

# Understanding nomadic realities

## Case studies on sexual and reproductive health and rights in Eastern Africa

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# Preface

Since its foundation in 1957, the African Medical and Research Foundation (AMREF) has been dedicated to working with disadvantaged communities: the very poor, marginalized rural and urban populations, internally displaced, refugees, those experiencing chronic insecurity and nomads. Nomadic communities constitute a special category of socially and economically excluded group because of their unique lifestyles and the challenges of designing appropriate health services that meet their needs.

Services for disadvantaged communities that have little opportunity to engage with policy- and decision-makers are prioritised using the '*health systems approach*' to health in development. This approach recognises that a principle barrier to good health among poor communities is the gap between communities and formal health systems. The core of AMREF's business is to close this gap.

Within the Dutch funded Regional Nomadic Youth Reproductive Health Programme, baseline and end line quantitative studies were planned both for informing the project and building capacities in research among AMREF and government counterpart staff. Besides these studies, qualitative studies were undertaken to look into emerging issues that enable AMREF and partners understand better programming among nomadic communities.

The project aimed at addressing the daunting challenge of improving the sexual and reproductive health of nomadic youth aged between 10 and 24. The programme's specific objectives included: delivering sex education both for in- and out-of-school youth; improving access to quality and youth-friendly SRH services; reducing maternal and neonatal mortality; and countering dangerous 'traditional' practices (mainly focusing on female genital cutting). These are areas with relatively little research and documentation and therefore this project broke new ground in systematic documentation of these experiences. Within the AMREF Business Plan, this project has made a big step in the implementation of the AMREF operations research agenda.

The project was designed to have teams based in Kenya, Tanzania and Ethiopia. Each project team worked to achieve country-specific objectives which focused on increasing the knowledge and healthy behaviours of nomadic youth; strengthening health services and health personnel in order to provide SRH services and emergency obstetric care; supporting adolescent sexual and reproductive health rights at community, district and provincial levels.

Thanks to the leadership of Dr John Nduba, Technical Director of Reproductive and Child Health in AMREF and Dr Jacqueline Lampe of AMREF Netherlands that a capacity research

process were put in action. A series of workshops in which the full research cycles was shared; training was done in research proposal writing, implementation and analysis; and two write shops resulting in a special issue of the Exchange Magazine and this book. The AMREF staffs who have worked tirelessly to make this a reality deserve special commendation and now constitute an invaluable resource.

To achieve these aims AMREF linked up with the department of Development Policy and Practice of the Royal Tropical Institute (KIT) in the Netherlands to embark on the pathways of operations research. The unique point was that health providers and other AMREF staff were given the opportunity to improve on their research abilities and their writing and analysis skills.

The findings of the studies were used to inform the MFS2 programme currently in operation and at the same time the process led to a positive spill over effect of influencing similar processes within the work AMREF is doing for other programmes funded by DANIDA and the European Union.

Major outcomes of these studies include a better insight in decision-making patterns among the Maasai, understanding better traditional cultural beliefs and their influence in health in Tanzania and insights into the contribution of religious leaders among the Afar in Ethiopia. Understanding these unique contextual factors will without doubt be of benefit to the women, men and other actors within the arena of sexual reproductive health and rights in the region and Africa at large.

**Rumishael Shoo**

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Finally, we would like to thank Jon Stacey for the English editing of the book.

## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
CBHMIS	Community-Based Health Management Information System
CBO	Community-Based Organisation
CBRHAS	Community-Based Reproductive Health Agent
CHMT	Council Health Management Team
CHW	Community Health Worker
CORPS	Community Own Resource Persons
DHS	Demographic Health Survey
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
KIT	Royal Tropical Institute
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MNH	Maternal and New-born Health
NAP-GE	National Action Plan for Gender Equality
NBS	National Bureau of Statistics (Tanzania)
NCPT	National Committee on Traditional Practices of Ethiopia
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research (Tanzania)
NYRH	Nomadic Youth Reproductive Health
PHASE	Personal Hygiene and Sanitation Education
SNNP	Southern Nations, Nationalities and Peoples, Regional State (Ethiopia)
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic Health Survey
TTBA	Trained Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VEO	Village Executive Officer
WHO	World Health Organisation







# 1 Sexual and reproductive health of nomadic peoples in East Africa: An overview

Anke van der Kwaak, Gerard Baltissen, John Nduba, Woutine van Beek, Kristina Ferris and David Plummer

In the year that the global population reached 7 billion, several studies were conducted which examined the health of people who live in remote areas and who lead nomadic lives in Eastern Africa. This book presents some of the findings of those studies.

In order to reach the millennium development goals for reducing maternal mortality and ensuring universal access to reproductive health care (MDG5b), a range of conditions still needs to be addressed. These include: making pregnancies, childbirth and delivery safer; ensuring access to quality skilled care and lifesaving technologies; empowering young women with knowledge that enables access to reproductive health counselling and services; and ensuring that services include access to education, contraceptives, and safe abortion.<sup>1</sup> These prerequisites seem particularly limited for the groups of people in the present studies, namely, women who lead a nomadic way of life in remote areas of East Africa.

There are many initiatives underway that aim to attain the MDGs by 2015. For instance, on December 26, 2010, the Commission on Information and Accountability for Women's and Children's Health was formed by the UN Secretary General Ban Ki Moon, 30 commissioners were appointed from a wide range of stakeholder groups including governments, international organizations, civil society, the private sector, foundations and academia. Co-chaired by President Jakaya Mrisho Kikwete of Tanzania and Prime Minister Stephen Harper of Canada, its mandate was to improve transparency, ensure consistency in reporting for better results, and more effectively track resources spent on maternal, new-born and child health. This was part of the Secretary General's Global Strategy for Women's and Children's Health<sup>2</sup>, of which the *Every Woman Every Child* initiative is a supportive programme. Such initiatives target three main strategic areas: reducing financial barriers, creating a stronger policy environment for women's and children's health, and safeguarding the rights of young girls and women.

There are many important questions to be answered to ensure continuing progress towards achieving the MDG's. These include: how to engage (mainly male) decision-makers in order to create environments that enable reproductive rights and improved childbirth outcomes? How progress can be made in locations where living conditions are harsh, services are marginal and whose people are among the poorest of the poor? And what

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<sup>1</sup> See [www.womendeliver.com](http://www.womendeliver.com)

<sup>2</sup> <http://www.who.int/pmnch/activities/jointactionplan/en/> (accessed 20 January 2012)

needs to be known about local traditions, beliefs and the interplay between modernity and tradition among these groups in order for strategies to be meaningful and effective?

In the past decade, there has been a steadily growing understanding of the unacceptable impact of pregnancy and childbirth complications on the health and lives of women and their families. There has also been an expanding response to address the issue. Nevertheless, despite significant investments globally and after numerous interventions to improve this situation in sub-Saharan African countries, in terms of investment and expenditure, maternal health remains a relatively low priority than it deserves.<sup>3,4</sup> Nomadic people in Eastern Africa - the topic of this book - clearly still lack proper (reproductive) health services and support. Due to their mobile ways of life and cultural values, nomadic communities are seldom reached by health and development programmes and nomadic people often have limited, if any, access to quality health information and services. This is dramatically reflected in high maternal mortality figures in nomadic regions – the primary indicator of health systems failure in this area.<sup>5</sup>

## Nomadic groups

Nomadic people belong to communities that move from one place to another rather than settling in one location more-or-less permanently.

Nomadism is often seen as a way of life of people who do not live continually in the same place but move cyclically or periodically based. Migration is noncyclic and often involves a total change of habitat. There are three general types: nomadic hunters and gatherers, pastoral nomads and tinker or trader nomads.<sup>6</sup> The first group is often organized in small isolated bands moving through a delimited territory. The second group move with their livestock in an established territory to find pastures for their animals. The third group are trader nomads who sell or hire products or work as labourers (for example, gypsies and horticulturalists).<sup>7</sup>

Before the year 2000 there was an estimated 30-40 million nomads in the world.<sup>8</sup> It is not sure whether these numbers have actually increased or declined due to unavailability of statistics. From all nomadic groups in Africa most seemed to be written about the Maasai. For this book we were particular inspired by the work of the late Aud Talle about gender and Maasai pastoralism and Dorothy I. Hodson, who wrote about recognition and rights, and transnational identities.<sup>9,10</sup>

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<sup>3</sup> <http://siteresources.worldbank.org/INTPRH/Resources/3763741261312056980/RHActionPlanFinalMay112010.pdf> (accessed 12 July 2012).

<sup>4</sup> [http://www.who.int/pmnch/topics/maternal/app\\_maternal\\_health\\_english.pdf](http://www.who.int/pmnch/topics/maternal/app_maternal_health_english.pdf) (accessed 12 July 2012).

<sup>5</sup> Nduba, John, Morris G. Kamenderi, Anke van der Kwaak (2011). *Reproductive Health in nomadic communities: challenges of culture and choice*. Exchange on HIV and AIDS, Sexuality and Gender (1), 2011, nr 1, March.

<sup>6</sup> <http://www.britannica.com/EBchecked/topic/417292/nomadism> (accessed 11 June 2012).

<sup>7</sup> <http://www.britannica.com/EBchecked/topic/417292/nomadism> (accessed 11 June 2012).

<sup>8</sup> <http://www.newint.org/features/1995/04/05/facts/> (accessed 11 June 2012).

<sup>9</sup> Talle, Aud, (1988). *Women at a loss. Changes in Maasai pastoralism and their effects on gender relations*. Doctoral thesis, Stockholm Studies on Anthropology, University of Stockholm, Sweden.

<sup>10</sup> Hodgson, Dorothy, L. (2011). *Being Maasai, becoming indigenous*. Postcolonial politics in a Neoliberal World. Indiana University Press.

This book focuses mainly on the nomadic pastoralists, the second group in the earlier mentioned definition. They are attached to certain areas of seasonal movement, as they move their livestock between the permanent spring, summer, autumn and winter (or dry and wet season) pastures.

In general they have limited access to information and services, which is not simply due to the mobility that nomadic communities have, other factors also play a role. Generally, nomadic pastoral communities live in very traditional settings and they adhere strongly to traditional cultural values and beliefs. Some of these beliefs are known to lead to poor sexual and reproductive health outcomes. Nomadic communities have their own customs that guide them: in dealing with questions of sexuality; the role of women within the community; and the sexual education of their children. In most countries, there is a lack of understanding of these customs, values and beliefs, due to limited information and research among nomadic populations.

By focusing on sexual and reproductive health issues among pastoral nomads, this book seeks to fill some of the knowledge gaps concerning nomadic communities and how sexual and reproductive health might be improved as a consequence. The authors of the case studies are project staff in the African Medical and Research Foundation (AMREF). Between 2007 and 2010, these staff members were based in nomadic settings in Ethiopia, Kenya and Tanzania as part of an AMREF programme designed to improve sexual and reproductive health in nomadic communities. As part of this programme, project staff conducted field research among the respective nomadic groups, which resulted in the in-depth knowledge presented in this book.

The case studies focus on three main areas in relation to maternal health care: the impact of *cultural beliefs and practices on decision-making processes in nomadic communities* to the role of *traditional health care providers and their links to the formal health system*. These overarching issues emerged from both qualitative and quantitative data. We also concluded that these were the most relevant issues to share with policymakers, development practitioners and academics in the hope that greater knowledge and understanding will help to improve the reproductive health of nomadic communities in East Africa.

## The nomadic youth reproductive health programme

AMREF was founded in 1957 by three reconstructive surgeons working in Kenya who were concerned that rural Africans were unable to access the surgical care they needed. The surgeons concluded that if the patients were unable to visit them, then they would need to go to the patients – as a result the east African “Flying Doctors” were born. Continuing this innovative tradition, AMREF today carries out many interventions designed to deliver health care improvements, both in Kenya and beyond and the core programme has since been extended to Ethiopia, South Africa, South Sudan, Somalia, Tanzania, Uganda and Senegal.

Since its foundation, AMREF has been dedicated to working with severely disadvantaged communities: the very poor, marginalized rural and urban populations, nomads, camps for internally and externally displaced people, and those experiencing chronic insecurity. Services for disadvantaged communities that lack access to adequate health care and that have little opportunity to engage with policy- and decision-makers are prioritised using a so-called 'health systems approach' to health in development. This approach recognises that a principle barrier to good health among poor communities is the gap between communities and formal health systems.<sup>11</sup> The approach seeks to close this gap by improving the capacity of both formal and informal systems, empowering communities to participate in improving their own health, and finding workable approaches to delivering health services in hard-to-reach areas.

The research outlined in this book is derived from the work of the regional Nomadic Youth Reproductive Health Programme which aims to improve the sexual and reproductive health of nomadic youth aged between 10 and 24. The programme's central aims include: delivering sexuality education both for in- and out-of-school youth; improving access to quality, youth-friendly SRH services; reducing maternal and neonatal mortality; and countering dangerous 'traditional' practices (mainly focusing on female genital cutting).

Each project team in Kenya, Tanzania and Ethiopia worked to achieve country-specific objectives which focused on increasing the knowledge and healthy behaviours of nomadic youth; strengthening health services and health personnel in order to provide SRH services and emergency obstetric care; and supporting adolescent sexual and reproductive health rights at community and district levels.

## The Afar region in Ethiopia

The Afar State is located in the north eastern part of Ethiopia. The state is divided into 5 Zones, 32 *Woredas* (districts) and 390 *Kebeles* (the lowest governance structure) and it shares international borders with Eritrea and Djibouti. The people of Afar are predominantly nomadic. The majority lead pastoral and agro-pastoral lives, and regularly move in the search for grass and water for their cattle in the arid and semi-arid areas of Ethiopia, Eritrea and Djibouti. Most Afari inhabit the middle and lower Awash River valley.

