Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:_____ _____

Anna Newton-Levinson April 23, 2012

***"People Insult Her as Sexy Woman:"* Sexuality, Stigma and Reproductive Health among Widowed and Divorced Women--Documenting Social Change in Oromiya, Ethiopia**

By

Anna Newton-Levinson

Master of Public Health

Hubert Department of Global Health

_____

Rob Stephenson, Phd, MSc

Committee Chair

_____

Amy Webb Girard, PhD

Committee Member

"People Insult Her as Sexy Woman:" Sexuality, Stigma and Reproductive Health among Widowed and Divorced Women--Documenting Social Change in Oromiya, Ethiopia

By

Anna Newton-Levinson

B.A. Anthropology, University of California, Berkeley

Thesis Committee Chair: Rob Stephenson, PhD

An abstract of

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of
Master of Public Health
in Hubert Department of Global Health

April 2012

Abstract

***"People Insult Her as Sexy Woman:"* Sexuality, Stigma and Reproductive Health among Widowed and Divorced Women--Documenting Social Change in Oromiya, Ethiopia**

By: Anna Newton-Levinson

Background: Women in Ethiopia have far less power over their lives and health than their male counterparts. This is especially true of women living in rural communities and of those who are widowed or divorced. The latter, in particular, according to some reports from the field, lack resources and social capital and have poor access to health services. CARE's Results Initiative (RI), a large scale intervention based in Hararghe, set out to change gender and other social norms in ways that would affect family planning use. Anecdotal reports from the field had indicated that the RI program had transformed the lives of many women who were widowed or divorced. None of these reported changes had as yet been documented or measured.

Objective: The purpose of this study is to examine the lives and reproductive health needs of WDW in rural Ethiopia, and to document if and how they were influenced by CARE's program.

Methods: In an effort to understand the challenges and reproductive health needs of widowed and divorced women (WDW) and the life changes that they have experienced, we conducted twenty-three focus group discussions, in-depth interviews, and interactive activities with WDW and with other community members.

Results: Prior to the R.I. Program WDW experienced stigma relating to their sexuality, a stigma that had negative impact on their economic, social, and health support systems. After participating in the CARE RI program, WDW experienced positive changes in the way their sexuality was perceived by the community and by themselves. These changes, in combination with other factors, had positive effect on their economic and social support systems and on their access to health services and family planning.

Discussion: Although positive changes are taking place, further programmatic work is needed to address the lingering stigma attached to WDW's sexuality and their vulnerability to rape. The findings of this study indicate that while WDW have been heretofore addressed primarily as economic beings future interventions need to consider them as sexual beings as well and to take into account the impact of sexual stigma on WDW's overall well-being.

"People Insult Her as Sexy Woman:" Sexuality, Stigma and Reproductive Health among Widowed and Divorced Women--Documenting Social Change in Oromiya, Ethiopia

By

Anna Newton-Levinson

B.A. Anthropology, University of California, Berkeley

Thesis Committee Chair: Rob Stephenson, PhD

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of Master of Public Health in

Hubert Department of Global Health

April 2012

Acknowledgements

I am deeply grateful for the support I received during the process of completing this thesis. To my adviser Rob Stephenson for his constant support, enthusiasm and patience. To my committee member Amy Webb Girard for her thoughtful, always helpful comments and guidance. My profound thanks to CARE and those working with the RI program including Feven Tassew, Marcie Rubardt and Yosef Alemu for allowing me this amazing opportunity to conduct this research. I am also indebted to my research team in Ethiopia Berissa Abdela, Abdulaziz Mohammed, and the many other facilitators for their enthusiasm and energy, and without whom this research would never have happened. Finally to my family and friends, thank you for your never-ending encouragement and love --it is not taken for granted.

TABLE OF CONTENTS

Introduction **1**

Problem statement 1
Background 2
Objectives and Aims 3
Definition of Terms 4
Contribution to Literature and Programmatic Efforts 4

Literature Review **6**

Introduction 6
Women's Status in Ethiopia 6
Harmful Traditional Practices *8*
Education *9*
Marriage & Sexuality *9*
Bargaining Power in Marriage *12*
Health 13
Reproductive Health 13
Abortion *18*
Widowed and Divorced Women: An overlooked population 19
Economic Situation of WDW *20*
Social Status of WDW *23*
Divorce Practices *25*
The Practices of Widowhood *27*
Mental Health of WDW *28*
Sexual and Reproductive Health Needs of WDW *29*

Methods **31**

Study Setting 31
Ethiopian Administration *31*
Hararghe Zone & Oromiya Region *31*
Health System and the Health Extension Program (HEP) *34*
Program Background 35
Research Design 38
Tool Development *40*
Implementation 50
Data Management and Transcription 66
Analysis 67

Results **69**

Challenges in the Past 69
WDW's Sexuality *69*
Community Stigma *70*
Pregnancy *71*
Fear *72*
Past Support Systems 75
Changes in the Present 84

Community Perceptions of WDW's Sexuality 85
Family Planning (The less shameful option) *86*
Pregnancy *87*
WDW's Perceptions 88
Sexuality *88*
Family Planning *89*
Rape *90*
Unwanted Pregnancy *92*
Abortion *93*
WDW's Support Systems in the Present 94
How WDW Conceptualize Change 99
How the Community Conceptualizes Change 102

Discussion 105

Summary of Results 105
Larger Theory of Change 106
Relation to Literature 108
Limitations 109
Program Considerations 111
Implications for Public Health 113

Conclusion 115

References 116

Appendices 120

Appendix A: Interviewing Do's and Don'ts 120
Appendix B: IDI Interview Guide 121
Appendix C: SM Interview Guide 124
Appendix D: FGD Interview Guide 126
Appendix E: IRB Approval 128

Introduction

Problem Statement

Poverty and lack of status within society have major impact on the health of the majority of the world's population (WHO, 2012). This is particularly true for women, who suffer more poverty and social marginalization than men (United Nations, 1995). Women's poverty and low social status often prevent them from getting proper health care, including reproductive health care and family planning. This lack of access to family planning, in turn, further contributes to their economic and social marginalization (WHO, 2011). The relationship between family planning and economic and social status has been well documented: When women cannot control the number of children they have or when they have them, their economic, social, and physical well-being along with that of their family, declines. (Guttmacher Institute, 2010a; UNFPA, 2005; WHO, 2011).

Widowed and divorced women (WDW), often referred to as female-heads of household, are one of the most impoverished and marginalized groups in the world (Holmes et al., 2009; IFAD, 1999; World Public Opinion, 2008). In health and program literature, however, WDW are often overlooked or are seen primarily as economic or socially marginalized beings but not as persons who need or seek reproductive health care and family planning. WDW, indeed, are seldom seen as sexual beings with their own desires, an oversight that has undoubtedly contributed to the dearth of information about their sexual and reproductive health requirements. This study of WDW in Ethiopia assumes

that WDW are sexual as well as economic beings and specifically investigates the sexual and reproductive health needs of this understudied group.

Background

Ethiopia, which is located in the horn of East Africa, has a population of around 80 million, 77% of whom live on less than $2 a day, Ethiopia is among the poorest and least developed countries in the world (World Bank, 2011). More than 85 % of the population lives in rural areas which are often plagued by drought and insufficient access to food. The average life expectancy at birth is 59 years old (UNICEF, 2010). Health infrastructure is also very poor and most of the population lack access to higher skilled health services which are often concentrated in urban areas (FDRE MOH, 2006).

Women in Ethiopia are more disadvantaged than men, and WDW are more disadvantaged than women as a whole. Although new laws have been introduced into Ethiopia's constitution granting all women equal rights, traditional gender norms and customs, which limit women's autonomy, are still very strong in rural areas (Mabsout 2010). Women as a whole have little control over resources and often enjoy little independence in making health decisions, including decisions about their reproductive health and fertility (Woldemicael 2009). Rural women often marry early and are expected to have children right away. Contraceptive prevalence is very low (around 23%) and total fertility is high at an average of 4.8 births per woman (CSA, 2011). Gender-based violence is common and an accepted practice in many communities (Alemu et al., 2007).

More than married women, WDW lack resources and social capital and have poor access to health services (IFAD, 1999; World Public Opinion, 2008). As anecdotal evidence and now data from this research have shown, WDW have particular trouble accessing family planning services because of gender norms that attach shame and stigma to sexual activity on the part of non-married women (Stephenson, 2009). The difficulties of WDW in Ethiopia with respect to family planning are of growing concern because divorce is becoming more and more common (Tilson & Larsen, 2000). Globally the percentage of female-headed households is increasing (IFAD, 1999). In 2000 as many as 45% of first marriages ended in divorce, and most within the first 5 years, often as a result of early marriage practices (before age 15) (Tilson & Larsen 2000). According to the 2005 Ethiopian Demographic and Health Survey (DHS), the proportion of people who have been divorced has nearly doubled since the year 2000 (CSA, 2006). It is of great importance to document the sexual health needs of this growing female population.

Objectives and Aims:

The objective of this study is to understand the lives and sexual health needs of WDW and secondly to understand how the CARE Results Initiative program has affected the lives of WDW in Oromiya Ethiopia, and specifically how it has affected their sexual and reproductive health.

<u>Specific Aims</u>

1. To identify the challenges faced by widowed and divorced women in their communities before their participation in the CARE program with specific attention to their ability to access economic, social, and health support and reproductive health services in particular.

2. To understand what aspects of their lives changed since their involvement with CARE

3. To determine if these changes had impact on women's general health practices and their access to family planning services

4. To determine if community perceptions of widowed and divorced women have changed

Definition of Terms

In this study the term "sexual health needs" is used to encompass access to services such as contraceptive technologies and maternal health and gynecologic care and the ability to express and fulfill one's sexual desires. Since the term 'family planning' was often used in Ethiopia to refer to contraception and to birth spacing, it is used as such in this paper. Most WDW, however, were not trying to space children but to prevent having them in the first place.

Contribution to Literature and Programmatic Efforts

This thesis attempts to understand the sexual and reproductive health needs of WDW, how CARE met those needs, and what the larger affect this attention to sexual health needs had on the lives of WDW. Documenting how the lives of WDW have or have not changed through their involvement in the RI program will provide powerful understandings of the challenges faced by WDW and of the way some challenges can be

addressed through programs in the future. The project will contribute to a body of knowledge about the ways in which gender norms and social factors shape women's health care practices and has the potential to provide programmatic strategies for catalyzing future changes in gender and societal norms which can in turn have positive impact on women's health practices. This thesis fills a gap in our understanding of WDW in that it directly addresses their reproductive health needs and the ways in which those needs might be addressed.

Literature Review

Introduction

Public health literature makes strong connections between women's health, including reproductive health, and their status in society. A woman's status is often determined by her economic and social resources and includes political power, education, and social support. Poor women with few social resources find it particularly difficult to access health care, including reproductive health care, and have been the subjects of study in a good deal of literature on public health. Most of the literature on reproductive health needs, however, has dealt with married women. The reproductive health needs of widowed and divorced women, who are among the poorest and most marginal women in the world, have been little studied. This study of widowed and divorced women in Ethiopia will focus on their sexual and reproductive health needs.

Women's Status in Ethiopia

Despite progressive legislation that has given women federally recognized rights and protections, women's status in Ethiopia, as suggested in many studies, is far from equitable at all levels in society. Ethiopia is traditionally a patriarchal society in which women are unequal and subordinate to men. Two factors are cited as contributing to this situation: the predominance of 'Amhara-Tigray culture' which has been described as very hierarchical in nature and the common compliance with Sharia law among Ethiopian Muslims which also subordinates women to men. In 1994, a new Ethiopian constitution granted equal rights to women in areas such as marriage, inheritance, and

property as well as bodily integrity (Mabsout & van Staveren, 2010). Reform, however, has been slow and has not much penetrated rural areas where traditional norms and practices persist. Politically, women still have little power. They are not well represented in Ethiopian government (women constituted 22% of Parliament in 2010), and, as a result, there has been little emphasis given to enforcing the new legislation throughout the country (Mabsout & van Staveren, 2010; Tefera, 2010). In 2011, for example, Ethiopia ranked 149th of 157 countries in the Gender-Related Development Index (World Bank, 2011), which measures gender equality. One study notes that "politicians who championed women's land rights are highly unpopular and lost the last election" (Holmes et al., 2009).

Women are economically disadvantaged compared to their male counterparts as well. Traditionally, women do not inherit the same resources as their brothers, a practice that has been justified on the grounds that sons are the ones responsible for caring for their parents in their old age (Fafchamps & Quisumbing, 2005). Women also have less control over resources than men. In some areas, for example, women are not allowed to sell any cash crops under any conditions (Berhane et al., 2001). Although both parties to a marriage bring resources such as land and herd animals, the husband often brings much more (up to ten times the amount) and it is he who usually controls resources once the marriage has taken place (Fafchamps & Quisumbing, 2002). Women may make household decisions about what goods to buy day to day, but most women in rural areas feel that their husbands have final say on finances (Berhane et al., 2001). Fafchamps & Quisumbing (2002) found that decisions on what to grow are "essentially

the purview of the household head," as are decisions to rent out land or to give it away. In more than half of the households surveyed, the male head of household alone administered household finances and paid for food, clothes, school fees, and medical expenses.

Harmful Traditional Practices & Violence

Ethiopian women's lower status is also indicated by the persistence of harmful traditional practices and the general acceptance of violence against women despite the 1994 Constitution and National Health Policy (1993) both of which enacted legislation to discourage harmful traditional practices (HTPs) such as female genital cutting (FGC), child and abduction marriage and domestic violence. The 1994 Constitution was designed to protect women by granting them "[…] the right to protection from the state from harmful customs, laws, and practices that oppress women or cause bodily or mental harm to them" --FDRE, 1994: Article 35 (FDRE MOH, 2006). Nonetheless, the ban on FGC has not been implemented in rural areas where girls are considered unfit to marry unless circumcised (Berhane et al., 2001). Although the numbers are going down, 74% of Ethiopian women surveyed by DHS in 2005 had undergone FGC. Violence against women is also an accepted practice within Ethiopia. In 2005, the DHS found that 81% of Ethiopian women believed there was at least one justifiable reason for a husband to beat his wife.

Education

Male children are given priority when it comes to education. It is often assumed that educating girls is not as useful as educating boys, since girls are expected to marry and perform wifely duties (Berhane et al., 2001). Most boys, therefore, attend school while female children are kept at home to help with household tasks (Berhane et al., 2001; Bevan & Pankhurst, 2007), This inequity in access to education is part of a general prioritization of male children in the household: sons receive more attention than girls, and sisters are often expected to help prepare food for their brothers (Bevan & Pankhurst, 2007). In 2005, 29% of women were literate (compared with 59% of men), although younger women were more literate than their elders. Fifty percent of 15-19 year olds were literate in 2005, a suggestion that the younger generation is becoming increasingly educated (CSA, 2006). In the same year, however, 66% of women had no education, compared with 43% of men (CSA, 2006). The level of a woman's education, moreover, can exert great influence on her ability to negotiate for herself in marriage, on her ability to take care of her health, and on her ability to tend to the needs and education of her children (Woldemicael & Tenkorang, 2010). According to Woldemicael (2010) an individual's level of education had a strong impact on her health seeking behavior.

Marriage & Sexuality

From her birth, an Ethiopian woman is trained to fill the role of mother and wife (Berhane 2001). As suggested above, young girls are often kept at home to perform

household chores alongside their mothers. They are expected to marry young and to begin reproducing soon after. The greatest honor an Ethiopian girl can bring to her family is to make a good match and produce children, most especially sons (Alemu et al., 2007). Many parents still make marital decisions for their children, and marriages are often arranged without the input of either child. In some instances, child marriages, in which children are betrothed since birth, still occur.

Ethiopian women also marry young. Since they are expected to remain virgins until they are married, families will often marry a daughter at a young age to protect her from unwanted sexual activity or pregnancy(Tilson & Larsen, 2000). Marriage is also seen as a way to align two families or bring two clans together, and there is a good deal of pressure on girls to make a good match. Many families believe that girls make the best matches while still young (Alemu et al., 2007; Tilson & Larsen, 2000). Although the National Family Law was revised in 2000 to raise the minimum age for marriage from 15 to 18 years old, early marriages persist, especially in rural, more traditionalist communities (Alemu et al., 2007). In 1990 75% of married women were married by age 18, and 34% were married under the age of 15 (Tilson & Larsen, 2000). In 2005, the DHS reported that 66% of women were married by age 18, yet the same proportion (34%) of women were married by age 15. The median age at marriage was 16 (CSA, 2006).

Early marriage often has negative impact on women's status and health. Women who marry young are often less autonomous within their households than older wives. They

are likely to have less education as well, and are less able to make their own decisions with regard to economics, health care and family planning(Alemu et al., 2007; Mabsout & van Staveren, 2010; Woldemicael & Tenkorang, 2010). Women who marry young are also more likely to become pregnant early and to face additional maternal health risks, including such dangerous complications as obstetric fistula (Alemu 2007). Tilson & Larsen (2000) found that women who married young were at much higher risk of divorce. As will be discussed later in more detail, divorce has further negative impact on a woman's status and well-being.

Some forms of marriage are particularly detrimental to women's power. Although, abduction marriage is now illegal, in 2005 nearly 8% of Ethiopian women reported that they had been married by force or abduction (Alemu et. al, 2007). Abduction marriage often involves the kidnap and subsequent rape of a young girl who is then forced to marry her attacker (UNICEF, n.d.). In the past, boys from poorer families resorted to this approach when their families were too poor to afford a brideprice payment. New laws make this a criminal offense, but it is often difficult for women to get authorities to prosecute the men involved, and if the men are prosecuted, they serve little, if any, jail time (UNICEF n.d.).

Polygamy is common in Muslim communities and a woman's status in the household can often be jeopardized by the threat of her husband's marrying another wife (Berhane et al. 2001). Many women report that polygamy is a source of psychological and social distress to already existing wives, who are seldom consulted by the husband, and must

stretch household resources to accommodate another member of the family (Berhane et. al. 2001). Wives who are second or third in line may experience decreased bargaining power within marriage as well as fewer resources for themselves and their children (Bevan & Pankhurst 2007).

Bargaining Power in Marriage

Numerous studies have demonstrated that unequal assets and unequal control of resources limit women's general bargaining power within the household and thus further limit their ability to care for themselves. As mentioned previously, women generally bring fewer assets to a marriage than do men, and this is one reason that women, have less control over the household's assets than do their husbands. A woman's lack of power over resources is often reflected in diminished bargaining power in general. Control over resources and general bargaining power are also affected by a woman's age at marriage, by her education level, and by how assets will be divided if the couple becomes divorced (Carroll, 2006; Fafchamps & Quisumbing, 2002). Mabsout (2010) argues that a woman's general bargaining power is most affected by larger social factors such as a community's acceptance of domestic violence or its practice of FGC. Both control over resources and larger societal influences, it would seem, affect women's general bargaining power within marriage and therefore their ability to care for their own health.

Health

Although the 1994 Constitution granted women the right to equal health care, women's continuing inequality and subordinate status impinge on their access to it. The 2006 National Reproductive Health Strategy notes that "despite a biological tendency toward higher survival rates, girl children are 4 percent more likely to die during infancy than boys (FDRE MOH, 2006). Since girls have lower status in their families than boys, boys are more likely to be given priority not only for schooling but also for things like food and health services (Bevan & Pankhurst, 2007). A woman's bargaining power within marriage has impact on her health as well. Studies have indicated that women who lack bargaining power have less access health services (Berhane et al., 2001; Woldemicael & Tenkorang, 2010). If a woman needs her husband's permission to see a doctor, or to leave the compound at all, for example, it impedes her ability to care for herself (Berhane et al., 2001). According to Woldemicael & Tenkorang (2010) women who had some input on household and budgetary matters were more likely to seek maternal health care than those who did not.

Reproductive Health

Women's reproductive health is particularly influenced by their lower status within Ethiopian society. Women who are less autonomous in marriage are also less able to take care of their reproductive health both in terms of accessing maternal health services as well as in terms of controlling their fertility (Berhane et al., 2001; Woldemicael & Tenkorang 2010). Pressure to reproduce is still engrained in rural

culture, and reproduction is central to a woman's status as a wife (Alemu et al., 2007; Berhane et al., 2001). Large families are prized and, according to the 2011 DHS, the total fertility rate (TFR) remains high at an average of 4.8 births per woman. Although this is a drop from 2005, when the TFR was 5.4 births per woman, fertility in rural areas is still higher at 5.5 (CSA 2011). As will be discussed later, failure to produce children is also widely regarded as grounds for divorce (Tilson &Larsen 2000).

