ONE
2011

ON HIV AND AIDS, SEXUALITY AND GENDER

Exchange

Reproductive health in nomadic communities: Challenges of culture and choice

By John Nduba, Morris G. Kamenderi and Anke van der Kwaak[1]

Since the late 1980s, improving maternal health and reducing maternal mortality have been key concerns of several international meetings, including the Millennium Summit in 2000.[2] One of the eight Millennium Development Goals (MDGs) adopted after the summit involves improving maternal health (MDG5). Although reproductive health is not specifically named, it is widely recognised that ensuring universal access to reproductive health care, including family planning and sexual health, is essential for achieving all the MDGs, and vice versa.[3]

Young Maasai women in Kenya participating in a health education session.
(Photo by Jeroen van Loon/AMREF).

Youth sexuality is a critical determinant of reproductive health particularly in developing countries. Access to family planning services, safe motherhood, prevention and treatment of sexually-transmitted infections (STIs), including HIV and AIDS, and the elimination of gender violence would improve the lives of the poor and spur economic and social development.

Nomadic communities' reproductive health is a critical issue. The lifestyle of moving from place to place for subsistence seems to deprive these communities of basic services. This trend has been complicated by remoteness, physical

This issue

1. Overview
5. Insight
9. Findings
12. Informing practice
14. Country focus
16. Links and resources

Editorial

Eliezer F. Wangulu *Managing Editor*
Anke van der Kwaak *Guest Editor*
Gerard Baltissen *Guest Editor*

Preventing needless deaths among hard-to-reach mothers

Thousands of women die in pregnancy or childbirth yearly. Ninety per cent of them, the UN Population Fund (UNFPA) says, are in Africa and Asia. Most victims die from severe bleeding, infections, eclampsia, obstructed labour and the effects of unsafe abortions, for which effective interventions exist.

The International Conference on Population and Development and the Millennium Development Goals target a 75 per cent reduction in maternal deaths between 1990 and 2015. According to CHANGE, young women whose bodies are not properly developed especially due to chronic malnutrition are most vulnerable. Early child marriage and taboos on adolescent sexuality contribute to teen pregnancies by denying most of the girls the power, information, and tools to postpone childbearing.

The hard-to-reach nature of nomadic areas is compounded by the inhabitants' itinerant lifestyle, poor road transport infrastructure and communication in general. Nomadic ways deprive these communities of basic services as do distance to health services, insecurity, high illiteracy rates and local beliefs and practices, besides poor training of staff at the few available health facilities. Although women increasingly want contraceptives, their husbands are reluctant, fearing loss of fertility. Children, most of who provide labour, do not attend school beyond age seven.

Health systems rarely prioritise nomads' maternal health, further complicating their lot. Also, formal maternal health services are insensitive to pastoral culture and beliefs, such that some women shun antenatal clinic just to avoid being examined by male midwives. Thus, although UNFPA's state of the world's midwifery report 2010 notes progress on MDG 5 (improve maternal health) and 4 (reduce child mortality) that has resulted in one-third drop in maternal deaths, nomadic communities are yet to benefit from these efforts. Family planning is crucial to comprehensive sexual and reproductive health as it provides essential, often life-saving services to women and their families. By helping women delay pregnancy, avoid childbearing, or space births, effective family planning programmes not only advance women's health, they also allow them and families to better manage household and natural resources, educate them and address each member's healthcare needs. The best programmes increase equity among couples and enhance their communication and negotiation skills.

UNFPA proposes widespread campaigns at community levels to offer information on maternal health, such as the risk of traditional practices, potential complications of childbirth, the need to seek emergency obstetric care and various options for treating fistula. This advocacy should target village chiefs, religious leaders and traditional birth attendants, whose change of mindset is crucial, besides pregnant women and their families. Reproductive health staff that send away young girls seeking help should be re-trained to offer youth-friendly services.

The good news is that various organisations are trying to improve nomadic populations' situation by prohibiting early marriage and female genital cutting and encouraging girls' education. Alternative rituals and creation of safe space for girls are other measures.

Logistics is key. District hospitals should be equipped urgently to deal with emergencies and measures instituted to address the health needs of hard-to-reach nomads, especially pregnant women since no woman should die giving life! ■

distance to health services, high levels of illiteracy and local beliefs and practices.

On the other hand, HIV incidence among pastoral communities appears to be relatively low; Talle relates this to the cultural identity of the Maasai. Although the Maasai value multiple sexual partners and engage in large sex networks, their sexual morals are not loose and their sexual interactions are regulated by a strict morality of prescribed sexual partners according to age-set and kinship affiliation[4].

It seems that in most countries, reproductive health practices and needs of nomadic communities are not well understood due to limited information. It was against this background that African Medical Research Foundation (AMREF) implemented a programme targeting young nomads from 2006 to 2010. This article shares some insights and experiences from the programme and discusses some important challenges and issues related to nomadic reproductive health.

Programme in Eastern Africa

Nomadic pastoralists are some of the poorest sub-populations living in remote areas. They rarely seem to utilise services of professional midwives and other reproductive health care providers. This results in many complications during pregnancy. Furthermore, bearing many children in the nomadic community is generally considered a status symbol, meaning, there is little regard for family planning.

Female genital cutting (FGC) is another problem that results in many women experiencing difficulties during delivery. Customs that transcend generations require girls to be circumcised and married off young and to have their first child soon after. These traditional nomadic lifestyles are observable in Kenya, Ethiopia and Tanzania.

AMREF's overarching vision is better health for Africa and its mission is to ensure that every African enjoys the right to good health by helping create vibrant networks of informed and empowered communities and health care providers working together in efficient health systems. With support from the Dutch Ministry of Foreign Affairs, AMREF implemented a programme on reproductive health care for or among nomadic youth. It mainly targeted male and female aged 10 – 24 years. More than 135,000 of them were in Ethiopia, Kenya and Tanzania.

Here are some of the findings that were gathered through a baseline study. The findings from qualitative studies will also be presented (in other articles in this edition) to provide a more in-depth understanding of nomadic reproductive health realities and needs.

Early marriage and sexual practices

Adolescence and youth, in particular the period between 10 and 25 years, involve sexual experimentation that may lead to STIs and unintended pregnancies. Sexual practices in this age group may include early sexual debut, having multiple sexual partners, engaging in unprotected sex, having sex with older partners and consuming alcohol and illicit drugs.[5]

Findings indicated that the sexual debut of nomadic youth in Kenya and Ethiopia, on average, is at 15. In Tanzania, youth generally initiate sexual intercourse at age 16. Such differences in sexual practices are often influenced by cultural and social environments.

An Afar mother with her three children. (Photo by Demissen Bizuwerk/AMREF).

Early marriage or child marriage is defined as the marriage or union between two people in which one or both partners are younger than 18 years.[6] From our findings, early marriage was more pronounced among the youth in Ethiopia. The median age of marriage was 16 years in Ethiopia and 18 years in Kenya and Tanzania. It was observed that there was limited knowledge on sexuality among the nomadic youth in the three countries. Specifically, issues of pregnancy were not well known. The attitude towards teenage pregnancy was encouraging with very few youth in Kenya and Tanzania advocating for it. However, more than half of the youth in Ethiopia supported teenage pregnancy.

Local beliefs and knowledge

Despite global efforts to eliminate FGC, it remains widespread in nomadic communities, as indicated by the high proportion of nomadic youth who reported having a circumcised sister. A possible explanation for this is the belief among nomadic youth that circumcised girls are different from uncircumcised girls in important ways. For example, many justify FGC because of its associations with family honour (respect), cleanliness, a woman's ability to walk for long distances and women giving birth with ease.

These differences are usually linked to socio-cultural identities and women themselves are sometimes unwilling to give up the practice because they see it as a long-standing tradition passed on from generation to generation. Practitioners of FGC are often unaware of the implications of the practice, including its health risks.