The Afar Region is one of the poorest, least developed and under-serviced regions of Ethiopia, often bypassed by national development efforts. Only in recent years have efforts been made to provide essential infrastructure such as road access, administration, and basic education and health services.

The Afar Region has a total population of 1,411,092 of which 55.73% is male. Population growth is high (2.2%) and the fertility rate is 4.9 children per woman.<sup>12</sup> Health indicators

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<sup>11</sup> AMREF Corporate Strategy, 2007-2017, [www.amref.org](http://www.amref.org).

<sup>12</sup> [http://www.csa.gov.et/pdf/Cen2007\\_firstdraft.pdf](http://www.csa.gov.et/pdf/Cen2007_firstdraft.pdf) (accessed 12 July 2012).



reveal the Afar Region to be at a significant disadvantage: maternal mortality stands at 801/100,000 compared to a national figure of 673/100,000 live births.<sup>13</sup> A high proportion of women in Afar experience high-risk pregnancies and deliveries. Factors contributing to adverse pregnancy outcomes include early marriage, female genital cutting, heavy workload and unhealthy practices during pregnancy. At the same time, utilization rates of reproductive health services are low, few births (6%) are attended by skilled personnel, and Afar is not equipped to provide emergency care. Moreover, uptake of contraception is among the lowest in the country (6.6%).<sup>14</sup>

Afar has very limited professional human resources, infrastructure and health care systems. In terms of health infrastructure, the region has: 1 regional hospital; 1 district hospital; 14 health centres; 43 health stations and 93 health posts. The ratio of health professionals to population numbers is very low with one physician serving 138,900 people (WHO standard is 1:10,000), and one nurse serving 5,426 people (WHO standard is 1:5,000).<sup>15</sup> Health service coverage is also lower when compared to most of other regions of Ethiopia.<sup>16</sup>

The health care delivery system is organised into 4 tiers. The most basic tier is the primary health care unit with one health centre and 5 health posts, designed to serve 25,000 people. The health post is supposed to be staffed by two female Health Extension Workers (HEWs) to provide preventive and limited curative services. In general, the health posts and the health extension programme in the region are in their infancy, and much remains to be done before they can be considered fully operational.

## The Magadi and Loitokitok districts in Kenya

The AMREF Nomadic Youth Reproductive Health Programme was established in two different sites in Kenya: Magadi and Loitokitok.

Magadi, a division of Kajiado North district, is located southwest of Nairobi and northeast of the Tanzanian Lake Natron. With 2340 square kilometres the area is only sparsely populated. In 2009, the population of the Magadi division was estimated to be 31,571 (Kajiado District Strategic Plan, 2005-2010).

Loitokitok district is located 230 KM south east of Nairobi, at the foot of Mount Kilimanjaro on the Kenya-Tanzania border. Loitokitok district was formerly a division of the larger Kajiado district, of the Rift Valley province. Based on the 1999 national census, the district has an estimated population of 141,000 people. The district has poorly developed road infrastructure and lacks efficient means of transportation.<sup>17</sup> Loitokitok has 15 health

<sup>13</sup> CSA & ORC Macro (2005). *Ethiopia Health and Demographic Health Survey, 2005*.

<sup>14</sup> Kibua, Thomas (2009). *AMREF case studies*.

[http://www.sadieu.org/opencms/opencms/data/en\\_data/media/downloads/AMREFDOCS/AMREFcasestudies2009.pdf](http://www.sadieu.org/opencms/opencms/data/en_data/media/downloads/AMREFDOCS/AMREFcasestudies2009.pdf) (accessed 20 May 2012).

<sup>15</sup> Afar Regional State Health Bureau (2005). *Malaria prevention and control programme strategic plan 2006-2010*.

<sup>16</sup> Family Health Department, Ministry of Health (2006). *Report on Safe Motherhood community-based Survey*. Ethiopia.

<sup>17</sup> Ntiati Paul (2002). *Working Paper 7: Group Ranches Subdivision Study in Loitokitok Division of Kajiado District Kenya*.

facilities each of which is mostly operated by a sole practitioner. These health facilities are sparsely distributed and consequently, most people walk long distances for care (AOP 4 of Ministry of Health; Loitokitok District).

Both Magadi and Loitokitok are inhabited predominantly by the Maasai people. The Maasai are semi-nomadic people who live as extended families under a communal land management system. Under this system, cattle and children are the most important elements of Maasai life. One consequence of these traditional values is that a woman's social worth is largely determined by how many children she gives birth to. Traditionally, the Maasai rely on meat, milk and blood from cattle for protein and caloric needs.

In Maasai culture, most of the key productive and reproductive functions are carried out by women though it is the man who assigns the daily duties. There is low representation of women in education and employment and this appears to be the result of the cultural practices that subordinate women, including forced early marriage, and low representation of women in decision making processes, positions of authority and key institutions (Kajiado district strategic plan for 2005-2010).<sup>18</sup>

The health system in Kenya is organized in a referral hierarchy, starting from communities, to dispensaries, to health centres, to district hospitals, provincial hospitals and finally to national referral hospitals. At the community level, the workforce consists of community health workers (CHWs) whose biggest role is health promotion and education whereas at the dispensary level service providers dispense basic obstetric care and treatment. Comprehensive obstetric care is offered starting at the district level.

While the pyramidal organization of the health system works well in settled communities, it falls short when it comes to meeting the needs of nomadic communities living in arid and semi-arid areas. This is due to low attractiveness of remote posts and difficulty in recruiting health workers to these areas, long distances to facilities posing challenges of access, and poor infrastructure among other issues. The Kenyan Government has developed policies that guide the implementation of health programs including reproductive health, but the lifestyle and environment of nomadic communities poses considerable challenges for the implementation of these policies.

## The Kilindi district Tanzania

Kilindi is one of several newly established districts in Tanzania. Kilindi is located in the Tanga region in north eastern Tanzania on the Indian Ocean coast. Until 2005, it was part of Handeni district, but it has since become autonomous in an attempt to improve basic services. Geographically Kilindi is bordered by Simanjiro district in the north, by Kiteto in the west, by Handeni in the east, by Bagamoyo and Kilosa in the southeast and in the

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<sup>18</sup> <http://www.ncapd-ke.org/UserFiles/File/District%20Strategic%20Plans/Kajiado%20FINAL%20Modified.pdf> (accessed 12 July 2012).



south by Mvomero district. According to the 2002 census, Kilindi district has an area of 6,129 km<sup>2</sup> and a population of around 163,400, with a growth rate of 2.2%. It has four divisions, 15 wards and 64 villages.<sup>19</sup> Most of Kilindi is hilly or mountainous. There are five main ethnic groups in Kilindi – namely, Maasai, Nguu, Zigua, Kaguru and Kamba – and a number of smaller groups such as Iraqw, Chagga, Pare, Meru and Shambaa. Maasai are full nomads. Their lives are typically based on migration from one point to the other in search of the greener pastures for their livestock. Other ethnic groups are semi nomadic, basically agro-pastoralist small groups of Pare, Chaga and Sambia who are farmers.

Health services in Tanzania are organised into a hierarchical or pyramidal structure. The first or entry level of service delivery operates at the grassroots/village level, including primary care through dispensaries and health centres, which serves 80% of the population. The secondary level operates at the district and regional level, and receives referrals from primary health care facilities. The tertiary level corresponds to the 21 regional hospitals in Tanzania, which operate as specialist referral hospitals. In Tanzania family planning and maternal health services for young people are integrated with adult care at all levels.<sup>20</sup>

Tanzania has spearheaded a number of efforts to improve adolescent sexual and reproductive health. Indeed, the National Adolescent Health and Development Strategy, 2004–2008 foresees a healthy and well-informed Tanzanian population with access to high-quality reproductive and child health services that are accessible, affordable and sustainable and provided through an efficient and effective support system. In realizing its vision, the strategy promotes, facilitates and supports, in an integrated manner, the provision of reproductive and child health services to men, women, adolescents and children in Tanzania. Studies have shown, however, that recent health reforms may have compromised these efforts.<sup>21</sup>

## Combined baseline assessment

In 2007 and 2008, baseline surveys were carried out in all three countries to gain a deeper understanding of the nomadic communities' existing SRH challenges and needs, and to set benchmarks for interventions. These findings have been brought together in a synthesis report, providing a cross-country analysis of SRH issues in nomadic communities in Ethiopia, Kenya and Tanzania.<sup>22</sup> The analysis shows that nomadic communities are generally characterized by poor reproductive health outcomes. Early sexual debut, early marriage, low access to reproductive health services, low education levels, and the prevalence of potentially harmful traditional practices such as female genital cutting are important contributing factors. In addition, the capacity of the formal health care systems in nomadic settings is generally very weak: service providers, if present, show limitations in

<sup>19</sup> National Bureau of Statistics Tanzania and ORC Macro (2005). *Tanzania Demographic and Health Survey 2004–05*. Dar es Salaam, Tanzania.

<sup>20</sup> <http://www.measuredhs.com/pubs/pdf/FR173/FR173-TZ04-05.pdf> (accessed 12 July 2012).

<sup>21</sup> [http://www.measuredhs.com/pubs/pdf/DM3/tanzania\\_youth\\_booklet.pdf](http://www.measuredhs.com/pubs/pdf/DM3/tanzania_youth_booklet.pdf) (accessed 1 July 2012).

<sup>22</sup> *Reproductive health in nomadic communities: challenges of culture and choice*. Editorial and overview of Exchange issue number one in 2011 on reproductive health in nomadic communities. Nduba, J., Kamenderi, M.G., Kwaak, A. van der, KIT 2011

their ability to provide services and generally lack the knowledge and skills required to address the traditional nomads' sexual and reproductive health needs effectively. In this context, the informal health system plays a pivotal role. Traditional birth attendants continue to be important providers of maternal health services in remote and hard-to-reach nomadic settings in East Africa.

This programme is being implemented in Ethiopia (Afar Region), Kenya (Kajiado and Loitokitok districts) and Tanzania (Kilindi District in Tanga Region), with funding from the Dutch Ministry of Foreign Affairs accessed through AMREF in the Netherlands. The case studies in this book are the outcome of monitoring, evaluation, research and learning in the regional Nomadic Youth Reproductive Health Programme.

## Capacity-building in research

Conducting research was an important element of the Nomadic Youth Reproductive Health Programme. Within the programme, research capacity building strategies have been implemented for project staff to enhance their ability to develop and implement research and to integrate results into practice. In June and October 2009, and May, July and October 2010, a series of workshops was conducted by the AMREF-KIT research alliance, in which research proposals were developed. The studies were carried out between November 2009 and January 2010 once ethical approval was achieved. A research analysis and report-writing workshop was held in the summer of 2010. Participatory learning approaches were used for these workshops. These approaches included participatory group tasks, presentations, interactive plenary sessions, and limited lecture sessions. A 'write shop' in September 2010 and in December 2011 developed the material in this book and led to recommendations for interventions; the development of ideas for new programmes; and actions to increase sexual and reproductive health among nomadic populations in East Africa.

## Structure of the book

The book consists of three parts. In the first part *Beliefs and Values*, the authors show how cultural values, gender relations and religious beliefs influence maternal health, uptake of family planning, prevalence of female genital cutting and practices around childbirth. The chapter by John Nduba and Anke van der Kwaak is about setting the scene in relation to sexual and reproductive health programmes and pastoralist communities. They show the challenges of culture and choice. In the next chapter Peter Ngatia Nguura argues that traditional beliefs also have structure, produce resilience and show characteristics that might be leveraged for promoting sustainable improvement in pregnancy outcomes and women's health in general among the Maasai. In the following chapter Godson Zakaria Maro shows us the controversies around beliefs and values associated with family planning in nomadic communities of Kilindi Tanga, Tanzania. George Saiteu Lukumay shares with us then the case of Salima, twenty years of age, and shows how the lack of knowledge can affect someone's well-being. Fentaw Seid Haile

elaborates in his chapter on religious beliefs among the Afar and this part concludes with a chapter by Hannah Mason in which she gives an extensive overview of the practice of female genital cutting in Ethiopia.

In the second part, *Pathways to Childbirth*, the different actors and factors that impact on pregnancy and delivery are presented. Jemal Yousuf Umer describes the contribution of health extension workers to maternal health among the Afar, in Ethiopia. In the following chapter Mazengia Ayalew Mekonnen is doing the same for traditional birth attendants in among the Afar, David Kawai is discussing the roles of traditional birth attendants among the Maasai in Kenya. In the last chapter of this second part Henerico Ernest Malagi argues for the need of collecting community-based health information in Tanzania.

In the third part, *Power to Decide*, case studies of power relations and decision-making processes among the different nomadic groups are presented. Lepantas Charles Leshore shows us how the main decision-makers are the men among the Maasai of Magadi. Paradoxically, the men are often unavailable when decisions need to be made. Anne Muthoni Gitimu describes in the subsequent chapter how it works for women and their access to perinatal care. Kassahun Negash Yalew then explores on the roles of religious leaders in mother's decision-making among the Afar in Ethiopia. In the last chapter of this book Joris van Oppenraaij discusses that environmental health can be a gateway to sexual and reproductive health programme.

The volume concludes with conclusions and recommendations.



## Beliefs and values

The beliefs and values of the pastoralist communities seem to be deeply rooted and leading to the maintenance of several practices and rituals constructing and organizing the daily life and routine of pastoralist. Birth practices, female genital cutting, specific health beliefs and practices seem to prevail and seem at first sight not so much affected by modernity and globalization. But conflicting views and beliefs are seen in the societies under studies. The belief of abstaining from sex following childbirth intersect with expectations that men will inevitably need to find sex elsewhere and with the more recent possibility that women too can enjoy other sexual partners without risking pregnancy thanks to contraception. Programs need to be aware of all these at first sight paradoxically beliefs that inform the day to day practice.