Despite cultural pressures to produce children and to have large families, women register a strong unmet need for family planning. In 2011 the DHS reported that 25% of women surveyed said they either wished they had delayed or had not had their most recent pregnancy. While this estimate has decreased from the 2005 estimate of 34%, it is still quite high. A quarter of Ethiopian women say they have been unable to achieve their desired fertility goals.

A woman's ability to have the number of children she desires, and to time them appropriately, is very important to her own well-being and to the well-being of her family (Guttmacher Institute, 2010a; UNFPA, 2005). In Ethiopia, maternal mortality remains very high (470 maternal deaths per 100,000 live births as of 2008) and childbirth can be risky to a woman's health (World Bank, 2011). As has been well documented, women who have smaller families are less able to invest time and resources in their children (Allen 2007; Bogale 2011; Guttmacher 2010). The following table indicates that while there have been gains in levels of contraception and a small

decline in population growth in the past six years, access to contraception is still limited while maternal mortality remains high (CSA 2006; CSA, 2011; WHO, 2011).

Table 1: Ethiopia Reproductive Health Key Indicators

Indicator	Year	Level	Year2	Level2
Population total (million)	2007	73.7	2010	83
Population growth (annual %)	2008	2.6	2010	2.1
Total fertility rate (births per woman ages 15-49)	2005	5.4	2011	4.8
Contraceptive prevalence (% of married women ages 15-49)	2005	15%	2011	29%
Unmet need for contraceptives (%)	2005	34%	2011	25%
Median age at marriage (years)	2005	16.5	2011	--
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	560	2008	470

*Adapted from World Bank Report 2011 with updates from the 2011 DHS

There is strong legislative support for the expansion of reproductive health services, but access and uptake of them has been difficult. In 1993 the Transitional Government of Ethiopia developed its National Population Policy with the aim of bringing the rate of population growth and the resources available within the country into balance(Transitional Goverment of Ethiopia, 1993). The policy recognized the problems of low contraceptive use and high fertility. It also noted that the status and education level of women limited their access to reproductive health services and thus contributed to overpopulation. The policy, however, failed to provide many concrete guidelines for change, and a ten year review of the policy found that uneven progress had been made (Ringheim et al., 2009).

In 2006 the National Reproductive Health Task Force, chaired by the Ministry of Health (MOH), developed the National Reproductive Health Strategy which was intended to

build upon the precedents set by the Millennium Development Goals (MDGs). The goal of the National RH Strategy was to garner multi-sectoral support for improving reproductive health and to further address the reproductive health needs of the Ethiopian population (FDRE MOH, 2006). The National RH Strategy rightly acknowledged the negative role played by the low status and low education of women in Ethiopian society and the negative effect of inadequate health care infrastructure, and it set ambitious goals, such as increasing the contraceptive prevalence rate (CPR) to 60% by 2010 This goal, unfortunately, was not met.

Despite governmental support and strategic planning for improved reproductive and sexual health services, access to and use of family planning is still quite difficult for many Ethiopian women. Access is limited by lack of infrastructure in general as well as by some communities' lingering resistance to family planning and smaller family size (Beekle & McCabe, 2006). Though progress is being made, many women feel that the number of children they have is either up to God or up to their husband. Since husbands are generally the primary providers, they have final say about whether their families should have more children or not (Bogale et al., 2011). Control of reproduction, therefore, is often in the hands of men.

Encouragingly, recent estimates suggest that gains have been made in the past ten years. The 2011 DHS estimated that 29% of currently married women were using some form of contraception which is a large increase from 15% in 2005. Women's continuing lack of access to, and use of, family planning, however, is well demonstrated by the fact

that while 86% of the women surveyed by DHS knew about at least one method of contraception, the overall CPR remained quite low (CSA, 2011). Women's knowledge about contraceptives in Ethiopia, moreover, remains lower than that of women in many other African countries such as Ghana, where 96% of women know of at least one method (Ko et al., 2010).

Although great strides have been made to improve Ethiopian health care delivery through the new Health Extension Worker program (as will be discussed in further detail in the methods section, p. 34), many challenges persist: stock-outs of supplies are frequent, providers are still in need of training for both service delivery and contraceptive counseling, and contraception options remain low (FDRE MOH, 2006, Ko et al., 2010).

Contraceptive options, moreover, and especially long-acting forms of contraception, are limited, further hindering women's ability to use family planning (Ko et al., 2010). Most women rely on two forms of contraception. Injections are by far the most popular form with 21% of women using them in 2011. The second most popular form is implants with 3.4% of women using them (CSA, 2011). The latter have replaced the pill which was the second most popular form of contraception in 2005 (CSA, 2006). Lack of options means that women often do not find a contraceptive method that fits their needs or preferences. The scarcity of long acting contraceptive options, moreover, means that women have to return to the health centers more frequently. This can be problematic for many, given the long journeys involved, the numerous household duties women

have to perform, and the pressure frequently placed on women to first seek a husband's permission (Ko et al., 2010, Woldemicael & Tenkorang 2010).

Abortion

Another important factor in women's ability to control their fertility is access to abortion. In 2005 Ethiopia adopted more progressive and more lenient abortion legislation, but again legislation has failed to have as much impact on access to and use of services as it might. In 2005 the government legalized abortion in cases of rape and incest, in cases of fetal impairment, and in instances when the health or life of the woman or fetus was at stake. Abortion was also legalized for women with physical or mental disabilities, for minors who are physically or psychologically unprepared to raise a child, and in cases of grave or imminent danger that can only be averted through termination of the pregnancy (Singh et al., 2010). The Ethiopian MOH produced a publication in 2006 which delineated guidelines for the provision of safe abortion services in hopes of informing more health professionals about the changes in the law (Singh et al., 2010). Recent studies estimate that the number of abortions per year in Ethiopia are around 382,000 (*estimates range from 330,000 to 435,000), with an estimated yearly rate of 23 per 1,000 women (Singh et al., 2010).

Access to safe abortion, however, remains almost entirely centralized in major urban areas. Guttmacher estimates that 6 out of 10 abortions in Ethiopia are still unsafe (Guttmacher Institute, 2010b). In rural areas knowledge about the laws is limited, not to mention access to and use of abortion services, which are generally located in larger

town centers. The real number of abortions may, in fact, be much higher given that many poorer, rural women may be unlikely, or unable, to seek care for abortion complications. Most public hospitals (98%), health centers (79%) and private or NGO facilities (84%) report that they provide post-abortion care services but many fewer report that they provide the procedures themselves (50% of all facilities) (Singh et al., 2010). The most frequent providers of abortion services are public hospitals or private/NGO facilities but again these are mainly located in urban areas or in town centers which can be very difficult for rural women to access.

Widowed and Divorced Women: An Overlooked Population

While the status of women and the reproductive health concerns facing married women have been well documented in Ethiopia, much of the literature on reproductive health leaves out an important population: women who have been widowed or divorced (WDW). Globally speaking, widowed and divorced women are even more subject to lower status and discrimination than married women and thus merit special attention (World Public Opinion, 2008). Although the experiences of becoming widowed or divorced are in many ways different, WDW, as well as women who are separated or abandoned, are in the circumstance of no longer having a husband. In strongly patriarchal societies, like Ethiopia and much of the developing world, this break from being associated with a man has consequences which follow similar patterns regardless of how the break occurred. Thus, we will consider WDW as a group.

20Globally, according to the literature, the percentage of female-headed households (women without husbands) has been on the rise (IFAD, 1999). This increase in female-headed households has been attributed to the migration of male workers, to the deaths of men in civil conflicts and wars, and to diseases like AIDS (IFAD, 1999). According to the DHS, WDW make up around 11% of the women surveyed in Ethiopia (CSA, 2006). In a 2007 study, Bevan & Pankhurst found that as many as 25% of the households in her study areas were female-headed. The female heads of house were mainly divorced women or women who were abandoned by polygamous husbands.

Economic Situation of WDW

Globally, WDW are primary discussed in in terms of their economic circumstances, being often referred to as "female heads of-households." Discussions about the economic situation of female-headed households (and WDW) often focus on three areas: land rights and inheritance, poverty, and food insecurity. The patriarchal cultures which shape women's lives in the developing world often limit their ability to purchase land or control assets, and once separated from a man, they frequently decline into poverty (Sossou, 2002).

Although many countries have recently developed laws to give women equal rights to property and the ability to inherit, traditional cultural practices often dominate, resulting in an unfair distribution of assets (Benschop, 2004). It is well documented that in many countries, widowed and divorced women are not given a fair share of property (Benschop, 2004; Fafchamps & Quisumbing, 2005; Tilson & Larsen, 2000). Widows may

be evicted out of their home by a husband's family or, as Human Rights Watch has documented in Kenya, the husband's family may confiscate all of the couple's property (Benschop, 2004; HRW 2003 in Carroll, 2006). Divorced women face similar property rights violations. Even when women have made significant contributions to the household or have bought their own land, they are still required to prove it in court and may often be ruled against because courts are reluctant to break with customary traditions (Benschop, 2004; Carroll, 2006). Indeed, women are often viewed as property themselves. They are seen as belonging to a husband or male relative, an identity which limits the likelihood of their asserting their desire or right to own land or assets (Bevan & Pankhurst, 2007; Benschop, 2004; Owen, 2012). The payment of dowry or brideprice further underpins the notion that women belong to men since it affirms that the husband has paid for his wife (Benschop, 2004).

In Ethiopia, the National Family Law (2000) dictates that upon divorce, assets will be divided according to who brought them to a marriage and that those acquired during a marriage must be divided equally. The law, however, fails to have impact on the majority of the population. Fafchamps & Quisumbing (2005) note, that in Ethiopia distribution of assets upon divorce is not always performed in a fair or legal manner. The distribution of assets between parties, moreover, doesn't necessarily match the assets brought into the marriage. In fact, some previously divorced Ethiopian men bring far more to their second marriages because of this unequal distribution (Fafchamps & Quisumbing, 2005). A divorced woman is often expected to return to her family

because she has few assets of her own, but if her family doesn't take her back, she must find a way to feed and care for her children on her own (Tilson & Larsen, 2000).

Women's inability to claim their rights to property and assets means they will often face a decline in economic status when widowed or divorced (Benschop, 2004; Tilson & Larsen, 2000). Thus, a large portion of the poorest households are female-headed. Globally, an estimated 41% of female- headed households live below the locally defined poverty line and close to 1/3 of women in the world are homeless or live in inadequate housing (Benschop, 2004). In many instances, WDW are unable to access credit or other resources because it is assumed they have little collateral or that they will be unable to pay the loan back due to the absence of a male partner (Benschop, 2004).

WDW must struggle to pay for daily expenses such as household items and clothing as well as school fees for children. Their increased poverty and their inability to control assets or farm land, in turn, may result in greater food insecurity. Although there is some debate in the literature as to whether female-headed households are more food-insecure than other households (see Mallick & Rafi, 2010), and though food insecurity may vary by region, some research in this area indicates that WDW are particularly vulnerable to food price shocks (Holmes et al., 2009; Smith et al., 2006). Ethiopia's food insecurity program, the 'Productive Safety Net Program,' has had difficulty in addressing the needs specific to female-headed households. Divorced women have had difficulty even registering in their own right for program (Holmes et al., 2009). On the whole, the

economic situation of female-headed households has most often been discussed in terms of property rights and legal violations, and it is on these terms that they are regarded as targets for program planning and for foreign and governmental aid.

Social Status of WDW

In addition to economic hardships, WDW also face increased discrimination and social stigma. According to a World Public Opinion poll, many countries, especially those in the developing world, have issues with discrimination against widowed and divorced women (World Public Opinion, 2008). In the majority of nations surveyed less than 30% of respondents said there was no discrimination against widowed or divorced women. The social challenges of being widowed or divorced are often framed in terms of human rights violations. This is especially true in relation to widows. As Margaret Owen, an activist on behalf of widows' rights and a UN Consultant, asserts: "widowhood represents a 'social death'" for many women which robs them of their status in their communities(Owen, 2008) . Women in patriarchal societies are often defined by their connection with their husband, and when he dies, the widow becomes associated with his death (Bremmer & Van Den Bosch 1995 in Loomba, 2010; Sossou, 2002). It is on this basis that widows are subjected to stigma and blame from their husband's family and from the community (Sossou, 2002).

Widows in India, for example may often be called names such a witch, sorceress or even prostitute (Owen, 2008). In many cases, this association of the widow with her

husband's death necessitates a 'cleansing' of sorts to rid her of bad luck or negative associations. Cleansing rituals involve a variety of *tasks* depending on the culture and may range from being washed with special herbs to being forced to have sex with another male relative, a custom which will be discussed later on in more detail (Sossou, 2002). In some instances, widows must "prove" that they themselves were not the cause of their husband's death (Owen, 2008; Sossou, 2002). Widows in West Africa, for example, may be forced to sit with the corpse for several days under the belief that if the widow survives she did not kill the man (Sossou, 2002).

Expectations with regard to grieving are also gendered (Sossou, 2002). Men are not expected to demonstrate grief for the death of a wife in the same way as women are for the death of a husband. As Sossou (2002) explains in her study of widows in West Africa, widows are expected to demonstrate intense grief in formalized ways that are often accompanied by dangerous practices. Widows can be forced to drink water that the corpse has been washed in. They may be confined indoors, prohibited from washing for several months, forced to eat from dirty broken plates and so on (Owen, 2008). In many cases, as Sossou (2002) points out, these practices are more tied to "exalting the position of the dead man than allowing a real outlet for the widow's grief."

While men may remarry soon after a burial, a widow must wait much longer, usually a year (Sossou, 2002). Widows are often socially restricted as well. Tradition may prevent them from having social interactions and going out in public and may sometimes isolate

them for long periods. Loss of connection with a husband as well as with the husband's family often makes the experience of widowhood a stark descent into social restriction. Several international NGOs advocate for the rights of widows including Empowering Widows in Development, an umbrella organization for more than 50 grassroots organizations around the world. The UN has also recognized the difficulties that widows experience and has released several publications on widows' rights (Loomba, 2010; Owen, 2008).

There is less research on the social implications of divorce for women than for widowed women. This may be a function of the fact that the widow's perceived victimization stems from her involuntary loss of a husband. In India, divorce is highly stigmatizing and wives are often blamed for the separation (Amato, 1994) . Men tend to receive more social support from their families after divorce than do women who often must return to their family household and be seen as an economic burden (Amato, 1994). In India, divorced men are also able to remarry more easily than divorced women since older women are less able to marry in general (Trivedi et al., 2009).

Divorce Practices

Globally speaking, divorce practices are too varied to discuss in detail. We shall therefore restrict our discussion of divorce practices to those in Ethiopia. In Ethiopia, according to the literature, divorce is fairly common and accepted. In the DHS 2011 survey 7.4% of the sampled women were divorced. According to the 2005 DHS survey,

the proportion of people who have been divorced has nearly doubled since the year 2000. The survey also noted that women were more likely to be widowed or divorced than men (11% vs. 3%) which seems to indicate that men remarry with more frequency than women (CSA, 2006). Tilson & Larsen (2000) estimated that in Ethiopia 45% of all marriages will end in divorce within 30 years of marriage, most within the first five years. Fafchamps & Quisumbing (2005) write that marriage in Ethiopia is fluid and that divorce is frequent as are serial marriages. These findings are consistent with earlier anthropological studies (Pankhurst 1992 in Fafchamps 2005). Divorce is more common among Amhara and Christian populations than in Oromo and Muslim populations. This is most likely due to the fact that husbands are customarily required to return the brideprice upon divorce. In Muslim marriages, therefore, a man will often take on another wife rather than divorce his first one (Bevan & Pankhurst 2007; Tilson & Larsen, 2000).

Both men and women can legally initiate divorce in Ethiopia. The National Family Law (2000) stipulates that divorce may be granted upon mutual consent and that both men and women can initiate it. Surprisingly, it is fairly common for women to begin divorce proceedings; in fact, some studies have found that both men and women perceive women to be the more frequent initiators of divorce (Pankhurst 1992 in Tilson & Larsen, 2000). The most common reasons cited for divorce by women were childlessness, abuse by husband, wasting money, adultery, exerting too much control over their activities, forcing sex, homesickness, and large age differences between spouses. Men

cited childlessness and adultery as well as not keeping the house correctly and failure to obey them or challenging their authority (Pankhurst 1992 in Tilson & Larsen, 2000). Tilson & Larsen (2000) similarly found that two of the biggest predictors of divorce were childlessness and early age at marriage for women. They also noted that a woman's ability to have influence over who she married had great impact on her likelihood of divorce later on (Tilson & Larsen, 2000).

Some research in Ethiopia has suggested that women do not face stigma in their communities because divorce is an accepted practice (Tilson & Larsen, 2000). Others have said that widows and divorced women do not experience differences in social support. Research on divorced women in Addis, for example, suggests that they do experience a decrease in social support though the differences are not as stark as one might expect (Bekele, 2006). This research, however, was conducted in the capital city where social relations are likely to be much different than for women in rural areas.

The Practices of Widowhood

As with the practices of divorce, the practices associated with widowhood vary globally and we shall confine our discussion to Ethiopia. Widows made up 3.2% of the Ethiopian women surveyed by DHS in 2011. Widowhood must legally be observed for 180 days in Ethiopia before a woman may remarry (FDRE, 2000). This is perhaps an attempt to discourage rapid remarriage and widow inheritance. In Muslim and polygamous communities it is common practice for the brother or other male relative of the

deceased to 'inherit' his wife. This often has to do with the family having paid a brideprice for the woman. She is given to someone else in the family because she has already been paid for (Bevan 2007). While the federal government seems to be discouraging the practice of widow inheritance, the practice is still quite common in rural communities (Aschenaki, 2006).

Remarriage upon widowhood or divorce is expected in Ethiopia; many women are expected to remarry soon after separation (Bevan & Pankhurst, 2007). In some communities, however, women may only remarry if the man is also previously divorced or widowed, or is taking her on as non-primary wife (Bevan & Pankhurst, 2007). Many women chose not to remarry because they and their children would be of much lower status in a polygamous household (Bevan & Pankhurst, 2007).

Mental Health of WDW

The social isolation and economic hardship faced by many WDW throughout the developing world often result in mental health challenges, though only a small portion of the literature on WDW focuses on their mental health. In India, for example Patel et al. (2006) found that marital status (being widowed or divorced) significantly increased the odds of having a common mental health disorder (OR= 2.5, P=0.03). Other studies in India also find that WDW are at higher risk for mental health difficulties (Trivedi, 2009). In Ethiopia one study found that the prevalence of a depressive episode was significantly higher in widowed (9.4% of women) and divorced (8.2%) women than in

married women (4.8%) (Deyessa et al., 2008). In much of the literature on these issues, however, there is little discussion or detail. Many studies merely state that being widowed or divorced increases the risk of developing problems with mental health.

Sexual and Reproductive Health Needs of WDW

While the reproductive health of married women and occasionally youth is addressed in global contexts, the sexual and reproductive health of widowed and divorced women remains, for the most part, off the radar both globally and in Ethiopia. The DHS and National Reproductive Health (RH) Strategies in Ethiopia, for example, report on married women, but fail to acknowledge that widowed, divorced or separated women may have their own reproductive health needs. The Ethiopian DHS surveys only include married women in their assessments of reproductive health needs and contraceptive use. Although Ethiopia's National RH strategy does well to acknowledge youth as a subpopulation whose needs for reproductive health have yet to be adequately addressed, there is no mention of women who have been previously married , no mention that is of WDW. Some issues relating to sexual health have come up more frequently with the AIDS epidemic and the increasing number of women who have become widowed due to the virus. The disturbing practice of 'widow cleansing' has been of particular concern since it may be linked to the spread of AIDS. 'Widow cleansing' is practiced to some extent throughout much of West and East Africa. Depending on the culture, this ritual is performed in order to 'cleanse' a widow of her association with death, to rid her of evil spirits or to break her bond with the spirit of her

dead husband. A widow is often cleansed by being forced to have sex with a male relative or a village appointed 'hyena' (a man with noted sexual prowess who is responsible for cleansing widows) (LaFraniere, 2005). If a widow refuses, it is believed, she will become sick or die or bring insanity and disease to the community (LaFraniere, 2005; Owens, 2008). Thus, village elders or her own family will often force her to go ahead with the practice.