Through education programmes, these cultural beliefs are being addressed and communities are starting to accept alternative rites in which all age and gender sets are involved.

> *"Nomadic pastoralists are some of the poorest sub-populations living in remote areas. They rarely seem to utilise services of professional midwives and other reproductive health care providers."*

HIV and AIDS knowledge remains critical to preventing the spread of the disease. Although knowledge of the pandemic was observed to be sub-optimal among nomadic youth, those in Ethiopia were even less knowledgeable. The most common mode of HIV transmission was through sexual intercourse. But mother-to-child transmission of HIV was one of the least known methods. Nomadic youth who had considered going for an HIV test were very few in Kenya, Ethiopia and Tanzania. However, youth in Ethiopia were less likely to consider going for HIV test. Because Ethiopian youth were less likely to see themselves as at risk of contracting HIV, they were equally less likely to consider HIV testing.

Health extension worker provides ante-natal care during a home-to-home visit. (Photo by Demissen Bizuwerk/AMREF).

Fertility choices and decision making

The reproductive choices made by young women and men have an enormous impact on their health, schooling and employment prospects, as well as their overall transition to adulthood[7,8]. Unintended pregnancy is a major health problem among young people in Sub-Saharan Africa[9] where, it is estimated that 14 million such pregnancies occur every year, with almost half among women aged 15-24 years[10].

Teenage pregnancy was also common among the respondents with the majority of young women in Kenya becoming pregnant at age 17 and in Ethiopia at age 16. Kenyan youth, however, were more likely to get married at age 18, so becoming pregnant at age 17 was likely a sign of unprotected pre-marital sex.

Perceptions of fertility are also important because they can indicate the future reproductive behaviour of nomadic youth, setting the pace for timely and focused interventions. From the findings, nomadic youth in Ethiopia felt it was appropriate for young people to marry below the age of 18. In contrast, those in Kenya and Tanzania preferred marriage over 18 years.

While nomadic youth generally preferred to have many children after marriage, those in Ethiopia desired to have more (seven on average). The desire to have a larger number of children among nomadic youth may hinder contraceptive use. Culturally, having many children is generally considered a status symbol.

The findings revealed low knowledge levels on modern contraception among nomadic youth with the pill, injectables and the condom being the most commonly known methods. However, youth in Ethiopia and Tanzania showed a lower knowledge level on individual methods of contraception.

Contraceptive use among nomadic youth was extremely low with those in Ethiopia being the least users. This reflected low knowledge of modern contraception. Enhancing contraceptive knowledge among nomadic youth seems essential to spur higher use. Deliberate efforts are therefore required to make contraceptives culturally acceptable in nomadic communities. This and awareness of decision-making structures where the men and the mothers-in-law are the most decisive in local practice, are key issues that need to be taken into account when organising awareness programmes. For example, men in Kenya kept the identity cards of their wives with them, to ensure that they could not go anywhere without their consent.

Nomadic youth who had considered going for a HIV test were very few in Kenya, Ethiopia and Tanzania. However, youth in Ethiopia were less likely to consider going for HIV test.

Quality of reproductive health services

In nomadic settings, community structures provide reproductive health services. The major players are traditional herbalists, local healers and traditional birth attendants (TBAs).

The study found that traditional herbalists/healers were perceived to be more effective and reliable by nomadic communities. They are seen as being culturally closer to the people, trusted and very knowledgeable on community health problems.

However, this trust can be abused by traditional healers. For example, claiming that they could heal HIV and AIDS is misleading and can ruin prevention-related efforts.

TBAs are also important in the provision of services although their knowledge is sometimes insufficient, putting young women at risk. If traditional healers/herbalists and TBAs are properly trained, they could complement other caregivers in bringing reproductive health services closer to the nomads.

Several factors were found to hinder the quality of services offered by biomedical health providers. Health facilities, especially dispensaries, are served by staff without adequate skills on youth-friendly reproductive health services. Health providers dealing with youth from the surveyed health facilities felt very uncomfortable discussing sexual behaviours related to STIs/HIV with youth clients. Out of nine interviewed staff, only three reported feeling comfortable discussing sexual behaviours related to STIs/HIV.

A young mother with her child in Tanga, Tanzania. (Photo by Jeroen van Loon/AMREF).

Lack of basic training and or post-basic training among health providers was another problem. It was revealed that very few health staff had ever attended refresher or post- basic training courses specifically on family planning, clinical skills, programme management or HIV/STI counselling, diagnosis and treatment. Out of nine members of staff interviewed, only four (two from each level of facility) had ever attended such courses. The rest had never attended. The training was mainly on contraceptive counselling and reproductive health education.[11]

From the baseline studies, it was clear that access to reproductive health services among nomadic youth is low. Very few youth, especially those in Ethiopia, had visited a clinic in the six months prior to the survey. One potential barrier was lack of adequate skills among staff to provide youth-friendly services. This is an important prerequisite in scaling-up access to reproductive health services. It was also noted that providers mentioned feeling uncomfortable when discussing reproductive health issues with youth. This could potentially discourage the youth from seeking such services in the future.

Lack of basic training among providers was evident. Training of service providers on reproductive health was and is therefore extremely essential.

Geographical access or distance, cultural barriers and awareness may also lead to low demand for reproductive health services. In terms of accessing reproductive health services, adolescents generally show poorer health-seeking behaviour for themselves and their children than adults, and experience more community stigmatisation and violence, suggesting larger challenges to the adolescent mothers in terms of social support. Young people in particular are reluctant to seek health service for their sexual and reproductive health needs.[12]

Lessons learned

- Access to reproductive health care services among nomadic youth is wanting and it is recommended that this be addressed by improving attendance at formal schools; decentralisation of reproductive health services to make them closer to nomadic communities; and training reproductive health care providers to offer youth-friendly services. The introduction and use of mobile phones may help in easing communication between providers and communities.
- The involvement of traditional herbalists, local healers and TBAs could capitalise on the trust communities have in them to fight negative practices that hinder reproductive health service provision. This will also help address cultural beliefs that encourage female genital cutting among nomadic communities. ■

Dr John Nduba
Director, Reproductive and Child Health

Morris G. Kamenderi
Research Assistant
Africa Medical Research Foundation (AMREF)

Anke van der Kwaak
Senior Health Advisor
KIT Development and Policy

Correspondence
Dr John Nduba
E-mail: john.nduba@amref.org

Morris G. Kamenderi
E-mail: kamenderim2002@yahoo.com

AMREF Headquarters
P. O. Box 27691-00506
Nairobi
Kenya
http://www.amref.org

Anke van der Kwaak
Royal Tropical Institute
T +31 (0)20 568 8497
E-mail: a.v.d.kwaak@kit.nl
Mauritskade 63 [1092 AD]
P.O. Box 95001, 1090 HA Amsterdam
The Netherlands
http://www.kit.nl.

References

1. The authors would like to thank Gerard Baltissen and Eliezer Wangulu for their contribution to this volume of the *Exchange*.

2. United Nations Millennium Declaration. Fifty-fifth Session of the United Nations General Assembly. New York: United Nations; 18 September 2000 (General Assembly document, No. A/RES/55/2)

3. Sachs DS: *Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health* (Geneva: World Health Organization, 2001).

Other references for this article are available at http://www.exchange-magazine.info/.

Using safe spaces and social networks to convey reproductive health information to nomadic girls

By Anne Gitimu, David Kawai, Charles Leshore and Peter Nguura

Peer educators in Kenya use music and dance to convey important SRHR messages. (Photo by Jeroen van Loon/AMREF).

The status of girls reflects society's sexual and reproductive health. Nomadic girls' low social status mirrors their isolation, limited friendship networks, early marriage and female genital cutting (FGC), which undermines their sexual and reproductive health. Yet few sexual and reproductive health programmes reach these girls. This article discusses a new approach used to reach Maasai girls in Magadi and Loitokitok divisions of Kajiado County in Kenya with relevant information and services.