## 2 Reproductive health in nomadic communities: Challenges of culture and choice

John Nduba and Anke van der Kwaak<sup>23</sup>

Since the late 1980s, improving maternal health and reducing maternal mortality have been key concerns of several international summits and conferences, including the Millennium Summit in 2000.<sup>24</sup> One of the eight Millennium Development Goals (MDGs) adopted following the Millennium Summit involves improving maternal health (MDG5). Although reproductive health is not specifically named, it is widely recognized that ensuring universal access to reproductive health care, including family planning and sexual health, is essential for the achievement of all of the MDGs, and vice versa.<sup>25</sup>

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 poor people and spur economic and social development.

When we look at nomadic communities, reproductive health is a crucial issue. The lifestyle of moving from place to place for subsistence seems to deprive nomadic communities from basic reproductive health services. This trend has been complicated by remoteness, physical distance to reproductive health services, high illiteracy levels and local beliefs and practices. On the other hand, it seems that the incidence of HIV among pastoralist communities is still relatively low; Talle relates this to the cultural identity of the Maasai: although they value sex with multiple 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.<sup>26</sup> It seems that in most countries, the reproductive health practices and needs of nomadic communities are not well understood due to limited information. For these reasons the African Medical Research Foundation (AMREF) implemented a programme targeting young nomads from 2006 to 2010. In this article some insights and experiences as observed and studied within the AMREF programme will be shared, some important challenges and issues related to nomadic reproductive health will be discussed, and the articles in this special issue will be introduced.

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<sup>23</sup> The authors would like to thank Morris G. Kamenderi, Gerard Baltissen and Eliezer Wangulu for their contributions to and comments on this article.

<sup>24</sup> 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)

<sup>25</sup> Sachs, DS (2001). *Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health*. Geneva: World Health Organization.

<sup>26</sup> Talle, A (2010). *Living beyond AIDS in Maasailand; discourse of contagion and cultural identity*. In Dilger, H and U Luigi (eds.) *Morality, Hope and Grief. Anthropologies of AIDS in Africa*. New York: Berghahn Books, Epistemologies of Healing volume 7. pp. 148–172.

## Programme in Eastern Africa

The nomadic pastoralists are one of the poorest sub-populations living in remote areas. They rarely seem to utilize the services of professional midwives and other reproductive health care providers. This contributes to many complications during pregnancy. Furthermore, bearing many children is generally considered a status symbol for the position of the family within the nomadic community, which means that there is little regard for any kind of family planning. A further complicating factor is female genital cutting, which results in many women experiencing difficulties during delivery. Customs that transcend generations call for girls to be circumcised and married off very young and then 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 can enjoy the right to good health, by helping to create vibrant networks of informed and empowered communities and health care providers working together in strong health systems. With support from the Dutch Ministry of Foreign Affairs, AMREF implemented a programme focusing on the reproductive health care of nomadic youth. It mainly targeted nomadic youth, male and female, in the age range of 10–24 years and planned to reach more than 135,000 of them in Kenya, Ethiopia and Tanzania. Some of the findings from a baseline study and qualitative studies will be presented here to provide a better view of nomadic reproductive health.

## Early marriage and sexual practices

The periods of adolescence and youth – in particular between 10 and 25 years – involve sexual experimentation that may lead to acquisition of STIs and unintended pregnancies. Sexual practices in this age group may include early sexual debut, having multiple sexual partners, engaging in unprotected sexual intercourse, engaging in sex with older partners and consumption of alcohol and illicit drugs.<sup>27</sup> Findings indicate that nomadic youth were debuting sexual intercourse at an average age of 15 years. The same trend was similar in Kenya and Ethiopia, although those in Tanzania initiated sexual intercourse at an average age of 16. Sexuality and sexual practices differ in context because of cultural and social environmental differences that exist in the society.

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 old.<sup>28</sup> 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.

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<sup>27</sup> Urassa, W, C Moshiri, G Chalamilla, F Mhalu and E Sandstrom (2008). *Risky sexual practices among youth attending a sexually transmitted infection clinic in Dar es Salaam, Tanzania*. BMC Infectious Diseases, 2008, 8:159.

<sup>28</sup> McLyntire, P (2006). *Married adolescents: No Place of Safety*. Geneva: World Health Organization.



It was observed that there was limited knowledge on sexuality among the nomadic youth in the three countries. Specifically, the issues surrounding pregnancy were not well known. The attitude towards teenage pregnancy was encouraging, with very few young people in Kenya and Tanzania advocating for it. However, more than half of the youth in Ethiopia readily expressed the belief that teenage pregnancy was beneficial.

## Local beliefs and knowledge

Despite global efforts to promote the abandonment of female genital cutting, it remains widespread in nomadic communities. The prevalence of female genital cutting was indicated by the high proportion of nomadic youth with a circumcised sister. One of the possible explanations for this prevalence was nomadic youth's belief that circumcised girls were different from uncircumcised girls. Family honour (respect), cleanliness, the ability to walk for long distances and women giving birth easily were used as rationales to continue the practice. These differences are usually linked to socio-cultural identities, and women themselves are sometimes unwilling to give up the practice. They see it as a long-standing tradition passed on from generation to generation. The practitioners were often unaware of the real implications of female genital cutting and the health risks that it poses. These cultural beliefs are being addressed through education programmes, and communities are starting to accept alternative rituals in which all age and gender sets of the communities are involved.

Knowledge on HIV and AIDS remains critical to preventing the spread of the disease. Although the knowledge on HIV and AIDS was observed to be sub-optimal among nomadic youth, those in Ethiopia were 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. Very few nomadic youth in Kenya, Ethiopia and Tanzania considered going for an HIV test, but those in Ethiopia were the least likely. Given that Ethiopian youth were less likely to perceive themselves at risk of contracting HIV, they were equally less likely to consider going for an HIV test.

## 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.<sup>29,30</sup> Unintended pregnancy is a major reproductive health problem among young people in sub-Saharan Africa<sup>31</sup>, where it is estimated that 14 million unintended pregnancies occur every year, with almost half occurring among women aged 15–24 years.<sup>32</sup>

<sup>29</sup> Lloyd, C (ed.) (2005). *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*. Washington, DC: National Academies Press.

<sup>30</sup> World Bank (2007). *Development and the Next Generation*. World Development Report. Washington, DC: International Bank for Reconstruction and Development.

<sup>31</sup> Bakole, A, FH Ahmed, S Neema, C Ouendraogo and S Konyani (2007). *Knowledge of correct condom use and consistency of use among adolescents in four countries in sub-Saharan Africa*. African Journal of Reproductive Health 2007, 11(3):197–220.

<sup>32</sup> Hubacher, D, I Mavranzeouli and E McGinn (2008). *Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it*. Contraception 2008, 78:73–78.

Teenage pregnancy was common in Kenya, with a majority of young women becoming pregnant at age 17, and in Ethiopia at the age of 16. Youth in Kenya were, however, shown to get married at age 18, and, therefore, becoming pregnant at age 17 was likely to be a sign of unprotected pre-marital sex. Fertility perceptions are important because they can indicate the future reproductive behaviour of nomadic youth, providing an opportunity for timely and focused interventions. From the findings, nomadic youth in Ethiopia desired a boy and a girl to get married below the age of 18. In contrast, those in Kenya and Tanzania preferred them to get married at ages above 18 years.

While nomadic youth generally preferred to have many children after marriage, those in Ethiopia desired to have more (an average of seven children). 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 indicated low levels of knowledge 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 level of knowledge on individual methods of contraception. Contraceptive use among nomadic youth was extremely low, with those in Ethiopia showing the lowest contraceptive use. This was a true reflection of the low level of knowledge on modern contraception. Enhancing contraceptive knowledge among nomadic youth seems essential to spur higher contraceptive 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 mothers-in-law are the most decisive in local practice, are key issues that need to be taken into account when organizing awareness-raising 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.

## Quality of reproductive health services

Community structures actually provide reproductive health services in nomadic settings. The major players are traditional herbalists, local healers and traditional birth attendants (TBAs). Nomadic communities perceive traditional herbalists/healers to be more effective and reliable than modern health care services. They are culturally closer to them, trustworthy and were very knowledgeable on community health problems. However, this trust was at risk of abuse by traditional healers. For example, claiming that they could heal HIV and AIDS was misleading and could ruin any efforts or programmes geared towards prevention. TBAs are also shown to be important in the provision of delivery services, although their knowledge sometimes was 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, but only if entrusted with tasks they can perform competently.

Several factors were shown to hinder the quality of services offered by biomedical health providers. The staff at health facilities – especially dispensaries – does not have adequate skills

to offer youth-friendly reproductive health services. Health providers dealing with youth reproductive health at the health facilities surveyed felt very uncomfortable discussing sexual behaviours related to STIs and HIV with young clients. Out of nine staff members interviewed, only three reported feeling comfortable doing so. A lack of basic training and/or post-basic training among health providers was another contributory factor. 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 the nine staff members interviewed, only four (two from each level of facility) confirmed ever having attended such training courses, while the other five had never done so. The training was mainly on contraceptive counselling and reproductive health education.<sup>33</sup>

From the baseline studies it became clear that access to reproductive health services was low among nomadic youth. Very few youth, especially those in Ethiopia, had visited a clinic in the six months prior to the survey. One potential barrier was a lack of adequate skills to provide youth-friendly services. Youth-friendliness of reproductive health services is an important prerequisite in scaling-up access to reproductive health services. Since providers mentioned feeling uncomfortable when discussing reproductive health issues with youth, this behaviour could potentially discourage a young person from seeking the same services again. A lack of basic training among providers was also evident. Training of service providers on reproductive health was and is, therefore, essential.

Geographical access or distance, cultural barriers and awareness may also lead to low demand for seeking reproductive health services. In terms of accessing reproductive health services, adolescents have shown poorer health care-seeking behaviour for themselves and their children, and experience increased community stigmatization and violence, suggesting bigger challenges to the adolescent mothers in terms of social support. Young people in particular are reluctant to seek health care services for their sexual and reproductive health needs.<sup>34</sup>

## Lessons learned

Access to reproductive health care services among nomadic youth is wanting, and it is recommended to increase this by also aiming at improved attendance to formal schools, to decentralization of reproductive health services closer to nomadic communities, and to train reproductive health care providers to offer services that are youth-friendly. The involvement of traditional herbalists, local healers and TBAs is a prerequisite to utilize the trust that communities have in them to fight negative practices that hinder reproductive health service provision and to address cultural beliefs that drive female genital cutting practices among nomadic communities. The introduction and use of mobile phones may be a solution to improve communication between providers and communities.

<sup>33</sup> AMREF Tanzania (2008). *Adolescent Reproductive Health Baseline Survey among the Nomadic Youth in Kilindi District, Tanga, Tanzania*. Draft Report, July 2008. AMREF Tanzania.

<sup>34</sup> Atuyambe, L, F Mirembe, ZM Tumwesigye, J Annika, EK Kirumira and E Faxelid (2008). *Adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood in Wakiso district, central Uganda*. Reproductive Health 2008, 5:13.





### 3 Pregnancy and childbirth among the Maasai: A gendered cultural space

Peter Ngatia Nguura

It is easy to regard traditional culture as a barrier to safe pregnancy and childbirth, not to mention gender equity more widely. It is true that traditional Maasai culture is patriarchal and that women are afforded little responsibility for decision-making, including decisions concerning their own health. However, this study shows that traditional culture has structure, resilience and characteristics that might be leveraged to promote sustainable improvements in pregnancy outcomes and women's health in general. Among the key issues are the possibilities of influencing positive outcomes that are in accordance with successful fatherhood as well as women's health, and to subtly shift male roles to more shared and participatory approaches to health. The conservative resilience of traditional culture might then offer an advantage that positive change is both embraced and sustained.

#### Gender rights: a culture war or a beneficial engagement?

How can public policies and health programmes more adequately engage nomadic men and boys in achieving gender equality and reducing gender disparities in health and social welfare?

The efforts of the Tanzanian and Kenyan governments to encourage the Maasai to modify their traditional semi-nomadic lives in favour of a more settled existence have had limited success. Communities have resisted and have continued with their age-old customs, instead demanding grazing rights to many of the national parks in both countries.<sup>35</sup> Development practitioners working with the Maasai for the last four decades have not succeeded in eliminating risky cultural practices or in promoting widespread adoption of gender rights and equality.

The upside of maintaining cultural traditions is that the uniqueness and beauty has been preserved and Maasai culture become in many regards the 'face of Africa'. This has led to a tourist boom for the community and the region at large and to tremendous gains in environmental conservation. The downside has been that risky cultural practices (including female genital cutting, early marriage and gender-based violence) have also endured at great cost.

Maternal mortality among the Maasai in Kenya is reported to be well above the national average of 488 deaths per 100,000 live births.<sup>36</sup> Traditional practices, such as female genital cutting and early marriage, contribute to maternal and infant mortality because of their close links to birth complications.

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<sup>35</sup> Mohamed, A, D Willetts and J Eames (1987). *The Last of the Maasai*. Camerapix Publishers International.

<sup>36</sup> CBS, MoH, KEMRI and CDC (2003). *Kenya Demographic and Health Survey*. Nairobi, Kenya.

