological process is over. This is due to the belief that if menstruating woman stays in the living home with her blood, she will bring curse on the family. A woman at the time of menstruation is called as '*Mequwa*' meaning '*untouchable*'. Fear of women's blood as a reason to curse the family made the people to construct an isolated hut which is called '*menstrual hut*' used by women at the time of their menstruation every month.

A documentary film prepared by Walta (2004) on the Gumuz people, narrated the process of isolating menstruating women that is, a women at times of menstruation will notify it to another women, by isolating herself from insights. Then, she will stay in a reserved place or in a '*menstrual hut*' till the physiological process is over. During these times, she is restricted from cooking, fetching water, touching materials used by other members of the family. Moreover she is not allowed to touch growing plants and open and close the main gate of the living home. In a very similar manner, women after child birth are secluded from making any contact with other people especially men.

All materials used by women after child birth, are perceived as sources of pollution and no one is allowed to touch them due to pollution restrictions. A woman participant reported "*after I give birth and come back home, everybody particularly men*

are not allowed to have contact with me. All materials I touch could not be touched by anybody. Even I am restricted from touching growing plants. If I do so, it is believed that, their growth will be deteriorated'' (Woman participant IV).

Her expression shows how pollution restrictions are highly associated with women's blood as a result of the people's belief that women's blood which is a natural physiological process is perceived as highly pollutant. All materials used by women in the post partum seclusion period are also removed from the living home as well as from the village. Usually, dishes, drinking cups and sleeping materials used by a woman after delivery are removed from the village.

After child birth, a woman is expected to fulfil certain pollution restrictions. For instance, cooking food, fetching water, opening and closing the main gate of the living home are not allowed for her. She is given materials like cups and dishes to be used only by her. It is believed that she is clean from her blood on her fifteenth day of seclusion then, her hair will be shaved and her head is decorated with Dueia, which is a red soil. Her husband will slaughter a goat or a chicken for the purpose of ritual sacrifice. Only following this, she joins back the family and starts cooking (Key informant VII).

According to the custom, it is only ritual sacrifice, cleansing ritual ceremonies and the allocated period of time for seclusion that make women free from pollution restrictions. Pollution restrictions applied to both a woman after delivery and a menstruating woman is almost similar. The resemblance between isolating both menstruating women and women after child birth confirmed that the bigger issue is women's blood. Women's blood in the society is believed to be highly pollutant and source of curse.

During the whole period of pollution restrictions of the post partum period all household activities are performed by co-wives, women relatives or neighbours of the delivered mother. Paradoxically, though women during and after child birth are perceived as pollutant to the family, having more children among the Gumuz is believed to be a real blessing mentioned in their proverb *Indapiqu chinka indiguta* which means giving a large number of children is a real blessing.

4.1.2.3 Purification Rituals

The end of post-partum seclusion ranges from 15-30 days. Some key informants said that the usual habit is on the thirteenth day. Some women participants on the other hand reported that it is usually done on the fifteenth day after delivery. The ritual sacrifice starts when a woman after delivery comes home. A chicken or a goat is slaughtered and a skin from the chicken's neck is put under the right arm of the baby to thank *Musa* for the safe delivery and to ask him keep the baby healthy. One of key informants informed that, *"When a woman after delivery returned back to the village with her new born, a chicken is slaughtered and a skin from the chicken's neck will be tea red and put on the right arm of the child to ask Musa for the wellbeing of the child and to keep away any sickness or deformation"* (Key informant VII).

The sacrifice after delivery is basically performed for the health of the new born child and to thank *Musa* for the safe birth of the child. The health of the mother is not that much a big concern. The focus is on the new born particularly if it is a baby boy. Although son preference is a common practice, the Gumuz also prefers girl children for the reason of female exchange marriage and for girls are important to laborious works in the society.

After the seclusion period is over, often on the thirteenth day after delivery, the delivered mother stands at the main gate of the living home at 2:00 o'clock in the morning. Her hair must be shaved. Her husband slaughters a got or a chicken for the purification ritual in order to make her clean from the cursed blood. It is after this process that she starts to cook and sleep with her husband (Key informant I).

The purification ritual is basically conducted in an attempt of making women clean from cursed blood which is perceived as pollutant in the society's belief. What is clearly visible here is that, as (Weedon, 1999, Hartman, 1981) stated, the personal for women under the system of patriarchy is inevitably bound up with the meaning, status and control of women's own bodies and reproduction. Patriarchy deliberately puts women in inferior and insignificant position and one of its neglecting and undermining women's personality goes up to the extent of making

women helpless at the time of their labour and perceives women's natural physiological process problematic to men and to all other people.

In the whole process of the practice of solitary child birth and post partum seclusion, participants explanations shows that women's blood is believed to be "pollutant" "unclean" "problematic" "a threat to the health of children and men" "a threat to the wellbeing of the village" "contaminating and source of deterioration to the growth of plants" "source of curse" etc. It is clearly a patriarchal conspiracy accompanied by different meanings and values pervade all aspects of the people's culture and often justified and associated with cultural and religious justifications because patriarchal scholarship always seeks to hide the real issue in the name of tradition, custom, religion etc.

Patriarchy is a system which pervades all aspects of culture and social life and male power permeates every aspect of women's lives. Patriarchy consistently defines and moulds women's bodies, sexuality and reproduction in the interest of men often with the objective of making women inferior and less important beings than men (Weedon, 1999). If we look at this study finding, women's ability of motherhood and physiological process is interpreted and defined as useless and women are considered as inferior beings as a result of their natural and physiological process.

Radical feminism and Radical feminist analysis confirmed the fact that women do not have the power to control their own fertility and reproduction (Weedon, 1999, Basealy, 1999). This is clearly seen among the Gumuz women of Ethiopia where women even do not have the right to deliver in their own home and are not allowed getting a birth attendant. Furthermore, women's blood is believed to be pollutant to the health of a family because its uncleanness will bring punishment from *Musa*.

Second wave feminism in the west introduced its famous principle “*the personal for women is political and theoretical*” which turned the focus to the body as the primary site of women’s oppression (Weedon, 1999, Hartman, 1981). This is clearly visible among the Gumuz of Ethiopia where women’s blood and physiological process is perceived as pollutant. It also reassures the radical feminists’ analysis that is, the basic class division is between the sexes and that the motive force in history is striving of men for power domination over women (Hartman, 1981). Here among the people, one of the ways by which men strives for power domination over women is through making and perceiving women’s reproductive roles less important and problematic.

Radical feminism reclaims women’s capacity to motherhood as the source of potential strength and resistance to patriarchy (Weedon, 1999). Patriarchy knows the very important and significant contribution of motherhood, but do not want to acknowledge it as an important role because it is performed by women. Here in the study participants’ explanations, patriarchy and patriarchal attitudes tries to explain women’s physiological process and blood as pollutant through religious doctrines.

4.2 The Social Position of Gumuz Women

Social position matters a lot on individual’s health well being. Health problems are not only linked with biological problems. They are also highly associated with individuals overall life situations particularly the place of a person in her or his own society determines the opportunities and resources one could be able to access including health care services. Inferior social position also maximizes women’s vulnerability to harmful traditional practices and aggravates the violations of women’s human rights in the name of culture and tradition. In addition, since women possessed a wider range of reproductive needs than men, inferior social position negatively shaped women’s health than men’s. As a result, indicators of

Gumuz women's social position are very important to understand why woman sustained and exercise the practice of being isolated at times of their child birth.

4.2.1 The Place of Women in the Society

Gumuz women in most of their life aspects in their own society are positioned in structurally disadvantageous position. They always have hard and time consuming daily domestic chores. However, women's engagement in arduous productive and reproductive activities are viewed as "less important" than men's work.

4.2.1.1 Inferior Social Position

The very perception of the society towards women's personality is highly expressed through a belief that "women are created for the purpose of serving men". This belief of the society is stated by a documentary film prepared by Walta (2004) as follows: "*It is for the purpose of serving a man Musa created a woman*" This perception of the people towards women as servants of their husband's resulted to women's engagement to endless productive activities. The same film also confirmed that, only honey making and hunting are usually perceived as men's work.

Though women perform almost all productive works, men are considered to be "bread winner of the family". As a result, men are highly respected and they are the only decision makers both in their family as well as in the society. Men are also believed to be more knowledgeable in all social, political and economic matters, naturally brave and stronger than women.