On the whole, however, WDW are primarily discussed in terms of economic needs and status and to some extent in terms of human rights. They are very seldom discussed in terms of their sexual and reproductive health. When WDW's sexual health is discussed it is often in the context of their victimization as widows and not in the context of their being independent actors with their own needs and desires. As we can see, there is little information or understanding about the sexual health needs of WDW, a function perhaps of social and cultural taboos which make inquiries about the sexual health of this group difficult to make. It is the intention of this study to shed light on this little explored area of research.

Methods

Study Setting:

Ethiopian Administration

Ethiopia is structured into nine regional states including the Oromiya region which is the largest and most populous. The regions are divided into 68 different zones and each zone is divided into administrative districts called *woredas*, which generally have a capital town with developed healthy facilities such as a hospital. *Woredas* are divided into *kebeles* or neighborhood associations. *Kebeles* are the smallest administrative units and have around 5,000 people. Each kebele has an administrative center led by community leaders. Kebele centers are also usually the location of central meeting places and health posts which provide basic health prevention and referral services.

Hararghe Zone & Oromiya Region

The RI program and subsequent research were carried out in the East and West Hararghe zones of the Oromiya region located in the eastern areas of Ethiopia. The two zones have an estimated population of 2,555,635 (Stephenson, 2009).

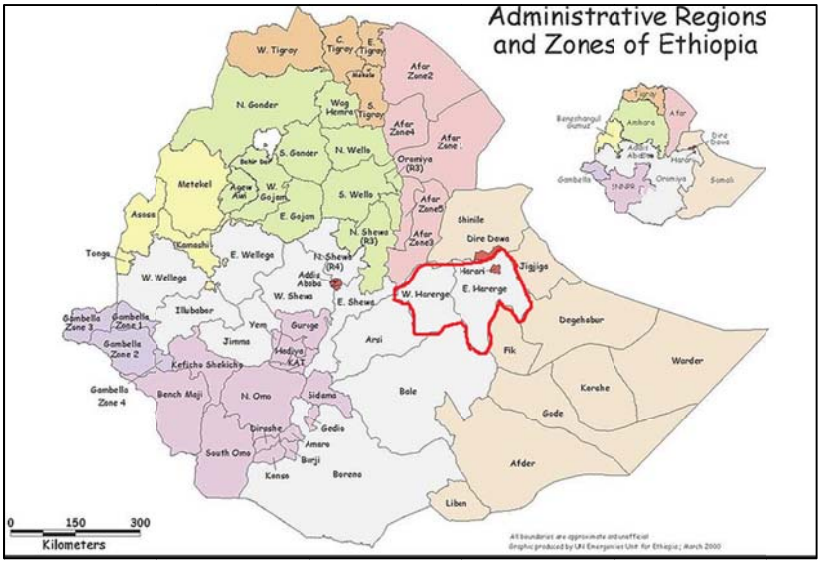

Figure 1: East and West Hararghe Regions of Ethiopia
Source: UN Emergency Unit for Ethiopia

Most of the area is rural and is characterized by lush rolling hills and arid low lands. Larger towns that serve as administrative and economic centers are most often located along the main paved highway which connects the capital, Addis Ababa, and the second largest city in the east, Dire Dawa. The most common sights, however, are farmlands connected by unpaved, dirt roads.

Figure 2: Farmland in West Hararghe

Most of the population subsists on farming and pastoralist activities. Surplus products are sold at markets in town centers. Men usually dominate farming activities while women play supporting roles and often take charge of marketing activities. Agricultural products include sorghum, maize, beans and vegetables, as well as goats and cows. The major cash crop, however, is chat which provides no nutritional value but is chewed frequently as a stimulant. Rainfall can be erratic resulting in food shortages and insecurity. Poverty in general is high in these areas.

The Oromiya region is mainly populated by the Oromo tribe. The primary language is Oromifa, although Amharic is generally understood and spoken frequently in towns. The population is predominantly Muslim, and Sharia law governs many of the social and cultural norms. Gender inequalities are high and men retain social and economic dominance.

Educational levels are low throughout the population but markedly so among women. At baseline, 47% of men reported ever having attended school whereas only 15% of women had received any kind of schooling (Stephenson, 2009). Women are married young (75% of women reported marriage before the age of 16), and early child bearing is common. As stated previously, fertility is also high (6.2 for Oromiya in 2005) (CSA, 2006) and contraceptive use is very low. At baseline 34% of women also reported an unmet need for family planning.

Health System and the Health Extension Program (HEP)

The Ethiopian government developed its National Health Policy in 1994. The policy emphasized the provision of primary care in a 'decentralized and equitable fashion.' In 2003 the government rolled out the Health Extension Program (HEP) which was designed to provide basic preventive services at the community level. Health Extension Workers (HEWs) are all women who are over the age of 18 and have attained at least a 10^{th} grade level education. HEWs receive a year of vocational training to provide a 'package' of 16 basic healthcare services at the kebele level (Wilder et al., 2008). The package of health care services covers four topic areas: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication. The family health component includes provision of family planning counseling and services. Two HEWs staff a health post (HP) designed to serve one kebele of 5,000 people. HEWs provide these basic services at the HP and refer patients out to higher level facilities as needed. The HEP was part of a lager four tier system which is comprised of Primary Health Care Units (PHCU) which include a Health Center (usually located in a larger town) and its catchment of 5 HPs (and thus serves 25,000 people). The next level up is the district hospital usually located in the woreda capital, then zonal hospitals and finally specialty hospitals located in larger urban cities which provide sub-specialty care (FDRE MOH, 2006). HEWs play a key role in CARE's RI program. The RI program trains HEWs more in-depth in family planning provision and uses them to teach and engage both target groups and the larger community in dialogue about gender norms and family planning.

Program Background

Project Background: CARE Social Change for Family Planning Results Initiative (RI)

The Social Change for Family Planning Results Initiative (RI) is a four year project designed to increase and sustain family planning uptake by addressing the social and cultural barriers to family planning use. The RI project works in three East African countries-- Kenya, Rwanda and Ethiopia-- addressing specific cultural and social barriers to family planning use within each.

The Social Action and Analysis tool (SAA) developed by the Sexual & Reproductive Health Team (SRH) at CARE headquarters, in partnership with the United States Agency for International Development (USAID), was a key component of the project. SAA is an "approach for working with communities through regularly recurring dialogue to address how their social conditions perpetuate their health challenges."(CARE, 2008).

In Ethiopia, CARE identified regional offices in the West and East Hararghe zones of the Oromiya as places in which to base the RI program. The Hararghe zone of the Oromiya region was chosen for several reasons. First, the Oromiya region had a very low contraceptive prevalence rate of around 14% and high fertility. Oromiya was characterized by conservative social and gender norms which resulted in early marriage and high fertility rates.

Another reason for implementing the program in Hararghe was that it could be anchored within two standing CARE programs which were currently running in the area.

The Health Improvement and Women Owned Transformation (HIWOT) program was a previous family planning project implemented by CARE in the Hararghe region that was phased out in June 2009. The project served "to establish and strengthen institutional linkages and access to high quality and reliable community based SRH services which aimed to improve sexual and reproductive health" (Summer, 2008). This project was helpful in establishing relationships with key partners and Health Extension Workers (HEWs) in the communities. The HIWOT program was instrumental in laying a good foundation for further work on FP/SRH in these communities.

The RI project was also designed to be implemented in conjunction with the Household Income Building and Rural Empowerment for Transformation (HIBRET), later renamed the Multi-Year Assistance Program (MYAP). MYAP worked with East and West Hararghe in reducing the number of chronically poor families by providing food and cash assistance to meet their basic needs. The project was extended for an additional three years to continue alongside the RI program. Coupling the RI program with the MYAP project allowed CARE to deliver multiple services thereby conserving resources.

To develop an appropriate and culturally sensitive intervention, CARE first conducted a situational analysis in 2008 which identified community norms relating to FP use and gender roles. The situational analysis consisted of informal community discussions with groups of community members (such as women, men, youth and elders).

In 2009 CARE conducted a formal baseline survey with a sample of 600 women and 300 men from kebeles in East and West Hararghe. The survey was intended to provide

"baseline measures of fertility and family planning behavior, and the range of social, cultural, economic and attitudinal factors thought to influence such behavior" (Stephenson, 2009). Additional informal qualitative interviews were conducted with a few community focus groups as well to determine major themes relating to gender norms and family planning use.

Ethiopia RI Program Activities

The results of the situational analysis and baseline survey indicated that three groups (newly married couples, youth and WDW) were experiencing particular difficulties within their communities. The RI program worked within 30 kebeles (administrative units) in East and West Hararghe.

The RI program focused on three main activities:

1. Developing the quality of FP services: The program developed the capacity of HEWs to challenge social norms by providing trainings on social change and counseling

2. Holding homogenous group meetings: Within each kebele, each of the target groups (newly married, youth and WDW) were invited to attend bi-weekly meetings which featured both interactive activities and discussion about gender norms and social change as well as an informational presentation on health or family planning. Homogenous group discussions were led by community based SAA facilitators, CARE Community Facilitators (CFs) and HEWs who received training in the SAA process through CARE.

3. Initiating community dialogues: Finally the RI program facilitated community dialogues with the larger community in each kebele. Homogenous groups were also invited to present dramas or engage the general community in dialogues in attempt to challenge social norms.

   *This component was still ongoing when during data collection this summer.

Research offices & Data Collection sites:

The CARE field offices in West and East Hararghe are located in the woreda capital towns Chiro and Grawa. The CARE field office in West Hararghe, which is in the town of Chiro (formerly Asbe Teferi), was the base for most of the fieldwork. In West Hararghe data collection occurred in four kebeles within the Doba and Chiro woredas. In East Hararghe training and data collection took place over two weeks. Data was collected in two kebeles in Grawa and Kurfachelle Woredas. Kebeles in both West and East Hararghe had similar demographic characteristics though East Hararghe tended to be more mountainous.

Research Design

As the focus of this paper is particularly on WDW, only issues relating to them will be discussed. In the preliminary situational analysis CARE identified WDW as a potentially marginalized group within their communities unable to access many services including food aid and family planning. Women who were sexually active and used contraception outside of marriage were often stigmatized. The goal of this research was twofold: first, to understand in more depth what challenges WDW faced in their communities and how these challenges impacted their sexual health, and second to understand how the RI program had affected both the women and their communities.

1. Understanding the lives and challenges of WDW:

Although WDW were identified as a marginalized population by CARE, little was known about the specific challenges they faced within their communities and how these challenges impacted their sexual health. Most of the information on WDW in the region was anecdotal and thus needed documenting.

2. Documenting the impact of the CARE RI Program:

   The second goal was to understand whether the CARE RI program had had an impact on the activities and self-perceptions of WDW as well as on the community's perceptions of them in the past three years. In an attempt to understand both the experiences and points of view of the WDW and the community's attitudes towards them we conducted interviews and activities with women who were currently widowed or divorced as well as with general community members.

Target Population

Widowed and Divorced Women (WDW)

The main focus of this research was women who had either been widowed or divorced for at least three years. The number of years was important as women needed to have been divorced or widowed since the beginning of the RI program. It was also important that women had experienced life as a WDW before RI began in their community. We chose women who were between the ages of 18 and 45, a period when sexual activity and childbearing were most common. All women were residents in an RI program kebele and were actively participating in the RI program.

Community members

In order to understand whether changes were occurring in the greater community's perceptions and treatment of WDW, we also conducted focus groups with members of the community. Community focus groups were selected based on the following criteria:

- Resident of the same RI kebele that was sampled for WDW interviews
- Of reproductive age, between 18 and 49 years old
- Either currently married or never married
- Not involved in any of the CARE RI program components.
  *Attempts were made to recruit participants who were not involved in any CARE programs (e.g. Village Savings and Loan Associations (VSLA) or food aid) but often it was difficult to find people who had no contact with CARE at all, so most groups were split with 50% not having any involvement and 50% having some type of relation to CARE.

Tool Development

A variety of interview methods-- including In-depth Interviews, Focus group discussions, Social Mapping and Pile Sorting activities-- were used to gain a broad view of the status of WDW in Hararghe. Preliminary interview guides for each form of interview were developed at Emory University and further refined upon arrival in Ethiopia in consultation with CARE staff. Changes included developing roles cards for the sorting activity that were based on cultural norms in West and East Hararghe.

The guides were reviewed and translated into Oromifa by CARE staff during the initial training. Prior to implementation in both West and East Hararghe, each guide was piloted by the interviewers and logistical issues were discussed.

Guides for Interviews and Activities

All guides were designed to elicit information about the challenges faced by WDW in their community before their involvement in the RI program and about how things have changed since their involvement. In an attempt to avoid directly linking CARE with changes in the participants' lives, the guides were designed so that direct questions about the CARE program came only at the very end of the interviews. That is, the guides did not initially ask questions like "What effect has the CARE program had on your lives?" Instead, the guides were designed to ask about women's experiences and self-perceptions "three years ago "(before their involvement with the CARE Program) and" today" (after three years of involvement with the program). At the end of the interview, participants were asked more directly about their experiences with the CARE program: "How has your involvement with the CARE RI program contributed to the changes we have discussed?" The guides were also designed to gather information about key areas of interest both in the past and present. Key areas of interest for this research were formulated in congruence with the CARE RI program's goals, which were to challenge social, gender and power norms in a way that would have impact on family planning use.

Table 2: Kay Areas of Interest	
*Economic Power/Support	-how a woman supports herself and her family -sources of income
*Psycho-Social Support	-support from community/friends/family -feelings of isolation
*Health Care	-ability to access health services
*Family Planning	-ability to access family planning services -use of family planning services -perceptions of WDW using family planning
Unplanned/Unwanted Pregnancy	-what happens to a WDW who becomes pregnant -what does she do -how does the community react
Marriage and Separation Norms	-the process of and reasons for divorce in Ethiopia -cultural and societal treatment of women without husbands -differences between married and WDW
Change over time	-how the challenges WDW faced have changed in the past 3 years
CARE Program Impact	-how the CARE RI program has impacted the lives of WDW
* **Key Areas of Interest**	These four themes are specifically probed in all activities with the WDW.

Preliminary Care Staff Interviews

Preliminary interviews were conducted with CARE staff to better understand their view of the RI program and their perception of changes occurring with respect to WDW. The guides for these interviews were less formal in nature and were primarily aimed at getting background information. The interviews also included direct questions about the staff's own perceptions of WDW such as "Have your thoughts about WDW changed since you started working with them?"

In-Depth Interviews (IDIs)

In-depth interviews (IDIs) were conducted with both widowed and divorced women on an individual basis to document personal experiences. Given the more intimate nature of a one on one interview, IDIs also provided an opportunity to ask more sensitive questions about family planning use and sexual activity. The interview guide had four sections: family and story of separation from husband, challenges in the past, changes in the present, and experience with the CARE RI program. The IDI would, ideally, proceed as follows:

Women were first asked questions about their family and the situation surrounding their divorce or widowhood. Then women were asked about challenges they faced in their lives three years ago and were allowed to answer anything that came to mind. Once the woman answered, the interviewer probed more specifically about the four key areas of interest (economic support, social support, health care and family planning). Next the woman was asked to think about her life today, and about what had changed over the last three years. She was given a chance to answer freely what came to mind and then was probed on changes in the four areas of interest. The IDI guide included questions which asked more specifically about a woman's desire to use family planning and her current sexual activity. The woman was asked about why she thought the changes she discussed had occurred in her life. Finally, the woman was asked about her involvement with the CARE RI program and about how the program had contributed to any changes she had discussed.

Group Interviews

Group discussions are helpful in determining a set of norms and values within a specific group of people (Hennink 2011, Krueger 2007). While the IDIs with WDW were focused on documenting personal stories of change, it was also important to understand larger social norms from both the perspective of WDW and their communities.

Focus group discussions, supplemented with interactive activities, were held with groups of widowed and divorced women and with groups of male and female community members. Interactive activities were particularly useful in that they gave participants tools with which to express norms and values in concrete terms (Colucci, 2007; Hennink et al., 2011).

Social Mapping (SM) with WDW

While the IDIs with WDW were focused on documenting personal stories of change, the SM group activities aimed to understand social norms for WDW and their perceptions of themselves within their community. Social Mapping (SM) or community mapping is an interactive activity often employed in social science and public health research to delineate community norms and practices which have impact on health (CARE, 2011; Colucci, 2007; Darbyshire et al., 2005). The use of mapping activities has gained in popularity since the late 1980's, growing out Participatory Rural Appraisal (PRA) which sought to empower communities to engage in program development and needs assessment (Chambers, 1994; Di Gossa, 2008)The process involves having participants draw a map of their community and having them mark places of interest such as the

location of services they access. While SM can often be used to locate specific *facilities* in a community, for the purposes of this research (IAPAD, 2011), SM was used as a tool for discussion about the mobility of WDW and their access to services in their communities. The SM activity was followed by additional group discussion questions with regard to the same issues and was to proceed as follows:

The SM activity ideally began with a group of six to eight participants who were either widowed or divorced. Widowed and divorced women were separated into different groups for SM activities in recognition of the fact that although both were without husbands, widowed and divorced women might have different experiences. The group sat in a circle around two pieces of paper on which they drew their maps. The interviewer explained the purpose of the activity and facilitated the drawing of the maps. While it would have been ideal to have the women draw the map themselves, many of them had minimal education and felt uncomfortable drawing with a pen and paper. Instead, the facilitator drew while the women pointed where things should be on the map. This use of the facilitator was also beneficial in that the facilitator could label the map according to four key areas of interest: economic support, social support, health care and family planning. The activity involved drawing two maps, each of which had a past and present component:

Map 1: Widowed and Divorced Women

The first map was used to prompt WDW to reflect on their mobility and on their access to services in their community both three years ago and today. On each map, the

general boundaries of the community were drawn by the facilitator using landmarks such as roads, rivers, and towns. Then participants were asked to imagine a hypothetical widowed or divorced woman in their community and to think of what she did three years ago. The interviewer asked them to describe the places this woman would go for the four key resources pertaining to economic support, social support, health care, and family planning. The facilitator then drew these areas on the map. After drawing the location for each resource on the map, the interviewer was directed to probe the women, asking, for example, if they faced any challenges in accessing family planning or some other resource in the past. Then, using a different colored pen to draw, the interviewer asked the women to describe any changes in the places they would go in the present for the four resources. The interviewer was then directed to probe about why changes had or had not occurred. The interviewer also asked the women to imagine that their hypothetical widowed or divorced woman had become pregnant and to describe what she would do and where she would go.

Figure 3: Social Mapping with Divorced Women in West Hararghe

Map 2: Married Women

The second map was used to elicit WDW's perceptions of the differences between themselves and married women in their community. The interviewer asked the women to imagine a hypothetical married woman and to draw a map depicting locations for the four key resources three years ago and today. The interviewer probed the women about the similarities and differences between married women and WDW.

Figure 4: Map of Resources for Married Women

The social mapping activity was then concluded and the group was asked a few final discussion questions about women's ability to move unaccompanied in their communities and about whether the CARE RI program had changed where women go. Each map was photographed and copies were saved to analyze later with transcripts from the group.

Community Focus Groups & Pile Sorting

In order to better understand community perceptions of, and attitudes towards, WDW and their use of FP, focus group discussions, including pile sorting activities, were conducted with sex segregated groups of male and female community members. Sex segregated groups were used to ensure that all participants, and especially women, could discuss their opinions freely. (Women in Hararghe cultures often deferred to men). Pile sorting has been used frequently in social science research to elicit participants' understandings of the relations or differences between various items or people (Chang et al., 2005; Weller & Romney, 1988).