The situation of adolescent girls is complex. Deep-rooted traditions of patriarchy and subordination of women and girls make it difficult for the girls to realise their reproductive health rights in many parts of the world (UNICEF 2009). Like their counterparts in nomadic settings, Maasai girls are just a disadvantaged lot. Their lives are marked by early marriage, limited schooling, illiteracy, frequent childbearing, social isolation, limited life options and chronic poverty (NCAPD 2005). Maasai girls also lack strong friendship and social support networks that are known to play important roles in girls' lives, including reducing vulnerability to HIV infection (Bruce and Hallman 2008).

- Social networks are close friends and neighbourhood contacts.
- Safe spaces are physical spaces that give girls and women security and privacy that they need to freely discuss their sexual reproductive health needs and concerns.

Gaps in service provision

Among the nomadic communities of Magadi and Loitokitok divisions in Kajiado County, male groups are socially organised along an age-set system *(olporor)* and can be easily reached. Maasai women and girls, however, do not belong to an age set system. They are often referred to as children *(nkerai)* and their status is based on the age-set of their husbands, which, however, does not entitle them to any special benefits from the age system.

Similarly, the girl-child receives little or no attention regarding personal matters especially sexual and reproductive health issues, including high levels of unprotected sex among adolescents. Rampant early marriages in the community are a violation of human rights and increase young women's vulnerability to STIs, including HIV. Generally, the community finds early marriage and gender-based violence (GBV) including female genital cutting (FGC) acceptable. And yet few programmes in the area address the sexual reproductive health (SRH) needs of nomadic girls.

Reproductive health project

The Nomadic Youth Reproductive Health Project, based in Loitokitok and Kajiado, was a four-year (2007-2010) project funded by the Dutch government.

The project aimed to reach in and-out-of school youth, ages 10 to 24, with reproductive health information particularly on HIV, STIs, unwanted pregnancies, early marriage and FGC. It also sought to train Ministry of Health staff to provide youth-friendly services and to enable local communities to advocate for nomadic youth's reproductive health rights.

> *Rampant early marriages in the community are a violation of human rights and increase young women's vulnerability to STIs, including HIV.*

The project used social networks and safe spaces to give sexual reproductive health information and services to the girls. A key question the project addressed was: "What are the most appropriate channels for offering sexual and reproductive health services to the hard-to-reach Maasai girls? The idea was to improve the girls' sexual and reproductive health through effective and culturally-appropriate methods.

Specific objectives included:

- To pilot the use of safe spaces and social networks as a sexual reproductive health intervention for nomadic girls and women.
- To gauge the effectiveness of the safe spaces and social networks' intervention for SRH information dissemination and grassroots advocacy in increasing the uptake of SRH information and services.
- To document lessons learned from the pilot project.

Safe spaces and social networks

The project used the small-group approach to reach Maasai girls and their mothers with information and services. Girls and mothers from close neighbourhoods and in some cases the same churches formed regular meeting fora where they discussed sexual and reproductive health issues. The groups were meant to have a multiplier effect in their villages. Below are some of the components of the safe spaces and social networks.

1. Girls' and mother-girl fora

The girls identified these spaces and made them their meeting places. Safe spaces served as girls' meeting places and for building social networks. The girls had an opportunity to meet on their own and also have fora with their mothers under the guidance of a health worker or a trained peer educator. They had fixed fora for discussing reproductive health issues.

Forty-six safe spaces identified by the girls were created in the two project sites. Each forum had 10 girls on average.

Grandmothers play an important role in the traditional Maasai culture. (Photo by Jeroen van Loon/AMREF).

The safe spaces were either in schools on Saturdays or in churches after Sunday services. Some girls met in homes of mothers who were their role models. The project regularly brought together 432 girls and 200 mothers. The mother-girls fora consisted of some 10 mothers and their daughters who met once a month. Several fora were created in the community with the help of community leaders. During the sessions, the girls discussed the reproductive health challenges with the help of a facilitator. The girls did beadwork — a Maasai woman's cultural speciality — as they discussed their issues.

Sessions with mothers included self-esteem, life skills, developing future aspirations, pregnancy prevention, sexual and reproductive health and HIV and AIDS. The project had 46 mother-girls' fora.

Girls and mothers also did beadwork during their discussions. Discussion fora were formed following negotiations with custodians of culture and also with mothers so that the girls would be allowed to meet on their own or with their mothers without causing any conflicts at community or household levels.

Josephine Nkonene, a class seven pupil aged 15, who comes from Oldonyonyokie area in Magadi Division, and a member of Oldonyonyokie Mother-Girls Forum, now understands the effects of female genital cutting which "...include bleeding and even death." She says: "The forum has helped me to improve my performance in class because I now focus on my education. The false pride derived from FGC cannot distract me."

The head teacher of Oldonyonyokie Primary School, Patrick Sayianka, relates the good performance of girls and delayed FGC to the fora. In 2010 for example, Magdalene Mampai, a member of the forum, obtained 309 points in the Kenya Certificate of Primary Education (KCPE), the highest in the school ever. Magdalene was an ambassador of health in the school and her community.

> *The forum has helped me to improve my performance in class because I now focus on my education. The false pride derived from FGC cannot distract me.*
>
> *Josephine Nkonene, a class seven pupil aged 15*

2. Creating a link to youth - friendly services

Eighteen heath facilities in the project area were equipped with obstetric equipment and supplies and health workers trained to offer youth-friendly services. Through advocacy, the project convinced health workers in the project area to have service hours, convenient to the youth. Youth-friendly services aim to overcome barriers to accessibility and use. Youth peer educators were linked to the fora to assist the girls to access these services and also provided them with SRH information. Through peer education, 7,963 girls were reached.

Christopher Lemomo, 22, a community health worker and peer educator says pregnancies especially in schools have gone down as a result of the sessions. Girls have also become confident and can ask their mothers to buy them sanitary pads as a right. The girls could not approach their mothers over such an issue before for it was a taboo subject.

3. Mentorship

Providing mentorship in pursuing education and on the value of a girl who is uncircumcised or unmarried at a tender age to the girl groups was spearheaded by Maasai female community role models. These are uncircumcised married women or those who have resolved not to circumcise their daughters. The project also trained youth peer educators to provide mentorship to the young girls in addition to reaching their peers with sexual and reproductive health information.

4. Cultural Elders Fora

Reproductive health issues that need community support and intervention were referred to cultural leaders. FGC and early marriage had already been identified by the girls as the practices they would like changed. The issues were addressed by cultural leaders. Leaders' fora were formed by elected age-set leaders who the project facilitated to meet and who were sensitised on sexual and gender-based violence including FGC.

Elders met on their own to discuss community issues before they took them to the larger community. The project exploited the unique opportunity of involving the cultural gatekeepers in directly leading community discourse on the risky cultural practices in the community.

Dialogue with cultural leaders and negotiating for alternative rites of passage for the girls in place of FGC was undertaken.

These fora were crucial to helping mothers and girls meet, which is not a norm in the community and also supporting the decisions that they come up with.

Towards change among nomadic girls and women

The safe spaces and social networks have led to transformational changes among nomadic girls. Girls' access to RH information through the safe spaces in the community has increased, their sources of support have grown and they have gained confidence and self-esteem after learning new skills.

Teachers and church leaders testify to these changes. Forty-six safe spaces or girls' fora have been established with 432 girls meeting every month to discuss RH issues and ultimately 7,963 girls have been reached. The girls' fora have proposed the introduction of an alternative rite of passage as a viable option for FGC (NYRHP Reports 2008-2010).

Communities' attitudes about girls' involvement in public activities are changing and male leaders have become more positive and supportive of girls' efforts to improve their reproductive health. This is unlike before when girls had no control over their sexuality and major decisions rested with the parents, especially the father, who could give them away in marriage without consulting them.