Even though this unequal gender power relationship is culturally defined and socially constructed, the perception of making women inferior beings is considered as God given and irreversible. Therefore, women's work is always seen as a service giving than a contribution.

“Women are already ordered to perform too much works by Musa. It is him who ordered them to serve their husbands. In addition, they are stronger than their husbands in performing too much works. Musa also ordered them to obey, respect and listen their husbands because men are wise enough in leading family matters. I have two wives. I always advise them how they must behave. They always listen to my words and obey me and it is me who administer them properly” (Key informant VI).

If we look at the idea that women are created to serve men from a feminist point of view, it is a patriarchal agenda of making women dependant and less human. It is obvious that every patriarchal society develops explanations in order to assert female inferiority and femaleness. The very existence of femaleness in religious doctrines explained as the purpose of helping man to survive instead of women living for themselves and by themselves is one of the reasons why Gumuz women experienced a very low social position in their own society.

According to the religious explanation of the people, women are created to serve men and it is the order of *Musa*. One can ask critically, why do women only serve men? Why men do not serve women? Here we can say that it is clearly a patriarchal propaganda which works in religious systems to secure men’s power domination over women. As Hartman (1981) asserted, the original and basic class division is between the sexes and the motive force in history is striving of men for power domination over women. Besides, it highly shows the fact that androcracy always works to subsume female’s position in all social systems and institutions. This inferior social position of women in the society perception is a bigger contributor to the sustainance of the practice of isolating women at times of labour because it is this kind of beliefs of the people that deprived women’s personal honour and human dignity indirectly exposed them to the practice.

4.2.1.2 Gender Division of Labour

Gender division of labour which is culturally determined on the basis of sex, often puts women in disadvantageous position, is also an indicator to the lower social position of women in a given society. The gender division of labour for Gumuz women is disproportionately assigned and exposes women to hardship and discomfort. Works assigned to be performed by women couldn't be done by men because women's work in the society is perceived as less worthy than men's work.

Gumuz women are solely responsible to many activities like cleaning forests for agriculture, transporting seeds to the field and grain to granaries, hoeing, weeding, harvesting, threshing, carrying marketable items, fire woods, and water to and from the house using a carrying material called 'Endeha'. Child rearing and caring for the old and sick people are also women's responsibilities.

A documentary film prepared by Walta (2004) on the lives of the Gumuz also confirmed the involvement of Gumuz women in almost all productive and reproductive works in the society including grinding grain, making porridge, 'Borde' which is a local drink etc. The documentary film also narrated that in all of their activities of making food and drink as well as serving it to male members of the society, women are serving downing by their knees and men are served first and women served themselves at the end.

In our culture women are expected to be seen carrying heavy loads using 'Endeha' otherwise they are considered as weak and ideal. It is also our custom beginning from old times that women must perform heavy workloads. We ourselves sometimes felt sorry for them; however it is Musa who ordered them. In addition, they are stronger than men in accomplishing too many works (Key informant IV).

His expression shows the rigid and deep rooted belief of the society on the burden of women's work. Contradictorily the same key informant also convinced that, he and others felt sorry for them but they cannot change it since it is a long established tradition and God determined women's task as a result, "Women themselves considered the burden as a normal inherited way of life and fulfilling such heavy

workloads is perceived as strength and accomplishing one's female responsibilities'' (Key informant IV).

The material base up on which patriarchy rests lies most fundamentally in men's control over women's labour power (Hartman,1981).The same is practical among the Gumuz of Ethiopia because the power domination of men is manifested by their control over women's procreative and labour powers through marriage and the sexual division of labour. Patriarchy determines what part women shall or shall not play through making a fundamental polarization between men and women often with the interest of men to exploit women's labour. Gumuz women experienced a very disadvantageous gender division of labour clearly socially constructed and culturally determined with the attempt of exploiting them accompanied by religious justifications which *"Musa ordered women to shoulder heavy work load than men"*.

In most known societies, the socially acceptable division of labour by sex is one which accords lower status to women's work (Hartman,1981).Similarly, Gumuz women of Ethiopia experienced the patriarchal justification existed in many cultures that is, making and considering women's work insignificant and non productive while paradoxically men used and controlled incomes generated by women to the family.

4.2.2 Women's Access to Human Capability Potentials

Meanings given to femaleness in many societies are used to determine the social and economic spheres to which women have accesses. This condition kept women very far from fundamental human capability potentials.

4.2.2.1. Women's Access and Control over Resources

Despite the fact that Gumuz women contribute a lot to the social and economic life of the people, both through their remunerative work on farms and through the

unpaid work they render to their family, they are systematically excluded from accessing and controlling resources.

Control over resources is directly related to a situation in which women have the power to make decisions about the use of a particular resource, which is directly related to ownership rights of women. In this perspective, Gumuz women are totally out of controlling resources as a result of the inferior social position given to them in their society. Everything in their family belongs to husbands. Even if they are divorced, they do not have the right to claim any property, they are left carrying their '*Endeha*' which is a material used by many Gumuz women to carry goods. A woman participant reported "*in our custom it is the husband who decides on everything in the family. My tiring efforts to the family are nothing. He always told me that, I didn't bring it from my father's house rather it is found in his house so that nothing belongs to me*"(Woman participant I).

Key informant seven also confirmed women participant one's explanation. The usual justification of husbands is that their wives come with bare hands from their fathers' house so that; everything in their family after marriage is the property of their husbands. Even though divorce from the side of wives is not common in the society, if husbands want to divorce their wives, women left the house without taking anything except carrying their own '*Endeha*.'

All key informants and women participants of the study assured that women in the society do not possess the right to control and access over resources except very few incomes gained from activities like selling items including collected woods even the income gained from selling such goods are spent for household consumptions.

Men maintained control over women's labour by excluding women from access to some essential productive resources (Hartman, 1981). This is a reality of Gumuz women of Ethiopia. This is despite the fact that Gumuz women engaged themselves in endless productive activities of the society.

Socially constructed justifications stood to femaleness systematically excluded Gumuz women from access and control over resources both in the family and in the public spheres. The main rationale behind excluding women from controlling resources is the cultural justification that is, their inability to wisely lead the family and there is a wide spread belief that women are not wise enough in controlling resources which is a patriarchal objective of making women powerless and obedient to men orders and purely sustained the very inferior social position of Gumuz women in the society and one of the contributor to women's poor health.

4.2.2.2 Women's Access to Health Care Services

Gumuz women have a very poor access to health care services; particularly reproductive health services. The primary reason is the widely rationalized practices and beliefs towards pregnancy and delivery which is the basic research problem of this study.

If complications occur at times of delivery, women may not be seen by anybody. It is because when the labouring mother leaves the living area she may not be seen by anybody. If she is observed and followed by women relatives, it is after a long period of time, these women may inform prolonged and obstructed labour to the villagers and elderly women may give her herbal treatment usually by putting the herb on the outer abdomen of the labouring women and praying for her at a near distance. One of the key informants of the study said, *"there is a health care post that is not very far from our village. But we don't have the trend to go there. In addition, we are poor people so that we can't afford the money to be paid. If we go, we are afraid that they may ask us money. Thus, we preferred to use our own traditional medication"* (Key informant I).

Normalization of prolonged labour is a common practice. It is only when things are getting very bad that herbal treatment and prayer is done. Delivery complications are not connected to insufficient biomedical monitoring of

pregnancy and child birth because there is a very serious lack of awareness about the importance of health care services during pregnancy, delivery and post partum period.

The highly dispersed settlement pattern of the people in the wereda and the people's high reliance in the traditional medications and practices like isolating a labouring woman without a birth attendant in bushes are exacerbated the problem and curtailed Gumuz women even from accessing the already available health care services.

The historical legacy of ethnic and class oppression of the people also contributes much to the lesser access of women to health care services because it makes the people to stick on traditional medication and traditional practices since they don't have health centres around them for a long.

Previous regimes did not bother about Gumuz people particularly before the Derg (an administrative regime stayed from 1974-1991 in Ethiopia). We have never seen even a single clinic in Mandura wereda. A health post was found in Chagini (a town eight hours walk from Mandura wereda). In addition, we don't have money to pay if we are able to go to Chagini. Leave alone health care we were not able to get salt for our food (Key informant VI).

This historical ethnic and class oppression of the people has a double impact on the lives of women. First, it is because women have wider reproductive needs than men. Secondly, they are victims to additional cultural, gender and religious oppressions in their own society.