The pile sorting activity was conducted first to get people thinking and to make them feel at ease. Both of these effects were intended to generate further discussion(Hennink et al., 2011). Pile Sorting or ranking involved a group of six to eight participants sitting in a circle. Participants sorted cards into piles according to specified categories. The pile sorting activity for this research was to understand how community groups saw the roles of WDW compared to those of married women.

To begin, the moderator explained the process of the activity to the group. Participants were then asked to sort a variety of cards with the names of activities or decisions into piles according to who would be most likely to engage in them: married women, WDW, both or neither. Role cards included activities such as farming, using family planning, and making decisions about money. The moderator held up one card at a time, reading the word(s) aloud, and asked the group to make a decision about which pile the card

should go into. Then the moderator probed the group about why they placed that card in the pile. For example, if the group decided that family planning belonged only under married women, the moderator might ask why they placed the card there and then probe the group about why WDW would not use FP. If the group decided that the card should be assigned to neither married women nor WDW the group was asked who should have that role. For example, if a group decided that neither married women nor WDW should make decisions about money the moderator might ask who should make those decisions for WDW. If there was disagreement in the group the moderator tried to have them reach a consensus. During this process a note taker wrote down which cards had been sorted into what pile and why, recording any differing opinions in the group. The piles were photographed.

Figure 5: Pile sorting during a focus group discussion at a Health Post in West Hararghe

After the pile sorting activity was concluded, the guide switched to a more traditional focus group format. The group was asked questions relating to community perceptions of any changes that mighty have occurred over the last three years. The group was then

asked about attitudes towards WDW using FP and unplanned pregnancy. Finally the focus group concluded with questions about whether participants had heard of the RI program.

Implementation

During the research period, two studies were being simultaneously conducted for the RI program by two different researchers. My project (the WDW project) and the Cognitive Interviewing (CI) project (conducted by another researcher) worked collaboratively during the training and data collection periods to maximize time and resources. While the projects each had a different focus, they were both qualitative in nature and thus some parts of the trainings were similar. Budget and staffing constraints necessitated that some staff help with both projects. Since staff members were borrowed from their usual work at CARE and were working on two projects at once, there was a lot of pressure to move quickly, and this had significant impact on the implementation process.

Staff

Due to time and budgetary limitations, CARE staff in West and East Hararghe were recruited to conduct interviews for both projects. Most were working with the RI program either as community facilitators (CFs) or program managers. In an attempt to reduce potential bias, we planned to use staff for interviews only in kebeles with which they did not regularly interact. During data collection, however, we found that some staff had worked in the past with some of the kebeles which they interviewed. Thus,

our attempt to preclude bias was only partially successful. Most of the research team had secondary education but only a few had post-secondary education. All were fluent in Oromifa and Amharic with varying levels of fluency in English. The research teams in both West and East Hararghe were mostly made up of men as there were more male staff working at CARE than women. This was less than ideal when interviewers discussed issues of gender and sexuality since women could have been reluctant to talk about sexual issues in front of men. The staff were divided into teams, one for West and one for East Hararghe. Each team had three to five men and two women. The men were used for the group interviews (SM activities and community FGDs) as these interviews were less personal in nature than the IDIs which questioned women directly about their sexual activity and personal FP use. Only women interviewers were used for the IDIs.

It is important to note that one of the difficulties faced by many NGOs is the need to restructure staffing due to shifts in funding and management. During the research period many of the interviewers were informed that they would be losing their jobs in the fall and thus their morale may have been affected.

Training

In both West and East Hararghe a short training was conducted to familiarize staff with the interview guides and to develop interviewing and facilitation skills. Due to aforementioned timing and staffing limitations, only three weeks in West Hararghe and a week in East Hararghe were allotted to conduct research. Thus, there was constant pressure to move quickly through the training in order to maximize time in the field. All

members of the research teams participated in the trainings but some took on the role of interviewer and some were assigned note taking responsibilities.

West Hararghe

The training in West Hararghe included eight CARE staff members: one intern, one supervisor and six community facilitators (CFs) who worked in kebeles where RI was conducted. Two of the CFs were women and the rest were men. The training in West Hararghe lasted five days and included translations of the interview guides.

Days 1-2: During the first days of training the research team discussed the purpose of both research projects and the different types of interview guides that would be used for both studies. The group read the guides and discussed them, clarifying interview questions they didn't understand.

Training was combined with group translation of the interview guides from English to Amharic and then to Oromifa. Translations were proposed by the entire group and a designated note taker wrote down the agreed upon translation. The written notes were then given to an assistant to be typed up. Although including translation during training was intended to save time and though including it as this point did allow the group to familiarize themselves thoroughly with the questions on the guides, the process produced a jumbled format. The discussion of translations took time away from practicing with the guides and took longer than anticipated. Thus, the team had to rush through other components of the training and was not able to fully discuss the last focus group guide in much detail.

On the second day of training the West Hararghe research team read through and translated the SM guide. In the afternoon the team was briefed on ethical considerations and on the interview process from start to finish. Below is a list of the key elements in the interview process that were discussed:

Interview process:

1. Greet participants
2. Find a private location; sit facing each other or in a circle
3. Give an Introduction:
    a. Explain purpose of the research
    b. Explain rules of consent (it is voluntary, confidential, participants may stop the interview at any time)
    c. Get permission to audio record
    d. Outline expectations of participants (there are no right or wrong answers; interviewers are most interested in what participants have to say; interviewers want honest opinions) For FGD specifically: participants should speak one at a time and respect each other; different opinions are important
    e. Ask if there are any questions before the interview begins
4. Turn on audio recorder
5. Conduct Interview
6. Ask for questions or final thoughts
7. Thank participants
8. Debrief with researcher

Day 3: Interviewers were given a chance to practice interviewing each other using the IDI guide. Each interviewer practiced interviewing using a section of the guide; another facilitator role played a widow or divorced woman. All interviewers practiced a section of the interview in front of the group and were given feedback from their colleagues,

the supervisor and the researcher. The interviews were practiced in Oromifa, however, which limited the researcher's ability to monitor the interviewers' skills. Given time constraints, the period devoted to training practice was limited. Each interviewer only practiced for about 10 minutes.

Good Interviewing Skills Dos/Don'ts:

After doing practice interviews, the interviewers were asked to brainstorm examples of good interviewing and examples of things to avoid during interviews. This exercise was designed to make sure that everyone was on the same page about interviewing skills (See Appendix # for list of 'Do's and Don'ts' that was generated during training in West Hararghe).

Probing

Probing is a technique used in qualitative research interviewing to draw more detailed and in-depth information out of your informant. This type of probing is specifically motivational and expansive and uses verbal cues (aha, mmhm), or further questions (why?, how is that?, tell me more?) to encourage participants to continue speaking (Hennink 2011). The research team also discussed probing and made a list of examples of ways to probe.

Probing Examples:
-rephrase the participants answer to clarify it
-"why?"
-"what do you mean by…?"
-"what is the reason for…?"
-"is there anything else you can tell me about…?"
-"can you give me an example…?"

Day 4: In the morning the group went over the translated SM guide and practiced conducting the SM activity. Many of the facilitators were familiar with traditional social mapping which focuses on identifying locations of resources but many were unclear about how mapping could be used as a tool for discussion. The researcher role played social mapping with the supervisor to clarify the process and to show how the map might be used as a tool for discussion. Facilitators were shown how to draw a general map, ask questions one at a time about where WDW would go in their communities for key areas of interest, label each on the map, and then probe further. The role playing also illustrated how to probe the answers given. In the afternoon the team piloted the SM guide in a nearby RI kebele which was not going to be included in the formal sample for the study.

Day 5: The community FGD (CFGD) guide was translated and written out by one of the facilitators because time was running out for training and translation. Due to time constraints the team was unable to go over the CFGD guide in depth or practice with it before pilot testing began and instead went over the guides in the car en-route to pilot testing. Since the CFGD guide was similar to the guides used for focus groups conducted in the past, the team felt relatively comfortable with it. The CFGD guide was piloted with a mixed group of men and women in a neighboring kebele although for official research purposes the guide would be used only in gender segregated groups.

The IDI was also piloted on the fifth day of training in kebeles in which we were conducting research. Feedback was given on the pilot interview and formal IDIs began

shortly after. Pilot tests were conducted with all guides in West Hararghe which enabled the research team to discuss logistical problems such as how to draw and label the maps and how to make seating arrangements. The pilot tests also allowed the research team to fully practice with the guides. The quality of the interviews, however, was difficult to assess. Because of time constraints the pilot interviews were not translated or transcribed and thus not fully reviewed prior to continuing with data collection. This was unfortunate because after the interviews were transcribed, it became clear that more practice with and constructive feedback about interview skills had been needed. Though full transcripts would have provided more concrete examples of areas to work on, the program supervisor did listen to segments of a selection of audio recordings after the first few interviews and gave helpful feedback.

East Hararghe

The second training was conducted in East Hararghe after the first set of interviews were completed in West Hararghe. The major difficulties in the first phase of interviews in West Hararghe had involved confusion about the interview guides and about the interview processes, especially probing. Taking what was learned from the first round of interviews and determined to avoid the jumbled nature of the first training, the researchers attempted to make the second training more structured and focused by setting a clear time schedule and allowing more time for practice and discussions about probing. Since the interview guides were already translated, there was more time to do practice activities. The researchers also split up the group of interviewers so each group

could focus on just one research project. This was designed to prevent interviewers from getting confused about the slightly different methods required for each project. Within each group, moreover, female interviewers only practiced the IDI guide and the male interviewers only practiced the SM and community CFGD guides. A three day training was conducted with six staff members: the program supervisor, the East Hararghe site manager, two male CFs and two female CFs. Members of the CI Project research team sat in for parts of the training as well.

In the previous round of interviews an introduction was not formally included in the written guides as the interviewers felt they could remember what to include in their introductions. However, during data collection in West Hararghe, it was sometimes unclear whether interviewers remembered the full list of points to cover. Thus, prior to the second round of interviews in East Hararghe an introduction checklist was developed so that interviewers could make sure they included every part of the introduction.

Day 1: The East Hararghe research team was given an introduction to and overview of the purpose of research and the different types of guides. A few errors that were identified in some of the guides were fixed and new copies were printed and distributed. An introduction checklist was also included in the new guides. The introduction checklist included the following:

Introduction Checklist

1. **Thank you for coming**

2. **Introductions**: Introduce self, note taker and other research team
3. **Purpose**: "We would like to understand the social and family planning needs of W/D women in Hararghe and their experiences with the CARE RI program. We hope that by understanding these needs that we can develop better programs for them and their communities in the future."

4. **Consent**:
   -voluntary
   -confidential, won't use any names in our research documents
   - can skip any questions if they don't feel comfortable

5. **Permission to Audio record**: We don't want to miss anything in our discussion today so we would like to record it. Is this ok?

6. **Turn on audio recorder**

7. **Expectations**:
   -we are most interested in what you have to say, please share what you think is important
   -there are no right or wrong answers
   -our feelings won't be hurt, please share your honest opinion

   FGD Expectations:
   -we are interested in all different opinions
   -please respect each other and keep what you hear in the discussion confidential
   -please try to speak one at a time so that we can hear you on the audio recorder

8. **Any questions before we begin**?

The whole team then reviewed the IDI guide and the two female interviewers practiced interviewing each other through role play and received feedback from other team members and the researcher.

Day 2: On the second day the research team reviewed and practiced the SM guide. The two male CFs and the program manager took turns leading the SM activity while the

rest of the group role played WDW. Then the group went over the interview process (as listed above in the West Hararghe training) and brainstormed interviewing skills.

Probing Activity: Since probing had been a particularly difficult part of interviewing in West Hararghe, more of the East Hararghe training focused on probing techniques and practice. The group first brainstormed different ways to probe. Then, using an excerpt of a transcript that lacked probing, the group identified areas that could be probed more and discussed what types of probes would have been helpful. The researcher and supervisor also role played good probing technique. Interviewers were encouraged to think about what kinds of probes they could use and then were asked to try them out during practice.

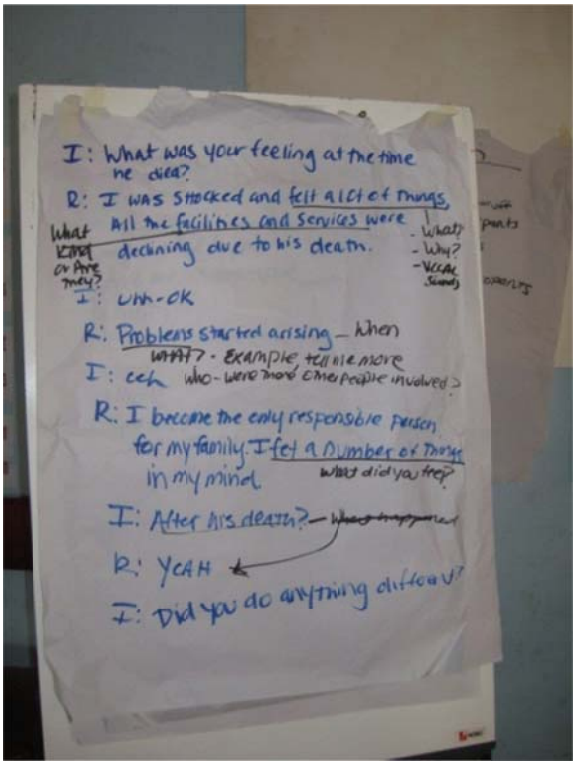

Figure 6: Probing Activity, East Hararghe Training

Day 3: On the final day of training the research team reviewed the Community FGD guide and the male interviewers practiced the guide and pile sorting with feedback from the rest of the group.

While the East Hararghe training had more time for practice and discussion of probing, it was still unclear to what degree the interviewers understood the process they were involved in. Some participated much more than others in the training, perhaps due to comfort level with English or general shyness. The degree of participation may (or may not have been) influential in their interviewing abilities.

In both East and West Hararghe, language barriers were somewhat of an issue for both training and practicing. Since the trainings were conducted mainly in English by the researchers it was also necessary for the project supervisor to step in and translate occasionally which was helpful for clarification. However, the language barrier also made it difficult to monitor what was being translated by the supervisor, the degree to which the training was understood, and the progress of the research team's interviewing skills. All interviews, including practice and pilots were conducted in Oromifa. The feedback that was given by other team members during practice was minimal. Most of the researcher's feedback had to do with reminding them to maintain eye contact and with asking them if they did the full introduction. The researcher also encouraged them to keep probing.

Monitoring the degree to which interviewers felt comfortable with their tasks was complicated by their general enthusiasm for the project and perhaps by a cultural hesitancy to say that they didn't understand something.

Recruitment

After training was completed formal interviews were scheduled in the targeted kebeles and participants were recruited. Interviews were conducted in two Woredas in both West and East Hararghe. More interviews were conducted in West Hararghe than in East Hararghe as West Hararghe was the base for research and encompassed more of the kebeles in the RI program. A total of twenty-three interviews were conducted overall, though not all interviews were used for analysis due to transcription difficulties.

Table 3: Interview Types Across Field Sites

Interview Type	West Hararghe	East Hararghe
CARE Staff	2	-
IDI		
Widowed	3	1
Divorced	3	3
Non-RI Divorced	-	1
Social Mapping		
Widowed	2	1
Divorced	2	1
Community Focus Groups		
Women	1	1
Men	1	1
Total*	14	9

*A total of 15 interviews were used in final analysis

Target kebeles were identified by the CARE RI program manager based on ease of access, proximity to a non-RI program kebele for simultaneous data collection for another research project, and size of WDW population. Interview participants were

identified by key informants, usually either the CARE community facilitator or the HEW assigned to the kebele. This was potentially problematic as it could have affected who was recruited and how participants responded to questions (see Limitations for further discussion, p. 110). While the potential for bias was present in this selection process it provided the simplest way to identify participants in the program because of the lack of a formal registry of program participants. These key informants were much more able to identify who was active in the program and who had enough social clout within the community to successfully encourage people to participate in these interviews.

Data Collection

Interviewees were often assembled at a central meeting place, usually near the kebele administration building, the morning of the scheduled interviews. The research team would arrive, greet the participants, and explain the purpose of the research then take interviewees for IDIs and group interviews. We explained the purpose of the interviews in the following way: "*We would like to understand the social and family planning needs of widowed and divorced women (like you) in Hararghe and your experiences with the CARE RI program. We hope that by understanding these needs we can develop better programs for you and your communities in the future*." Efforts were made to find private locations for conducting interviews but this was often challenging. Interview locations included health posts, school rooms, open fields, private homes and open shelters, which although initially uninhabited were often subject to passersby from the community or invaded by groups of young children. Those present in the interview

included the participants, the interviewer, a note taker and most often the researcher. Interviews were conducted mainly in Oromifa (two were conducted in Amharic) by the trained interviewer and ranged in length from 25 to 60 minutes.

Figure 7: Social Mapping Activity, East Hararghe

Before the start of the interview, participants were informed about the purpose of the research and their rights as participants, including the right to stop the interview at any time and to skip any questions they felt uncomfortable answering. Because of low literacy rates in the population, participants were read the information aloud by the interviewer and consent was obtained verbally. Participants were asked for their permission to be interviewed and also to be audio recorded. Participants were also encouraged to speak freely and to ask any questions they might have.

Following each interview, the interview team (interviewer, note taker and researcher) held a debriefing session to discuss the main themes that came up during the interview as well as any logistical issues that arose. Constructive feedback was given to both the interviewer and the note taker on interviewing skills during the debriefing sessions.

Often feedback included discussion about ways to probe further, engage the participant, and develop better interviewing skills such as:

- making sure that the interview was not interrupted
- making eye contact and active listening during interview
- not interrupting participants

It was unclear how much feedback the interviewers understood during debriefings because some of the same difficulties continued to reappear.

The data collection process had a few challenges as well, mainly relating to note taker roles, interviewing skills, and confusion about guides. During early interviews there was often confusion about the note-taker's role. This generated a lot of discussion between the note taker and the interviewer and might have interrupted the flow of interviews and the development of rapport with the participant. Note-takers were confused about the degree of detail they needed to include in taking notes and would often try to stop the interview or get the participant to repeat what they said. This was disruptive and not the intent of the interview style. This confusion was resolved by clarifying that the note-takers should try to take down as much information as possible but that their main purpose was to serve a backup in case the audio recording failed. After the first few interviews, note takers settled into their role. Once these clarifications took place, the interviews flowed much more smoothly.

As interviews were transcribed, it became apparent that there had still been some lapses in interviewing skills and in understanding of the guides. As noted earlier,

probing during the interview process proved to be a challenge. Often interviewers would miss important opportunities to probe such as when a respondent would say something like “after the death of my husband I felt many things” The interviewer would move on to the next question instead of asking what things the participant felt. Or a participant would say “it is forbidden to use FP” and the interviewer would not ask why or how so? Problems with probing may also have been tied to cultural concerns. Interviewers might have thought answers were implied or might have felt it inappropriate to ask further questions on certain topics or to even to ask too many questions of someone in general.

Interviewers also had some confusion about the interview guides. For example, interviewers would sometimes forget to guide the participants to talk about the differences between past or present and the timing of experiences would get jumbled. It was also unclear to what degree interviewers understood the impetus behind some of the questions. This was reflected in their responses to the way participants sometimes answered questions. For example, if a participant answered a question in a way that they had not anticipated interviewers sometimes struggled and would try to ask the question again in a different way to get the answer they had anticipated.

These challenges were most likely due to lack of time to fully practice and discuss the interview guides and to language and cultural barriers. If interviewers had had more time to practice and if pilot tests could have been translated before proceeding with the next interviews, more constructive feedback could have been given. Nonetheless,

interviewers improved with practice and the process was consistently refined throughout data collection.

Data Management & Transcription

Interviews were documented both with an audio recording device, a note taker and the debriefing notes of the researcher post-interview. All interview recordings were stored on a password protected computer and deleted from the recording device once uploaded.

Due to limited time and budget the transcription and translation process was more difficult than anticipated. Fluent English and Oromifa speakers were difficult to identify. Those who were proficient in English were often professionals who were busy and who had high expectations for compensation. This may have been further complicated by the perception that the research study was being conducted by a foreigner and was associated with a large NGO and thus must have a large budget (which was unfortunately not the case). Several attempts to negotiate with potential transcribers fell through because of price negotiations and this resulted in lost time.