Parent-teen communication has also improved. Mothers are eager to bring their daughters to the Mother-girls fora to jointly discuss reproductive health issues. These discussions enable girls to express what they know and communicate their desires in matters of sexuality. Through the fora, girls have explicitly said that FGC is harmful to their lives and curtails their education, as fathers want to marry them off after circumcision. Thus FGC is a major cause of early marriage.

Gracie Lenaibankinyela, aged 40, also a member of one of the mother-girls fora, has a daughter in class six at Oldonyonyokie Primary School. She heard about the forum from other women while fetching water. She was informed of the risks and consequences of FGC as she planned to circumcise her daughter and decided against the girl undergoing the rite.

> *"Girls and mothers also did beadwork during their discussions"*

In 2009, 46 girls successfully rejected FGC and sought refuge at schools that offer protection to girls escaping the rite. Four circumcisers have also publicly denounced FGC and said that they will no longer circumcise girls.

Greater community confidence in discussing sensitive cultural issues is being observed. At baseline, the community was silent on matters of reproductive health. For example, FGC was a taboo subject never discussed in the presence of young people and in-laws.

Currently, young people discuss the subject with their parents and the community is no longer shy to broach the subject. Through these discussions, the community is beginning to appreciate the value of using modern contraceptive methods and treating STIs.

When the project started, girls could not open up and express themselves in mixed fora in boys' presence. Maasai women are not supposed to speak in the presence of men. However, as a result of exposing the girls to open discussions in the safe space fora and mother-girls fora, girls have learnt to speak without fear even before the men.

Lessons learned

- Conventional youth programming does not reach the large population of marginalised and disadvantaged nomadic girls who are in need of reproductive health information and services. Innovative approaches which consider the socio-cultural and economic environment are better able to address the reproductive health challenges of the nomadic youth.
- In order to increase girls' participation in reproductive health issues, it is important to create a safe environment for them and to involve their mothers in issues of SRH.
- To successfully give nomadic girls and mothers a voice in their reproductive health requires the support of the cultural leaders who give direction on various issues in the community.
- Safe spaces and social networks for girls are powerful strategies for RH advocacy at the community level.

Challenges

Normalisation of safe spaces: this being an idea that is not in the mainstream Maasai culture is no small task. Sustainability mechanisms should be explored so that the approach is part of the Maasai society even after the end of the project.

Opportunities

- Other studies among the Maasai community have shown that men are key decision makers. Therefore, bringing young warriors *(morans)* on board is very important, as they are custodians of culture. Practices such as early marriage, FGC and multiple partners are cultural. In order to change such practices, male involvement at all levels is critical. Since Maasai men are socially organised, their cultural structures should be used to involve them in improving SRH among girls and women as well as their own.
- Income-generating activities are crucial to improving livelihoods among women and also enhancing autonomy. Embedding this in mothers' groups would empower women and hence improve their lives and that of their daughters.

"In 2009, 46 girls successfully rejected FGC and sought refuge at schools that offer protection to girls escaping the rite."

Maasai mother with her child in Loitokitok, Kenya. (Photo by Jeroen van Loon/AMREF).

Future plans

The project plans to carry out a comprehensive sample survey on sexual reproductive health and compare the outcomes to baseline values to gauge if there has been any significant change in the sexual and reproductive health indicators of nomadic girls. Also, new media such as mobile phones should be incorporated in the interventions so as to upscale dissemination of SRH information and services to mothers who can then share with their girls. ■

Anne Gitimu
Project Officer - Kibera Integrated School Health Project

Peter Nguura
Project Manager - Nomadic Youth Reproductive Health Project

Charles Leshore
Project Assistant - Nomadic Youth Reproductive Health Project

David Kawai
Project Officer - Nomadic Youth Reproductive Health Project

Correspondence

Anne Gitimu
E-mail: anne.gitimu@amref.org

Peter Nguura
E-mail: peter.nguura@amref.org

Charles Leshore
E-mail:charles.leshore@amref.org

David Kawai
E-mail: David.Kawai@amref.org
African Medical Research Foundation-Kenya
P.O. Box 30125-00100
Nairobi, Kenya

References

1. Centre for Study on Adolescence. 2009. Innovative approach to sexuality education of young people piloted in Kenya. Region Watch; Sexuality in Africa magazine
2. Judith Bruce and Kelly Hallman. 2008. Reaching the girls left behind, Gender and Development, 16:2,227-245
3. National Coordination Agency for population and development. 2005. Kajiado District Strategic Plan (2005-2010). Ministry of planning and National development.

Other references for this article are available at htt://www.exchange-magazine.info/.

Exchange ON HIV AND AIDS, SEXUALITY AND GENDER

Promoting modern family planning among Tanzania's nomadic communities

By Henerico Ernest, George Saiteu and Godson Maro

Women and girls are responsible for all domestic tasks. (Photo by Jeroen van Loon/AMREF).

Use of modern family planning among nomadic communities in many African countries is still limited. A study in Kilindi District of Tanzania revealed that although many nomadic youth know about modern family planning methods, they do not use them due to various factors, including cultural beliefs, sexual norms, stigma and fear, long distances to health facilities and male dominance in decision making.

Family planning (FP) refers to use of measures designed to regulate the number and spacing of children within a family[1]. It contributes to maintaining the health of the mother, children and the entire family, ensuring that each family member has access to the limited available resources for survival. Access to family planning is critical for birth spacing and protection from unwanted pregnancy and the achievement of women's reproductive health desires. This has an additional value in terms of other reproductive health issues, such as deciding on the place of delivery, and prevention of sexually-transmitted infections (STIs) including HIV. It is especially pertinent to the nomadic communities.

Experience from the Nomadic Youth Sexual and Reproductive Health project, in Kilindi, shows that nomadic communities do not use modern family planning. The reasons are both social-cultural and structural. Kilindi District is in the Tanga region of north eastern Tanzania. It has four administrative divisions and 20 wards. Nomadic communities reside in six of these wards.

Deprivation of sexual rights has been a persistent social-cultural problem. For example, nomadic women in the area are subjected to forced sexual abstinence for three years after conception and are severely punished if they conceive through extramarital affairs. Knowledge, awareness and access to modern FP methods that can postpone pregnancies but allow sexual contact within marriage can minimise the risks of unplanned pregnancies, STI s and HIV.

Improvement and increase of FP services uptake and use of health facility-based maternal health care services will contribute to the achievement of MDG5, which deals with the improvement of maternal health. Data from the Tanzania Demographic and Health Survey (TDHS) of 2004/5 shows that total demand for FP in Tanga region was 60.6 per cent and unmet need for family planning stood at 20.1 per cent[2].

A study on factors influencing FP and maternal health care uptake was done in the six wards of Kikunde, Pagwi, Mvungwe, Kisangasa, Saunyi and Mkindi. Findings would inform the ongoing Nomadic Youth Sexual and Reproductive Health Programme and interventions by other stakeholders.

Objective of the study

The study sought to contribute to improved maternal and reproductive health of nomadic communities in Tanzania, by establishing factors relating to uptake of FP and maternal healthcare services among youth in Kilindi district. During the study, 583 youth responded to a questionnaire on FP. Additionally, observational check lists were used to collect information from 10 health facilities in the district, while focus group discussions (FGD) and in-depth interviews provided a broader perspective from people on the subject. Focus group discussions were done with groups of mixed ethnicity and for different age categories. They included 12 male groups and a similar number of female groups. Forty in-depth interviews were held with respected traditional leaders, religious leaders, government officials, traditional birth attendants, traditional healers, health service providers, the district reproductive

Fathers and their children wait for services at a health post in Tanzania. (Photo by Jeroen van Loon/AMREF).

and child health coordinator and selected youth representatives from the community.