It is evident that cultural and social norms among the Maasai perpetuate inequalities and violence against women and constitute significant barriers to safer pregnancy and motherhood. Addressing these cultural barriers to gender equality is, therefore, an urgent priority. However, as Barker et al. (2010)<sup>37</sup> put it, the question still remains: how can underlying social norms and institutions be changed to support greater gender equity?

In responding to this question, this paper explores the findings of explanatory research carried out using focus group discussions and key informant interviews among the Maasai of Magadi Division, Kajiado North District in Kenya in 2010. The paper explores Maasai cultural beliefs and values surrounding pregnancy and childbirth as both a favourable cultural entry point for gender equality policy implementation and gender sensitive health programming and as a key element of reducing mortality related to childbirth. The paper concludes that these positive cultural beliefs and practices constitute a resilient cultural platform on which sustainable, community-owned and -led gender equality initiatives and public policies can be founded.

## Exploring cultural engagement for sustainable change in gender equality and rights

Gender as a concept refers to masculinities and femininities, the relations between women and men, and the structural context that reinforces and creates these power relations.<sup>38</sup>

The Maasai are a highly patriarchal society. Of particular interest to the present study is that men are the key decision-makers in families and communities. Male culture is organized into age sets, with chosen age set leaders. There are no age sets for women, nor are there other formal cultural structures that recognize their 'voice'. There are strict gender roles, with women taking on almost all of the household tasks and men taking supervision and decision-making roles. Maasai women are responsible for building their homes, which are made from mud, sticks, grass, cow dung and urine. Women also milk the cows, collect water (an arduous task), cook and look after the children.

However, as explained below, pregnancy and childbirth among the Maasai ushers in a temporary cultural reversal of a kind. Pregnancy is a unique period, almost a 'sacred space', an 'amnesty' period and a refreshing break for the woman, who is normally fully occupied with many household responsibilities and who is also sometimes faced with gender-based violence. Pregnancy and childbirth bring a temporary cultural reversal of all these duties. It is the time for husbands to stop gender-based violence, provide care and support, and to spend more time about the home. Time has come for the overworked woman to rest and eat well.

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<sup>37</sup> Barker, G, M Greene, E Siegel, M Nascimento et al. (2010). *What Men have to do with it: Public Policies Promoting Gender Equality*. Washington, DC: The International Centre for Research on Women and Instituto Promundo.

<sup>38</sup> Ruxton, S (2009). *Man Made: Men, Masculinities and Equality in Public Policy*. London: Coalition on Men and Boys. Available at [www.comab.org.uk](http://www.comab.org.uk).

## Cattle and children as cultural treasures

The great value associated with cattle and children among the Maasai is evident in one of their famous prayers, which states “*Meishoo iyiook enkai inkishu o-nkera*”, which translates as “*may the Creator give us cattle and children.*”

The traditional Maasai lifestyle centres on their cattle, their primary source of food. A man’s wealth is measured in terms of cattle and children. A herd of 50 cattle is respectable, and the more children the better. A man who has plenty of one but not the other is considered poor.<sup>39</sup> The childbirth process is also symbolically described using cattle. For instance, when a woman gives birth, the traditional birth attendant (TBA) helping her comes out of the hut and gives four loud shouts to the entire *manyatta* (homestead), announcing “*natomonok kitoichete*”, meaning “*we have given birth.*” The child’s father will respond “*kainyo e toiwaki?*”, asking “*what has been born?*”. If the infant is a boy, the TBA will respond “*olbingae*”, meaning a young male calf, and if it is a girl, she will say “*entawuo*”, meaning a young female calf. For a boy, a bull will be slaughtered so that the mother can drink the blood and be able to breastfeed him well, while a calf will be slaughtered for a mother who has given birth to a girl so that she is fed on its blood. It is also noteworthy that like cattle, children are not counted. This is a cultural taboo, for such counting is perceived to bring bad omen to these valued treasures.

In all the focus group discussions and key informant interviews in this study it emerged that the birth of a child is regarded both as an additional member of the family and as a hope for a bright future for the entire community. While some of the participants and informants viewed childbirth as a sign of blessings and prosperity in the family, others view it as a way of gaining respect and status in society. The more children men have, the higher the status that is accorded them. The cultural celebrations of childbirth and the experience gained caring for the new-born are said to enhance the bond between husband and wife and are a proof of maturity.

## Successful pregnancy and childbirth: a father’s cultural honour and prestige

A successful childbirth is seen as bringing the father happiness and affirming his usefulness in the community.

“When a woman is pregnant and delivers a child successfully, I become very happy, since family membership is increased and I am seen as useful to the society.”

– 35-year-old male participant in a focus group discussion at Entasopia

In line with this quotation, the study revealed that community respect is accorded to the woman, husband and family after a successful birth. It is also notable that a pregnancy is

<sup>39</sup> Briggs, P (2006) *Northern Tanzania with Kilimanjaro and Zanzibar, A Climbing and Trekking Guide*. Chalfont St Peter, UK: Bradt Travel Guides.

not an individual affair but an affair of the immediate family, extended family, and the community at large. The care that a woman receives during pregnancy is seen to have a direct effect on the success of the birth. To ensure that this occurs, the culture demands that a pregnant woman receive good care and prescribes specific cultural practices to achieve this.

Likewise, Maasai men value fatherhood, and they can be successfully engaged both as fathers and caregivers. Fatherhood is seen as a socially desirable role for men and is central to their self-esteem. Fatherhood is also, therefore, a powerful potential entry point for strengthening equitable family roles, to promote joint responsibility and for sharing tasks.

### **Special care for pregnant women as a cultural norm and practice**

Women also support (at least some) cultural norms, such as giving pregnant women special care. Female respondents revealed that during pregnancy they liked the better treatment they received from others in the household. Participants were happy about being relieved from heavy duties and being given support, encouragement and tender care by their husbands. This traditional practice accords with modern health guidelines insofar as it affords the pregnant mother much-needed mental and bodily rest during pregnancy. Women also reported that during pregnancy they received encouragement and that their husband, families and community at large were very supportive. Both male and female participants in focus group discussions reported that it is of cultural importance to avoid quarrelling or harsh conversations with a pregnant woman.

### **Gender-based violence as a cultural taboo during pregnancy and childbirth**

Among most Kenyan communities gender-based violence has been part of the 'socio-cultural landscape' for many years to such an extent that a widely touted local saying is that *"If you love your wife, you got to beat her up."* However, with increased national campaigns and activism on gender equality and rights, the government has enacted laws that criminalize violence against women, including domestic violence.

The Kenyan law on gender-based violence seeks to ensure: (i) protection for victims; (ii) appropriate responses from services; (iii) prosecution of offenders; and (iv) a framework for prevention. Unfortunately, patriarchal attitudes among the police and the broader community continue to limit the effectiveness of the policy as envisioned by the law. Nonetheless, among the sedentary communities that embraced modernity earlier than the remaining nomadic communities, gender-based violence, domestic violence and rape are now more readily reported,<sup>40</sup> and convictions are more often successful. Among the

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<sup>40</sup> African Woman and Child Feature Service, 10 March 2010.



Maasai, however, where cultural traditions are very much intact, gender-based violence is more prevalent and yet largely ‘invisible’ because it is so ‘normalized’. Government administrators serving the Maasai community and keen to see change have tried to tackle gender-based violence head-on, including by arresting perpetrators, but this approach has met with resistance because it is not fully embraced by the community. The legal protection enshrined in the law is, therefore, yet to afford full benefit to Maasai women, who are not yet confident enough to reject violence or to report it.

The study shows that gender-based violence is common, but the arrival of pregnancy alleviates this experience for pregnant women somewhat. Women clearly expressed their relief that pregnancy was accompanied by a culturally rooted exemption from being violated. Respondents emphasized the cultural expectation that men should not beat their wives when they are pregnant, since this could harm the unborn child.

### A time for a nutritious feeding

Unlike at other times when the woman is responsible for feeding the family, pregnancy offers her a chance to be fed and looked after. Respondents reported that ‘nutritious’ foods such as meat, blood or liver were considered essential during this period. Pregnant women were advised to eat plenty of meat and animal fat to reduce heartburn during pregnancy:

“I remember when I was expectant, my husband ensured that I got what I craved and drank enough blood, since what I am carrying takes a lot of blood from me.”

– Older woman, aged 55 years, in a focus group discussion

It was clearly stipulated that it is now the husband’s turn to ensure that the wife is well fed, as reported by a young pregnant woman aged 34 years who was a key informant:

“...during pregnancy, I like it when we are given a lot of food to eat... eat... eat and you are allowed and left to rest.”

### Cultural exemption from heavy duties

Generally, it is the task of the Maasai woman to build the house, to milk the cows, to cook and to fetch water and firewood. Fetching water and wood are demanding tasks; women often have to carry heavy loads long distances in the hot sun. However:

“During pregnancy women are exempted from heavy duties; for instance, fetching water from a far distance with the help of the donkeys, since some of the short women are forced to use their bellies to push the container onto the back of the donkey during loading of water containers, and this can hurt the unborn child.”

– Pregnant woman, aged 36 years, in a focus group discussion

The significant factor in this cultural practice is that men receive 'cultural authorization' to temporarily depart from the strict gender roles that otherwise exist at home.

## Involving fathers in birth planning

Research in Africa generally shows that male involvement in health care at the household and community level is poor; however, Maasai culture demands that during pregnancy men become involved in birth planning to ensure a successful birth.

While some of the respondents in this study felt there was no need to prepare for a childbirth, most respondents said that birth planning is necessary, with the responsibility mainly falling on the husband, who is supposed to ensure that basic supplies are available (including razor blades, clothes, soap, petroleum jelly, enough paraffin in case delivery happens at night, enough food and money for emergencies). Special care is also afforded to the nursing mother. The husband also has to ensure he gets a fat sheep to prepare a special meal called *orpudal*, which is a mixture of solid fat and meat. This meal is supposed to help the woman regain her health and strength quickly after delivery.

## In a nutshell: communities for change

Individuals and communities are generally assumed to consider that change is undesirable and that change is threatening. However, communities also know that failing to change also has consequences and can affect their reputation. It is, therefore, possible that the key is how to navigate the uncertainties and that this makes all the difference between success and failure when it comes to cultural change.

A policy review published by the Men and Gender Equality Policy Project identified three main reasons why many gender equality programmes have failed to bring about cultural change. First is the relatively small scope of existing interventions designed to engage men and boys, both in terms of duration and in focus, with few seeking to impart lasting policy change. Second, the programmes have been 'menstatic', assuming that men will never change and, therefore, ways to work around gender barriers are favoured over approaches that seek change. Finally, most gender equality campaigns focus on men as aggressors, often with little acknowledgment of men's potential roles as change agents.<sup>41</sup>

This paper, however, takes the view recommended by Lang (2003)<sup>42</sup> on the need to work from the ground up, identifying local traditions, norms and masculine characteristics that

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<sup>41</sup> Barker, G, M Greene, E Siegel, M Nascimento et al. (2010). *What Men have to do with it: Public Policies Promoting Gender Equality*. Washington, DC: The International Centre for Research on Women and Instituto Promundo.

<sup>42</sup> Lang, J (2003). *Working with Men to End Gender-Based Violence: Lessons for the South Asian Context*. Background paper prepared for the United Nations Economic and Social Commission for Asia and the Pacific's (UNESCAP) Sub-regional Training Workshop on The Elimination of Violence Against Women in Partnership With Men, New Delhi, India, 2–5 December 2003: <http://www.unescap.org/esid/GAD/Publication/DiscussionPapers/15/series15-main-text.pdf>.

are conducive to ending violence, since interventions that appear to be ‘top down’ or ‘foreign’ have a high likelihood of failure.<sup>43</sup> This paper explores ways of opening up gender-sensitive spaces in a highly patriarchal cultural system. What we want to highlight is the evidence that gender-sensitivity and equality may not really be so alien even in highly conservative traditional African cultures.

It is clear to us that the logic for gender rights and equality is woven closely into the Maasai tradition, but in its own unique way. As Cornwall reports, “our task is to consider men and boys not just as beneficiaries of women’s work or holders of privilege or perpetrators of violence against women, but also explicitly as agents of change, participating in reform, and potential allies in search of gender justice”.<sup>44,45</sup> What is now needed is an extension of this cultural logic in culturally acceptable ways that lead to community ownership and adaptation of large-scale and all-time gender equality and rights practice.

## Recommendations

This study recommends the on-going exploration of cultural traditions and practices by policymakers and development practitioners as a way to identify favourable entry points and leverage for programme interventions. It also recommends the positive engagement of men and boys in reproductive health and rights programmes. This would involve shedding the negative bias of perceiving men as barriers to women’s equality and rights.

## Conclusion

Cultural beliefs and practices surrounding pregnancy and childbirth among the Maasai constitute a potential cultural space which health programmers and policymakers can utilize to successfully launch and nurture gender equality and rights programmes in the community. Cattle and children are the two high-value cultural pillars for the Maasai, and innovative and culturally sensitive reproductive health programming needs to exploit the cultural value of fatherhood to bring about increased gender equality and rights and male involvement in reproductive health at the household level.

<sup>43</sup> Barker, G, M Greene, E Siegel, M Nascimento et al. (2010). *What Men have to do with it: Public Policies Promoting Gender Equality*. Washington, DC: The International Centre for Research on Women and Instituto Promundo.

<sup>44</sup> Cornwall, A (2000). *Missing Men? Reflections on Men, Masculinities and Gender in GAD*. IDS Bulletin 31:2. In Ruxton, S (ed.) (2004) *Gender Equality and Men: Learning from Practice*. Oxford: Oxfam GB: [http://www.oxfam.org.uk/what\\_we\\_do/resources/geneqmen.htm](http://www.oxfam.org.uk/what_we_do/resources/geneqmen.htm).