Difficulty in securing transcribers ultimately necessitated some creativity and the use of several methods to transcribe the interview audio recordings. Interviews were mostly transcribed by either CARE staff or an external transcriber fluent in Oromifa and English using traditional methods: the transcriber would create a verbatim transcription from the audio file in the original language (Oromifa) and then translate the transcript into English. However, due to time constraints some interviews were verbally translated and

simultaneously transcribed by the researcher. Verbal transcription was less than ideal as the interviews were not transcribed verbatim and were subject to both the translator's and the researcher's interpretation. Additionally some interviews were not translated at all due to time constraints and to poor sound quality.. A total of 15 interviews were ultimately transcribed.

Analysis

Qualitative analysis of the interviews took place between February and March 2012. All transcribed interviews were analyzed using MaxQDA analysis software. In addition to the interviews, notebooks from research assistants and the researcher's field notes were used to supplement interview materials. All materials were read and detailed memos were produced which included overarching themes, and questions and reflections about the data. Codes were then developed, and a detailed codebook was produced consisting of both deductive and inductive codes. Deductive codes included things like economic support, social support, health service and family planning. These codes were also divided into sub-codes which took into account discussion about these issues in the past (before the CARE program) and in the present (after the CARE program). Codes that were unclear were placed into the general code section.

Inductive codes were developed to describe thematic trends that came out of the data which were repeated throughout and across interviews. A codebook was produced with inclusion and exclusion criteria for each code, and the sub-codes which were included under parent codes.

In total there were 27 parent codes and 35 sub-codes which were applied across all three types of interview documents. Documents were coded and read through several times to fully develop themes. Codes were compared across different interview types and compared and categorized to understand relationships between codes. Cross-cutting themes such as sexuality and fear were explored and compared across other codes to develop understandings of their relations and ultimately their effects on other codes.

Results

Challenges in the Past

WDW's Sexuality

Widowhood and divorce meant changed community perceptions of WDW's sexuality. When women separated from men through widowhood or divorce, their sexuality received new emphasis and was constructed as uncontrolled, unpredictable, and threatening to the community. WDW's sexuality, in short, became something which must be monitored or reigned in. In a community focus group, for example, one married woman stated: "*A WDW has more sexual desire"* (*Married Woman, East Hararghe*). Other community focus group discussions on the topic of WDW's sexuality, often included the question of 'who' the WDW would be having sex with. The assumption was that women without men were desperate to find new men and would use their wiles to do so. Thus, in many interviews WDW talked about how they were suspected, or feared being suspected, of "looking for men" or "looking for a new husband." Women who kept themselves dressed well or were too clean were often accused of trying to "look for men" by making themselves pretty. This increased attention to WDW's sexuality was especially stigmatizing because of the taboos attached to sex outside of marriage for women. This sex was often referred to in interviews, as 'illegal sex' (which may be partly a function of translation, but it implied that sex outside of marriage was against cultural and religious custom and was extremely shameful in the community.) Sex outside of marriage was also described as something that was carried on in secret and at night.

In the past, communities were especially vigilant about WDW's relations with married men. Wearing new clothes, for example, could induce suspicion of association with someone else's husband: **"***Yes, when the divorced women have cleaned and dressed well they suspected us as we look for others husband"* (*Divorced Women, West Hararghe*). While some wives were said not to trust their husbands with WDW, it was most often the case that WDW were blamed for attempts at seduction. WDW repeatedly described the community's suspicion that they would have relations with another woman's husband, often saying things like "his wife might suspect you" or they would think you were trying to "take her husband."

Community Stigma

This notion that WDW's sexuality was unpredictable and uncontrolled was seen as threatening to the community and resulted in increased stigma with regard to WDW. The general community attitude toward WDW in the past was perceived to be negative by the WDW themselves, *"They don't like me, even when I say good morning nobody responds"* (*Divorced Woman, West Hararghe*). WDW were shamed by names like '*harmella*' which was a negative term referring to a widowed or divorced woman: "*We did not have any social support we are that time nominated as bad name called harmala/ naashida "(Widows, East Hararghe)* This term did not have an exact definition, but it had a negative connotation and referred to a woman who was no longer under the control of her husband and made decisions on her own. That the community had no positive terms with which to describe a widowed or divorced woman indicated the

stigma and negative attitudes WDW faced. The theme of shame and stigma occurred throughout the women's interviews but it was most strongly associated with issues relating to sexuality and family planning.

Pregnancy

Unwanted pregnancy was the ultimate shame for WDW because it constituted proof of sexual activity. Women spoke of their fear of unwanted pregnancy throughout the interviews. When women were asked what would happen if a WDW became pregnant they responded that it would be a very big problem. Women with unwanted pregnancies would often be insulted by the community and even by their families. If they gave birth, the children would be insulted as well and called '*dikala*' (bastard) or by the mother's name: *"People insult her as sexy women and talked where are she bring from, she has no husband." (Widow, West Hararghe)*

Unplanned and unwanted pregnancies resulted in several other consequences for WDW as well. Many women said that women with unwanted pregnancies would become poor as a result. Others associated pregnancy (and extramarital sex) with disease.

"*She becomes poor, she put herself in poverty, no one can support her, she has her child and her child is also exposed to problem, no one sees her and her children, even when they are sick no one supports them, even she may get disease from the sex she did*" (*Divorced Woman, East Hararghe*)

Unwanted pregnancy ultimately resulted in social alienation for WDW. Many women said that a pregnant WDW would lose social support and would experience a great deal of shame from all parts of the community.

"Where are she move her parents even hate her, she are looked as bitch (dog)." (Widow, East Hararghe)

"She will be ashamed. There are some who kills themselves. If she doesn't have a husband how could she get pregnant? It's a shame." (Divorced Woman, West Hararghe)

The community's desire to know who impregnated the woman or where the child came from was also a theme that came up frequently.

"*That is a shame. She stay in her home, she will never come out of her house because she fears that she may be asked to tell from where she got pregnant."* (WIDOW, EAST HARARGHE)

"Nobody can support me as it [pregnancy in WDW] is not good in our culture. Even if she face a problem, she wait all her problem alone, no one supports her. If she gives birth, the baby's father may be looked for and then the community may make them to join together. Otherwise if the father is not known she waits the entire problem herself without any support. "(Divorced Woman, West Hararghe)

Unwanted pregnancy often meant exile, attempted abortion or even death. Facing social exclusion, a WDW might attempt to leave her kebele. She might also try to get rid of the baby by taking drugs, poisons, going to a midwife or by throwing the baby down a gorge. She might even kill herself if she felt she had shamed herself and her family.

"*She may disappear from the area. She may die. She is unable to live well."* (Divorced Woman, East Hararghe)

"*Previously she either take local drug and killed herself or goes to distant areas to get birth by lying to others as if she had been fired by husband due to disagreement or might even throw the child in a bush*" (Widowed Women, West Hararghe)

Fear

Fear was also a major theme throughout the interviews, and one major source of women's fear was the stigma they faced in their communities. Women were afraid to interact with men lest they be suspected of seducing them or inviting unwanted sexual

advances. Sitting with men, talking to men or laughing with men were seen to be invitations for more: "*If I laugh with a man, he would come to my home that night."* (Widowed Women, West Hararghe).

Past Support Systems

The stigma attached to WDW's sexuality and their subsequent fear of community sanctions had great impact on their support systems and ultimately on their overall well-being. Women were asked about their support in the past (three years ago) before they began participating in CARE's RI program and many said they faced challenges and suffered greatly after separation from their husbands. There was little difference between widows and divorced women with respect to this issue. Separation from a man had direct impact on women's ability to access many forms of support. Interviews focused on three key sources of support which contributed to the overall well-being of a woman: economic support, social support and health care. Economic support is defined here as women's ability to support themselves and their family through material or other means; social support is the ability to rely on others for psychological and emotional validation. It also includes help in negotiating social issues and solving problems, including legal ones. Health care means help in maintaining physical well-being and in recovering from illness. "Family planning" or contraceptive use while tied to health care is treated as a separate category, so as to facilitate understanding of WDW's the sexual and reproductive health needs.

Economic

Economic support or the ability to provide for oneself and one's family was the most frequently discussed support system and the most vital one in women's minds. Economic and material support systems were also the most tangible forms of support and thus may have been easier to discuss. As previously stated, in East and West Hararghe the main forms of economic support were farming crops, animal husbandry and marketing. Most rural women relied on their husband's farming and pastoralist activities to generate income and feed their family, although some participated in marketing by selling vegetables, chat[1], coffee or spices.

When a woman was divorced she had to leave her husband's home and the resources which accompanied it. Many of the women interviewed returned to a family member's house but some women had no place to go. One woman told of having to sleep outside until her children could help her build her own house. WDW were often forced to leave all the resources that the marriage provided including farmland, crops, animals and other kinds of property. They were often unable to repossess shared resources and had to start over again with nothing. According to one divorced woman in West Hararghe,

"*Because he hurt me and I returned to my parents I feel very sad because I am back with my children so I feel very much. He didn't give me any support when I left his home. Because I left my resources, especially chat, which we got a lot of money from to fulfill our needs, I am currently independently supporting all my children. Even I can't go to court to get a share of the resources." (Divorced Woman, West Hararghe)*

[1] Chat is a plant which is cultivated for its stimulating properties. The waxy green leaves are chewed recreationally by the majority of the population. The Hararghe zone is the heart of chat growing country and chat is fast replacing other vital crops because of the huge market and demand.

WDW were especially worried about their lack of resources when it came to supporting and caring for their children. The burden of providing for children and managing their education fell solely on the mother:

"If I was with my husband, my husband had different roles for my children especially to buy clothes to send them to school. But now since I am alone, I do all these activities, I am the only person to buy clothes for my children and to send them to school, to do everything for my children. My children ask me for everything that they want that is why I am working hard to answer their requests."(Divorced Woman, West Hararghe)

Women found ways to stretch resources, but most worried about finding additional forms of support to care for their children. They often spoke about 'working hard' to fulfill their children's needs.

In the past, WDW relied on a variety of means to support themselves and their children including farming, though this was extremely difficult on their own. A WDW's economic hardship was further exacerbated by their frequent inability to get credit and establish themselves as independent economic beings.

"In the last three years I have faced some problems because I am not living with my husband, I faced problems, especially to get a loan, I have no resources, no one will lend me money because they fear I will not be able to repay the loan. The money lenders say if you lose the money we give you, how can you return it because you live alone and don't have a husband and don't resources, how can you pay back the money?" ('Divorced Woman, West Hararghe')

The lack of association with a man meant that they were unable to get credit from lenders who felt they had no way of ensuring that the women would repay their debts. Some women said they were able to find ways to get credit including begging wealthy people for loans or extra grain.

Though many women able to own some farmland, they were often unable to make use of that resource. Farming is physically demanding, and often required the help of others to harvest and plant crops. In these communities the practice of '*gusa*' was a socially organized way to overcome this difficulty. Individuals or families could traditionally 'beg *gusa*' from other community members, neighbors or family, which meant they sought support with farming activities. The societal expectation was that these community members would then assist the individual in need and some kind of reciprocity would be developed.

Fear of WDW's sexuality and potential for husband-stealing, however, often prevented WDW from relying on this system though they were often the ones who were most in need of it. Both widows and divorced women told painful stories of seeking assistance from neighbors, family members and community members and being denied or even met with violence. A widow in East Hararghe recounted her experiences with asking for help on her farm after the death of her husband: "*When I ask his relatives and my neighbors to help me on my farm some of them help me and the others hit and abuse those who helped me. They fear to assist me. If I ask them again to help me on my farm, their wives suspect me, then they target to hit and destroy my house" (Widow, East Hararghe).*

Actions like these reinforced WDW's fears of even asking for help or associating with men in general:

"If their husband come to help me with anything around the house, then their wives wouldn't let them in, they don't trust them. I bought my own land but couldn't hire anyone to do it I was scared." (Divorced Woman, West Hararghe)

Some women displayed great strength and determination in handling these difficulties. A divorced woman in East Hararghe told of asking her relative for help on her farm. He agreed to help her but when his wife heard about it she made a fuss and accused him of having other intentions. The man then agreed not to help the divorced woman and she was left to attempt the farming on her own: "*Then I get disappointed, if he refused to help me who is going to force him. How could he say like this [. . .] I went to farm with my son then sow the grains through my son is ten years old he helped me to sow all the grain…we finished by ourself what we could have done with the guy and get a fruitful result." (*Divorced Woman, East Hararghe) Although, in the end, the woman was able to plant the field, she expressed regret over what she could have accomplished if she had had the help of others.

Given the difficulties of farming, WDW often had to resort to marketing activities to support themselves. Once again, however, sexual stigma got in the way. Getting to markets outside their *kebele* required walking a few hours both to and from their destination. To fully participate in marketing women often had to travel back home at night. Since travelling at night was often associated with sneaking around to do sexual things, sexual stigma often limited WDW's marketing activities. Women feared the community would suspect them of seeing men in secret. WDW, therefore, were cut off from the material resources they had had as married women and were further restricted in efforts to support themselves by the community's uneasiness about their sexuality.

Social

Women received social support through a variety of means-- by discussing their problems with friends and family, by attending community events such as meetings, weddings, funerals, and by seeking administrative or legal assistance through leaders. Separation from a husband had direct impact on WDW's social support in that the women lost connection to and the protection of the man's extended family. But, the stigma attached to the sexuality of WDWs resulted in greater social isolation and lack of support:

"While he was alive I had a respect from all side, but after his death everybody looks me as if a women without a husband and that was why I feel a lot about respect." (Widow, West Hararghe)

"As we have no husband we had no one to discuss with, we were bothered alone." (Divorced Women, West Hararghe)

WDW noted that other community members, especially other women didn't like them and refused to talk with them. Their fear of this social stigma made them afraid to interact with others, and especially men.

"They don't like me; they think I will steal their husband. If I have a new clothe I can't make myself wear it in public, I will be so scared because they might think it's a gift from one of their husband. They tell me too, directly. They tell me why can't you return back to your husband. If I pass by them I won't even look their way, and if any of their husband are around and the husband say something to me, then I know I am in trouble with the wives." (*Divorced Woman, West Hararghe*)

"*But as I had no husband and I keep myself and my clothes clean, I fear the community, I don't want to visit anybody's house because they may suspect that I may take her husband. That is why I separate myself for a moment" (Divorced Woman, West Hararghe)*

"In that time we could only protect ourselves by going home early, not reaching where men sit, and being serious at men." (Widowed Women, West Hararghe)

Many women were afraid to attend community meetings and funerals and were hesitant to participate in social activities like chewing chat. In focus group discussions community members, and especially men, often attributed this hesitancy to the WDW's own fear and not to community pressure.

"Previously those W/D women not participated on the public meeting, even not come to funeral and other community events" (Married Men, East Hararghe)

"*Previously they were afraid of any one who wanted to give them 'chat' for chewing, they would send a small child to bring it to them because she had a fear of other women who might see her talking to a man; she had been covering her face when she go to funeral ceremonies and came back without talking to any woman*" (Married Men, East Hararghe)

"Even we are afraid of going there for talk, we don't ask for chat. We simply pass by them without talking to them" (Widow, East Hararghe).

Social gatherings weren't the only form of support WDW lost. Some WDW were unable to access legal support from kebele leaders.

"*We couldn't even go to kebeles administration head because their wife come and ask why we went to kebele leaders and other community not considers as positive our communication especially with men."* (*Divorced Women, West Hararghe*)

Though some women did report receiving support from friends or family members if they were young, the majority felt very unsupported by the larger community. The lack of social support for these women resulted in a much more isolated and less engaged life than they had had while married. In both interviews and reports from interviewers women mentioned not feeling fully human in the past: *"I don't go to meeting, I don't*

have any information about what the society is doing. I don't look like human being."

(Divorced Woman, East Hararghe)

Health

A woman's ability to access health care meant being able to go to a health post or health center in her kebele or a health center in a nearby town. In the past, before the HEW system was completely rolled out, rural women often had to make longer trips into nearby cities or towns to find health care. The ability to get care not only for themselves but also for their children, both to prevent illness through immunization and treat illness, was essential. The lack of a husband meant that women often had fewer resources and that paying for health services, especially for more serious health issues, was difficult to manage for WDW. Many women reported that in the past they had no money to go to the hospital.

"*I have never been ill in the past years, my children didn't have a headache, God has protected me, I often pray to God saying "Don't make me sick and my children, I have no money to go to Hospital" There is a saying that God hears "Harmallaa" because she is not with somebody she is close to God."* (Divorced Woman, East Hararghe)

"*I do nothing, I have no money to go to hospital. I suffered a lot at that time."* (Widow, East Hararghe)

WDW's access to health service, therefore, was limited by concrete financial barriers but, once again, it was also limited by the stigma attached to WDW's sexuality. Women reported being afraid that the community would 'whisper' or suspect that they were really going to the health service to seek family planning services or seek care for a

pregnancy which of course implied that they were sexually active. These suspicions and WDW's concern about them often prevented women from seeking health care at all.

"I do have a fear. If I go to hospital people say 'she got pregnant and go there to find pills" fearing that I don't go to hospital" (Divorced Woman, East Hararghe)

"Three years ago, we were protecting ourself from males, if we becomes sick we fear going to hospital" (Widowed Women, East Hararghe)

"In the past I am afraid of going to hospital fearing that they may say she prostituted and get pregnant." (Widowed Women, East Hararghe)

Women even reported avoiding HEWs for fear they might be suspected: *"I didn't responds to her (the HEW) if she called me because the community perceived as I used family planning."* (*Widowed Women, West Hararghe*)

Family Planning

Family planning use was not only stigmatized for WDW, it was also difficult to access. In the past, levels of awareness about family planning varied. Some women reported knowing about it but being unable to access it, while others said they had little knowledge of it. Since health posts were still being constructed, both lack of access to and knowledge about family planning were often related to the fact that health services were not available.

"R: As the level of awareness varies among us, those who had uncertainties would go to Debeso to get injectable FP. Later on its services reached here.
I: Did W/D women use FP that time?
R: Yes, those who had awareness. Most of us didn't know. Now we all learned its benefit to all and started to take FP." (Divorced Women, West Hararghe)

This quote tells us that while some women were able to travel to health posts and use family planning, the majority of women did not.

The stigma attached to their sexuality, however, made access to family planning even more difficult for WDW. The use of family planning by WDW was considered outright shameful in the community: "*Previously the community used to condemn those WDW who ever access FP service" (Married Women, West Hararghe).* Some WDW were hesitant to acknowledge any interest in using it.

"No one use it. As they had no husband what they served for." (*Widowed Women, East Hararghe)*

"I have no interest. If I have a husband I use it because I have no husband, how can I use it? This would be shameful in the community that is why I have no interest to use.'' (*Divorced Woman, West Hararghe*)

Since travelling long distances for health care could be dangerous, having male accompaniment was important. WDW did not have husbands to accompany them to health posts, and it was not acceptable for them to go alone. If WDW travelled to health posts without a companion, they could be suspected of being secretive about health services and it might be assumed that they were using family planning. If they asked a man to accompany them, getting such assistance was difficult and could rouse suspicions about their having sexual activity with the man in question.

"T*he W/D ones go alone and even no one knows why she goes to the health services (whether she goes for having contraceptive service or any other health service). For married one, she goes alone but they decide together with her spouse to use family planning service. Sometimes there might also happen that the married ones take contraceptives without letting know (hiding) their spouses. If someone accompanies widow/divorced ones, he might be suspected for having hidden sex partnership with her and as if they go for abortion. So no one dare to accompany WD women for sake of having contraceptive services. "(Married Men, West Hararghe)*

"I: Before the past three years, if your children get sick would you take them to hospital?"
P: [Sound] no, taking to hospital was dishonor" (Widowed Women, East Hararghe)

As this quote suggests, even taking children to the hospital on one's own was stigmatizing for WDW. Asking a male relative or a child for help them when they encountered health problems, was acceptable most of the time, but sometimes it was difficult to get assistance from male relatives, and this meant further suffering or even death:

"*No, no we were not travel alone [to health facilities] we called for someone from our relatives and they accompany us."* (*Widowed Women, West Hararghe*)

But sometimes it was difficult to get assistance from male relatives which meant further suffering or even death: *"If we ask men to take them to hospital most of the time they deny and they will pass (die) on our hands" (Widowed Women, East Hararghe*).