Knowledge and access to FP methods

The study showed that 77 per cent of the youth have some knowledge of modern FP methods and know at least one method of avoiding pregnancy such as condom use, injectables and pills. The majority of other key informants also understand the term family planning. During a focus group discussion in Kikundu ward, a woman in the 21 to 30 years age group said: "…family planning is a child birth plan set by both father and mother regarding the number of children and child spacing they want…"

Most key informants said that FP methods and services were available at dispensaries. However, they were aware that they had to buy injectables at health facilities. Pharmacies, peer educators and community-based distributors were mentioned as the sources of condoms and pills, but since not every village has a pharmacy or a dispensary, distance from these facilities affected usage. It was further noted that free condoms were easily available from health centres as well as community distributors.

Cultural reasons hindering modern family planning uptake

People distrust modern FP methods because of their side-effects. Some women believe that if they use oral pills, they will become infertile. Such women prefer to use traditional methods such as breastfeeding, abstinence, the withdrawal method and other less scientific methods such as wearing pieces of sticks around their waist (which is supposed to prevent pregnancy while worn), or the myth that drinking cold water after having sex will prevent pregnancy. A respondent at Chamtui Village described a traditional method during an FGD: "…there is one traditional method, there is a piece of some kind of tree they do get from traditional midwives, they call it *mapande*, which they wear around their waist to avoid getting pregnant until they remove it."

The project has, however, been providing community health education, sensitising and mobilising them on the use of available reproductive health services and at the same time debunking FP myths.

A traditional healer pointed out that most Maasai people use the 'breastfeeding method' of family planning. During the two years of breastfeeding, the mother is not allowed to play sex with her husband. Other respondents reported that when the woman is four months pregnant, she stops having sex with her husband till the baby is two years old. The husband is fined two or three cows if he violates this rule.

> *"…family planning is a child birth plan set by both father and mother regarding the number of children and child spacing they want…"*

The responses indicate that cultural practices can protect women from unwanted pregnancy, but the women are denied sex for two years.

The reality is different for men as some are polygamous or have extramarital affairs and end up exposing their wives to STIs, including HIV.

While study results show that some traditional methods are effective in family planning, others are based on beliefs, norms, stigma and fear and influence use of modern FP methods and maternal healthcare services. Decisions on family planning are taken only by husbands or, in their absence, by other males in the family. They decide on the number of children women can have and the spacing between them.

Women are not involved in decision making on FP and are only partially protected by traditional methods mentioned earlier.

Lack of knowledge, especially on the importance of using family planning and distance from health delivery points, also leads to decreased use of modern FP. There is need for a campaign to influence people to change their attitude towards using modern FP methods and explain their efficacy and benefits.

In Kilindi, males make decisions on health service utilisation and on modern FP in particular. It is vital that women are involved in making these decisions because they affect their health.

Lessons learned

- Most people in nomadic communities know some methods of modern FP but they do not use them because of deeply-ingrained myths and cultural beliefs such as the idea that modern FP methods cause infertility.
- Some people want to use modern FP methods, but are hampered by long distances to health facilities.
- Some women are willing to use modern FP methods, but they encounter resistance from their male partners/husbands who generally hold the decision-making power in the relationship.
- Traditional methods of FP are mostly used instead of modern ones because they are readily available, have no side-effects and are trusted.

Young mother and child in Kilindi, Tanzania.
(Photo by (Photo by Jeroen van Loon/AMREF).

Challenges

It will require concerted effort by government, civil society organisations and communities to bring about the desired changes. However, the following challenges stand in the way of increasing the uptake of modern FP: women need to be involved in decision in all matters relating to their reproductive health, especially modern FP utilisation, without entering into conflict with cultural norms and values and people need to be mobilised to utilise health facilities while also respecting traditional family planning methods.

Recommendations

The government should take measures to offer efficient health services to the communities including locating health facilities closer to the people. Non-governmental organisations should also be involved by supplementing government FP and maternal heath campaigns especially through education programmes to change people's attitude and wrong perceptions on modern FP. Lastly, the community should work hand-in-hand with government, NGOs and MoHSW in emphasising the importance of FP. Knowledgeable community members such as village health workers should educate other members of the community on the importance of using modern FP.

In conclusion, government and NGOs should provide education on modern FP with a view to influencing the nomadic communities of Kilindi to use the methods. Approaches toward this goal should include use of peer educators, health educators and other educational networks. Males should also be targeted to change their attitude towards modern FP use. At the same time, women should be empowered to be able to participate in making decisions pertaining to their reproductive health. ■

Lessons learned

- Accessing FP methods is a problem mainly due to long distances to health facilities.
- Some women are willing to use modern FP methods, but they encounter resistance from their male partners/husbands.
- Traditional FP methods are popular because they are readily available, have no side-effects and are trusted.

Acknowledgement

We thank the Dutch Ministry of Foreign Affairs for funding this study. Also our gratitude goes to the National Institute for Medical Research for support during research processes and also the Kilindi community for accepting to be involved in this research. We also thank Kilindi District authority for allowing this study to be conducted in the district.

We sincerely thank Anke van der Kwaak and Gerard Baltissen from the Royal Tropical Institute (KIT) of Amsterdam, Netherlands for facilitating at the writeshop at which this article was written.

Henerico Ernest
Project Officer- Monitoring, Evaluation and Research
Nomadic Youth Sexual and Reproductive Health Project (NYSRH)

George Saiteu
Project Assistant
NYSRH Project

Dr Godson Maro
Project Manager
NYSRH Project

Correspondence

Henerico Ernest
E–mail: Henerico.Ernest@amref.org

George Saiteu
E–mail: George.Saiteu@amref.org

Dr Godson Maro
E–mail: Godson.Maro@amref.org
AMREF-Tanzania
1019 Ali Hassan Mwinyi Rd
Upanga
P.O. Box 2773
Dar es Salaam - Tanzania

Reference

1. http://encyclopedia2.thefreedictionary.com/family+planning.
2. Bureau of Statistics Planning Commission (Tanzania)
3. Macro International Inc: Tanzania Demographic and Health Survey 2004/5.

Other references for this article are available at htt://www.exchange-magazine.info/.

Maternal health beliefs, attitudes and practices among Ethiopian Afar

By Jemal Yousuf, Mazengia Ayalew and Fentaw Seid

Afar girls prepare a camel to carry their properties. (Photo by Demissen Bizuwerk/AMREF).

Studies among the Afar of Ethiopia have revealed that maternal health is affected by factors that include transport and women's education besides availability of health infrastructure and skilled health workers. Cultural beliefs, attitudes and practices have also been found to be critical in determining mothers' health.

Maternal health refers to the health of women during pregnancy, childbirth and the post-delivery period. While motherhood is often a positive and fulfilling experience, it is linked to suffering, ill health and even death for too many women.

Ethiopia's maternal morbidity and mortality rates are among the highest in the world[1,2,3] with the situation of Afar women being particularly dire. The Afar population is estimated at 1.5 million, with 90 per cent of them adhering to a pastoral lifestyle. Among the Afar, maternal mortality is 801 per 100,000 live births, compared to the national average of 673 per 100,000.[4,5] In 2007, a programme was initiated to address some of these problems. The Pastoralist Reproductive Health Programme was funded by the Dutch Ministry of Foreign Affairs through the African Medical Research Foundation (AMREF) in the Netherlands. The four-year project started in January 2007 and ended in December 2010.

Some major challenges were identified during the programme's implementation and related studies. Notably, the Afar showed scanty use of health services, particularly those related to mothers' health.

To better understand this, we carried out a study on availability and accessibility of services focusing on culture, attitudes, beliefs and practices that influence use of maternal health services. The objective of the study was to explore factors contributing to the low use of maternal health services among the Afar.

Methodology

A community-based qualitative study was conducted in Afar Regional State from April to May 2010 to understand the local birth culture and the cultural beliefs, attitudes and practices that influence the use of maternal health services. The study was carried out through 47 in-depth interviews and four focus group discussions (FGDs) with women of child bearing ages, trained traditional birth attendants (TTBA), and key informants.