<sup>45</sup> Courtenay, W (2000). *Constructions of masculinity and their influence on men’s well-being: 215 a theory of gender and health*. Social Science and Medicine, 50.



## 4 Beliefs and values associated with family planning in nomadic communities of Kilindi, Tanga, Tanzania

Godson Zakaria Maro

Family planning is not new to the nomadic communities of East Africa, but the cultural determinants of how family planning is viewed and implemented need to be better understood. Having children is a pivotal matter of status for nomadic men in the region, and this influences how family planning is understood and used. In particular, instead of being used with the intention of reducing the number of offspring, both traditional and modern family planning methods are justified as a means of spacing childbirth for the benefit of both the mother and the child.

Difficulties arise because there are many and often conflicting ideas about the effectiveness and side-effects of both traditional and modern family planning methods. For example, beliefs about abstaining from sex following childbirth intersect with expectations that men will inevitably need to find sex elsewhere and with the more recent possibility that women too can enjoy other sexual partners without risking pregnancy thanks to contraception. Of course, the implications for the control of sexually transmitted infections (STIs), including HIV, are obvious. Moreover, these conflicting views overlay a deeper debate which concerns the erosion of traditional values and the threat that modern cultural imports might pose to social integrity. Without understanding all these factors, programmes will be less effective, and paradoxical, contradictory and potentially dangerous practices may well become common.

Africa is a large continent with a variety of social and cultural characteristics regarding reproductive health and sexuality. There are geographical, historical, religious and cultural differences, as well as differences between urban and rural populations, not least in terms of access to and use of family planning methods and maternal health care services.

The introduction of modern family planning services in sub-Saharan Africa has come late, starting in urban centres and slowly expanding to rural areas. Although some African traditions utilized different methods to space births, modern family planning has not been readily or widely accepted.<sup>46</sup>

For example, in Tanzania, studies have shown that there is a large unmet need for family planning services, particularly among teenagers. It also shows that family planning is predominantly for spacing births, but fears associated with it often curtail effective use. Modern family planning service provision is perceived to be lacking in two main areas:

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<sup>46</sup> Sahl, H, J du Guerny and L Stloukal (2000). *Provision of reproductive health services in sub-Saharan Africa: Lessons, issues, challenges and the overlooked rural majority*: <http://www.fao.org/sd/wpdirect/WPan0044.htm> (accessed 22 September 2010).



accessing a regular supply, and addressing the rumours and fears associated with family planning.<sup>47</sup>

## Who are the nomads?

Nomadic communities who participated in this study include five main ethnic groups. The Maasai are nomadic pastoralists, while the Kaguru, Kamba, Nguu and Zigua are agro-pastoralists, whose main livelihood is either both keeping livestock and farming or mainly farming; however, all live in the same general geographical area. The Nguu and Zigua groups are more similar in their cultural practices and only differ in the part of the area in which they reside.

Although both groups share the same locality, their different cultural practices and beliefs are likely to extend to different opinions on family planning. Twenty-four focus group discussions and interviews were conducted with respondents from the three main ethnic groups to explore beliefs and values associated with family planning in their culture.

Findings from the cross-sectional explorative study on 'Factors influencing uptake of family planning and maternal health services among nomadic communities in Kilindi District, Tanzania'<sup>48</sup> contributed greatly to the information shared in this area. In the discussion we will address all the main ethnicities and their different values and beliefs concerning modern family planning.

## What is family planning?

In these five communities family planning is generally understood as the way people decide to space their children. All of the different ethnic groups are aware of both modern and traditional family planning methods. Nearly all respondents knew of birth control pills, injectable contraceptives and condoms. Norplant and the intrauterine device were also known by many respondents.

Traditional methods such as wearing sticks around the waist, drinking cold water immediately after sex and not having sex during pregnancy and for at least three years after delivery were also known. Cultural beliefs and values regarding both modern and traditional family planning methods differ between ethnic groups. However, all groups believe that family planning is important for the health of mother and child.

Women from the Kaguru ethnic group defined family planning as follows:

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<sup>47</sup> Marchant, T, AK Mushi, R Nathan, O Mukasa, S Abdulla, C Lengeler and JR Schellenberg (2004). *Planning a family: priorities and concerns in rural Tanzania*. African Journal of Reproductive Health 8(2)11–23.

<sup>48</sup> Maro, G . et al (2009). *Influencing uptake of family planning and maternal health services among nomadic communities in Kilindi, Tanga, Tanzania*. Nomadic youth sexual and reproductive health baseline survey. Kilindi, Tanzania (unpublished).

“Family planning is a childbirth spacing between children ...it is important for the health of child and mother.”

– From focus group discussion of women aged 20–30 years, Kilindi, Tanga, 2009

Respondents of Maasai background were more specific in defining family planning as a method of spacing childbirth by three to seven years rather than limiting the number of children. The rationale for this practice is that it benefits the health of both the mother and child:

“What we understand by family planning is planning for your children so that if you use family planning you will be able to have another child, let’s say, after three years.”

– From focus group discussion of women aged 20–30 years, Kilindi, Tanga, 2009

Nguu and Zigua participants had similar understandings. They regard it as planning when to have children, and thereby giving enough space between children born to the same mother. A male respondent shared the following:

“The way I understand this is planning for the number of children you want to have with differing age intervals. It is like when you have the first child, then you wait until he/she is four or five years old, then you can add another one until there are at least five of them. This is how I understand it.”

– Male focus group discussion participant aged 30 years, Kilindi, Tanga, 2009

## Traditional methods of family planning

Although all groups understand ‘family planning’ to be a method for spacing children, they nevertheless have different traditional methods for achieving this, depending on their choice, beliefs and myths associated with child-spacing methods.

In the Kaguru ethnic group it is believed that the traditional method of wearing traditional sticks called *msalaka* during sex is one of the ways to prevent pregnancy. Both men and women from this ethnic group seem to be aware of this method. For example, according to respondents, women can wear small sticks tied around their waist with a thin string during or immediately after intercourse to prevent pregnancy. A focus group discussion with men aged 30 years and above confirmed this:

“They wear traditional sticks in their waist called *msalaka*; these sticks help to prevent conception.”

– From focus group discussion of men aged 30 years and older, Kilindi, Tanga 2009

Women from the Nguu ethnic group also mentioned using the same type of small sticks as the Kaguru, but they have a different name – *mapande* – and women also tie them around their waist throughout the entire time they do not want to get pregnant. In the Nguu community, people seem to prefer modern family planning methods which are available in health facilities, but some people also use this traditional method.

The tree used by both ethnic groups is the same but with different names (*msakala* or *mapande*). The picture below shows some small pieces of tree for avoiding pregnancy tied together with some beads around the waist for family planning purposes.

Traditional family planning method, Nguu and Kaguru ethnic groups (2009)



Although traditional use of the *msakala* or *mapande* seems to be widely known, it is also evident to some people that it may not be reliable. Here is part of the conversation between the interviewer (I) and respondents (R), women aged 20–30 years in Kilindi District:

I: All those you have mentioned are modern methods; are there any traditional methods?

R2: Traditional! There are others who say that there are small blocks (pieces of tree) or things you can wear around the waist and avoid pregnancies.

I: OK. Tell me more about it.

R2: Only those sticks are tied around the waist; no other.

R2: Others say that if you drink cold water on the last day of your menstrual period you won't get pregnant, but I am not sure if it is true.

R3: I have heard that cold water cools the womb to not get pregnant.

R4: Ooooh, in this method you first have to have sex then you put cold water on the spot and that cools the womb.

I: Cools the womb?

R1: I don't know if it's true, but there is one woman I know who had used the method and produced twins.

The evidence reveals a lack of consensus about methods: some trust the local methods and are not aware of the misconceptions surrounding them; some are unsure whether the methods are reliable; and others actually believe that using the traditional methods can lead to multiple births.

Among the Maasai, the main traditional method is not to have sex for an average of three years after delivery. There are no traditional herbs or devices used during this time – the method simply relies on abstinence. This practice is implemented in a systematic way, where the woman should not even be touched by her husband until three years have passed following delivery. In this case there is a separation of the married couple; in most cases the man goes to other wives or other women for sex. Women in this study expressed their dissatisfaction with this method:



“Maasai don’t take any medication or herbs for family planning. Why? She can stay without sex and withstand the whole period of three years. So you do not need to say let me take the medications or do whatever.”

– in-depth interview respondent, traditional birth attendant, Kilindi, Tanga 2009

Some women in the Maasai community have just started to use modern family planning such as injectables secretly without their husbands knowing. This allows them to have sex with other men (which, of course, risks exposure to STIs). According to one woman:

“After delivering, a woman and her husband stay apart for three years without meeting or having sex. That is a major thing they are using, but there are those women who usually use injectables or pills so they may have sexual relations with other men, but her husband actually will not touch her till the completion of three years.”

– In-depth interview respondent, Christian religious leader, Kilindi, Tanga 2009

The study reveals that the traditional practice of the couple abstaining from sex for three years after delivery combined with modern methods to prevent pregnancy can result in risk to both partners.

## Beliefs around modern family planning

Most respondents from all three main nomadic communities were aware of at least two or three modern family planning methods. However, knowing about other methods was not necessarily associated with their use, often due to beliefs associated with them.

Modern religious beliefs are not seen as a major factor that influences access to and use of modern family planning methods in these communities. Most Maasai are Christian, Kaguru may be either Moslem or Christian, and most Nguu and Zigua are Moslem. Religious leaders from both Christian and Moslem denominations stated that they do not prevent their members from using modern family planning and they trust that the decision to use modern family planning methods lies between two partners. On the other hand, they also asserted that people in their communities did not always believe in or use modern family planning methods, and it is clear that while the religious leaders may not actively speak out against modern family planning, they do not promote it either.

In the discussion with representatives of the Zigua ethnic group it was revealed that older women and men believed that the new methods of family planning were introduced for the purpose of killing young women or sterilizing them and making them unable to become pregnant.

“They say if you use injection or pills, you should not use them because it can cause the uterus to disappear or be destroyed ...our men refuse such a thing.”

– Male focus group discussion participant, aged 30 years or older, Kilindi, Tanga 2009

In contrast, men in the Kaguru community believe that people in their community prefer modern family planning:

“Nowadays people prefer to use new methods of family planning; the traditional one has lost its popularity.”

– Male focus group discussion participant aged 30–40 years, Kilindi, Tanga 2009

Maasai people seem to hold contradictory beliefs about the effectiveness of modern family planning. For example, a Christian religious leader who is also Maasai said:

“Now due to our culture, people themselves don’t believe if it’s true that through pills you can plan a family ...when women stay for a long time without becoming pregnant you will hear them saying ‘she has gone secretly for the modern family planning.’”

– In-depth interview respondent, Christian religious leader, Kilindi, Tanga, 2009

This contradiction is illustrated in the following extract. Here we hear a claim that people do not use pills for modern family planning because they will not work. On the other hand, they do believe that modern family planning is the reason for a woman’s lack of pregnancy. Maasai women in the study argued that modern family planning has side-effects on health: cancer, permanent infertility, loss of sexual pleasure, blood loss, loss of appetite and loss of periods. Here is what women aged 20–30 years from a Maasai group say (Interviewer (I), Respondents (R)):

I: Now, let’s talk on beliefs around family planning. What beliefs do people have on modern family planning?

R1: First belief that people have is that modern family planning methods bring cancer to women.

I: Mmmh.

R2: Others say it brings infertility.

R3: Yeah.

I: Mmmh. OK. There are people who have not contributed on this, and it’s their turn now. For you others, what do they say, what beliefs do people have?

R4: Others believe that if you use those methods, like injections, you will never have desire for a man again; others say they don’t use them as they lose sexual pleasure.

I: Mmmh. OK.

R5: Also they say, if you take pills, you bleed lots of blood; that is the reason others say they don’t use them.

I: Mmmh.

R4: Others believe that you find if you use injection you lose your appetite and get poor health.

R6: Another belief is that pills may affect you, and they can disagree with you.

I: How? What happens?

R2: Maybe you won’t get your period.

– Focus group discussion of women aged 20–30 years, Kilindi, Tanga 2009

In view of the above interviews, it appears that people from the Maasai community still mistrust modern family planning.

## What is the situation then?

Family planning is an area of conflicting values and beliefs. The research revealed evidence of paradoxical and contradictory views – either because methods do not work for birth spacing or because they can prevent you from conceiving when you want a child. In either case, the negative view prevails. Another instance that shows the flux in traditional beliefs is the Maasai practice of abstaining from sex after childbirth. The belief dictated that a husband and wife could not have sex for three years after the child was born, and this is still practised. This practice allowed couples to space the births of their children. With the advent of modern family planning, women can now secretly obtain modern family planning, which allows them to have sex without worrying about becoming pregnant. However, because the taboo on sex between husband and wives remains, these women chose to have sex with other men instead. Thus, the traditional and modern methods exist side by side, in contradiction with one another. These conflicting ideas about family planning reflect larger contradictions in the lives of these communities, as they struggle to come to terms with modernity and their traditional way of life.

The Maasai tend to believe that most new knowledge and skills will degrade their culture, and so elders urge youth not to follow the new ideas. Take, for example, the following quote in a discussion about condoms:

“Elders say that young people of today are destroying our traditions and are taking on new traditions.”  
– Female focus group discussion participant aged 20–30 years, Kilindi, Tanga, 2009

The unmentioned aspect of sexual rights, including addressing sexual desire and Maasai women’s risk of acquiring STIs by practising secret unsafe sex, is also one of the cultural practices on which traditional beliefs on family planning in this Maasai community can have an undesired negative effect.