WDW dealt with this issue in different ways. Many did nothing and simply hoped that they and their children would not get sick. If they did get sick WDW might try to 'sleep off' the illness: *"When I get sick three years ago I fear going to hospital simply sleep in home for two weeks" (Divorced Woman, East Hararghe).*

Some women resorted to seeking services privately or secretly away from the clinic: "*Forget about family planning service, if I get a headache I will not go to hospital, I will send one of my children to buy headache tablet. I do have a fear. If I go to hospital people say 'she got pregnant and go there to find pills" fearing that I don't go to hospital"* (*Divorced Woman, East Hararghe*)

Finally, some women did voice a desire to use family planning in secret:

"Before the past 3 years I simply fear the society, no one calls me to a meeting, sometime I heard about family planning. After that we wished a doctor be our neighbor so that he can give us hiding it. At that time we thought that a doctor exposes our problem to others." (*Divorced Woman, East Hararghe*)

Most WDW, however, had little or no ability to take care of their health needs. Women were shamed out of accessing health services because they feared being accused of using family planning. Sexual health and family planning weren't even conceivable for most WDW. And it is not clear that they were able even to consider their own sexual desires.

Changes in the Present

After the CARE RI program began in 2009 WDW were assembled into discussion groups which met every two weeks to discuss issues relating to gender norms and family planning. Discussion groups would eventually present their discussion at community meetings to create dialogue around these issues. The WDW interviewed had all participated in the RI program and were at various stages of completing discussion groups. In the interviews and group discussions conducted for this study, WDW and community members discussed their present experiences and perceptions of community norms and the changes they had observed over the past three years. Once again, the most important theme had to do with perceptions of WDW's sexuality.

Community Perceptions of WDW's Sexuality

Community focus groups suggested that small shifts are occurring in perceptions of WDW's sexuality, though stigma still remains. Community FGDs, for example, included a pile sorting question about who could initiate sex (married, WDW, both, none). This question was often met with embarrassed laughter from community members, but they often agreed that both married women and WDW had sexual desires.

"R1: The w/d woman, as she a one who eats and drinks to have natural desire, initiates sex by making herself attractive to men. Whereas the married one has had her husband she waits for his request.

R2: I say both because, the married one similarly eats and drinks to have sexual desire so that she initiates sex. We heard from elders that whenever a married woman needs sex, she uses different signs like wearing head scarf tied in two sides of her neck. While the W/D one appears cleaner and attractive." (Married Men, East Hararghe)

A few community members viewed WDW's sexuality positively and as natural part of being human: *"I think the WD should use contraceptives as they might have sex partners" (Married Man, West Hararghe)*

Some participants, however, still felt that sexual activity on the part of WDW was shameful and against community norms. Some men in West Hararghe were very critical of WDW's sexual activity, maintaining that it was shameful or illegal: "*If she prefers to use and go for illegal sex she has a right to do so but, we don't appreciate this." (Married Man, West Hararghe*) Sexual activity among WDW was also still linked to the dangers of sexual disease: "*But, as to my view W/D should not go for sex even from the view point of HIV/AIDs protection."* (Married Man, West Hararghe)

Married women were also still concerned about who the WDW were sleeping with: *"NT – What do you say if you see the woman taking FP? R – We wonder with whom she is doing sex?" (Married Women, West Hararghe)* Some women in the same *kebele,* however, were more accepting: "*NT-Whom do W/D women initiate sex? R-Any W/D woman at the time of internal desire for sex look for someone and do*." Overall, positive and negative sentiments about WDW sexuality were entertained by men and women both and in both West and East Haraghe.

Family Planning (The Less Shameful Option)

Changing community perceptions about WDW's sexuality were tied to changing perceptions of family planning and unwanted pregnancy among WDW as a group. Many community members admitted that use of family planning by WDW was better than the more shameful outcome which was unwanted pregnancy. Some members of the community still did not approve of sexual activity for WDW, but they recognized that WDW might have 'uncertainties' or might be raped and felt the ability to protect themselves was important.

"No, it is immoral to insist WD women to use family planning." (Married Man, West Hararghe)

"R1– I think it is better for her to protect unlawful pregnancy.
R2– let's take our daughters, for example, whatever it is better than the shameful pregnancy.
I-- What is expected from that W/D woman to prevent pregnancy?
R3-- Besides those who are raped and faced unplanned pregnancy, she should be helped to get medical assistance." (Married Women, West Hararghe)

"*WD ones should have the right to practice safe sex to protect themselves from HIV/AIDs and unwanted pregnancy*." (Married Man, West Hararghe)

Community members who accepted sexual activity on the part of WDW as a natural occurrence were also in favor of WDW using family planning to prevent unwanted pregnancy and spoke about it in terms of its benefits to them.

"R1 – Say if a widow/divorce woman has boyfriend or being raped they can check themselves
R2 – previously the community used to condemn those W/D women who ever access FP service.
NT – So you are saying widow/divorced who have boyfriend?
R 1– Yes, for instance if she need to do that thing she can use FP" (Married Women, West Hararghe)

"I: what do you think of a W/D woman using FP?
R1: We think positive way. As she planned to live safe life.
R2: Her act is good because she might start relation with a man and they might have planned to marry each other soon. But human desires might not allow them to abstain and commit sex. The other is she decided not to have more orphans in her family by adding birth." (Married Men, East Hararghe)

<u>Pregnancy</u>

Though, on the whole, community attitudes towards pregnancy among WDW were still fairly negative, they were also starting to change. Community members did say that they would support a pregnant WDW and even help her. Interestingly, the male community members seemed to be more sympathetic to helping a pregnant WDW than the women.

"*But still for W/D FP is more important […] We married women have no community pressure or stigma to be pregnant or give birth, but W/D has think more for what the community say to them, suffering to participate day to day activities during pregnancy and what will be happen to her after she gave birth. Other thing also men cheat them in most case so FP is important for W/D women."* (Women, West Hararghe)

"You know Pregnancy comes from God, and pregnancy cause tiredness, so we support her." (Married Men, East Hararghe)

"*R, Any one makes mistake and get pregnant and this W/D woman has had orphan children of her former spouse, she has to go alone to be checked.*
I, Why does she go alone?
R', There is shame to be heard or seen in such situation." (Married Men, East Hararghe)

WDW's Perceptions

Sexuality

WDW's views about their own sexuality were less clear. Some WDW reported that they knew of other WDW in their community who were sexually active and using family planning. In a few communities women insisted that there were some WDW who were unafraid to make of their relations with a man public. Still, in no interview did WDW claim to be sexually active themselves, a strong suggestion of hesitation to assert sexual desires and/or freedoms.

"I: have you had sex after you got divorced?
R: no I haven't, I have been single, no one has come forward, I live in the middle of my brothers.
I: aren't there other divorced women who have sex?
R: oh yes there are. Even in the community.
N: so they come at night, in the dark hiding so people don't see them.
R: no, they don't even hide they come in broad daylight." (Divorced Woman, West Hararghe)

I: so what does the community say?
R: they say things about them. They talk the same thing about me.

Although they themselves did not admit to having relationships, some women did say they would not advise other women to refrain from being sexually active:

"*I don't tell them to avoid men or to hold off their desires, I tell them protect themselves. Before I would never ask a man if I wanted to have sex, but now anytime I want I will ask. I have learned now, thanks to CARE. We used to be forced before but now that I have learned, I can have even more than he does."* (*Divorced Woman, West Hararghe*)

Family Planning

Views of family planning by WDW were also mixed. Some women maintained that they did not use family planning because it was still shameful in their community: *"I have no interest. If I have a husband I use it [FP] because I have no husband, how can I use it? This would be shameful in the community that is why I have no interest to use. If I have another husband, I use FP to have an interval because as I have no husband what is the use of FP?" ('Divorced Woman, West Hararghe')*

Some women said they knew other WDW who were openly having relationships with men and using family planning, and some reported that they felt much more comfortable accessing family planning services in the present, but as with community members, most WDW construed access to family planning as a mode of protecting themselves from the worst consequences of rape. The notion that WDW face 'uncertainties' such as rape came up time and again. *"It [FP] is good if it is not available we are exposed to different problems. As I am like a man I return to my home in the evening, around 4 or 5 hours, if I do not have FP methods, I may be exposed to different disease and I will also have unwanted pregnancy."* (Divorced Woman, East Hararghe) Since unwanted pregnancy was, and still is to some degree, the ultimate shame for WDW, family planning protected them against shame as well. Family planning,

therefore, was discussed in terms of protecting women from things beyond their control and was rarely openly discussed in terms of the women's voluntary sexual activities.

Rape

The dangers of being attacked or facing unwanted sexual advances have been a major issue for WDW both in the past and present. WDW often needed to travel long distances to markets in larger towns to sell their products. This frequently required that they travel by themselves and sometimes at night. Many women mentioned the fear that they would face male sexual advances along the way: "*You see, we are females we care because if somebody catch up we cannot challenge him, we do not know what may happen on the road. That is why we are afraid" (Widowed Women, East Hararghe*). This danger seemed almost to be a given part of life for WDW: "I *think the worst animals is human being, they may rape you since you are females he will make you as he likes he may even let you down and take away your donkey*."(Widowed Women, East Hararghe)

Sadly, women worried more about the outcome of the possible rape than about the act itself. When they discussed family planning as a way to protect themselves from rape they meant that family planning protected them from the worst outcome, which was pregnancy. Women reported using hormonal methods such as Depo injections, pills and to some extent insertables such as Implanon. Women also reported carrying condoms with them when they travelled back and forth to protect themselves from pregnancy and disease (usually HIV/AIDS).

"*Now there are so many problems you be exposed to whenever you move you may be forced to do sex so there are so many options to protect yourself from unwanted pregnancy and disease that you have to use like pills, needle, condom, all these are options for you. Because I face similar things, I advise like this, as I have already used. In order to maintain her not to fall back from her way of living (be poor). "*(*Divorced Woman, West Hararghe*)

The degree to which women thought of family planning as protective in the case of rape is of some concern and will be taken up in the discussion section.

"P1: You have to go by taking that thing (pill/EC)…as I think because if you get raped it will prevent unexpected pregnancy.
P2: In addition you are not in their hand they may hurt you seriously. But if you have that thing, nothing happens" (Divorced Women, West Hararghe)

The most popular form of family planning was Emergency Contraception (EC). Women were very excited to have learned about EC. The ability to prevent pregnancy after an unexpected sexual encounter was heartening to WDW. Women eagerly reported that their newly acquired knowledge that they could take the pill up to 72 hours after sex to prevent pregnancy.

"I have never taken pills so far, but she taught me that even if I am single I need to protect myself because I go many places, markets so I have to protect myself. I carry it with me and if anything happens I will take it. If it gets dark when am coming back from market the chances are I might get raped, so if that happens she has shown me how to take it so I take it (EC) immediately." (Divorced Woman, West Hararghe)

WDW really appreciated their new knowledge about and access to family planning. In discussing improvements in their life they often brought up family planning and the idea that they could protect themselves, and they related this protection to the CARE RI

program and what they had learned in their meetings.[2] WDW noted that learning about family planning and EC, in particular, was one of their favorite parts of the program.

"Yes I like that [FP] very much. I used to worry so much before, but now I am happy because I am alone now and if something happens to me this is how I will protect myself. [. . .]if something happens I would rather die. [. . .]I tell them, everyone looks or desires a single woman I tell them to protect themselves before anything happens. If something happens then you can use these things. I tell them, CARE has let us use these things to protect ourselves."

In responding to the question about what advice they would give to another woman who became widowed or divorced, many women responded that they would advise her to protect herself by using family planning as well.

"I*nitially we didn't communicate them (HEWs) even for other objectives as they perceive us for the use of family planning but now we are aware and convince others." (Divorced Women, West Hararghe)*

"*We have [FP] in our bags whenever we move from place to place and we also challenge to convince the complainers."* (Divorced Women, West Hararghe)

<u>Unwanted Pregnancy</u>

Many WDW felt that the situation with regard to unwanted pregnancy had changed. From their point of view community stigma relating to pregnancy had been reduced. Most WDW (and community members) also agreed that unwanted pregnancy was not as much of a problem because of the present improved access to family planning. WDW often said that unwanted pregnancy wouldn't even be an issue because of family planning: "*Now we are conscious and many things are changed so she is advised not get pregnancy. She wouldn't even get pregnant."* (*Widow, West Hararghe*)

[2] This may be highly influenced by the RI program's emphasis on family planning promotion. See limitations in the discussion session.

"*After the new project established a lot of work has been done. There is a rare case for a pregnancy to happen to who is separated from her husband."* (Divorced Woman, East Hararghe)

"Earlier she decided upon her soul not to live but now, after a lot of things available to us like pills, injections, and condom we are able to solve the problems" (Divorced Women, West Hararghe)

Attitudes toward the unwanted pregnancies that still occurred have also changed. In the past the community focused on finding the man who impregnated the woman and ensuring that he married or supported the WDW and her child. In our interviews there was a sense that while unwanted pregnancy was still shameful, pregnant WDW would be treated with empathy by the community or at least not ostracized as much.

"Nowadays, if she get pregnant and get birth of child without marriage, the community ask for the father and let him provide food and other things." (Widowed Women, West Hararghe)

<u>Abortion</u>

Women talked about abortion both in the context of past and present methods of dealing with unwanted pregnancy. In the past a WDW might attempt to abort by taking drugs or poison or by going to a local midwife. Stories of abortion in the past were often associated with negative outcomes, especially death: *"Three years back no FP service and has low awareness about FP, women not take FP at that time, some women when they got pregnant take drug that lead them different consequence for example in our community we know three divorced women died because of the drug they took to abort pregnancy"* (Widowed Women, East Hararghe). Women said that they could go to a midwife and ask her to 'rub' or 'massage' their belly with smooth stones: *"P1: Before*

three years she go to local midwife. P2: I go to local midwife and tell her that I want to abort and then she rubs me, and I will get rid of it" (Divorced Women, West Hararghe).

In the present many women said that abortion wouldn't happen as much because of the reduction in unwanted pregnancies. Other women presented abortion as an approved of option for women. Abortion was now medicalized and performed at a clinic or the hospital. Some women even knew about the gestational cut-off for abortion services: "*they go to Asebe, if its early enough less than three months or else it's hard to get it out. There are also some who died trying to get it out at a later stage of their pregnancy." (Divorced Woman, East Hararghe)*

Community members also spoke about abortion as preventative, but they preferred that WDW use family planning rather than risk an unsafe abortion. A married man in West Hararghe told the story of his sister who died while trying to abort. He regretted the loss and thought often of who the child would have turned out to be if it had lived.

WDW Support Systems in the Present

" In the past we were not of the society if we get sick we don't go to hospital those women who do not talk to us but now thanks to God they talk with us.[. . .]. She can go anywhere to look for work and get money. In the past years she do not go to get FP service. But now days she use FP and go anywhere without fearing if something happen to her, she will not fall in problem like the past." (*Divorced Woman, East Hararghe*)

WDW also experienced positive changes in their support systems after the CARE RI program began. Once again, these changes were related both to material factors and to changes in perceptions of their sexuality.

Economic

Women were most excited, for example, about the establishment of savings groups through which WDW could borrow money to help them with large expenses[3]. Savings groups had impact on all aspects of WDW's well-being. Not only were savings groups helpful for economic purposes, they also provided social support (problem solving) and support for unexpected health expenses.

"*I go to the saving group members and tell them the problem I have faced to discuss upon it and they give me a solution*." (*Divorced Woman, West Hararghe*)

"We put money together and use it turn by turn. We support each other, since we got this education. Before nobody cares about you, but now if you get sick they help you to get to a medical facility they may take you there. There has been so many changes." (Divorced Woman, West Hararghe)

As the community was now less suspicious of their sexuality, women also reported that community and family members were more willing to assist them with farming activities than before.

"*The changes I get is, I have a farm of chat before three years no one buys the chat from me, I do not sell it properly those who buy and trade chat fear society to come to my farm. But after the past 3 years I use my farm as I like, I collect it by labor workers and fix a price so that when the buyer comes I sell and generate more in-come than those who have husband."* (Divorced Woman, East Hararghe)

"*But now after we have an awareness I even go to everybody's house and ask for support for farm activities 'gusa'. Even when I ask for support, nobody is absent, everyone supports me on farm activities*." (*Divorced Woman, West Hararghe*)

[3] Village Savings and Loan Association (VSLA) groups were not part of the RI program per se but were being implemented by CARE at the same time. The RI program recognized that WDW were being left out of savings groups and thus promoted developing savings groups which WDW could also participate in.

WDW were also able to go to men in the village for support without fear. Some women attributed this to the availability of family planning:

"R: nowadays I can go to all brothers (men in the village) even at night time.
I: what made this change?
R: Expansion of FP services any one can take. This means if I ask any male for labor support, I am not worried and he also thinks the availability of FP services so that no shame thing will occur." (Widowed Women, West Hararghe)

Social

To some extent women reported that the community was more accepting of them and was no longer as stigmatizing of them and their sexuality as in the past: "*After the past years, they invite me to participate on meeting, I go and participate. When I go there, I recognized society has learnt a lot and changed and then I started going to the meeting. I become better; we also started helping each other…and continues to participate*." (Divorced Woman, East Hararghe)

A widow in West Hararghe said that after participating in community discussions (most likely organized by the RI program) they were no longer afraid to interact with the community.

"P-After the discussion there is no fear of any things and we talk equally.
I-Do you have gets support from the community?
P-They supports us.
I-Are they suspect you now as before?
P-No suspect ion we get relief after discussion." (Widow, West Hararghe)

More importantly WDW did not feel as afraid of the community and felt confident about speaking to others and attending social gatherings and community meetings: "*In*

the past before I was involved in the program I was afraid of talking with someone but now I will say anything I like and talk to whom I want [. . .] My social life has completely changed in all areas, when I go place to place I don't fear sitting with men." (Divorced Woman, East Hararghe)

Some women reported however that they still did have issues with the community and were afraid to interact with them: "*To some extent I fear. It's my son who participate actively in social affairs and I still have a fear*." (Widow, East Hararghe)

Upon completing a focus group discussion, widows also commented that we (our research team and possibly me in particular) had come to talk to them because we were helping to 'fight their enemies.' This seemed to suggest that things were still problematic for them but that they felt they had more social status.

Since participating in the RI program discussions and in savings groups, WDW also have begun to support each other.

"I have discussed my problems with similar women to me, we have discussed what and how to do work activities and live together we fear to move alone everywhere." (Divorced Women, West Hararghe)

"*We other women who don't have husbands, live together and organize because CARE made us aware. No problems now we are happy to support each other. I participate in others' activities and they also participate in my activities*."

Thus WDW's support from the community was growing as was their confidence to ask others for help and to participate in social events. Additionally, WDW's own sense of support from other women like themselves had increased.

Health

WDW were able to access health service more easily as well. To some extent this change had to do with infrastructure and with women's greater economic independence. But to some extent it had to do with changes in the way the community and WDW perceived of their sexuality. Changes in health care infrastructure enabled WDW to access service in their kebele and to avoid travelling long distances: *"So much change, the health center is right at our door. If we feel sick or get a headache we get treatment fast." (Divorced Woman, West Hararghe*)

Accessing health care was also facilitated by women's own economic independence and success. Since participating in savings groups, women trying to get credit were no longer constrained by the fact that they lacked a husband. Thus they could get funds to pay for health services:

"Concerning health if I get sick or my children get sick. We have a saving association from there I will get money and take them to hospital. When I borrowed money from the association it is non-interest bearing. Since we have no husband, no one lend us. If my children get sick I will take them to hospital, but when I get sick three years ago I fear going to hospital simply sleep in home for two weeks, but now if I want I can go anywhere else I like. If I need to go I can move without asking permission." (*Divorced Woman, West Hararghe*)

But because of changes in the way the community and WDW perceived of WDW's sexuality, WDW also felt more confident about accessing health services (and family planning). They could now do so freely and without fear.