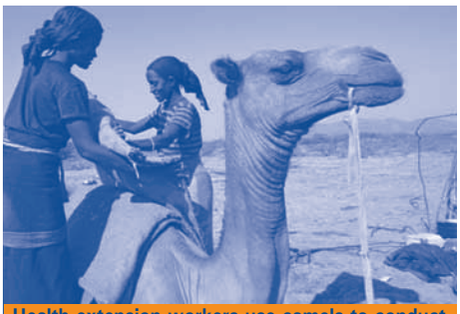
Cultural beliefs, attitudes and practices of maternal health

Use of maternal health services is influenced by cultural beliefs, attitudes and practices of the pastoralist community. There are several cultural barriers to women's use of health facilities. One of them is women's fear of male midwives touching their bodies, especially their reproductive organs. Afar women are reluctant to be examined by male midwives as stated during a focus group discussion with women of child-bearing age: "It is only God and my husband who have the right to see me naked. It is really impolite (culturally) and unacceptable in Afar to expose the reproductive health organs."

Other women had been afraid to be treated by non-Afar medics. However, the situation had changed due to education and awareness-creation by the health personnel. There was now acceptance of being attended to by non-Afar and most women also now recognised the need to go to health facilities. Another woman respondent in an FGD said: "We used to deliver at home. But now we go to health facilities. It is as a result of health education delivered to us at home by health professionals."

The main reasons for delayed referral to health services and preference for home delivery are religious beliefs and traditional attitudes within the community. When pregnant women fall sick, they often seek advice from traditional birth attendants (TBAs) and traditional healers. TBAs and traditional healers often keep them at home and pray for them (make 'du'aa') in the hope that they will recover. Religious leaders also provide advice on reproductive health issues to the community in line with the Quran. Some religious leaders conduct rituals when the pregnant women approach them with health and social problems.

The male decision in maternal health is crucial to permitting women to go to health facilities as well as providing money for treatment. Language barriers and diseases like HIV and AIDS also discourage use of health services. "If we go to the health facility, there is a possibility of being referred to another. In the towns we don't have relatives where we can spend the night. The other issue is we cannot speak Amharic and we cannot communicate with people. So we are afraid to go to health facilities unless we have a serious problem," said a woman key informant at Awash District, the study site. The formal health system is also not particularly 'sensitive' to the preferences and traditions of the pastoralist community. For example, according to an informant, delivery beds that allow for a semi-sitting position are not available in the health facilities.



Health extension workers use camels to conduct home visits in remote places.(Photo by Demissen Bizuwerk/AMREF).

According to TTBAs and health providers, the preference for the sitting position by the Afar women while delivering, which they believe hastens the delivery, is not practised in health facilities, and is yet another factor that discourages them from delivering in health facilities.

Services offered vary based on the type of facility and the health providers' competence. The range of services offered by a health facility was found to play a role in giving pregnant women confidence to use them. A facility offering caesarean section fully-equipped with drugs, equipment, supplies and with trained personnel can inspire confidence in its clients. "The deployment of a gynaecologist paid by AMREF has brought a difference in terms of ultrasound equipment utilisation, ANC follow-up and related services," a health provider in Awash said.

Discussion

Cultural beliefs, attitudes and practices are the main factors affecting maternal health in Afar. These factors along with pastoralist community mobility patterns and the inaccessibility of existing health facilities have resulted in low use of antenatal services, delivery and postnatal care as revealed by discussants and key informants in this study.

Pastoralists' use of health facilities

Traditional health services were designed for sedentary communities and are generally unsuited to nomadic lifestyles. Therefore, static structures cannot adequately serve the mobile communities who live in the vast and sparsely populated dry lands of the Rift Valley. Moreover, delivery facilities are often inappropriate for the needs and preferences of the population. The study found that in Afar, 53.9 per cent of settled communities used health facilities compared to 46.1 per cent for nomads. On the other hand, during adverse weather conditions such as drought that lead to massive cattle loss, there was pressure on modern health services.[6]

Why pastoral women prefer home delivery

Home delivery is preferred due to the accessibility of the untrained TBAs and is generally accepted by pastoralist communities who live in remote areas where there is no functional health facility. This finding confirms a previous study done in North West Ethiopia that revealed why women preferred to deliver at home. The presence of relatives, trust in TBAs, cultural reasons and lack of money were among reasons why the women shunned health facilities.[7] Informants repeatedly said inadequate capacity, shortage of drugs and other supplies, lack of skilled personnel and preference for female midwives were among the reasons why they did not use health facilities.

Despite several capability gaps with TTBAs to manage complications, communities express more positive experiences with them than the formal health facilities. This result is consistent with the findings of Mesfin et.al.[8] who reported preference for TBAs as a result of trust. Home delivery is social, cultural and economical. It is social in terms of its capacity to lend itself to the performing of all the rituals and festivities (if the neonate and the women are healthy); easy access to meat and milk, or 'an honourable burial' – in case of death. It is cultural, because women always report health facility delivery as "not our tradition" while it is economical because it is less costly, less time-consuming and does not remove one from the domestic chores.

Decision-making about maternal health

The husband makes most decisions on maternal health within the study area because of traditional male dominance. Husbands and senior family members, such as in-laws, strongly influence women's use of health facilities. The most dominated are younger women with no formal education. Thus, it is important to target all influential family and community members, including religious leaders, in order to ensure that women have access to essential health services that can improve their health. This is particularly important because of evidence suggesting that there is a wide variation in attitudes towards and perceptions of the value of health services, not only between but within ethnic and religious constituencies.[9]

Factors that delay maternal health care

Women and traditional healers define 'problems of pregnant mothers' as physiological and spiritual. According to Mesganaw and Getu, such classifications lead to a conclusion that modern health institutions are not helpful for certain disease conditions. The physiological abnormalities such as bleeding, prolonged labour (if it does not respond to du'aa — prayer) and swelling of feet are understood to require attention of formal health service providers, while dizziness, puerperal psychosis, protrusion of tongue, prolonged labour and lack of appetite are mostly associated with jinni (evil spirit) and are to be dealt with by traditional healers and religious leaders.

There are three types of delay caused by low levels of skilled attendance, which contribute to high maternal deaths. The first delay regards deciding to seek care at the household level, caused by lack of information and inadequate knowledge about danger signals during pregnancy and labour; cultural/traditional practices that restrict women from seeking health care and lack of money.

The second delay involves inability to access health facilities due to poor roads and communication networks and poor community support mechanisms.

The third delay regards the length of time between arriving at the health facility and receiving care. This results from inadequate skilled attendants; poorly-motivated staff; inadequate equipment and supplies and a weak referral system.

A young mother receives information about breastfeeding from a community health worker. (Photo by Demissen Bizuwerk/AMREF).

Lessons learned

- Traditional delivery beds should be provided in health facilities because Afar women believe that the sitting position during delivery speeds up the labour.
- A static health facility is not helpful for pastoralist lifestyles because they are not accessible and do not respect Afar cultural beliefs.
- Female midwives are needed in the health facilities to attract Afar women who abhor being attended to by males.

Continued on page 14

Sexual and reproductive health challenges among Botswana's San women

By Edward Pettitt

The San, also known as 'Basarwa' or 'Bushmen', are the first peoples of southern Africa and are well known for their traditionally semi-nomadic hunter-gatherer lifestyle as depicted in the popular 1980 comedy film *The Gods Must Be Crazy.* Though many people still imagine the San as untouched 'stone-age' hunters roaming freely in the bush, this image is far from the present-day reality. Over time, the San have been displaced and have lost the rights to their ancestral lands and natural resources to farming, livestock production, mining and the development of game reserves.

A group of San women performing a traditional dance. (Photo by Edward Pettitt).