A key informant who is a government worker in Mandura wereda explained the administration's response to the very limited health care services given to women and the responses of the administration to the practice of solitary child birth as follows:

The people in the area do not have the habit of using the already existing health posts. The scattered pattern of the settlement also kept them away from health care posts. Now we started organizing the people to resettle them in the area where they could easily access different infrastructures like health care, schools, water, electricity etc. Health extension workers also provide health education

and teach the negative effect of bush delivery. However, the people often preferred to stick on the already long established tradition and are less interested to give up the practice (Key informant VII).

4.2.2.3 Women's Access to Education

Despite the fact that poverty among the people is the primary reason for the illiteracy of women in one way or another, one of the discriminatory treatments Gumuz women are experiencing at their early age is their denial of going to schools. Culturally, Gumuz women are expected to serve their in-laws and spouses throughout their life rather than going to school. Females are mainly considered as vital assets in terms of exploiting their labour through unequal agricultural and house workloads both before and after their marriage.

Girls' importance for the inherited practice of '*Chifa*' which means polygamy is also one of the reasons for the deprivations of girls to education. Polygamy among the Gumuz is conducted for different reasons. The first one is that men always tend to have additional labour force to employ in the field. That means having more wives means more labour force in production. In addition, the culture interprets having more wives as an implication of increased production and prosperity of an individual. The reproductive role of women is another major reason for the widespread practice of polygamy because children in the society are considered as social and economic assets so that a man who has more wives will be of having more children.

There are five types of marriage practices among the Gumuz. These are, '*Manjika uma*' which means female exchange marriage, where a man can have more wives as he likes as far as he has a sister, daughter, cousin, aunt or other female relatives for exchange. The other one is '*Biicza*' which is marriage by bride wealth in which payment is made when a man do not have sister or female relatives for exchange. '*Mekola gafa*' or levirate marriage is also a wide spread marriage type where there is inheritance of widowed women by her husband's brother or close male relatives.

'Datsoko' or marriage by abduction is another marriage practice that is conducted when a man does not have a sister or a relative to exchange as well as a bride payment. The last one is 'Mesaqua daguna' which means marriage by elopement. It is taking a girl to marriage with the consent of the girl.

These all marriage practices are often done for the advantage of man usually made through arrangements without the consent of the girl and nobody cares about the age difference between marriage partners. An old man can marry a teenage girl. The marriage system in general is one of the main reasons for the denial of girls' education. On the other hand, most of women participants of this study confirmed that they don't like polygamy due to its negative effect on their life. *"Our culture allows man to marry whatever number of wives he likes. My husband has two more wives. I am not happy because after he brought a wife next to me his attitude towards me has turned negative. In addition, we have many children. We are highly impoverished. What can I do? I do not have any where to go"* (Woman participant VII).

Her expression shows how the practice of polygamy brought multiple economic and psychological effects on the lives of Gumuz women. They failed to do anything since it is a long existed practice of the people and perceived as normal and could not be changed in any ways. Contrary to this, that is the wide spread practice of polygamy, one key informant has a different stand and experience: *"I know the disadvantage of polygamy. I observed how husbands are unable to feed their children and wives in our neighbours. I married to one wife because I learned a lesson from those who married two and three wives"* (Key informant IV).

Access to education for girls is not only constrained by their importance to laborious works and female exchange marriage, the inadequate expansion of schools in the area also contributes a lot. According to the Wereda education bureau statistical report, the participation of Gumuz girls in Mandura Wereda is almost nonexistent particularly in secondary schools.

Table 4: Ethnic and Gender Based 9-10 Grade Enrolment of Mandura Wereda

Ethnic group	Grade level				Total		
	9 th grade		10 th Grade		Male	Female	Total
	Male	Female	Male	Female			
Gumuz	67	5	11	-	78	5	83
Shinasha	-	-	-	-	-	-	-
Others	146	139	71	74	217	213	430
Total	213	144	82	74	295	218	513

Source: - Benishangul Gumuz regional state, Metekal zone, Mandura wereda education and capacity building bureau (2008).

In 2008, Gumuz girl's participation in secondary schools is very low in the area. No Gumuz girl was found in tenth grade in all over Mandura wereda and only five female students are enrolled in ninth grade level. In addition, the limited access of Gumuz girls to education in the area is directly or indirectly associated with the historical legacy of the people's exclusion from development infrastructures just like it has a negative implication on health care access. Many of the key informants of this study stated the historical exclusion and oppression of the people and its effect on the present scarcity of schools.

During the reign of Hailesillassie, there was only one primary school in the whole Mandura wereda which was located in the area called Genete Mariam. The Gumuz experienced exclusion, mistreatment and oppression from different feudal imperial administrations of Ethiopia. It was only us who have started accessing relatively better infrastructures during the reign of the Derg. Today we have more relatively better infrastructures, but the legacy of exclusion has an effect. Even today there is no preparatory school throughout Mandura wereda. Students are obliged to go to Pawe (which is a special zone in Benishangul Gumuz regional state) in order to attend 11 and 12 grades. Look in addition to the cultural oppression females encountered in the area; do you think they could go to Pawe to attend their preparatory schools? (Key informant VI)

Gumuz women are excluded from accessing both health care and education which are human rights of every human being. Their access to health care and education is constrained by multi dimensional and intertwined factors. The denial of Gumuz women's access to education is linked with their importance to laborious works and exchange marriage. Exchange marriage is a patriarchal undermining of women's personhood. Patriarchy perceived women as objects of exchange and used women as objects and gifts for bride price in male transaction (Cohen *et al.*1999) which is a direct experience of Gumuz women that curtailed their access to education. It is clear that, it is education which could primarily helped them to develop libratory knowledge against their own cultural oppressions. Gumuz women's deprivation of education is still a bigger contributor to the sustenance practice.

Inclusive thinking and building multiplicity and difference in feminist analysis is very important. It is to show how multiple dominations affect women's life situations because different social rearrangements and experiences shaped the lives of women and their social position. Gumuz women's access to health care and education is not only constrained by patriarchal, cultural and religious oppressions, the inadequate number of hospitals and the limited numbers of schools are also the result of the historical exclusion of the Gumuz's from development discourses.

The very reason why it is important to identify the social position of Gumuz women in the perspectives of their access to resources, education, health care etc is due to its importance to realize why they are exposed and victimized to the practice. These all situations seriously affected Gumuz women's access to human capability rights and it constantly exacerbated and sustained the practice of isolating women at times of labour and child birth.

4.3. Experiences and Perceptions of Gumuz Women about Their Own Child Birth Seclusion

The inherited social bias conducted against Gumuz women and their lower social position lead them to lose control over their own reproductive health life. If we look at the tradition and the people's belief, it is gradually perceived as unproblematic. Identifying and looking for solution to women's issues require carefully listening women's words and what the problem means for them. The major reason most feminists asserted the necessity to listen to the words of women is to honour their moral and legal personhood as well as to bring real libratory knowledge in research undertakings.

Women participants of this study experienced solitary child birth. It is with different cases and experiences of seclusion. The direct narrative experiences of women participants should tangibly express the real picture on what is going on in the lives of Gumuz women which is helpful for everybody to look for social rearrangements.

4.3.1 Labour Experience

Women participant one gave birth to five children. One of them died. She delivered two of them near Beles River where as the rest three in bushes. She managed all of the child birth process by herself.

Woman participant three knew that it is a must for her to act in accordance with the stated culture, but she asserted how good it was for her to get help from another woman because as she expressed, managing both the labour pain and the activities of taking the baby out from her genital is a suffering.

Woman participant six gave birth to seven children, but she lost three of them. Two of them died during their infancy and one of them after growing young. She specifically explained how giving birth outside at night, in the stated cultural ideal, was a real suffering for her. *"I delivered two of my children at mid night outside home.*

It is our custom. I hate the cold outside even it is the cold outside at mid night caused sickness to my two children that finally killed them."

4.3.2. Women's Perception towards the Practice

Woman participant one in her direct explanation, confirmed that she disliked the stated way of giving birth in her society. *"The main reason people told me to leave the living home at times of my labour is that children will die because they will be cursed if I deliver at home. For me, I prefer to give birth in my house instead of being exposed to the sun heat and the cold outside particularly at night."*

Her explanation is a confirmation about the dislike women have towards the practice. She doesn't like it rather it is the cultural imposition that forced her to do it. The weather condition outside home is the bigger compliant she posed.