"But now after we learned about our right we are not afraid of going to hospital we also take our children to hospital" (Widowed Women, East Hararghe)

"*I go there and take medicines it can also be injection. In addition if my children get sick with money I have I will take them to hospital without fearing anybody*." (*Divorced Woman, West Hararghe*)

How WDW Conceptualize Change

"*The former was a time of darkness and we got light now"* (Widowed Women, West Hararghe)

On the whole WDW felt that there had been positive changes in their lives over the past three years. When first asked about the changes they had observed, WDW most often spoke of their economic status and of the education they had received. WDW framed these changes in specific ways in terms of: confidence, knowledge and equality. Ultimately they credited the efforts of CARE and of the government.

Confidence: "*Now we are not afraid*"

Having confidence was very important for WDW. The phrase "*now I do not have a fear"* was repeated throughout interviews when discussing the changes WDW had experienced. Women felt unafraid of asking others for help on their farm or interacting with others in community gatherings: "*It was so hard to ask for support of labor as his wife might suspect you. [. . .]But now we have self-confidence and do not be afraid."* (Widowed Women, West Hararghe) Their fear of travelling back and forth had also decreased and they were able to profit more economically: "*Now days my fear has disappeared, I oftenly go to town to buy and sell commodity" (Widow, East Hararghe).*

Women were unafraid to go to the health post and even to use family planning.

"Yes three years ago we fear to use family planning but now we don't" (*Widowed Women, East Hararghe*)

But before I was trained I didn't approach the extension workers and even asks her a salutation. I didn't responds to her if she called me because the community perceived as I used family planning. Now after the training we are convinced and live with them without any fear. (Divorced Women, West Hararghe)

Knowledge: "N*ow we are aware*"

Women often attributed this confidence and change to having knowledge. WDW spoke about the present with phrases like "n*ow we are conscious*" or "*now we are aware*." The awareness mostly given by CARE as well as by government HEWs influenced both the women themselves and the community. Women attributed community tolerance to education: "*But now with this education we have [. . .] the wives don't mind anymore." (Divorced Woman, West Hararghe)* Education also resulted in more social support: "*Yes I have people to talk to, before I couldn't because I was scared. And they are also very supportive thanks to this education we received."* (*Divorced Woman, West Hararghe*). Knowledge of family planning was also quite powerful for WDW, especially in preventing unwanted pregnancy. In discussing ways to prevent pregnancy they felt able to solve the 'problem': "*Now after we are educated if she get problem she knows how to solve. We have learned a lot." (Widowed Women, East Hararghe)*

"*Because there is this education now, they might go to take the needle, or they may get abortion*." (*Divorced Woman, West Hararghe)*

Women were helping each other to learn more and often spoke of advising each other: "*We began to get advice from others, previously we were not educated that is why we*

faced different problems, but now we advise our children and each other." (Widow, East Hararghe)

Rights and Equality: "N*ow all are equal*"

The theme of women being equal and having rights was very important for WDW. WDW felt that now they knew men and women were equal and that WDW were equal with the rest of society, and they felt such knowledge allowed them to take part in society more fully than before. Equality meant that they could attend meetings and participate, and this further enabled them to discuss things with the community.

"*People become conscious because of participating on different community meetings and discussion on every community concern equally .Both male and female participate equally now and what isn't before."* (*Widow, East Hararghe)*

"*P: What we fear is what you know, we have no husband. When we go to somebody participate on guza they say why did she come what do she want and we will get afraid.*
I: What about today?
P: They do not say, today all house are equal." (Widowed Women, East Hararghe)

"In the past years we were not educated, we can't go and work somewhere else, but after the new program came and taught, … all human being are equal, you can go anywhere for work and bring up your children" (Divorced Woman, East Hararghe)

Having rights was also enabling for WDW. Knowing they had rights meant that they felt more confident about accessing services. "*But now after we learned about our right we are not afraid of going to hospital we also take our children to hospital." (Widowed Women, East Hararghe)*

WDW also attributed changes in access to family planning services to "g*enerosity of our government. Rights given and shared." (Widowed Women, West Hararghe)*

CARE

Ultimately women did feel that the RI program had made a difference in their lives. They attributed their education and the newfound confidence it gave them to CARE. The training and discussions CARE provided changed community perceptions: "[. . .] *but after this training from CARE, they love now, they like me when I have a problem they help me. I go to their home, and this is only after we go the training form CARE." (Divorced Woman, West Hararghe)* WDW also felt that the education they received from CARE made them more confident about interacting with the community: *"You [CARE] brought us the change, after an order is passed to teach those who don't have husband, we started learning and become aware, before that we pass by people covering our face, but now we are not afraid of anything. " (Widowed Women, East Hararghe)* Women repeatedly expressed happiness and thankfulness for the CARE program: "*Do you mean the change come for us (I: Yes) It is come due to the new project established (inaudible). When they call us for meeting we feel happy and go for the meeting. We also thank them for calling us and gave these opportunities*."

How the Community Conceptualizes Change

The community also perceived changes in both the attitudes of the WDW themselves and in community attitudes and attributed these changes to similar factors as the WDW themselves. Equality and rights allowed women to participate more in the community. Community members, however, tended to emphasize changes in WDW's confidence, though some also acknowledged changes in community attitudes as a whole. In

describing changes in WDW attendance at social gathering a married man said things *"changed because they decided to quit fear and wanted to change their life." (Married Men, East Hararghe)* Similarly women in East Hararghe noted changes in the WDW's fears about going to the health post:

"Started to use FP, not fear to go HP" (Married Women, East Hararghe)

"It change in mentality of W/D, in addition community attitude also changed" (Married Women, East Hararghe)

Interestingly, community groups in East Hararghe tended to describe changes in attitude and confidence, while in West Hararghe the interpretation of change was often couched in terms of rights.

"*If women has the right to initiate or refuse [sex], they might be protected from unwanted pregnancy and other sexual chaos. I think Health Extension workers and CARE Result Initiative staffs are now teaching people against such imbalances hence, things might get improved in the future."* (Married Men, West Hararghe)

Married women in West Hararghe spoke about rights for all women. Married women acknowledged that WDW could send their children to school independently and access reproductive health services because they had rights. But they also spoke about married women and WDW both as having rights.

"R-Nowadays government provided rights to women to change.
R' -Different rights given to women.
NT – DO you mean policy changes of government that brought the change
R – Yes, different lows and regulations that provided the right." (Married Women, West Hararghe)

"R- Previously we were suppressed let alone raising such issues [initiating sex] we used to be excluded from normal discussions.

R' – In the past we were meant to stay calm and at home but now we have democracy/freedom to come out and discuss due to CARE's arrival and also advices we got." (Married Women, West Hararghe)

Community members also acknowledged CARE's contribution to the overall changes they had seen.

"*They were grouped as homogeneous and learned a lot." (Married Men, East Hararghe)*

"CARE organized them and give them advice against problems and solutions." (Married Women, West Hararghe)

"It is after your work with this community, most of change after this project intervention" (Married Women, East Hararghe)

"*By participating on such meetings she can learn what rights and duties she has and thereby enjoy the rights*." (Married Men, East Hararghe)

Discussion

Summary of Results

Past Challenges

Prior to this study, WDW were primarily seen in terms of their poverty and social marginalization. They were not seen as sexual beings and very little data was available on their sexual health needs. This study focuses on WDW as sexual, as well as economic and socially marginalized, beings and shows that perceptions about the sexuality of Ethiopian WDW have played a major role in their poor economic situation, in their low social status, and, ultimately, in their lack of access to health care Once separated from a husband, WDW in Ethiopia were perceived of as sexually out of control. The community's desire to control this sexuality was extremely isolating and alienating and the women's own fear of the community's stigmatizing and isolating power contributed to their difficulty in accessing the services and support that were vital to their well-being. Unwanted pregnancy, which constituted proof of sexual activity on the part of WDW was the ultimate shame and resulted in extreme social alienation and even death through botched abortions or suicides. WDW, however, were unable to prevent pregnancy both because they lacked access to family planning services and because they feared using them and thereby incurring community stigma.

Changes in the present:

The results of this study show that knowledge about family planning and increased access to sexual health care, through the CARE RI program, have helped alleviate many

of the challenges WDW faced in the past. Community perceptions of WDW's sexuality and family planning use have begun to change, and while sexual activity among WDW is still not fully accepted, some members of the community have begun to think of it as natural. The community, moreover, has begun to accept the use of family planning by WDW as a behavior that is preferable to the more shameful outcome of unwanted pregnancy.

Perhaps the biggest change lies in WDW's own relation to the community and in their ability to access services. Many WDW express increased confidence in themselves and a reduction in fear of the community and its stigmatizing power. Women attribute these changes to knowledge. Knowing how to protect themselves from unwanted pregnancy means having the power to prevent something that is extremely shameful and alienating. It means having a new sense of agency. Family planning, however, is mainly seen as a way for WDW to protect themselves from something shameful, not as a sign that they are free to be sexual.

Theorizing the Changes: Economic, Social and Cultural Capital

Another way to understand the social changes that have taken place is to see them in terms of the increases in WDW's economic, social, and cultural capital that followed their participation in RI discussion groups and savings (VSLA) groups. The economic support provided by savings groups, for example, gives WDW money to access services they need and allows them to support themselves without depending on men. The discussion groups and VSLA groups have given women more social capital by

encouraging WDW to support each other (in discussing problems for example) and to have more self-confidence in their interactions with the larger community. Social capital is broadly defined in social science literature, but here it is taken to mean social networks and support (Bourdieu, 1986; Putnam, 1995). WDW have also gained cultural capital in the form of education through CARE's groups (Bourdieu, 1986). Cultural capital refers to forms of knowledge, skills, education, and advantages that give a person higher status in society (Bourdieu, 1986). WDW have become more knowledgeable about family planning, for example, as well as about their right to participate in society and have access to health care. Part of WDW's new cultural capital also lies in the prestige that WDW took on in being special targets of CARE's RI program. This prestige undoubtedly helped to change community perceptions of WDW and this, in turn, gave women increased social capital.

CARE itself has prestige because the RI program is also tied to a food aid program which benefits the whole community. This is certainly one reason that community members speak highly of CARE and wish their programs would continue. If CARE emphasizes issues of gender equality, family planning and the importance of assisting WDW, then the community, which is keen on keeping CARE's support, may view those issues positively as well.

Gains in economic, social and cultural capital have combined to increase WDW's confidence, ultimately allowing them to access resources and achieve greater well-being. The power of social and cultural capital is well-supported in the literature and

has been shown to have strong impact on women's status (Caiazza & Putnam, 2005) and on positive health outcomes in general (Kawachi et al., 1997; Yip et al., 2007). Although the fear of WDW's sexuality has not fully dissipated, WDW have a new sense of agency and self-confidence, are now able to protect themselves from the shame of unwanted pregnancy, are less fearful of community stigma, and have support from one another and from the CARE program. All this has allowed WDW to access health and family planning services more freely.

Relation to literature

The literature does note that an Ethiopian woman's sexuality is often under the control of men. In Ethiopia, as in much of the developing world, a woman's life path is inherently tied to her sexual nature. The need to protect and control her sexuality dominates her younger pre-married life because she is expected to remain a virgin until she is married and is married young in order to 'protect' her virginity (Alemu et al 2007; Tilson & Larsen, 2000). The need to maximize sexuality and reproduce at the will of her husband comes next. (Bogale et al., 2011). The literature also recognizes that separation from a man through widowhood or divorce has significant impact on a woman's economic and social status (Owen, 2008; Sossou, 2002; World Public Opinion, 2008). Some of literature, for example, hints that sexuality is an issue for widowed women. Globally, widowhood practices often incorporate themes relating to sex. Widows are often expected to demonstrate chastity and faithfulness to their husband's memory (Sossou 2002). In India, for example, widows are restricted from eating spicy foods to

prevent lustfulness and must not beautify themselves with things like hair oil or bangles (Owen, 2008). The practice of widow inheritance in Ethiopia is also partly justified by the notion that it prevents the woman from becoming a sex worker (Aschenaki, 2006). According to the literature, both widowed and divorced women are in danger of being labeled prostitutes, especially if they demonstrate interest in another man (Sossou, 2002). The data in this paper, however, not only shows that women's sexuality is perceived as something that needs to be controlled, but it also strongly demonstrates that these perceptions of WDW's sexuality have major impact on economic, social, and health-related forms of support.

Limitations

This study is not without limitations. There are several potential problems in the research design and process as well as in participant recruitment and interview processes.

Training

The training would have benefitted from our having had additional time to go over interview questions with interviewers before the interviews took place. Having interviews transcribed immediately after they were conducted would have revealed limitations in the interviewers' knowledge about the interview guides.

Research Bias

Due to time and budget constraints the research team was primarily composed of CARE RI staff. As described in the methods section, interviewers were CARE RI facilitators who worked in *kebeles* that were not included in the study. Participants, nonetheless, understood that those interviewing them were associated with the RI program and may have felt pressure to respond positively, not only about the RI program but about the degree of change occurring in their lives. There was also a potential problem in the fact that interviewers were from a background or community similar to those of the interviewee's. The cultural similarities might have prevented some interviewees from discussing intimate issues. The presence of the researcher (a white foreigner) in the interviews could also have affected the way some participants answered questions, particularly in relation to economic matters. Recruitment was also carried out by key informants associated with the RI program. This was potentially problematic. In selecting participants, key informants may have chosen people who they perceived as being the 'most successful' in the program. The participants' understanding of the research purpose as well as their responses to interview questions could have been affected by this process. If participants knew that this research was being collected to evaluate the RI program or if they associated the research closely with the RI program, they might have changed their answers to reflect that. In one instance an enthusiastic CF came in after the interviews had been concluded and said, "*So! Has there been social change?*" While this could have been excitement about the project, it also felt as if he

were seeking to prove that his *kebele* was 'doing well' in terms of the goals of the project.

Both the interviewers and the recruitment process could have influenced participants' responses about the CARE program and about topics they knew to be related to that program. Throughout the interviews, participants conveyed fondness for CARE and approval of the programs that were being carried on in their communities. Family planning was an important issue to CARE, and some participants seemed eager to demonstrate their knowledge about what they had learned before questions were asked. Once again, however, this could also have been an expression of excitement about the program and about having learned new things.

Since there was no direct control group, we could not compare the changes our participants referred to with changes that might have occurred in communities with no ties to the CARE RI program. It is possible, therefore, that some of the changes we observed were due to external factors such as the Ethiopian MOH's own family planning promotion programs. The RI program has begun preliminary baseline interviews with new kebeles in the same areas for the next phase of the project. Comparison of the kebeles we interviewed with new kebeles could provide a means for further assessing the degree of change.

Program Considerations

Interviews yielded information which could be helpful to CARE in the next phase of the RI program and to future programs which seek to address issues of sexuality, stigma and

family planning. There is still community stigma about sexuality and unwanted pregnancy among WDW. While acceptance of family planning as a form of protection against shameful pregnancy is an incredibly helpful first step, further work is needed to address the shame that is still attached to the idea of WDW controlling their own sexuality. Since social norms often take a while to change, this may be something that comes with additional time and further community discussion.

When WDW spoke of family planning as a form of protection from unwanted pregnancy, the worst consequence of rape, it almost seemed as if they regarded contraception as a protection from rape itself an issues which deserves further exploration. At the very least, WDW seemed to accept rape or unwanted sexual advances as a part of life and not as something they could do anything about. Further attention to the issue rape and potential avenues for prevention are needed. Perhaps organizing community awareness of the issue and motivating people to recognize that rape should not be tolerated in their community could be a first step.

Some women mentioned using condoms to protect themselves from disease when they faced 'uncertainties' in their travels to and from market. It seems important to acknowledge that if these women are in fact referring to rape, there is little likelihood that they could persuade their rapists to use a condom. If, on the other hand, they are carrying condoms because of potential consensual sex, learning to negotiate condom use could be very helpful. Condoms are so infrequently used in this area, however, that

it would be important to work with WDW about how to persuade sexual partners to use them.

If, as has been suggested, some of the changes that have taken place are in fact linked to the social clout of being associated with CARE, it is important for CARE to consider an exit strategy which will avoid creating a vacuum and returning WDW to their previously marginalized status within the community. A divorced woman in West Hararghe, for example, talked of how much she feared losing an association with the program: "*All these changes have come because of the CARE-government commitment and I want to say thank you. We haven't ever seen another organization that supports us by giving us clean water, and supports our children etc. CARE-government is a big organization for us, when I heard that CARE is going to depart from here I feel very sad. CARE is good for us for our children and has done a lot of things for us, even roads are being constructed and maintained, and I fear if CARE departs from our area, I fear for my life. I wish CARE will stay for two to three years with us. I fear that we will go back to our poverty again if CARE departs." (IDI6)*

It is vital that changes which have taken place be sustained in the community after the program has finished.

Implications for Public Health

This study has several implications for the future. Since the study demonstrates that perceptions about the sexuality of WDW had great impact on their access to health services and other support systems, it clearly shows the importance of considering the

full woman when developing interventions that address the needs of female heads of house or WDW.

The study also suggests that economic, social and cultural capital are very influential in changing community stigma about sensitive issues. Greater economic agency, having new connections to others and having new forms of knowledge all gave WDW greater confidence about accessing services and seeking out support regardless of the community's stigmatizing powers.

Conclusion

WDW are often perceived of in terms of their poverty and social marginalization but they are not generally perceived of as sexual beings. Fear of Ethiopian WDW's sexuality, however, had negative impact on the degree of their economic support and social status as well as on their ability to access health care. This study shows that addressing WDW's sexual health needs through education about family planning did have impact on their ability to access support systems and on their overall well-being. The experience of receiving education and special attention from a well-regarded NGO also helped them gain economic as well as social and cultural capital. Improvements in these three forms of capital gave WDW confidence to seek further support and to access reproductive health care for themselves. It gave them the power, that is, to exercise more control over their own sexual health.

Although positive changes are occurring, further programmatic work is needed to address the lingering stigma attached to WDW's sexuality and their vulnerability to rape. The findings of this study indicate that WDW have been heretofore addressed primarily as economic beings and suggests that future interventions need to consider them as sexual beings as well.

References

Alemu, B., Asnake, M., & Wilder, J. (2007). Women's empowerment in Ethiopia: New solutions to ancient problems. Addis Ababa, Ethiopia: Pathfinder International Ethiopia.

Amato, P. (1994). The Impact of divorce on men and women in India and The United States. *Journal of Comparative Family Studies 25*(2), 207-221.

Aschenaki, A. (2006). *Assessment of Sexual Behavior related to HIV/AIDS in a community practicing widow inheritance in Digalu Tijo, Arsi zone, Oromia Regional State, Ethiopia.* Master of Public Health, Addis Ababa University, Addis Ababa, Ethiopia.

Beekle, A. T., & McCabe, C. (2006). Awareness and determinants of family planning practice in Jimma, Ethiopia. [Article]. *International Nursing Review, 53*(4), 269-276. doi: 10.1111/j.1466-7657.2006.00492.x

Bekele, S. (2006). *Divorce: It's cause and impact on the lives of divorced women and their children. A comparative study between divorced and intact families.* Master of Arts in Social Work, Addis Ababa Univesity, Addis Ababa, Ethiopia.

Benschop, M. (2004). *Women's Rights to Land and Property*. Paper presented at the Women in Human Settlements Development. http://www.unhabitat.org/downloads/docs/1556_72513_CSDWomen.pdf

Berhane, Y., Gossaye, Y., Emmelin, M., & Hogberg, U. (2001). Women's health in a rural setting in societal transition in Ethiopia. [Research Support, Non-U.S. Gov't]. *Soc Sci Med, 53*(11), 1525-1539.

Bevan, P., & Pankhurst, B. (2007). Power structures and agency in rural Ethiopia *Development lessons from four community case studies. Paper prepared for the Empowerment Team in the World Bank*. Washington DC: World Bank.

Bogale, B., Wondafrash, M., Tilahun, T., & Girma, E. (2011). Married women's decision making power on modern contraceptive use in urban and rural southern Ethiopia. [Article]. *Bmc Public Health, 11*. doi: 10.1186/1471-2458-11-342

Bourdieu, P. (1986). *The Forms of capital*. New York: Greenwood.

Caiazza, A., & Putnam, R. D. (2005). Women's status and social capital in the United States. [Article]. *Journal of Women Politics & Policy, 27*(1-2), 69-84. doi: 10.1300/J501v27n01_05

CARE. (2008). Social Analysis and Action (SAA) on inequitable attitudes towards gender and fertility. Homogenous group discussion facilitators guide.