## Conclusion and recommendation

Family planning is widely understood by nomadic communities as being a method of spacing childbirth. Spacing is practised using both traditional and modern methods, although all methods carry many misconceptions.

Interventions designed to encourage an increased use of modern family planning methods should aim to address a range of misconceptions and for the community to be comfortable using them. There are opportunities for new interventions to combine traditional with modern methods, which may well encourage people to use them more often and more consistently. Policymakers must be aware of the role that traditional nomadic cultural beliefs and values play in relation to family planning so that they can be specifically addressed in programming.

ተ.ቁ	የዕለት ቀን	የሰዓት ሰዓት	የሰዓት ቀን	የሰዓት ቀን	የሰዓት ቀን	የሰዓት ቀን
1	የሰዓት ቀን	254	345	599	118	12
2	የሰዓት ቀን	258	345	529	112	21
3	የሰዓት ቀን	3	345	903	188	9
4	የሰዓት ቀን	1	345	83	57	4
5	የሰዓት ቀን	1	345	69	41	7
6	የሰዓት ቀን	1	345	217	34	4
7	የሰዓት ቀን	1	345	8	18	18
8	የሰዓት ቀን	1	345	8	18	18



## 5 The influence of religious beliefs on maternal health in pastoralist communities in the Afar region of Ethiopia

Fentaw Seid Haile

Religious leaders have always exercised an important influence over maternal health, both directly and indirectly. The tradition of female genital cutting, for example, has significant implications both for women's health and for the outcomes of pregnancy and labour. These practices have become entrenched due to a mix of traditional and religious reasons and many religious leaders played an important role in maintaining those traditions. More recently, however, religious figures have been revisiting the basis for this practice and many have concluded that these practices do not have a sound religious basis and should be changed. Likewise, decisions about how and when to seek care were often not made by the pregnant woman herself. Instead, an elaborate 'chain of command' meant that men made the decisions, especially husbands and often religious leaders. This commonly resulted in delays in managing serious complications, with consequent adverse outcomes for the woman and the pregnancy.

### Religion continues to play an important role in women's health

Within Afar society traditional knowledge and practice plays a considerable role in addressing health problems in general and maternal health in particular. Despite many interventions by health and development agencies, most pastoralists continue to rely on the knowledge and ideas they receive through socialization and oral transmission down the generations.<sup>49</sup>

Poor utilization of health services by mothers is not a result of a single factor but is multifactorial. We argue that religious beliefs are one of the most influential factors on access to and use of services. As we see elsewhere in this book, religious leaders play a pivotal role in women seeking appropriate care in appropriate places and in a timely manner.

According to our research, religious beliefs, interpretations and the role of the religious leaders are influential in encouraging or discouraging women from accessing formal health services. The study demonstrates that religious leaders who use the sharia law sometimes guide community members towards harmful practices including female genital cutting.

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<sup>49</sup> Jemal Yousuf, Tedla Mulatu, Tilahun Nigatu, Dawit Seyum (2010). *Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia*. Discussion Paper No. 003/2010. AMREF Discussion Paper Series, Nairobi, AMREF 2010



In communities where religion and culture are highly intertwined it is not easy to separate religious from cultural factors, nor is it necessarily a valid distinction. In this respect, most informants agree that purely religious factors played a less significant role either in promoting or discouraging the use of health care services. Rather, religious leaders have mixed culture and religion and used religious faith to justification certain risky traditional practices. Some practices arise from inappropriate interpretation of sharia law. Examples include teachings concerning female genital cutting, property ownership and divorce, which all affect maternal health directly or indirectly.<sup>50</sup>

### **“Uncircumcised females are not fit either for Islamic prayer or for marriage”**

A community-based study was conducted to achieve the objectives of the study in Awash (zone 3) and Dalifage district (zone 5) of Afar State in Ethiopia in May 2010. The study took a small-scale descriptive case study approach using qualitative techniques. The study focused on describing and understanding the local birth culture in Afar and identifying factors that influence the use of maternal health services. Two cases in different zones were used for triangulation and saturation purposes and to explore whether differences in communities' behaviours and beliefs exist between different zones in the Afar region. The study took approximately two weeks per study site in April–May 2010.

The study found that, most of the time, religious leaders do not advise sending the woman to a health facility; instead, they say some prayers in the home. Most of the time the religious leaders say that the foetus or the mother will be looked after by Allah, so there is no need to worry about anything; just pray to Allah, and Allah will look after things.

Somewhere in the second or third trimester, the woman will find herself a traditional birth attendant. In a normal birth, the only time the woman visits the religious leaders is when she finds out that she is pregnant. She might inform the leader that she has had the baby, but otherwise religious leaders do not have a significant role to play in a normal pregnancy. The woman goes to the religious leader to pray for a healthy baby, a good birth and easy labour.

This is important because of the woman's own religious beliefs and interpretations – she believes that Allah has power to make her pregnancy go a certain way. When a woman finds out that she is pregnant, she will only tell her family in the first instance. Then the husband will go to the religious leader. He informs the leader that his wife is pregnant and asks the leader to pray for her to have a healthy baby and for an easy and safe delivery. Later, the woman herself will also go if she has a chance to meet with the religious leader – so if they meet by accident then she will tell the religious leader that she is pregnant and ask him to pray for her – but it is an informal encounter. In most other cases, it is not necessary to go to the religious leaders, unless there are complications.

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<sup>50</sup> District's sharia head speech during our discussion forum organized by AMREF in the region.

However, if there is a complication not related to delivery, such as malaria, she and her family will pray at home for Allah to cure her. If that does not work, she will go to a religious leader to ask him to pray on their behalf. If the sickness worsens, she will then need to go to a health facility. Sometimes, the religious leader suggests that she goes to the facility; in other cases, the husband will make the decision. If there is no facility, prayers will continue until she either recovers or dies. The couple might be willing and able to travel some distance to visit a health facility under these circumstances, but this depends on availability and cost of transport. If the facility cannot provide treatment she may be referred elsewhere, but in some cases she will not be taken because of a lack of money or knowledge about how the referral system works. Sometimes the community will subsidize her travel by selling their camels and cows. Decisions about whether to go to see a religious leader or to a health facility are always taken at the family level.

When a woman goes into labour, she will be attended by a traditional birth attendant in the first instance. Some traditional birth attendants have been trained to refer women to health facilities if they are unable to manage the delivery. If there are complications, the family and traditional birth attendant will pray together. Following this, the husband will go to the religious leader to ask him to pray. Sometimes, if the situation is serious, the family will invite the religious leader to visit the family's house. However, the leader is not allowed to see the woman while she is in labour; this role is restricted to seeing the traditional birth attendants and maybe the woman's mother or mother-in-law. The husband can ask for advice, and the religious leader will pray and may also advise that they should travel to a health facility. This elaborate 'chain of command' can result in considerable delay in obtaining medical care.

When the woman is back in her home after having the baby, the family may invite the religious leader to the home to pray, but this does not always happen. There is some evidence of a shift in beliefs. Formerly, the communities would have gone to the religious leaders for guidance as a matter of routine. However, there is a growing awareness of the need to visit the health facility as early as possible if they can afford it. If they do not have sufficient funds the only alternative when there are complications is to pray.

Prior to organizations introducing training on the dangers of female genital cutting (FGC), communities had very low awareness of maternal health services. However, communities are now broadening their focus beyond the purely religious aspects of well-being. Nomadic people increasingly accept that it is important to use the health facilities, especially if there are complications. If they have no resources they do not have any alternative but go to a religious leader or religious place such as a mosque. The husband and maybe also the mothers can go there to pray. Sometimes they can perform a ceremony in the house with the religious leaders and elders and family together, and they can have a ceremony to pray for the mother and the baby.

"Religious leaders of 29 districts from Afar had a meeting to discuss the necessity and reasons for FGC and, finally, agreed that there is no religious motive for FGC. But many Olmas or Derassa, who are local teachers in the mosques, strongly support FGC."

– Anti FGM workshop held at Afar region Semera organised by AMREF in collaboration with Regional Women Affairs.

According to the study participants, given their spiritual and moral authority, religious leaders have a great role to both promote biomedical and so-called modern health services and to explain their benefits. There is in reality no restriction from the Islamic perspective on utilizing health facilities, but some will interpret this differently. According to informants, key messages passed on by religious leaders are highly likely to be accepted.

The women in the study agreed that religious leaders provide important advice, based on the Quran, for dealing with pregnancy and delivery. An in-depth interview with a mother of child-bearing age indicated that:

“Religious leaders provide Quran-based advice to the community for giving care for pregnant mothers”<sup>51</sup>

The study revealed that religious leaders provide advice to the community in line with the Quran and some conduct rituals. Religious leaders and their spiritual authority influence pregnancy outcomes, but also the people themselves hold their own perceptions and religious interpretations; most of the time they will follow the leader’s advice, but sometimes they will follow their own understanding. Informants indicated that religious leaders often prepare and prescribe a “written piece of prayer drawn from the Quran” that aims to heal the woman in need. If she does not survive, the leader will pray over her body.

The study found that religious leaders often charge for this function and this charge impacts on the amount of money that is ultimately available for health care expenses at a household level. There is also the possibility that a system of fees and charges creates a pressure to resist changes to the system - as desirable as change might be.

One of the key informants argued that religious leaders contribute to pregnancy-related complications by mixing religious and traditional beliefs such as jinni (evil spirits) and that this contributes to delays in seeking appropriate health care when complications arise (for example, by attempting to manage pregnancy with herbs and spiritual prescriptions).

In this context, the discussions around the circumcision of girls make very clear how religious beliefs and health outcomes are interrelated. Female genital cutting appears in different forms and is carried out among girls of different ages; Afari girls are generally circumcised between four and eight years of age. Infibulations used to be the main practice, involving the total closure of the vulva, but nowadays less extreme cutting at an earlier age is becoming more common. Religious leaders have the potential to intervene and reduce the incidence of FGC.

Through awareness-raising around this issue, some younger mothers have become convinced that FGC is not prescribed by the holy book and that the practice is based on mixing certain religious interpretations with cultural traditions. As the result of awareness-raising forums, some religious leaders have decided to speak out against FGC.

<sup>51</sup> Jemal Yousuf, Tedla Mulatu, Tilahun Nigatu, Dawit Seyum (2010). *Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia*. Discussion Paper No. 003/2010. AMREF Discussion Paper Series, Nairobi, AMREF 2010



They argue that communities should stop circumcising their girls because bodily integrity is a core value within Islam.

## Conclusion

The analysis shows that religion plays an important role in the health of women and girls in Afar. Religious leaders are essential in getting the right message to the community so that the right decisions are taken in a timely manner. Confusion exists about what Islam prescribes. Since poverty and a lack of resources also influence access to both informal and formal health services, there seems to be an urgent need for uniform messages. Younger generations of both women and men and religious leaders might hold views that differ from those of the more conservative older generation who think that a girl can only be married and become a good mother when she is a Muslim and circumcised.

It is clear that there is an urgent need to strengthen programmes in which religious leaders are a key actor. Like other actors, they do not seem to have uniform ideas, but they are influential. Religious beliefs are based on interpretation, and the communities have to be made more aware that one can be a devoted Muslim without having a circumcised daughter.



## 6 Dealing with norms and beliefs on sexual and reproductive health: A case study from Kilindi, Tanzania

George Saiteu Lukumay

### Availability of sexual information to nomadic youths

Sexual and reproductive health-related conditions account for considerable morbidity and mortality in sub-Saharan Africa and are an important public health issue.<sup>52</sup> Young people in rural and hard-to-reach areas in Tanzania, such as in nomadic communities in Kilindi, share a lack of knowledge and access to information and utilization of sexual and reproductive health care services including for sexually transmitted infections, HIV and AIDS, and family planning.<sup>53</sup>

For information on sexual and reproductive health, adolescents are often forced to resort to unreliable sources such as peers, grandparents, older siblings, traditional healers, community-based organizations and, less frequently, science teachers.

Service providers are mandated to provide sexual and reproductive health information and services to young people (according to the policy guidelines on provision of adolescent-friendly health services), but these services are not widely utilized by young people.

Nomad communities in Kilindi District are isolated from sexual and reproductive health information in part because there are not enough health facilities to make this information available. In addition, there are different ethnic groups with their own norms on sexual issues. The Nguu, for example, are a semi-nomadic ethnic group who are both pastoralists and farmers. According to their norms and beliefs, parents do not discuss sexual issues with their children; they think that they will learn as they grow up through experience. As a result, young people gain most of their sexual knowledge from their peers. Failing that, girls should seek assistance from their aunt, while boys will be informed by their brothers.

### Documenting norms and beliefs in nomadic communities

In Kilindi District there are five main ethnic groups – the Maasai, Nguu, Zigua, Kaguru and Kamba – and smaller groups such as Iraqw, Burunge, Chagga, Pare, Meru and Shambaa. There is ongoing collection of data on youth sexual and reproductive health and rights issues among these groups by the Nomadic Youth Reproductive Health (NYRH)

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<sup>52</sup> Asino, R (2009) Adolescence Sexual and Reproductive Health Education: A review of approaches used in Sub-Sahara: [www.gfmer.ch/SRH/pdf/Adolescent-SRH-sub-Saharan-Africa-Asino-2009.pdf](http://www.gfmer.ch/SRH/pdf/Adolescent-SRH-sub-Saharan-Africa-Asino-2009.pdf) (accessed 1 July 2010).

<sup>53</sup> <http://www.amref.org/silo/files/amref-annual-report-2010.pdf> (accessed 17 July 2012).

Programme. The case study presented in Box 1 (below) is based on an interview conducted between the author and a young girl from a village in Kilindi District where the NYRH Programme is being implemented. It illustrates the consequences of the lack of knowledge, services and prevalent misinformation.