Woman participant two is somehow different from other participants because of her first child birth where it is allowed to be helped by elderly women. She stated her own perception about the practice as *"for the next birth I myself will manage the delivery. What can I do? Every woman gives birth in that way. I have to accept it."* She submitted to the practice because of her powerless position to challenge the already established system. She convinced herself that there is no other way of giving birth since it is the only determined way of giving birth in the society.

For woman participant three, it is the custom that obliged her to give birth outside without help. She asserted that she was interested if someone helped her at times of her labour. She said: *"I like if a woman helps me in my delivery. Look, while I am in labour pain, I am also taking the baby out from my genital and managing everything. Both the pain and the activities are to be managed at the same time. If it was not the order of Musa, it was good for me to be helped by another woman."*

Woman participant four like woman participant three wants to be helped by another woman as she said, it is the custom that obliged her to act in accordance with the practice. Woman participant five gave birth to four children and she lost

one of them. Her narrative experience was somehow different from other women participants. She reported that: *“I delivered all my children outside home, because my mother, when I grew up told me that I must deliver by myself outside home. In addition, all women I knew leave the living home immediately when they are in labour pain. I am strongly advised by my mother to bear the pain of delivery and push the baby out without fear and cry.”*

For woman participant seven her shy character was her first focus. This is may be the result of the socialization process that makes her shy which is common among many women in many cultural groups of the world. She reported *“I don't want to be helped by anybody because it makes me ashamed if someone is looking at my genitals. I prefer to manage everything by myself.”*

This study took this direct experiences and perceptions of women participants as the basic knowledge source. Feminist stand point theory took experience of an individual as the basic source of knowledge because this is very crucial in deconstructing the dominant conceptual frame work of research making often conducted from the perspectives of men's life as if it is also women's lives.

In many social groups of the world, women are considered as the others (Harding, 2004). This situation forced feminist researchers to interpret research findings from the perspectives of women's own life experiences since they are considered as the others in their own societies. Similarly Gumuz women experienced the same situations of being perceived as the others and their words are the main knowledge source of this study.

When knowledge is reconstructed from the perspectives of Gumuz women's lived experience, as Smith (1987) suggested to start thought from marginalized lives by taking everyday life as problematic, most women participants, almost all of them assured that they abhor the already established cultural practice of giving birth in isolation from people without attendant. According to women participants of the study, it is the custom that obliged them.

Women participants also expressed problems they encountered while giving birth in isolation from people. Particularly, one woman asserted that, managing both the pain and the delivering procedures was a miserable experience for her. Real Knowledge in feminist stand point theory is socially situated so that, the practice maximized her suffer of giving birth in addition to the labour pain existed naturally.

For woman participant six, it is the cold while she gave birth outside that killed her two children. The miserable experience she encountered is expressed by her own words and it clearly shows that, the cultural practice imposed on her forced her to lose her two children. These all lived experiences of women are very crucial to bring transformative and libratory knowledge and actions to be taken on behalf of women.

Table 5: A cross-case word analyses shows similarities of participant’s perception about the practice of being isolated at times of labour

Women participants	Responses of women participants	Cross- case similarity
Woman participant I	I prefer to give birth in my house instead of being exposed to the sun heat and the cold outside at night.	Women participant I, II, III, IV, V and VI similarly confirmed that they dislike the imposition of the culture. Except women participant VII who gave emphasis towards her shy character.
Woman participant II	Every woman gives birth in that way, I have to accept it.	
Woman participant III	If it was not the order of <i>Musa</i> , it was good for me to be helped by another woman.	
Woman participant IV	The custom obliged me.	
Woman participant V	My mother advised me to give birth in that way.	
Woman participant VI	It is our custom. I hate the cold outside particularly at night.	
Woman participant VII	I prefer to manage everything by myself, it makes me shy.	

Source: Participants’ of this study.

4.4 Reproductive Health Problems of Child Birth Seclusion

The harmful traditional practice of isolating women at times of labour could possibly be followed by delivery complications and prolonged labour because every pregnancy has its own risk full dimension. The position of the child may be incorrect and difficult to be managed through birth canal. If the woman is immature with narrow pelvis, child birth will become complicated; and if the pelvis and the foetus are disproportional, still birth will become very hard to be ended without harm.

4.4.1 Maternal Morbidity

Even without women informing any morbidity problems, one can easily predict so many problems Gumuz mothers possibly encountered. It is because; they give birth in isolation without a birth attendant, outside home where there is no prepared and clean birth environment. Women participants of this study informed morbidity problems resulted from isolated child birth.

Most of them informed abdominal cramp, waist pain, pelvic pain and post partum haemorrhage as the major morbidity problems they faced both at times of their isolated labour and even after the completion of the birth process. A woman participant reported *“I gave birth to these twins after one full day labour. I delivered them by myself; it was before two months. The labour was very painful and full of abdominal cramp. Still, I am experiencing pain around my pelvis and waist”* (WPP I).

Her explanation shows how relatively long labour she experienced without help and the prolonged labour left effects on her present health status. If diagnosis on her health could have been made, her real source of morbidity could have been identified, but she just expressed places where she experienced pain on her body even after birth. I asked her why she didn't go to a health centre and diagnosed. She replied that she even did not think about it. She further explained there is no such a trained in her village. According to many of this study key informants'

confirmation, the people are highly dependent on traditional herbal medicines for any kind of pain and do not have the trend to go to health care posts.

Woman participant six informed a series case of post partum haemorrhage. When I interviewed her she was on her tenth day after child birth. Post partum haemorrhage occurred from 24 hours to 12 weeks after delivery (Twicker and Wendle, 2010). Woman participant six informed that, *“I gave birth before ten days. The labour was long throughout the night and the day. I am still with continuous bleeding and abdominal cramp. I did not go to a health centre. I don't know how to go there. I managed all the delivery process by myself.”*

Her report indicated a serious case of post partum haemorrhage which is still existed with her tenth day after delivery. Post partum haemorrhage is often caused by abnormal involution of the placental site and occasionally resulted from retention of placental fragment related with childbirth complication (Twickler and Wendle, 2010). Many medical books also exhaustively recommended that haemorrhage must be clinically treated without dalliance. If haemorrhage is remained clinically not described and untreated, it will be followed by bacterial and viral infection as well as anaemia which is possibly followed by series morbidity and mortality of the mother. Infection caused by post partum haemorrhage should be clinically diagnosed and Antimicrobials should be given to the mother (Twickler and Wendel, 2010).

If we are talking about infection, Gumuz mothers are not only exposed to infection related to post partum haemorrhage, they are also obviously exposed to a high risk of infection problems because they deliver in bushes where there is no clean birth environment. It clearly makes them vulnerable to bacterial infections and contaminations possibly appeared during their child birth. This is despite the fact that clean or aseptic birth environment is the right of every mother and one of the major criteria of fulfilling safe motherhood.

The abdominal cramp reported by Woman participant VI is possibly the result of excessive contraction of the uterus caused by post partum haemorrhage. It is the main reason behind the cramp she experienced. Woman participant VI is clinically untreated and do not know if she has other problems possibly associated with post partum haemorrhage like anaemia because problems like anaemia and infection are associated with continuous bleeding left untreated .

If woman participant six does not treat her problem of haemorrhage with a medical assistance, the situation inevitably will lead her to chronic anaemia which is a problem caused by post partum haemorrhage or heavy delayed bleeding (Gabbe *et al.*2007). Post partum anaemia is a potential threat not only for maternal morbidity but also to maternal mortality. It is because women with continues bleeding will die unless clinically treated with blood transfusion.

What is the big problem here when I talked with women participants about reproductive health is that they are not clinically diagnosed and what they are informing depends on what they could be able to understand and express in their own ways. They often mentioned cramp, pelvic pain and waist related problems. Particularly, Woman participant VI does not know whether she has the problem of infection or anaemia which is a possible reproductive health problem of a woman with post partum haemorrhage.

All women participants of this study do not know whether they have the problem of eclampsia since they are very far from pre natal, delivery and post natal care services. They give birth without knowing their health status. Eclampsia is a life threatening complication of pregnancy, resulted when previously diagnosed with pre eclampsia which is high blood pressure and protein in the urine, develops seizures of coma (<http://www.Emedicine health.com/eclampsia/article-em htm> 2010). Medical explanations on the other hand confirmed unless the problem of eclampsia is identified during pregnancy and carefully managed at times of

delivery with professional birth attendant; it is a potential threat of maternal and neonatal death in most deliveries even in deliveries assisted by professionals.