The oppression and discrimination the San have suffered have resulted in a spectrum of poor health. While all southern African San are exceedingly marginalised due to their ethnic minority status, San women also face gender-related stigmatisation and abuse, which has particularly harmful effects on their sexual and reproductive health.

The Case of New Xade

In recent years, researchers and development workers have voiced concern that San women are losing the relative equality they once experienced with their male counterparts[1]. Though San women, proficient in specialised gathering techniques, were once the main providers of food and enjoyed high status in their communities, recent socio-economic and political changes have resulted in the loss of a large amount of their autonomy and influence.

These societal changes and disruptions in gender equity are especially evident in New Xade, a village of primarily San residents,

Continued on page 15

Continued from page 13

Conclusion

Opportunities: Conveying health information through daggu — a traditional way of communicating among Afar people after greetings — which includes health, social, political, environmental and other issues. This can be exploited by programme implementers and development actors.

Ensuring physical access to static health facilities and ensuring that they are staffed with trained human resources is vital, but not the main solution for improved use of maternal health services. Physical distance is not the only barrier.

Socio-cultural issues are barriers too. These barriers can be adequately addressed when communities work together with the health authorities to jointly design suitable health systems that respond to the maternal health needs of pastoralists. ■

Lessons learned

- Traditional delivery beds should be provided in health facilities because Afar women believe the sitting position during delivery speeds up the labour.
- Static health facilities are not helpful for pastoralist lifestyles because they are inaccessible and culture-insensitive.
- Female midwives are required in the health facilities to attract Afar women who abhor being attended to by males.

Jemal Yousuf
Pastoralist Project Manager

Mazengia Ayalew
Project Officer

Fentaw Seid
Project Assistant

Correspondance
Jemal Yousuf
E-mail: jemyous@yahoo.com
Mazengia Ayalew
E-mail: mazengia2007@yahoo.com

AMREF Ethiopia
House Number 629
Kebele, 12, Wereda 16
Djibouti Rd, Opposite St. Gabriel Hospital
P. O. Box 20855, Code 1000
Addis Ababa - Ethiopia

Reference:

1. Ethiopia Demographic Health Survey of 2005.
2. National Reproductive Health Strategy 2006-2015.
3. Family Health Department, Federal Democratic Republic of Ethiopia Ministry of health. 2006. Report on Safe Motherhood Community-based Survey, Ethiopia.

Other references for this article are available at http://www.exchange-magazine.info/.

A San mother and her child in the Central Kalahari Game Reserve. (Photo by Edward Pettitt).

who were relocated from the Central Kalahari Game Reserve in the late 1990s and early 2000s by the Botswana government as part of the largest resettlement programme ever undertaken in the country.

The village is located some 100km from Ghanzi, the district capital, and 70km from Xade, the former settlement in the game reserve. The results of this massive upheaval include increased sedentarisation, a socio-economic shift to pastoralism and wage labour and increased contact with strongly patriarchal majority groups such as the cattle-herding Tswana, Botswana's majority ethnic group.

Deprived of their traditional livelihoods and thrust into a foreign way of living, one in which the foraging contributions of women are viewed as inferior to the cattle-rearing and wage labour of men, the relative gender equality of San women in New Xade has diminished considerably.

Examining the problem

Though relocating the San from the Central Kalahari Game Reserve to New Xade may have improved their access to modern health facilities and social welfare programmes, the abrupt removal from their ancestral homeland and traditional semi-nomadic hunting and gathering lifestyle also had major, perhaps unintended, negative results. The effects of sedentarisation on women's reproductive health in New Xade and other San settlements are of great concern, as the following examples show.

Early childbearing and shorter birth intervals

A 2001 report by the Legal Assistance Centre based in Namibia suggested that the San's transition to a sedentary lifestyle has resulted in early sexual relationships and shorter birth intervals among women[2] Although some of the study's San informants disagreed on whether early sexual activity was prevalent in the past, many San parents today disapprove of such behaviour since it often results in their girls dropping out of school at young ages. The report also notes that the demands of the San's former semi-nomadic foraging lifestyle encouraged a relatively long average child spacing of four years, whereas the length of time between births has become much shorter with the adoption of a sedentary lifestyle.

Furthermore, the boarding hostel environment, in which hundreds of students are sent to towns far away from their families and live together in cramped quarters for several months at a time under the supervision of only one or two adults, has been identified as a key factor contributing to sexual harassment and pregnancy amongst female San students.[3]

Alcohol abuse and gender-related violence

According to a 2006 *Lancet* article, the increase in alcoholism among the San can be attributed to their loss of land, traditional livelihoods and community cohesion. It has also been linked to increased gender-related violence, especially among young people[4]. In New Xade, a community of fewer than 1,500 residents, there are more than a dozen shebeens, or home breweries. Although shebeens are illegal, alcohol licensing is rarely enforced and they have become a breeding ground for raucous behaviour and gender-based violence.

Rampant alcohol abuse is not unique to the San and has also been seen in other dispossessed indigenous communities that have lost traditional lands and livelihoods without viable alternatives, resulting in boredom and frustration, especially among the youth.

Advocating for change

Clearly, there is a need for governments, development agencies and community organisations to develop tailored and culturally-sensitive strategies to address the sexual and reproductive health challenges of the San in general and their women in particular. There is also a need for locally-initiated and culturally-sensitive HIV and AIDS and STI prevention campaigns in San communities.

Appropriate policy frameworks and national gender policies should be enacted to address existing inequalities and comprehensive life skills education, including components on sexual and reproductive health, teen pregnancy, alcohol abuse and gender issues, should be offered for youth in both school and community settings.

The Kuru Family of Organisations (KFO)

Organisations that aim to empower the San should spearhead efforts to address concerns related to gender inequalities and reproductive health.

One such organisation is the Kuru Family of Organisations. Kuru began as a community empowerment initiative of the Dutch Reformed Church located on freehold farm in Botswana's Ghanzi District. It is now a multi-dimensional non-governmental organisation operating in numerous settlements and districts.

In the past, Kuru's mission and vision statement explicitly mentioned "equality between men and women" as a "traditional value… of our culture [which] the day-to-day activities of Kuru should reflect" (as quoted in Felton & Becker 2001). Though the current mission and vision statements have omitted specific references to gender equality, gender equity remains central to the Kuru ethos. The KFO Community Health Programme, for example, works with the San in remote areas, including New Xade, to enhance social mobilisation for positive health promotion and increased access to gender-affirmative health and welfare services.

Continuous engagement through community conversations, such as a World AIDS Day event in which local San women were encouraged to voice their views on access to HIV counselling and testing services, is an activity that can be enhanced and replicated locally and regionally.

Conclusion

San are affected by numerous health issues that stem from their marginalised status in Botswana and other southern Africa countries. San women are particularly vulnerable as they suffer double stigmatisation due to their ethnicity and their gender; they are particularly affected with regard to their sexual and reproductive health. Furthermore, the effects of social disenfranchisement, poverty and gender inequalities are compounded by alcohol abuse.

The case of New Xade further illustrates the severity of these issues and the need for culturally-sensitive approaches towards sexual and reproductive health promotion in San communities.

References

1. Felton, S. et. al. 2001. A gender perspective on the status of the San in Southern Africa. Legal Assistance Centre: Windhoek.
2. Le Roux, W. 1999. Torn Apart: San Children as Change Agents in a Process of Acculturation. A Report on the Educational Situation of Children in Southern Africa. Ghanzi, Botswana: Kuru Development Trust and Windhoek, Namibia: Working Group of Indigenous Minorities in Southern Africa.
3. Ohenjo, N. et. al. 2006. Health of Indigenous People in Africa. The Lancet, 367: 1937.

Other references for this article are available at http://www.exchange-magazine.info/.