### **Box 1. Case study from Kilindi District, Nguu community**

Salima, a young woman aged 20, witnessed the first adolescent changes in her body when she was about 16. She was not aware of what was happening because her parents never told her about the changes associated with puberty. In fact, in the Nguu community, parents think that when girls grow up they will learn about puberty from their peers anyhow or they will seek advice from an aunt.

Salima was ashamed and went for some time without cleaning her body until she developed a bad odour. Her friends told her to put a piece of cloth into her vagina, but she subsequently got ill. When her mother detected the bad smell, she notified the girl's aunt, who came to talk with the girl about what was happening to her. Her mother thought that she had been raped by men on the street. Salima was brought to the health facility, where she was unable to get suitable treatment for her health problems. Instead, she was referred to the regional hospital for further management.

## **Improving sexual and reproductive health information**

Young people in nomadic communities need access to information about sexual and reproductive issues in their localities. It will bring a great change in the community when they become knowledgeable about sexual issues and understand their rights and where to get this information.

Parents need to remember that an adolescent's interest in bodily changes and sexual topics is natural, normal development and does not necessarily indicate movement into sexual activity. Parents must take care not to label emerging drives and behaviours as wrong, sick or immoral. Adolescents may experiment with or consider a wide range of sexual orientations or behaviours prior to feeling comfortable with their own sexual identity.

The teenager's quest for independence is normal development and need not be seen by the parent as rejection or a loss of control over the child. To be of most benefit to the growing adolescent, a parent needs to be a constant and consistent figure, available as a sounding board for the young person's ideas, without dominating or overtaking the emerging, independent identity of the young person.<sup>54</sup>

The case study could also be used in raising awareness in the community, where these testimonials will help other youth in the community learn about the situation, so that they can report to health facilities for further information.

Service providers have little or no knowledge and skills regarding adolescents and youth-friendly services; this drives adolescents towards endangering their lives by seeking help

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<sup>54</sup> <http://adamabout.com/encyclopedia/adolescent-development>

from unqualified people such as friends or relatives. Therefore, it is vital to ensure that all adolescents in the country have access to youth-friendly sexual and reproductive health and rights services, by upgrading existing services, establishing new services and empowering service providers to meet agreed standards. These are essential prerequisites in protecting adolescent sexual and reproductive health and rights.

The way to address sexual and reproductive health issues for the nomadic community is to make sure that young people can obtain information from different actors. Youth in nomadic communities do not access services related to sexual and reproductive health issues because the health facilities are so far away from where they live, so the government and other stakeholders could support these communities by ensuring the availability of health facilities and health providers who are knowledgeable with youth programmes who will help them to shape their behaviour by giving them appropriate information.

Addressing youth needs in most rural parts of Tanzania is lacking, especially in nomadic communities, and a small number of government and non-government organizations are involved in implementing some adolescent sexual and reproductive health interventions. The availability of information, education and behaviour change materials and other relevant resource materials needed for young people is limited. There is inadequate coordination among various stakeholders who implement adolescent programmes in different settings. Most interventions offered by the local government are based on family planning and immunization. Advocacy for a multi-sectoral approach is crucial for adolescent development in this setting.<sup>55</sup>

In conclusion, the government, all stakeholders such as non-governmental and community-based organizations and other activists for health issues – especially sexual and reproductive rights – should play a major role in advocating for the right to health in nomadic communities which have been isolated for many centuries without considering if they have sexual and reproductive rights.

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<sup>55</sup> [http://www.iywg.org/youth/resources/who\\_cah](http://www.iywg.org/youth/resources/who_cah) (accessed 17 July 2012).





# 7 Female genital cutting in Ethiopia: A changing practice?

Hannah Mason

Female genital mutilation and cutting (FGC) is widespread in Ethiopia. Though for several decades the government has undertaken efforts to eliminate the practice, the majority of girls are still circumcised. It seems that renewed efforts by the national government, the international community and civil society organisations, supported by criminalization of the practice in 2005 through a revision of the national Penal Code is having an effect, as prevalence of FGC in Ethiopia dropped by almost 6 percent over a five-year period between 2000 and 2005. However, change remains slow and the fact that a number of communities in Ethiopia where FGC is common practice, are pastoralist societies, poses an additional challenge as access to information and health provisions are scarce.

## A global practice

Ethiopia is one of many countries where female genital cutting<sup>56</sup> is practiced. 100 to 140 million girls and women worldwide are living with the consequences of FGC. FGC is practiced in a wide range of countries and communities: in approximately 28 countries on the African continent, among certain ethnic groups in a number of Asian countries (India, Indonesia, Malaysia, Pakistan); among some groups in the Arabian Peninsula (Oman, United Arab Emirates, Yemen); Iraq; occupied Palestinian territories and among certain immigrant communities in Europe, Australia, Canada and the United States.<sup>57</sup> In Africa alone, an estimated three million girls are at risk of FGC annually.<sup>58</sup> Reasons for performing FGC vary, but the motive usually depends 'not on one single factor, but on an entire belief system and values that support it'.<sup>59</sup> Reasons include custom and tradition (rite-de-passage from childhood to womanhood), preservation of virginity, control of women's sexuality and marriageability, religion and social pressure. The international community seems to unanimously agree on the fact that FGC has detrimental health consequences, both physically as well as mentally.<sup>60</sup> Apart from the immediate risks of severe blood loss, shock and infection, longer-term problems associated with FGC include infections of the urinary

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<sup>56</sup> There has been much discussion on the term to describe the practice of female circumcision. In 1990 the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) adopted the term 'female genital mutilation' (FGM) and in 1991 the WHO recommended its use to the United Nations. Since then the term FGM has been most widely used by international organisations. However, the normative value of FGM has been criticized, as parents do not perceive that they are mutilating their daughters when they circumcise them. This second strand of thought prefers to call the practice 'female genital cutting' (FGC), which is also the term used in this article. See also Neal Ford, 'Communication for Abandonment of Female Genital Cutting: An Approach Based on Human Rights Principles', in Michael Freeman (ed.), *Children's Health and Children's Rights* [Martinus Nijhoff Publishers; 2006]: note 1.

<sup>57</sup> UNFPA (<http://www.unfpa.org/gender/practices2.htm#12> (accessed 10 February 2011)).

<sup>58</sup> WHO (<http://www.who.int/mediacentre/factsheets/fs241/en/index.html> (accessed 10 February 2011)).

<sup>59</sup> Rahman, A. & N. Toubia, *Female Genital Mutilation: a Guide to Laws and Policies Worldwide* (London: Zed Books; 2000). Bartels, E., 'Female Circumcision among Immigrant Muslim Communities: Public Debate in the Netherlands', *Journal of Muslim Minority Affairs* 24 (2) (2004): 393-399.

<sup>60</sup> WHO. *Eliminating Female Genital Mutilation: an Interagency Statement*. UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO (Geneva: WHO; 2008): 11-12.



and reproductive tracts, infertility and a range of obstetric complications, such as postpartum haemorrhage and death of the baby.<sup>61</sup>

## Prevalence in Ethiopia

At the time of writing, the latest data on FGC prevalence in Ethiopia are from 2005<sup>62</sup>, which in this year stood at 74.3 percent. This is relatively high in comparison with countries, such as Kenya (27.1 percent in 2008/9) and Chad (44.9 percent in 2004), but sits under the averages of Egypt, Northern Sudan and Somalia, where the rate is 911 percent (2008), 90 percent (2000) and 97.9 percent (2006) respectively.<sup>63</sup>

The national average tells us little about the significant regional differences in prevalence. The approximately 77 million inhabitants of Ethiopia come from around 80 different ethnic groups, the major ones of which are the Amhara (30 percent), Oromo (30 percent), Tigrinya (6 percent) and Somali (6 percent). Among the latter group, FGC prevalence is almost universal (97.6 percent). In the Afar region in the north of Ethiopia, which counts about 1.5 million people and thereby constitutes about 2 percent of the total population<sup>64</sup>, the rate is estimated to be 91.6 percent.<sup>65</sup> Among the larger ethnic groups in the country, the Amhara and the Oromo the prevalence is 68.5 and 87.2 percent respectively; and among the Tigray the prevalence is below 30 percent. Several ethnic groups in the western and south-western parts of the country do not practice FGC at all. The practice is not associated with a particular religion: it is practiced by Muslims and Orthodox Christians as well as by the Falasha, Ethiopians of Jewish faith.

## Types of FGC practiced in Ethiopia<sup>67</sup>

The most severe type of FGC (Type III) can be found in the Somali and Afar regions, where respectively 83.8 percent and 97.3 percent of the segment of the female population who have undergone some form of FGC, are infibulated.<sup>68</sup> Nationwide, this accounts for 6

<sup>61</sup> See 'Ethiopia: Pastoralists battling FGC', IRIN 26/01/2011, <http://www.irinnews.org/printreport.aspx?reportid=91732> (accessed 28/07/2011).

<sup>62</sup> Demographic and Health Survey (DHS) Ethiopia 2005, as quoted in UNICEF 'Female Genital Mutilation/Cutting in Ethiopia', see [http://www.unicef.org/ethiopia/ET\\_fgm.pdf](http://www.unicef.org/ethiopia/ET_fgm.pdf) (accessed 16 August 2011). A more recent DHS has been carried out (2010), but data are not yet publicly available. See <http://www.healthmetricsandevaluation.org/record/ethiopia-demographic-and-health-survey-2010> (accessed 17 October 2011).

<sup>63</sup> Statistics from <http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html> (accessed 23 August 2011).

<sup>64</sup> <http://www.ethioidemographyandhealth.org/Afar.html> (accessed 16 august 2011).

<sup>65</sup> Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro, 2006.

<sup>66</sup> Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). *Good Practice: Harmonising Traditional Norms and National Law in Ethiopia*. [http://www.intactnetwork.net/intact/cp/files/1283853988\\_23%20Harmonising%20traditional%20norms%20and%20national%20law%20-%20Ethiopia%20\(GTZ%2008\).pdf](http://www.intactnetwork.net/intact/cp/files/1283853988_23%20Harmonising%20traditional%20norms%20and%20national%20law%20-%20Ethiopia%20(GTZ%2008).pdf) (accessed 19 August 2011).

<sup>67</sup> The World Health Organisation (WHO) has categorized the different forms of FGC into four types: 'Type I-IV'. Type I is excision of the prepuce, with or without excision of part or all of the clitoris; Type II is excision of clitoris with partial or total excision of the labia minora; and Type III is excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Type IV is pricking, piercing or incising the clitoris and/or labia. This type also includes several manipulations of the female genitalia: stretching the clitoris and/or labia, cauterization by burning of the clitoris and the surrounding tissue, scarring of tissue surrounding the vaginal orifice or cutting of the vagina, and introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it. Furthermore, Type IV includes 'any other procedure that fall under the above definition' (WHO).

<sup>68</sup> NORAD, The Norwegian International Effort Against Female Genital Mutilation, [www.norad.no/en/\\_attachment/107605/binary/6058?download=true](http://www.norad.no/en/_attachment/107605/binary/6058?download=true), 2007:14, (accessed 15 August 2011)

percent of the population.<sup>69</sup> Among the other groups clitoridectomy of various degrees (type I & II) is the norm.

## Socioeconomic factors

When trying to understand the differences in prevalence, type and age of FGC between Ethiopia and other countries, but also within Ethiopia itself, it is important to consider the socioeconomic background. It is, for example, significant that Tanzania, which has a primary school attendance of 70 percent, has a prevalence rate of FGC among 35-39 year old women of 16 percent, and 9.1 percent among 15-19 year old girls.<sup>70</sup> This indicates a generational development, whereby the prevalence of FGC is almost halved. Instead in Ethiopia, only 30 percent of the population attends primary school. When further comparing figures, Ethiopia also stands out (along with Somalia) in terms of a combination of low life expectancy, high mortality rates, high fertility rates, low school attendance and a more or less complete lack of health care facilities.

When breaking down the figures to the country-level, it is obvious that there is a rural/urban divide. According to the 2005 DHS, 75.5 percent of the rural population practices FGC versus 68.5 percent of the urban population. The discrepancy can be linked with the level of education: 30.7 percent of urban Ethiopian women have no education compared to 72.8 percent of rural women. In comparison, only 25 percent of women who have received secondary education or above continue the practice.<sup>71</sup> This could explain a slower decrease of the practice amongst the rural population. Furthermore, those living in rural areas are likely to be more affected by the health problems of FGC due to the scarcity of health care facilities in these areas: 88.6 percent of urban and 97.2 percent of rural Ethiopian women experience great problems in accessing health care<sup>72</sup>, which exacerbates post-FGC complications and decreases the chance of being informed on risks by professional medical personnel. These problems are particularly acute in, for example, the Afar region, which is predominantly nomadic in origin and the majority still practices pastoral and agro-pastoral ways. In fact, 86.6 percent of the total population lives in rural areas. In terms of access to health care, in 2006/7, there were only 10 physicians, 16 health officers and four pharmacists in the region, serving a total population of 1,418,000 in 2007/8.<sup>73</sup> Such low patient-physician ratio helps to explain the continued application of the practice as well as the severity of the health problems related to FGC that girls and women have to deal with.

<sup>69</sup> GIZ 2008: 1.

<sup>70</sup> Statistics from Population Reference Bureau, *Female Genital Mutilation: Data and Trends, 2010 Update*, <http://www.prb.org/pdf10/fgm-wall-chart2010.pdf> (accessed 23 August 2011).