Prolonged labour is the usual experience of women since they deliver without attendant. This is still despite the fact that having a birth attendant is one of the major criteria of safe motherhood. Though I didn't identify any obstetric fistula case among participants of this study, one can simply say that Gumuz mothers are potentially at risk to obstetric fistula. This is because they face prolonged labour without birth attendant and any medical assistance. The society's belief, that is, women in labour should manage everything by them and normalization of prolonged labour is a source to maternal morbidity problems in the society.

In delivery complications, if Gumuz mothers are lucky enough to escape death, they are inevitably exposed to lifelong disabling problems. As Woman participant I and Woman participant VI confirmed, even at the completion of the delivery process, they are still with pains around their pelvis, abdomen and waist since they are left untreated and unattended.

4.4.2 Maternal Mortality

Most key informants of this study confirmed and stated their experience of knowing many Gumuz women who died in bushes while labouring their babies untreated and unattended. According to key informants' expression, it is usually at the end of everything, villagers brought the dead bodies of mothers' from the place where they were labouring alone often in bush areas. Even sometimes women may not be seen by anybody when they died of delivery complications as a result of their isolation during their labour.

A documentary film by Walta (2005) also confirmed this situation that helplessness of Gumuz mothers at the times of delivery forced them and their babies to give their hands to death. The film also confirmed that it is usually the dalliance of the placenta that took women's life.

We know that the practice is very problematic, but it is our culture. In the rainy seasons, labouring mothers are rained with heavy rains; in the sunny time they are exposed to strong sun heats, even, at times of mid nights, women deliver outside home. Throughout my life, I know many women who died of labour complications outside home in bushes (Key informant III).

A woman key informant explained her life experience of observing maternal mortality as follows:

In our society, when women are in obstructed long labour stayed for two or three days, we put herbal on their abdomen and if it is not working, elderly people in the village will pray for them. In these all days, a labouring woman is not allowed to enter the living home till the delivery process is over. Fire will be made for her outside by women relatives and a kind of shelter is prepared for her if the process stays for many days, Prayer is the last measure to be taken for a woman in delivery complications. Nobody thinks to take her to hospital; we don't have the trend. In my entire life, I know many women who died of obstructed labour around bushes. (Woman key informant II).

These key informants confirmed the death of many Gumuz mothers as a result of their denial of access to health care and even a birth attendant. It directly violates women's human rights. Here, the human rights violation reached up to the extent of taking one's life and the right to live.

4.4.3 Infant Morbidity and Mortality

Most woman participants of this study informed infant morbidity and mortality of their own experience. From her five children, Woman participant I lost one child. Woman participant IV lost one of her four children. Woman participant VI, who gave birth to seven children, lost three of them, but two of them at their infant age. Most of women participants associated the sickness and death of their infant children with the outside cold they experienced during labour, particularly, at times of night and mid night. According to their explanation, the outside cold is the main reason that exposed their children to sickness and death.

Woman participant I said that she lost her child because of the wind blow outside. Woman participant VI also said that it is the cold at night that killed her two infant

children. These women linked the death of their children with the weather condition outside. Though they associated the death of their infants with the outside cold and wind, it is clear that their unattended child birth is a potential threat for the death of their infant children.

These all problems indicated how culture is still serving as an excuse for the violations of women's human rights. Gumuz women's reproductive health rights and freedom to choice to life wellbeing is violated by the traditional harmful practice of isolating women at times of labour. However, reproductive rights and freedom to choice one's own life wellbeing is irreducibly human rights of every human being.

The practice purely leads women to lifelong disability and maternal mortality. This is contrary to the fact that safe motherhood is an internationally recognized right of every women of the world. For radical feminists, depriving women's reproductive rights through arduous cultural practices is a patriarchal project aiming to clothe female objection. Radical feminism further asserted the importance of women's human rights respect ion and women must choose lives as men can (Cohen *et al.* 1999).

4.5 Justifications of Child Birth Seclusion

Culture is a complex whole. Sometimes it is difficult to distinguish cultural practices from religious practices because religions usually work and function with the stated cultural norms and customs of a given society. This creates difficulty in identifying to what extent religious practices influence culture and culture influences religion. Gumuz women's life is at risk caused by a harmful traditional practice of bush delivery which is mainly associated with cultural and religious justifications.

4.5.1 Religious Justification

In many of the deterioration of women's reproductive health, religions contribute a lot and create formidable barriers. Similarly, the practice of isolating women at

times of labour among the Gumuz is mainly associated with religious explanations.

As it is expressed before, most key informants of this study explained the people's religious belief towards the practice that is, the major explanation is if women delivered their babies in a living home, they will drop an impure blood at home and it is believed to provoke the anger of *Musa* who is there in the living home to protect the family from harms. It is also believed that the anger of *Musa* will be followed by disease. It will particularly bring the sickness and death of children. It is also believed that, the disease can be transmitted to the whole nearby villages and should kill many people.

The fundamental threat in the people's religious belief is women's blood. In a more similar manner, menstruating women are also isolated in a hut constructed for the purpose in fearing of women's blood drop at home because it is believed to provoke the anger of *Musa*.

If women deliver at home, children will be sick and the sickness will be transmitted to the whole village and kill everybody. Gumuz women know the consequence of delivering at home as a result, they don't want their children to die. It is also believed that if somebody is suffering from series sickness it is possibly caused by the curse of Musa as a result of the nearness of delivering mothers while giving birth (Key informant V).

His assertion shows how women and women's blood is believed to be problematic and even people's sickness is perceived as women's fault of being not very far from the living home or there is a belief that sickness is caused when delivering women are not travelling so distant from living home. If we stress on his expression, that is, "*Gumuz women know the consequence of delivering at home*" it obviously creates a psychological stress and threat on the delivering mothers. This makes mothers to travel far from the living home as far as they could, while they are in labour pain.

Giving birth in agricultural fields and near granaries is also forbidden as a result of the fear that blood drops on fields during delivery will bring the curse from *Musa*

and he will stop the growth of plants. These all restrictions and taboos maximize Gumuz women's suffering and made them fugitives running in getting a place where that is not prohibited while they are in labour pain.

4.5.2 Cultural Justifications

There are also cultural justifications associated with isolating a labouring woman. The first one is tradition itself. Since it is a long established and stated tradition, it must keep its status quo. Commitment to deliver in the stated way of the society tradition is expected as an obligation to be accomplished by every Gumuz women. Woman participant II and V confirmed that, it is their mothers and other women who thought them the tradition to deliver outside and without help. Since it is the only way they knew to give birth, and the society expects them to act in accordance with the tradition, they are committed to fulfil the stated way of giving birth.

For instance, when I was in one of the villages to talk with Woman participant III, she came to us and downed by her knees in front of us with her shouldered child. I asked her why? She replied that it is a tradition for women to down on their knees in front of new guests and men. Her action clearly shows how she is committed to fulfil the stated tradition.

Women participants of this study also confirmed that, if they do not act in accordance with the stated tradition, they will be exposed to insults from both elderly men and women. Their husbands will tell and insult them as if they are not good wives and mothers. They also will be blamed for bringing sickness to the village if they transgress the rules of solitary birth outside home.

In the tradition of the people, mothers are expected to bear the pain of delivery and to accomplish the delivery process courageously. It is only when mothers manage the pain of delivery alone and without complication that they are considered as "a proper Gumuz women". Women, who give birth by themselves courageously without any delivery complications and any birth attendant, are perceived as strong mothers who successfully accomplished a woman's work. As a result,

bearing the pain of delivery and giving birth without help is a stated cultural ideal which established a very strong hold in the society's belief.

If labour is prolonged and the new born is died, it is perceived to be the mother's weakness, neglect or failure to successfully give birth without problem. This cultural perception may have a big effect on mother's psychological wellbeing because mothers with prolonged and complicated labour considered themselves weak and they blamed themselves for the death of the new born if they experienced such an issue. Nobody associates it with biomedical problems and while paradoxically, the very reason could be women are left without help or birth attendant outside home at times of their labour.