How universal is access to reproductive health? A review of evidence

UNFPA. 2010

This new report by UNFPA analyses three often overlooked indicators of reproductive health: the adolescent birth rate, the contraceptive prevalence rate, and the unmet need for family planning. The report demonstrates that intensified efforts are needed to extend reproductive health to all, and that quality data are essential to monitor progress and identify priorities for action. ■

Find the PDF at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf

Maternal health: Investing in the lifeline of healthy societies and economies

WHO. 2010

One woman dies per minute in childbirth around the globe. Almost half of these deaths occur in sub- Saharan Africa. Despite the progress made in many countries in increasing the availability of maternal healthcare, the majority of women across Africa remain without full access to this care.

Three key approaches can considerably improve the health of women in Africa: maximising services of health workers; efficient financing mechanisms; and building political partnerships. ■

A PDF can be found at: http://www.who.int/pmnch/topics/maternal/app_maternal_health_english.pdf

The Case for integrating Family Planning and HIV/AIDS services: Evidence, policy support, and programmatic experience

USAID and FHI. 2010

The Case for Integrating Family Planning and HIV/AIDS services: Evidence, policy support, and programmatic experience set of briefs summarises the current state of integration between the family planning (FP) and HIV and AIDS fields. The briefs highlight recent developments in FP/HIV integration, including changes in the policy environment, new programmatic examples, and the latest operations research results. ■

Fro details, visit the PDF: http://www.fhi.org/en/RH/Pubs/servdelivery/FP_HIV_brief_package.htm

Women's sexual and reproductive health and rights in Ethiopia

Change. 2010.

Lack of access to contraception and voluntary family planning services is an ongoing challenge that women and families face in Ethiopia. These factors, exacerbated by gender inequality and harmful traditional practices, have led to high rates of maternal morbidity and mortality, including many deaths and injuries due to unsafe abortion. In response to these health challenges, the Ethiopian government has developed an integrated and comprehensive health approach through its health extension programme. ■

For more details visit: http://www.genderhealth.org/files/uploads/change/publications/CHANGE_Ethiopia_Study_Report_web_FINAL.pdf

The State of the world's midwifery

This two-pager is intended to strengthen midwifery capacity around the world. It has a lot of new information and data from 60 countries to examine the number and distribution of health professionals involved in the delivery of midwifery services; explore emerging issues related to education, regulation, professional associations, policies and external aid; analyse global issues regarding health personnel with midwifery skills, most of whom are women, and the constraints and challenges that they face in their lives and work and call for accelerating investments for scaling up midwifery services, as well as improving the skills of health care workers. ■

For more information, visit: http://gallery.mailchimp.com/19e3ec468ca65221a5c885f5a/files/SoWMy_FACTSHEET_EN_Final1.doc

Eight Lives: Stories of reproductive health

United Nations Population Fund (UNFPA). 2010

This publication relates the life stories of eight women who have endured various challenges related to poor reproductive health. Each story - from Bangladesh, Egypt, Guatemala, India, Moldova, Niger, Uganda and Zambia - gives a voice and a face to those most affected by the failures of dysfunctional health systems — and by gender inequality, violation of their human rights, blatant disregard for their social and cultural circumstances, and abject poverty. ■

To read their stories, see publication at:

PDF: http://gallery.mailchimp.com/19e3ec468ca65221a5c885f5a/files/eight_lives.pdf

UN Women launches its website

The UN organisation dedicated to gender equality and the empowerment of women, has officially begun its work. UN Women was created by a UN General Assembly resolution in July 2010, becoming fully operational on 1 January 2011. It merges and builds on four parts of the UN system: Division for the Advancement of Women, International Research and Training Institute for the Advancement of Women, Office of the Special Adviser on Gender Issues and Advancement of Women and United Nations Development Fund for Women. ■

Visit the agency's website at: http://www.unwomen.org

Getting to zero: 2011–2015 strategy

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010.

The strategy aims to serve in developing UNAIDS' partners' strategies to ensure more focused, aligned and country-owned responses and to guide investments to deliver innovation and maximum returns for people most in need. Building on the principles and priorities of the UNAIDS Outcome Framework, this Strategy will also serve as the platform to define the United Nations' operational activities and resource allocation for HIV. ■

For more information, see the PDF at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf

Making medical male circumcision work for women

The new report from AVAC and ATHENA Network's Women's HIV Prevention Tracking Project is an unprecedented collection of voices from Kenya, Namibia, South Africa, Swaziland and Uganda. It documents women's perspectives on male circumcision for HIV prevention and is based on the input of approximately 500 women in HIV-affected communities who were interviewed to elicit knowledge, opinions and recommendations.

Fro more information visit: http://gallery.mailchimp.com/19e3ec468ca65221a5c885f5a/files/Making_MMC_work_for_women_DEC10.pdf

Global HIV prevention progress report card 2010

Global HIV Prevention Working Group. 2010.

Since 2002, the Global HIV Prevention Working Group has issued regular reports on key topics relating to HIV prevention. These reports have included a range of high-priority recommendations to key stakeholders. To promote transparency and accountability in the HIV response, the Working Group analysed publicly available data and surveyed Working Group members to assess the degree to which the Working Group's recommendations have been implemented. ■

For more details, visit: http://www.kff.org/hivaids/upload/Global-HIV-Prevention-Progress-Report-Card-2010-PDF.pdf

Fast Car: Travelling safely around the world.

UNESCO.

Fast Car:Travelling safely around the world is a racing game that helps you to learn about HIV and AIDS prevention and takes you on a tour of some of the World's Heritage sites. The game aims to provide young people with accurate and reliable information about HIV prevention, intending to educate and entertain as well as promoting healthy behaviour. In this game, the player can race on circuits on five continents, and virtually visit some of the UNESCO World Heritage sites. It also presents images of sites and interesting facts about them as players race by.

There are two tracks for each continent - a Preliminary track and a Championship track. Every track has a set of check points. At the check point, one can take part in a Mini-Quiz, and possibly earn a time bonus. In the mini-quiz, the player will be asked a multiple-choice question related to HIV and AIDS prevention. ■

For more details, visit: http://www.unesco.org/new/en/communication-and-information/crosscutting-priorities/hiv-and-aids/fast-car-travelling-safely-around-the-world/

REPRODUCTIVE HEALTH IN NOMADIC COMMUNITIES: CHALLENGES OF CULTURE AND CHOICE

Exchange

is a publication of the Royal Tropical Institute (KIT) in collaboration with Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) in Pretoria, South Africa. Financial support for the production of this magazine was provided by the Dutch Ministry of Foreign Affairs.

Subscriptions for the print edition is 30 euro per year (4 issues); while subscription for the online edition is free. Charges may be waived for local and national level NGOs, health-care services and libraries in resource-constrained countries. See our website for more subscription information. Articles may be reproduced free of charge, provided that the source is credited and clippings are sent to the publishers.

***Managing editor:** Eliezer F. Wangulu (KIT)*

***Executive editors:** Eliezer F. Wangulu (KIT) and Vivienne Kemohan (SAfAIDS), E-mail: vivienne@safaids.org.zw.*

***Secretarial and administrative support:** Dorothy Timmerman and Ewa Cudowska (KIT)*

***Line-editing:** Tendayi Kureya, Zimbabwe*

***Editorial advisors:** Christine Ricardo, Consultant, E-mail:cricardo@alum.wellesley.edu, Jitendra Panda, Programme Development and Funding Officer for Progressio - Yemen and Somaliland, E-mail: jn_panda@yahoo.com and Anke van der Kwaak, Senior Health Advisor Royal Tropical Institute, The Netherlands, E-mail: a.v.d.kwaak@kit.nl.*

***Lay-out:** Kingston Ogango & Company, Nairobi, Kenya*

***Printer:** robstolk®, The Netherlands*

ISSN: 1871-7551

Exchange Magazine

Royal Tropical Institute
Information & Library Services
P.O. Box 95001
1090 HA Amsterdam, The Netherlands
E-mail: exchange@kit.nl
Web: http://www.exchange-magazine.info

Royal Tropical Institute

SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service