CARE. (2011). Social and Resource Mapping. *CARE Gender Toolkit* Retrieved 12/12/11, from http://pqdl.care.org/gendertoolkit/Pages/Community,%20Social%20and%20Resource%20Mapping.aspx

Carroll, S. (2006). *Divorce norms, intrahousehold bargaining, and household outcomes in rural Ethiopia.* Stanford University.

Central Statistical Agency (Ethiopia), & ORC Macro. (2006). Ethiopia Demographic and Health Survey, 2005. Addis Ababa, Ethiopia and Calverton, MD, USA: CSA and ORC Macro.

Central Statistical Agency (Ethiopia), & ORC Macro. (2011). Ethiopia Demographic and Health Survey Preliminary Repor 2011. Addis Ababa, Ethiopia and Calverton, MD, USA: CSA and ORC Macro.

Chambers, R. (1994). Participatory rural appraisal (PRA): Challenges, potentials and paradigm. *World Development, 22*(10), 1437-1454. doi: 10.1016/0305-750x(94)90030-2

Chang, J. C., Cluss, P. A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., . . . Scholle, S. H. (2005). Health care interventions for intimate partner violence: what women want. [Research Support, Non-U.S. Gov't]. *Womens Health Issues, 15*(1), 21-30. doi: 10.1016/j.whi.2004.08.007

Colucci, E. (2007). "Focus groups can be fun": the use of activity-oriented questions in focus group discussions. [Research Support, Non-U.S. Gov't]. *Qual Health Res, 17*(10), 1422-1433. doi: 10.1177/1049732307308129

Darbyshire, P., MacDougall, C., & Schiller, W. (2005). Multiple methods in qualitative research with children: more insight or just more? *Qualitative Research, 5*(4), 417-436. doi: 10.1177/1468794105056921

Deyessa, N., Berhane, Y., Alem, A., Hogberg, U., & Kullgren, G. (2008). Depression among women in rural Ethiopia as related to socioeconomic factors: A community-based study on women in reproductive age groups. [Article]. *Scandinavian Journal of Public Health, 36*(6), 589-597. doi: 10.1177/1403494808086976

Di Gossa, S. (2008). Participatory Mapping as a tool for empowerment: Experiences and lessons learned from the ILC network. In I. L. Coalition (Ed.).

Fafchamps, M., & Quisumbing, A. R. (2002). Control and ownership of assets within rural Ethiopian households. [Article]. *Journal of Development Studies, 38*(6), 47-82. doi: 10.1080/00220380412331322581

Fafchamps, M., & Quisumbing, A. R. (2005). Marriage, bequest, and assortative matching in rural Ethiopia. [Article]. *Economic Development and Cultural Change, 53*(2), 347-380. doi: 10.1086/425373

Federal Democratic Republic of Ethiopia Ministry of Health. (2006). *National Reproductive Health Strategy 2006-2015*. Federal Democratic Republic of Ethiopia Ministry of Health.

Federal Negarit Gazetta of the Federal Democratic Republic of Ethiopia. (2000). *The Revised Family Code*. (Proclomation No. 213/2000).

Guttmacher Institute. (2010a). Facts on Investing in Family Plannign and Maternal and Newborn Health. New York, NY.

Guttmacher Institute. (2010b). Facts on Unintended Pregnancy and Abortion in Ethiopia. doi: http://www.guttmacher.org/pubs/FB-UP-Ethiopia.pdf

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative Research Methods*. Thousand Oaks, CA: Sage Publications

Holmes, R., Jones, N., & Marsden, H. (2009). Gender vulnerabilities, food price shocks and social protection responses. London, UK: Overseas Development Institute.

IFAD. (1999). The Issue of poverty among female-headed households in Africa Retrieved 2/16/2012, from http://www.ifad.org/gender/learning/challenges/women/60.htm

Integrated Approaches to Participatory Development, I. (2011). Social Mapping. *Mapping Toolbox* Retrieved 12/12/11, from http://www.iapad.org/social_mapping.htm

Kawachi, I., Kennedy, B. P., Lochner, K., & ProthrowStith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health, 87*(9), 1491-1498. doi: 10.2105/ajph.87.9.1491

Ko, I. S., You, M. A., Kim, E. S., Lee, T. W., Kim, S., Kim, Y. M., . . . Lee, H. K. (2010). Family planning practice and related factors of married women in Ethiopia. [Article]. *International Nursing Review, 57*(3), 377-382. doi: 10.1111/j.1466-7657.2010.00805.x

LaFraniere, S. (2005, May 11). AIDS now compels Africa to challenge widows' 'cleansing', *The New York Times*.

Loomba, R. (2010). Lives of widows--A hidden issue. *UN Chronicle*. Retrieved from doi:http://www.un.org/wcm/content/site/chronicle/cache/bypass/home/archive/issues

2010/empoweringwomen/livesofwidows?ctnscroll_articleContainerList=1_0&ctnlistpagination_articleContainerList=true

Mabsout, R., & van Staveren, I. (2010). Disentangling Bargaining Power from Individual and Household Level to Institutions: Evidence on Women's Position in Ethiopia. *World Development, 38*(5), 783-796. doi: 10.1016/j.worlddev.2009.11.011

Mallick, D., & Rafi, M. (2010). Are Female-Headed Households More Food Insecure? Evidence from Bangladesh. [Article]. *World Development, 38*(4), 593-605. doi: 10.1016/j.worlddev.2009.11.004

Owen, M. (2008). Widows in Third World Nations. *Encyclopedia of Death and Dying* Retrieved February 19, 2012, 2012, from http://widow-speak.org/ww_owens_1.html

Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., Fernandes, J., . . . Mabey, D. (2006). Gender disadvantage and reproductive health risk factors for common mental disorders in women - A community survey in India. [Article]. *Archives of General Psychiatry, 63*(4), 404-413. doi: 10.1001/archpsyc.63.4.404

Putnam, R. D. (1995). *"Bowling Alone: America's Declining Social Capital" Journal of Democracy (1995)*. London: Routledge.

Ringheim, K., Teller, C., & Sines, E. (2009). Ethiopia at a crossroads: Demography, gender, and development. In Population Reference Bureau (Ed.). Washington D.C.

Singh, S., Fetters, T., Gebreselassie, H., Abdella, A., Gebrehiwot, Y., Kumbi, S., & Audam, S. (2010). The Estimated Incidence of Induced Abortion In Ethiopia, 2008. [Article]. *International Perspectives on Sexual and Reproductive Health, 36*(1), 16-25.

Smith, L. C., Alderman, H., & Aduayom, D. (2006). Food Insecurity in Sub-Saharan Africa: New Estimates from Household Expenditure Surveys. In I. F. R. P. Institute (Ed.). Washington D.C.

Sossou, M. A. (2002). Widowhood practices in West Africa: the silent victims. *International Journal of Social Welfare, 11*(3), 201-209. doi: 10.1111/1468-2397.00217

Stephenson, R. (2009). Social Change for Family Planning Results Initiatives in Kenya, Rwanda and Ethiopia: Baseline Results. In CARE (Ed.).

Summer, A. (2008). Documentation of Ethiopia's Situational Analysis Phase for the Social Change for Family Planning Results Initiative. In CARE (Ed.).

Tefera, A. A. (2010). *Women Representation in Parliament: Comparative analysis: Speical emphasis given to South Africa and Ethiopia.* Master of Legal Studies, The Centeral European University, Budapest, Hungary.

The Transitional Government of Ethiopia. (1993). *Health Policy of the Transitional Government of Ethiopia*.

Tilson, D., & Larsen, U. (2000). Divorce in Ethiopia: The impact of early marriage and childlessness. [Article; Proceedings Paper]. *Journal of Biosocial Science, 32*(3), 355-372. doi: 10.1017/s0021932000003552

Transitional Goverment of Ethiopia. (1993). *National Population Policy of Ethiopia*. Addis Ababa, Ethiopia: Transitional Government of Ethiopia Retrieved from http://www.un.org/popin/regional/africa/ethiopia/policy/index.htm.

Trivedi, J. K., Sareen, H., & Dhyani, M. (2009). Psychological aspects of widowhood and divorce *Some Issues in Women's Studies, and Other Essays, MSM, 7*(1), 37-49.

UNFPA. (2005). Reaping the Rewards of Family Planning *State of World Population 2005* Retrieved from State of World Population 2005 doi:http://www.unfpa.org/swp/2005/english/ch4/chap4_page2.htm

UNICEF. (2010). Ethiopia Statistics Retrieved 4/11/2012, from http://www.unicef.org/infobycountry/ethiopia_statistics.html

UNICEF. (n.d.). UNICEF supports fight to end marriage by abduction in Ethiopia. Retrieved from doi:http://www.unicef.org/ethiopia/ET_real_abduction.pdf

United Nations. (1995). The United Nations Fourth World Conference on Women. Beijing, China.

Weller, S. C., & Romney, A. K. (1988). *Systematic data collection* (Vol. 10). Newbury Park, California: Sage Publications, Inc.

WHO. (2011). Family Planning. *Fact Sheet No 351* Retrieved 4/12/12, from http://www.who.int/mediacentre/factsheets/fs351/en/index.html

WHO. (2012). The Determinants of Health Retrieved 4/18/2012, from http://www.who.int/hia/evidence/doh/en/index.html

Wilder, J., Giday, T., & Asnake, M. (2008). Ethiopia's Health Extension Program. Pathfinder Internation's Support 2003-2007. In P. International (Ed.). Ethiopia.

Woldemicael, G., & Tenkorang, E. Y. (2010). Women's Autonomy and Maternal Health-Seeking Behavior in Ethiopia. [Article]. *Maternal and Child Health Journal, 14*(6), 988-998. doi: 10.1007/s10995-009-0535-5

World Bank. (2011). Reproductive Health at a Glance: Ethiopia.

World Public Opinion. (2008). Poll: Across the world many see discrimination against widows and divorced women.

Yip, W., Subramanian, S. V., Mitchell, A. D., Lee, D. T. S., Wang, J., & Kawachi, I. (2007). Does social capital enhance health and well-being? Evidence from rural China. *Social Science & Medicine, 64*(1), 35-49. doi: 10.1016/j.socscimed.2006.08.007

Appendices

Appendix A: Interviewing Do's and Don'ts Training Guide

Dos:
Find a quiet, private, comfortable location
Be friendly and approachable
Speak slowly and carefully
Keep eye contact
Get CONSENT
Turn on tape recorder
Ask one question at a time
Give enough time for participant to respond
Respect their answer
Demonstrate that you are listening (aha, hmm, etc)
Appreciate their answer
Opening and closing questions are important
Facilitator and note taker should communicate well *
*(Potentially problematic later when note takers were interrupting interviews to clarify with interviewers)

Don'ts
Disrespect the participant
Converse in other languages or laugh
Forget to probe
Forget the *'ferenji'* doesn't know **
**(This point was added by the researcher to remind the facilitators that while the reasons for someone's response or actions might be obvious to them because they were from the same culture, they might not be obvious to an outsider. It was important to probe on these issues even if the interviewers thought they themselves understand the response or action.)

Appendix B: In-Depth Interview (IDI) Guide English (Divorced woman)

Topic: Personal stories of change in past three years, challenges faced as a WDW, family planning needs, and experiences with CARE program.

Target Audience: Divorced women between the ages of 20-49, who have been involved in the CARE program and who have been divorced for at least 3 years.

Supplies: refreshments, recorder, notepad,

Total Participation Time: 60 minutes

Let's start with talking about your family and household.

Opening

1. Can you tell me about your family?

2. Do you have any children? (*probe:* how many, how old, living at home)

3. Who else lives in your house?

I would like to ask you some questions about your previous marriage.

Divorce

4. How long were you married?

5. How long have you been divorced?

6. Can you tell me about your divorce? (*probe*: why did you divorce, how did you feel, why?)

7. What do you do differently now that you are divorced?

Now I would like to ask you about your experiences as a divorced woman in your community.

8. Think back three years ago. What were some of the challenges you faced or would have faced as a divorced woman in your community?

   Probes:

   -Economic Support (How did you, as a divorced woman, support yourself? work, food, etc)

   -Social Support (Did you have people you could talk to if you were having troubles?)

-Health Care (What did you do when you got sick?)

-Family Planning (services provided for divorced women – is there a need? Could you use family planning? What were your family planning needs 3 years ago?)

Now let's talk about things in the present.

9. How have things changed for you and other divorced women in your community over the past three years? (probe: things that have improved, gotten worse or more difficult)

   Probes:

   -Economic Support

   -Social Support

   -Health Care

   -Family Planning (what are your current family planning needs?, are you currently sexually active?) *Remind participant that this is all confidential if they are concerned. Can explain that we are wanting to use this information to help WDW have options available to help them prevent pregnancy and disease.*

10. Why do you think these things have changed? OR If they haven't changed, what would need to happen for the problems you brought up to change?

11. What would happen if a divorced woman were to get pregnant? (Probe: what would she do? Where would she go? How would the community react?)

Let's talk now about your experiences with the CARE program. Please remember that your answers are confidential and that you should feel free to be honest.

12. How did you get involved with the CARE Results Initiative program? (probe why did you get involved; how long involved?)

13. What kinds of things do you do with the CARE program? (*probe:* how often do you go to CARE program meetings/events)

14. What is your favorite thing about the CARE program? (probe: why?)

15. What is your least favorite thing about the CARE program? (probe: Why?)

16. Has the CARE program contributed to any changes that we discussed above? (probe: which parts?)

In the last part of our discussion, in thinking about all the things we've talked about today I would like to ask you a few final questions.

Closing

17. If a friend of yours in this community got divorced, what advice would you give her?

18. Is there anything else that you would like to add that you feel we should know about divorced women?

19. What suggestions would you give to CARE to improve the program?

20. Do you have anything else you would like to add?

Thank you for giving us your time and helping us with our study.

Appendix C: Social Mapping Activity & Focus Group Guide

Topic: Changes in mobility, autonomy and health for divorced women participating in the CARE RI program.

Target Audience: 6-8 widowed or divorced women (not currently married) between age 20 and 49 years old, who have been involved with CARE Results Initiative project for at least one year, and who have been widowed or divorced for at least 3 years

Supplies: refreshments, recorder, notepad, 2 large pieces of paper, 2 colored pens, camera

Total Participation Time: 60 minutes

We are going to do a mapping activity using different scenarios of a woman in your community and the places she goes for things like supporting her family, social support and family planning.

I would like to understand more about life in your community and where divorced women went on a regular basis before their involvement in the CARE program.

Please work together to draw a map of your community. *Provide colored pens and paper. Have the women use a new color for each question number. If the women cannot draw, assist them by drawing the map for them and having them direct you. Label each place that you draw with a name (market, health post etc).*

Scenario 1: Divorced Woman *(use two different colored markers for 3 years ago and today)*

1. Think of a divorced woman **three years ago**, where would she go frequently for:
   -Supporting her family (household income)
   -Social Support (seeing friends, etc)
   -Family Planning & Health Services

Allow women some time to discuss and draw the map. Have women explain why they have drawn each of the places that have to do with the three themes listed above.

2. Now imagine a divorced woman **today**. Are there differences in the places that divorced woman goes? (probe: more/less often, why?)

3. Now what if the woman is divorced AND pregnant? Where would she go? (probe: what happens to her? How would the community react?)

Scenario 2: Married Woman

Thank you for drawing that map. I would like to ask you to draw one more map to compare the experiences of divorced women with the experiences of married women. (*Use a new piece of paper to draw this map. Use two different colored markers, one for 3 yrs ago and one for today)*

4. Imagine a married woman three years ago, are there differences in the places she would go from the divorced woman for:
   -Supporting her family (household income)
   -Social support (seeing friends, etc)
   -Family Planning & Health Services

5. Now imagine a married woman today. Please show where she would go for the same things today. Are there different places she would go than 3 years ago?

Probe the women on the differences between divorced women and married women.

Verbal follow-up questions (*no map needed)*

Thank you for drawing these maps they have been very helpful. We are almost at the end of our discussion today. I have a few last questions.

6. Are there places that a woman in your community must be accompanied by a man to go? (Probe: why, what happens if she goes alone, what would a divorced women do if she needs to go to one of these places, would anything change the need to be accompanied by a man to these places?)

7. How has the CARE RI program changed where divorced women can go in there community?

8. Are there any suggestions you have for the CARE RI program?

We are now at the end of our discussion. Does anyone have any further comments on anything we discussed today?

Thank you so much for your participation today. Your discussion will greatly help our research and to improving CARE's program.

Appendix D: Community Focus Group Discussion Guide

Community Focus Group Questions

Topic: Community perceptions of WDW and expected behaviors/roles.

Target Audience: 6-8 Male or female (separate) members of the community who are between the ages of 20 and 49 years old and who have not been involved in the CARE interventions and who are not widowed or divorced.

Supplies: refreshments, recorder, notepad, pile sorting deck of cards, camera

Total Participation Time: 60 minutes

Pile Sorting on Expected Roles in the Community

We are going to do a short activity to begin our discussion today. We have several cards with a role written on each. Please place each card under either the married woman or the widowed/divorced woman or under both. Place each card under the person you think this role most applies to, or keep it to the side if it applies to neither.

Pile Sorting Directions

Category Cards*: Married Woman, W/D woman*

Role Cards*: Participates in community meetings, Farming, Gets FP services, Selling chat in the market, Fetching water, Going to the health clinic alone, Making decisions about children's schooling, Making decisions about how to spend money, Buying property, Initiating sex*

1. *Have group sort the role cards according to married woman and widowed/divorced woman. If they think that a card applies to both people have them place it in between the two. If they think that the card applies to neither then have them keep it to the side.*

2. *Have them explain why they have placed the cards in each pile. Probe them on the expected roles of married women vs. WDW. Ask them about the cards that apply to neither. Ask them who fills those roles for both married women and WDW.*

3. *Take pictures of the piles.*

Questions on WDW

Thank you for your help with that activity. Now I would like to ask you some further questions about WDW in your community.

1. What changes have you seen in widows and divorced women in your community over the past three years? (probe what do you think about these changes?)

2. Why do you think these things have changed? (Probe: what has caused these changes?)

3. What do you think about widowed and divorced women who use family planning?

4. How would your community treat a widowed or divorced woman who was pregnant? (Probe: what would be expected that she would do?)

5. Have you heard about the CARE RI program? (Probe: what do you know about it, what do hear, what do you think about the program)

One last question before we finish our discussion today.

6. Any suggestions for the future for WDW in your community? (things that need to be addressed still?)

We are now at the end of our discussion. Does anyone have any further comments on anything we discussed today?

Thank you so much for your participation today. Your discussion will greatly help our research and to improving CARE's program.

EMORY UNIVERSITY | Institutional Review Board

FROM: Donna Dent, MISM, MS
Lead, Research Protocol Analyst

TO: Robert Stephenson, PhD
Principal Investigator

DATE: January 16, 2009

RE: **Notification of Exempt Determination**
IRB00016414
Results Initiative Project: Understanding the Role of Social Change in Promoting Family Planning Use

Thank you for submitting an application in eIRB. We reviewed the application and determined on **1/16/2009** that it meets the criteria for exemption under 45 CFR 46.101(b)(2) and thus is exempt from further IRB review.

This determination is good indefinitely unless something changes substantively in the project that affects our analysis. The PI is responsible for contacting the IRB for clarification about any substantive changes in the project. Therefore, please do notify us if you plan to:

- Add a cohort of children to a survey or interview project, or to a study involving the observation of public behavior in which the investigators are participating.
- Change the study design so that the project no longer meets the exempt categories (e.g., adding a medical intervention or accessing identifiable and potentially damaging data)
- Make any other kind of change that does not appear in the list below.

Please do not notify us of the following kinds of changes:
- Change in personnel, except for the PI
- Change in location
- Change in number of subjects to be enrolled or age range for adults
- Changes in wording or formatting of data collection instruments that have no substantive impact on the study design

For more information about the exemption categories, please see our Policies & Procedures at www.irb.emory.edu. In future correspondence about this study, please refer to the IRB file number, the name of the Principal Investigator, and the study title. Thank you.

Sincerely,

Donna Dent, MISM, MS