One day we were out for a government task in one of Mandura villages. On our way, we saw a woman alone in labour under trees. The labour makes her shout. I and other men with me couldn't approach her because we know the culture do not allow us to approach a labouring woman. There were two women with us, who knew Gumuz language. They asked her to help, but she told them to leave her alone. They begged her to take her to the health post using the car we used to come to the area. She strongly advised them to be far from her. We waited them around and they told us everything. It was difficult for us to leave her alone however, we must leave for the work we were assigned to accomplish in the day. When we returned to the area, she was not there. We asked about her in the nearby village. People told us that she lost one of her child from twin infants she gave birth in the area (Key informant VII).

His explanation shows how she is resistant. Which is clearly the result of the cultural belief of the society and women themselves are the result of the socialization process of the culture. However, the practice forced her to lose one of her child who could have been saved if she had been willing to go to health centre or to be attended by at list by a traditional mid wife. According to the culture, asking to help her may imply *"you are not courageous enough to give birth alone without help."*

Another traditional belief is that if men see a labouring woman, they will be stressed and sick. A documentary film by Walta (2005) stated this belief as follows: *"If a woman delivers in the home in the presence of men, it will make men sick throughout*

their life.” This explanation is also one of the traditional beliefs that forced women to deliver outside home.

Religion and culture are the main reasons why the practice of isolating women at times of labour is exercised. Here, it is possible to bring both the radical feminists analysis and multi cultural feminist’s explanations. Patriarchy used different mechanisms to hide itself, like demanding group cultural rights that restrict the ability and the choice of individuals within the group. This is the reality Gumuz women experienced in the name of group cultural rights which is cultural relativism view point. It often hid itself in justifications like, this is how we do things and this is our culture. It is just like Anderson and Hill Collins (2010:499) stated *“Cultural beliefs, attitudes and values have often been used to justify the oppression of women. Justifications such as this is how we do things, this is part of our culture negate the fact that cultures are dynamic entities, that what is acceptable today is different from what was acceptable hundred years ago.”*

Many religions deprived female’s freedom by putting guidelines and rules about how to live even in the contemporary world(Cohen *et al.*1999). Religions are claiming the control of women’s bodies, sexuality and reproduction through many devices, which directly lead to the violation of women’s human rights (Rehmn and Breau, 2007). The religious justification created a very big imposition in excluding women from one of human capability potentials that is reproductive freedoms and reproductive health care services. (Narayan and Harding, 1999) also asserted that, the continuing and rising influence of cultural and religious justifications for women’s inequality is one important reason why it is so significant for women’s rights to be recognized as human rights.

4.5.3. Other Factors

Almost all key informants of this study repeatedly mentioned that the historical exclusion of the Gumuz and their ethnic and class oppression, limited the expansion of health posts in the area. The limited expansion of health care centres

has its own contribution to the existence of the practice because if access to health care was available in the area, at least the society could have been able to change the strong hold of the harmful traditional practice.

The very serious lack of the habit of using the already available few health care centres which is again associated with the historical ethnic and class oppression of the people is another factor to the presence of the practice. Previously, the people did not have enough access to health care services. This at the same time makes them not to have the habit of using health care posts. Instead, as most key informants of this study asserted, the people inclined more to the already known trend of using herbal medication.

Woman participant seven mentioned one problem that is her fear to be watched on her genital while giving birth. Women participants, particularly have a suspect to be attended by a men attendant which is one of the factors associated with the shy way of girl's socialization.

Finally I want to assert poverty as a very big factor to the continuity of the practice. Poverty in the area is stubbornly very high. As I observed in my stay and key informants confirmed to me, the area is highly poverty stricken and the situation made women even not to think about going to health centres. Women participants also confirmed to me that they are afraid of being demanded money in health care centres which indirectly contributed to the strong hold of the practice. The denial of girl's access to education due to different cultural and economic reasons limited women's awareness of human rights. If they were able to access to education, they could have been able to ask questions like why and for what reason, they are isolated at times of their labour.

Social life is constructed in intersectional hierarchical structures. One of this study theoretical framework that is multi-cultural feminism or intersectionality, shows how different historically and socially situated dominations highly matter on individual life situations. The practice of isolating women at times of labour among

the Gumuz is exercised as a result of different interlocking inequalities and factors. It seems Religious justification take the primary place; cultural justifications occupied the next.

Denial of women to access resources also restricted them from investing on their own health and girls restricted access to education matters a lot. In addition, the historical ethnic and class oppression also has contributed to the problem. These all interlocking inequalities and problems exposed and exacerbated the sufferings of Gumuz women caused by the practice. One can say that Gumuz mothers are victims to several dominations and inequalities as Patricia Hill Collins (1990) called it as "*a matrix of dominations*". This can properly be expressed in addressing the problem of Gumuz mothers.

On the other hand, one of the traditional explanations, that is, if men observe a labouring women, it will make them stressed and sick, shows a patriarchal attitude of making men more important beings than women. Here we must call and show the radical feminists analysis of patriarchy. It is like what Daly (1979) stated that, patriarchal practices work unambiguously in the interest of men. Since men in patriarchal systems always won bigger concern and care than women, this traditional justification, forced Gumuz women to leave their home while in labour pain in order to protect men from observing them which may create stress on them. Here, it is men's stress that won greater emphasis than women's labour pain. Therefore, women must face the outside rain, sunlight, wind, cold etc in order to protect men from being stressed. This traditional justification shows how patriarchy and very lower social position of women in the society possessed a very strong hold and reinforces and sustains the practice of solitary child birth.

Figure 1: Contributors to the practice of isolating women at times of labour



Source: participants' of this study

CHAPTER FIVE

Conclusions and Recommendations

5.1. Conclusions

The practice of isolating women at times of labour is exercised due to many socio-economic, religious, cultural and political factors. The religious explanations of making and perceiving women's blood impure and source of curse and diseases takes the primary place in the whole process of isolating women at times of labour. The seclusion process starts from the time of labour and continues throughout the post partum stage ranging from 15-30 days. All religious, cultural and economic reasons associated with the practice are accompanied by patriarchy. Patriarchy contributes much to the existence of the practice. Specifically, by perceiving women's nature and natural physiological process inferior and problematic.

The findings of this study also indicates that Gumuz women are isolated at times of their labour outside home without attendant as a result of the traditional practice that forced them to bear the pain of delivery and give birth without help to be "a proper women" in the society's cultural explanation.

The meanings and places given to femaleness developed through the socialization process of the society also contributes a lot to the lower social position of women which indirectly sustains the practice of solitary child birth. It is also believed that women's very existence is to serve men, not women exist by themselves and for themselves which clearly indicates the very lower social position of women in the society.

The unequal gender division of labour which imposes too much work on women than men and perceiving women's work less important than men's work is one of confirmations to the lower social position of women in the society. The reason, that, considering women's work as less important leads to the systematic exclusion

of women from accessing and controlling resources both in their family as well as in the public sphere.

This exclusion of women from accessing and controlling resources due to culturally made explanations has a negative implication on their health. It is because it is only women having the power to control resources, that, they could be able to invest on their health and resist culturally constructed harmful traditional practices.

Gumuz women are very far from accessing health care services particularly at times of pregnancy and delivery due to the traditional belief of managing birth solely without help. The long established trend of using herbal medication and the limited number of understaffed health posts indirectly sustained the practice.

Gumuz girls are highly denied of accessing education. The main reasons include perceiving women's domestic chores more important than education and girls' importance for female exchange marriage. As it is indicated in this study, in 2008, no Gumuz girl was enrolled in tenth grade level and only five Gumuz girls were enrolled ninth grade in the whole Mandura wereda where, around 40,746 people inhabited in the area. The inadequate access of girls to education indirectly contributes to the continuity of the practice.

Both access to health care and education are highly constrained by the limited number of schools and health posts caused by the historical legacy of the Gumuz's neglect in the feudal administrative regimes of Ethiopia. This history of the people's exclusion has multiple effects on women because they are already victims to many religious, cultural and gender oppressions in their own society.

The reproductive health of women is affected by the traditional practice of solitary management of child birth. Maternal morbidity problems were indicated by the study participants. They informed post partum haemorrhage, abdominal cramp

and pelvic pain as major reproductive health problems mainly resulted from obstructed labour. Many of key Informants of this study indicated the wide spread existence of maternal mortality problems directly caused by solitary management of child birth. Almost all key informants explained their experience of knowing many Gumuz mothers who died of birth complications as a result of helplessness or their deprivation of birth attendants.

Women participants informed infant mortality. They justified that it is mainly the weather condition outside home which caused the death of their infants. They also repeatedly asserted that the cultural imposition forced them to manage their delivery alone rather they prefer to be helped by women attendants.

Women participants also confirmed that if they are not committed to the stated way of giving birth, they will be insulted. Even, if there is any sickness of someone in the village, it will be associated with a delivering mother's neglect by shortening the distance of the delivery place from home at times of labour. Fearing of being a cause to somebody's sickness, women submit to the long established tradition of giving birth outside and without attendant.

5.2. Recommendations

Culture and tradition embedded many wrong deeds that directly violate individual human rights. The most surprising thing here is that, all harmful cultural deeds may have a meaningful contribution to the society. But, as Anderson and Hill Collins, asserts "*we would never gave up and accept practices that deny women's basic human rights!*"(2010). Based on these feminists stand, I recommended some ways out to the pain and suffering of Ethiopian Gumuz women.

First of all the language itself is a place of oppression and marginalization of women so that, all explanation of repressed and tabooed aspects of women's natural processes like the belief of women's blood as pollutant and women needs a

ritual cleansing after child birth and after menstruation, which are purely patriarchal conspiracies of making women's reproductive performance insignificant, should be replaced by new languages. Other representations are required to replace such tabooed aspects of women's lives because all of them are patriarchal meanings of making women inferior and problematic. Motherhood and women's physiological process should be a source of potential and respect. It must be acknowledged as important ability and quality of women and works should be done to achieve this objective.

Community based awareness creation is the first recommendation I suggest because change must come from within. Thus changing the society's perception about the practice is the first thing to be performed by concerned personalities and institutions. Awareness creation about fundamental human rights like the right to access health and education services is important. Works must be done on the idea that women must be viewed as citizens in their own rights who can fully exercise their sexual and reproductive rights without being reinforced with gender inequalities hid in customs and traditions.

One of a research question posed by this study is: why the practice of isolating women at times of labour is exercised by the Gumuz? The main reason why this study posed this question is because of its importance to identify and clarify the relevance of the practice to the society. It is because, identifying and clarifying its importance and meaning to the society will indirectly help to argue and disprove the practice by showing and explaining its negative impacts. This study findings show that religious and cultural explanations are the primary factors to the existence and sustenance of the practice. Therefore, building a counter analysis against the practice is possible based on the justifications given in the findings of this study. This is necessary to propagate the eradication struggle.

The findings of this study are also important to explain and work against the practice in the society, through awareness creation and other ways by showing and developing contrary justifications about the lesser importance of the practice when compared to its relevance. This work could be done by anybody indebted to help the application of women's human rights or anybody who has a stand, that is; women mustn't be deprived their basic human rights in the name of culture and tradition.

Health wellbeing is often associated only with the biomedical perspective. The social perspective is usually neglected and does not win enough emphasis when compared with its greater importance. It is very important for policy makers, health practitioners and researchers to give emphasis to social determinants of health and their importance in determining individual's health wellbeing. It is also important to assert and give emphasis to the fact that, social determinants of health play a crucial role to the existence of health disparities of a given society.

The notion of homogenising male and female difference in health is also another common problem particularly in rural settings. This is totally deconstructive. The service delivery in rural setting should give due attention to the multiple experiences of people that result from their gender, culture, religion, class, ethnicity etc. In addition, women must get distinguished emphasis since they have a wider range of reproductive health needs in the health delivery systems than men.

There is a very serious problem of domesticating international human rights. They are too general and seriously lack specificities to the context of different people with different cultural settings. I suggest specificities to the local context should reach to the extent of making harmful traditional practices like forcing women to leave the living home and to manage delivery without birth attendant, illegal through laws and taking legal measures on people who are responsible for the exercise of the practice will be helpful and necessary since it is a human right

violation issue and could not be seen different from taking one's life without getting help.

Ethiopian women are experiencing a very high maternal mortality rate. The main reason behind the death of mothers is not only caused by lack of accessing adequate maternal health care services, but also highly associated with harmful traditional practices like the practice of isolating women at times of labour. I suggest the designing of a distinguished maternal health policy which should specifically incorporate the reproductive health problems of rural mothers' and solutions to be exercised. It is because the health policy of the country alone may not properly address the problem village women of the country experience everyday due to their social position, cultural, religious and other forms of oppressions.

Policy makers and health practitioners should give due attention to the special needs and status of village women in rural family systems. They should consider women's very inferior social status and their inability to access resources which could enable them to invest on their health. In order to alleviate this problem, "women empowerment" particularly "economic empowerment" should be considered in women's health and development programs.

Another most important thing is making women self reliant through education. Improving women's literacy will make them aware of their choice and rights and it will help them to decide on their reproductive health issues. Barriers curtailed Gumuz women's access to education like laborious works and female exchange marriage must be taken as human right violations since they denied women's access to education. Specificities like illegalizing the actions of individuals who are depriving education to girls will be helpful. Expanding schools and health care provisions in the area will also have invaluable contribution to the elimination of the practice.

Though terms like dignity, equality and personhood overwhelmingly exist in liberal feminists' analysis; such claims are not successfully addresses issues when we deal with harsh cultural practices like the practice of isolating women at times of labour. It is basically because such practices are serious human right violations demanding radical rearrangements. If we are not able to search and demand radical changes, these practices will remain as normal processes taking the lives of women and their new born in the claims of collective cultural rights which is against the universal consensus of applying the principles of safe motherhood expected to be attained by all countries throughout the world.

Further to this, the demand for radical rearrangements is important because death and lifelong disabilities could not be tolerated and continued as if they can be reformed through process in some other times. If we also look at the situation of Gumuz women from the perspectives of human capabilities, they are highly isolated and deprived in all its forms. Health wellbeing is a very big one from human functioning capabilities because it is central in defining the very presence of human life.

Gumuz mothers' denial of bodily health and integrity right of human beings is not only leading them to miserable death, but also posing a moral question in every one's mind. Bodily health and integrity is attained through adequate access to health care services including reproductive health services so that expanding health care provision in the area is very crucial. Respect for autonomy of one's life choices is also a human right which Gumuz women seriously denied. They do not choose to endorse the practice as good for themselves; rather it is imposed on them through culture by their own society. As the study participants repeatedly confirmed, they are in serious problems and they need support to become capable of human capability functions and it is up to all human beings to look for radical solution since it is a very serious human rights violation issue.

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Glossary

Biicza: Marriage by bride wealth payment

Beles: one of the tributaries of the Blue Nile found in the Benishangul Gumuz regional state of Ethiopia

Borde: Locally made drink of the Gumuz and many ethnic groups of Ethiopia

Chifa: Polygamous marriage

Chagini: A town nearer to Mandura wereda

Datsoko: Marriage by abduction

Derg: A military administrative regime of Ethiopia reigned from 1974-1991

Dueia: A soil used to decorate body among the Gumuz

Endeha: A carrying material used by Gumuz women of Ethiopia

Genete Mariam: A small town in Mandura wereda

Impiqua: Child birth

Indapiqua chinika indiguta: Giving a large number of children is a real blessing

Manjika uma: Female exchange marriage

Mesaqua daguna: Marriage by elopement or marriage done with the consent of the girl

Mequa: Untouchable. (A menstruating woman among the Gumuz is called as *Mequa*)

Mekola gafa: Levirate marriage or inheritance of widowed women by her husband's brother or close relatives

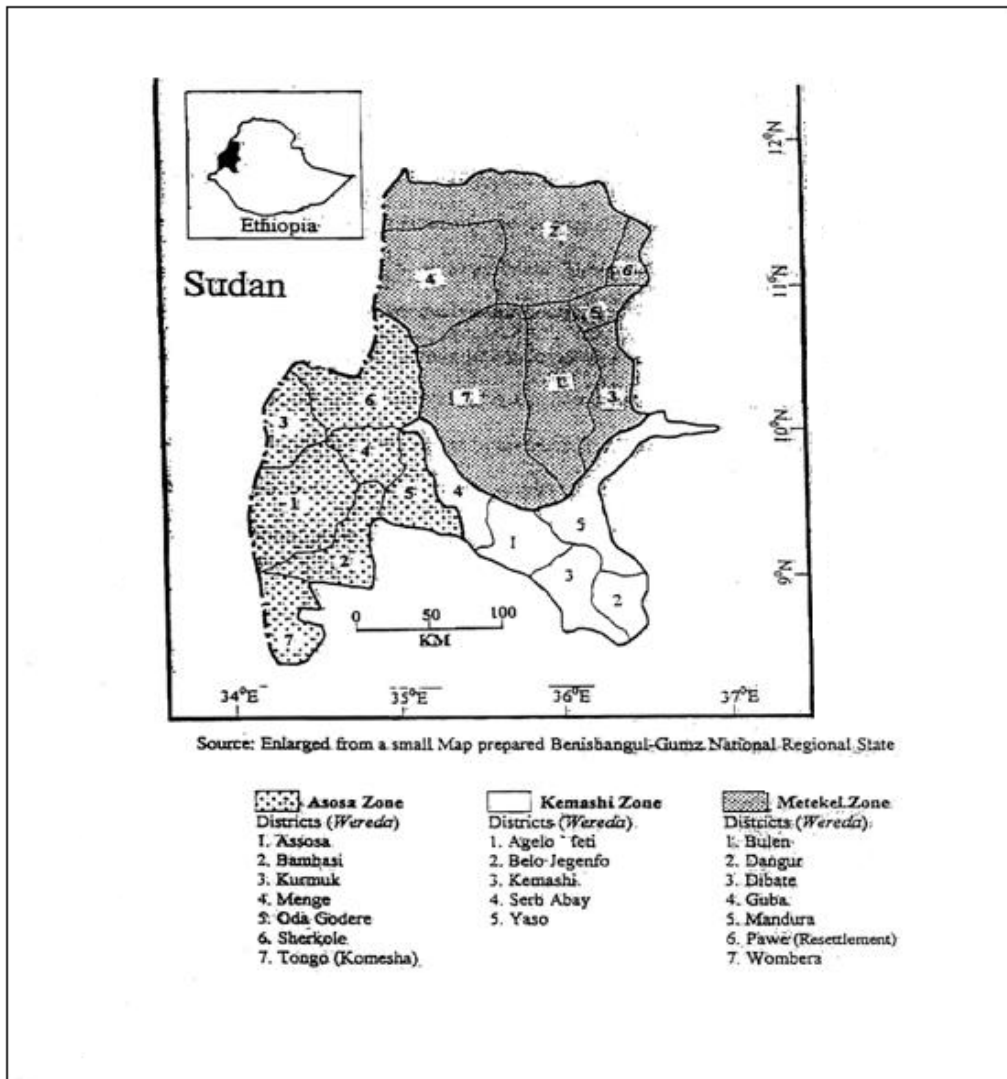
Musa: Supreme God and determinant of everything in the lives of the Gumuz

Pawi: A town near Mandura wereda

Walta: A centre for information and public relations. Produces documentary films, on the cultures of Ethiopian nations/ nationalities and peoples

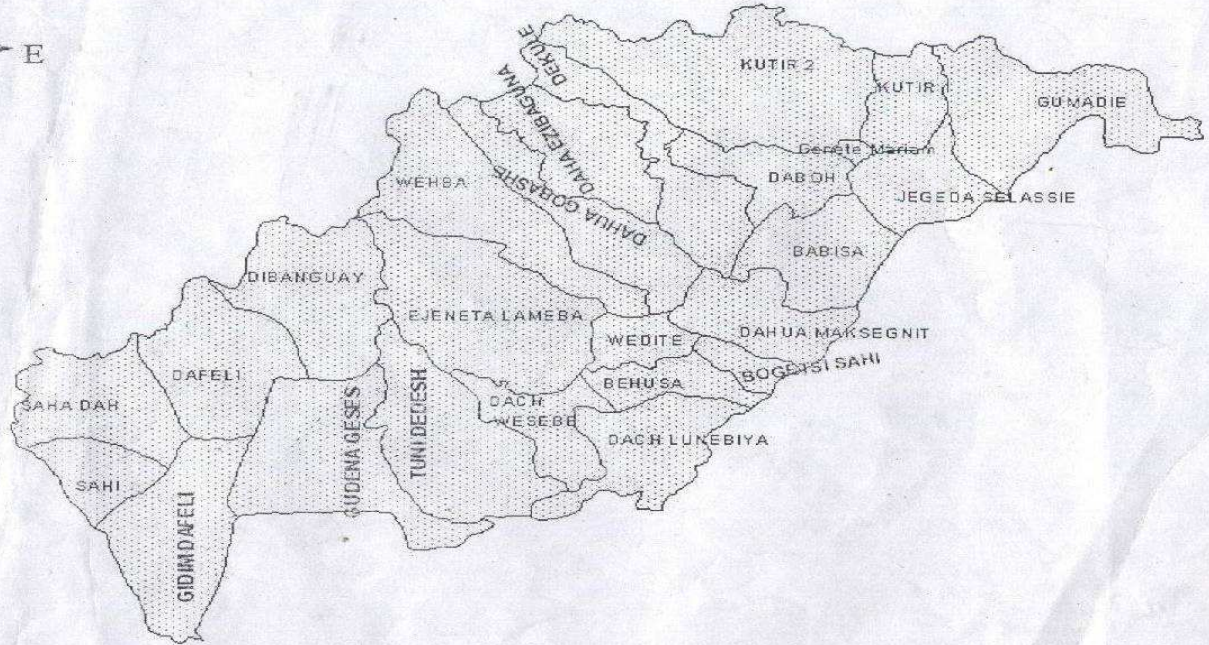
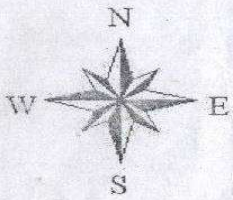
Wereda: The smallest administrative level in Ethiopia

Map 1, Benishangul-Gumuz Regional State



Map 2, Mandura Wereda

MANDURA WOREDA AND ITS KEBELES



Source: Mandura Woreda Administrative Bureau.

APPENDICES

Appendix I

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF GENDER STUDIES**

IN-DEPTH INTERVIEW GUIDELINE FOR WOMEN PARTICIPANTS

This in-depth interview is designed to collect data from women who gave birth in isolation. The in-depth interview questions provided guidelines for exploring the practice of isolating women at times of labour and its effect on women's reproductive health.

Date of interview -----

Place of interview-----

Informant's code -----

Part I. Background information

Age -----

Educational status -----

Marital status -----

Number of children -----

Part II. Questions about Women's Perception and Experience of Child Birth

Seclusion

1. How did you give birth to your children/child? Why?
2. Where did you give birth to your children/ child?
3. Do you like to go outside and left without attendant while you are in labour? Why?
4. Why do you think you are isolated at times of your labour?
5. What do you feel about being isolated at times of your labour?

6. How many hours or days you stayed outside during your delivery time?

7. Tell me your overall experience of being isolated at times of your labour.

Part III. Questions about Women's Reproductive Health

8. Do you have any health problem? Where do you feel the pain?

9. What is the reason do you think for your health problem?

10. Have you ever encountered any health problem and death of your infant children?

11. Have you ever gone to health care posts?

Part IV. Questions about Their Own Social Position

12. What are the shares of household chores in your marriage? Who is more burdened?
you or your husband?

13. What is your feeling towards polygamy?

14. Why do you think men are marrying many wives in your society?

15. Do you own and manage money and properties in your family?

Appendix II

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF GENDER STUDIES**

IN-DEPTH INTERVIEW GUIDE LINES FOR KEY INFORMANTS

This in-depth interview is designed to collect data from key informants who are opinion leaders of their society. The in-depth interview questions provided guidelines for exploring, the social position of women and why the practice of isolating women at times of labour is exercised.

Date of interview -----

Place of interview ----

Informant's code -----

Part I. Background Information

Age -----

Educational background -----

Part II. Questions about the social position of women and why the practice of isolating women at times of labour is exercised

1. How is the practice of isolating women at times of labour exercised?
2. What are the behind reasons of isolating a labouring women in your society?
3. Do you think it is a proper practice? Why?
4. Do you think the practice could cause problems? What kind?
5. Do you think a woman at the time of labour needs health care professional assistance? Why?
6. Are women in your society accessed to health care during their labour?

7. What is the place of women in your society?
8. Why men are marrying many wives in your society?
9. Do women have access to education in your society?
10. Do wives have the right to own and inherit properties and money?
11. Who shares the burden of productive works? Women or men?
12. What is the usual cause of maternal mortality in your society?
13. Do you ever know women who have lost their lives during labour in bushes?
14. What are the legacies and problems of the historical ethnic and class oppression?