<sup>71</sup> UNICEF, *Female Genital Mutilation/Cutting in Ethiopia*, [www.unicef.org/ethiopia/ET\\_fgm.pdf](http://www.unicef.org/ethiopia/ET_fgm.pdf), 2005, (accessed 15 August 2011).

<sup>72</sup> NORAD 2007: 13.

<sup>73</sup> Dawit Seyum et al. *The Dynamics of Female Genital Cutting (FGC): Cases From the Pastoralist Community of Afar, Ethiopia*, AMREF 2010: 7.

## Who circumcises?

Most sources state that the majority of circumcisions is carried out by traditional birth attendants (TBAs). The WHO defines the term as ‘a person who assists the mother during childbirth and who initially acquired skills by delivering babies herself or by working with other TBAs’. Throughout history, TBAs have been the main health providers for women during childbirth in many African countries. In a study undertaken in the Afar district in Ethiopia, all seven health practitioners who participated in the study were both birth attendants as well as circumcisers.<sup>74</sup>

## Reasons for performing FGC

Many studies have been undertaken to get a better understanding of the reasons for performing FGC. The picture in Ethiopia is mixed, as the country shows a huge variety in prevalence, type and age at which the circumcision is performed.

From the average age of the girls when circumcised, one can conclude that the majority of FGC cases is not performed as a rite-de-passage, as is for example common in Sierra Leone and Liberia.<sup>75</sup> The 2000 DHS found that over 50 percent of girls who undergo FGC do so before their first birthday (among the Amhara and Tigray populations the operation is usually performed on baby girls of 7-10 days old)<sup>76</sup>, and by 10 years of age 88 percent of those undergoing FGC have already been cut.<sup>77</sup> However, among the populations in Somali, Afar and Oromo some girls are circumcised between the ages of 7 and 9 years old, and there are groups who wait with performing FGC until shortly before the girl gets married, between the ages of 15 and 17.<sup>78</sup> In these cases, it is more likely that FGC is regarded as a rite-de-passage, or an essential condition for entering marital life.

The last two reasons are related to a general reason that is often given for performing FGC. This is the need for control of a woman's sexuality. Many Ethiopians believe that an uncut woman is more easily sexually aroused, is therefore more likely to have pre-marital or extra-marital sex and is therefore indecent, scandalous or improper.<sup>79</sup> On the other hand, when a woman is circumcised, she preserves her virginity and thereby the honour of the family. There is also an aesthetic value in being circumcised, as it is said to be cleaner and more beautiful. Some communities believe that the clitoris will continue to grow, if it is not cut. Uncut women are therefore less likely to find husbands, which in some communities leads to ostracisation of the girl and loss of honour for the family. Two respondents in a PRB study confirm some of the reasons as stated above.<sup>80</sup>

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<sup>74</sup> Dawit Seyum et al. 2010: 16-17.

<sup>75</sup> UNICEF Overview, [http://www.unicef.org/wcaro/overview\\_2947.html](http://www.unicef.org/wcaro/overview_2947.html) (accessed 23 August 2011).

<sup>76</sup> NORAD 2007: 9.

<sup>77</sup> Population Reference Bureau, *Abandoning Female Genital Mutilation/Cutting: An In-Depth Look at Promising Practices*, [http://www.prb.org/pdf07/fgm-c\\_report.pdf](http://www.prb.org/pdf07/fgm-c_report.pdf) (accessed 16 August 2011): 2006: 21.

<sup>78</sup> GIZ 2008: 1.

<sup>79</sup> Dawit Seyum et al. 2010: 27.

<sup>80</sup> Population Reference Bureau 2006: 21.

"The reason why infibulation is practiced is because the girl will be insulted and will be looked at as something open and used".

- Married Woman from Jijiga City, January 1, 2004

"In our society FGC takes place mainly to reduce high sexual desire of a woman and to develop high confidence during marriage. With women who are circumcised and stitched together, it is like packing the confidential resource that will be opened by the owner. The base assumption for circumcision in the society is to protect them from sex before marriage".

- Married Woman from Harar City, October 18, 2003).

Social pressure can be immense, and both men and women often actively support the practice. Male respondents in the Afar region answered that they were not interested in marrying uncircumcised girls. In fact, they were so appalled by women who were not circumcised, that they would not dare touch them.<sup>81</sup> Generally, women in Ethiopia demand FGC, as it is one of the few socially defined areas over which they have any control. They continue to support FGC primarily to protect their daughters' reputations and marriage prospects.<sup>82</sup>

In respect of the pastoral communities in Ethiopia, the outdoor lifestyle brings along an additional reason to practice FGC. In the Afar and Somali regions, there is the belief that FGC will protect the girl against rape. In a pastoralist community like the Afar, women often spend time of the land herding the cattle, thereby being less protected against sexual violence. According to NCTPE data, Afar and Somali people believe that it is more difficult to rape infibulated girls.<sup>83</sup>

Another important reason for continuing FGC is the belief that the practice is a religious requirement. The number of Muslims practicing FGC in Ethiopia is slightly higher than that of Christians,<sup>84</sup> but both groups associate FGC with religious obligations. Opinions vary on whether the practice is indeed prescribed by religious texts or not. Regardless of the interpretation of religious texts, religious leaders play an important role in the social acceptability of FGC.

Whereas a number of leaders increasingly support the abandonment of FGC, there appear to be both Christian and Muslim leaders who refuse to condemn the practice, or who prescribe the less severe *sunna*<sup>85</sup> type instead of infibulation. Teffera, for instance, found in her study that in some parts of Ethiopia, Orthodox priests have been known to refuse to baptize girls who have not undergone some form of FGC.<sup>86</sup> An Ethiopian Muslim leader,

<sup>81</sup> Dawit Seyum et al. 2010: 28.

<sup>82</sup> Population Reference Bureau 2006: 21.

<sup>83</sup> Ibid: 72.

<sup>84</sup> Sehin Teffera, 'Tackling tradition: examining successful strategies in the mitigation of female genital mutilation in Ethiopian communities', <http://www.kit.nl/smartsite.shtml?id=15983>: 4.

<sup>85</sup> The word *sunna* is Arabic and means in the 'way of the Prophet'. It is not an obligatory religious act, but one that is perceived as morally good, thus linking sunna-operations semantically to religion. See NORAD 2007: 10, note 12.

<sup>86</sup> Ibid: 59.

when asked his opinion about circumcision, answered that circumcision type III should not be allowed, but that 'if female circumcision is done according to the rulings of the Islamic Shari'ah, I do not order people to avoid it'.<sup>87</sup> In communities where religious leaders have an authoritative voice, such messages can cause confusion around the legitimacy of FGC.

Lastly, there are economic reasons for pursuing the practice. TBAs often earn money or are given goods for performing FGC, thereby making a living.<sup>88</sup> Seeing the level of poverty in Ethiopia, it is not surprising that TBAs are hesitant to fully stop practicing FGC.

## Anti-FGC programmes/policy

### *Legal Framework*

Ethiopia has signed several international treaties pertaining to the rights of women and children. These include the Convention on the Elimination of all forms of Discrimination Against Women (ratified in 1991), the Convention on the Rights of the Child (ratified in 1991), the International Covenant on Civil and Political Rights (ratified in 1993) and the International Covenant on Economic, Social and Cultural Rights (ratified in 1993).<sup>89</sup> In 2004 the Ethiopian government also introduced the Criminal Code Proclamation No.414/2004, specifically criminalizing harmful traditional practices. This Proclamation became law in 2005.<sup>90</sup> Though previous provisions in national and international law protected women from sexual violence, the specific law banning FGC removes uncertainty about its details and is therefore expected to be more effective.

### *Policy Initiatives*

On a political level, several efforts are made to put an end to the practice of FGC. In 1987 a National Committee (NCTPE: National Committee on Traditional Practices of Ethiopia) and the Ethiopian Women Lawyers' Association were established to help overcome traditional practices harmful to women's and children's health. The government supports advocacy programs both to prevent as well as provide aid to victims of FGC. UNICEF reports that in May 2005 the Ethiopian Woman Lawyers' Association published a small booklet in five languages outlining essential legal rights for women. In 2006 the government adopted a five-year plan, the National Action Plan for Gender Equality (NAP-GE) with the goal 'to contribute towards the attainment of equality between men and women, in social, political and economic development'<sup>91</sup>, which includes the goal to eliminate gender-specific violence such as FGC. An article from 2009 illustrates that several women parliamentarians openly condemn the practice.<sup>92</sup> The 2010 showing in Addis Ababa of the film 'Desert Flower'

<sup>87</sup> 'In-depth: Razor's Edge - The Controversy of Female Genital Mutilation. ETHIOPIA: IRIN interview with Sheikh Omer, a muslim religious leader', 01/03/2005, <http://www.irinnews.org/InDepthMain.aspx?InDepthId=15&ReportId=62475> (accessed 23 August 2011).

<sup>88</sup> Dawit Seyum et al. 2010: 30.

<sup>89</sup> Rahman & Toubia 2000: 147.

<sup>90</sup> UNICEF 2005.

<sup>91</sup> National Action Plan for Gender Equality, [http://www.dagethiopia.org/index.php?option=com\\_docman&task=doc\\_download&gid=12&Itemid=120](http://www.dagethiopia.org/index.php?option=com_docman&task=doc_download&gid=12&Itemid=120) (accessed 18 August 2011).

<sup>92</sup> UNICEF, 'In Ethiopia, African women parliamentarians condemn female genital mutilation', 14/09/2009, [http://www.unicef.org/infobycountry/ethiopia\\_51122.html](http://www.unicef.org/infobycountry/ethiopia_51122.html) 2009 (accessed 15 August 2011).

about the life of the Somali-born Waris Dirie, who was the daughter of a pastoralist family and underwent FGC at the age of 5, sparked a public debate. Such public attention helps to remove taboos as well as raise awareness about its potential harmful effects.

### *NGOs, CSOs and Religious Associations*

There are many different types of non-governmental organisations at work in Ethiopia, which aim to put an end to the practice of FGC. Their activities vary from advocacy, awareness campaigns, community mobilisation and networking to radio women's listening groups, building of health infrastructure to enlarge health and education access, training of midwives and health personnel and legal aid. Some organizations focus on individuals, whereas others are community-based. Projects will typically target different stakeholders: women, men, youth, children, religious leaders, heads of villages, district and regional officials, medics as well as practitioners. The starting point can be rights-based, health-based or from religious perspective, depending on the nature of the organisation or the success rate. On the whole, programmes and interventions are generally set up to support the most vulnerable groups of society, women and children in rural environments and with little education.

## Is the practice changing?

There is evidence that FGC prevalence in Ethiopia is decreasing. A short-term historical comparison of DHS data renders that the prevalence rate in Ethiopia has dropped over a relatively short period of five years down from 80 percent in 2000 to 74.3 percent in 2005. This can also be concluded when looking at prevalence per age group. A larger part of the younger generation is not circumcised: 73 percent in age group 20-24, while 80.8 percent in age group 45-49 is circumcised.<sup>93</sup> This leads to the conclusion that a part of the younger generation seems receptive to intervention programmes.

There are also indications that the practice as such is not necessarily always eliminated, but that the type of FGC is becoming less severe. A study undertaken by AMREF in 2008 refers to NCTPE statistics, which show that there has been a small shift from infibulations (type III) to the *sunna* type (types I and II).<sup>94</sup> A USAID study confirms the same trend. It must be noted that these changes are difficult to measure, as answers from TBAs do not necessarily give an accurate reflection of the type of circumcisions that they perform nor is it practically possible to have all girls undergo medical examination. The conclusion seems to be drawn from the fact that the recovery period of girls who have undergone the procedure is shorter and that they are less disabled right after the operation.<sup>95</sup> It has also been observed that some religious leaders condemn infibulation, but argue that *sunna* circumcisions are religiously required or desirable.<sup>96</sup>

<sup>93</sup> NORAD 2007: 14.

<sup>94</sup> Dawit Seyum et al. 2010: 33.

<sup>95</sup> Ibid: 75.

<sup>96</sup> UNFPA 'Abandoning Female Genital Cutting/Mutilation in the Afar Region of Ethiopia', 08/04/2010, <http://www.unfpa.org/public/news/pid/5141> (accessed 11 August 2011).

Several other issues remain. According to a 2007 article, a respondent states that the legal framework is not sufficient to put a full halt to the practice.<sup>97</sup> Under the Ethiopian Penal Code, FGC carries a punishment of imprisonment of not less than three months or a fine of not less than 500 Birr [US \$55]. Moreover, Ethiopia has not yet ratified the Maputo protocol.<sup>98</sup> Interviews with a number of people working at legal associations in Ethiopia on the issue state that a more severe punishment combined with the signing of the protocol would boost the deterrence of the legal provisions currently in place and increase its impact.<sup>99</sup>

Furthermore, criminalization itself is not sufficient to lead to behavioural change. Sensitivity and taboos surrounding the subject mean that few people will openly discuss FGC, let alone take legal action. A more general point is that children, usually the victims of FGC, are unlikely to testify against their parents. So far, there have been very few court cases, and in one case which was reported, the father who had his three daughters circumcised was let off free.<sup>100</sup>

There is also evidence that criminalization pushes the practice underground.<sup>101</sup> If it is indeed the case that traditional practitioners increasingly perform FGC behind closed doors, this could have serious implications on the level of hygiene and safety of the girls. If family members refrain from taking their daughters to hospitals to receive the needed care out of fear for prosecution, the question remains to what extent criminalization has the desired effect. Moreover, it casts a shadow over the reliability of statistics, as traditional health practitioners are less likely to admit the fact that they practice FGC.

On the political level, even if the government's commitment is there to improve the situation for women and girls, it often lacks the necessary resources and capacity to advance the issue effectively.<sup>102</sup>

A more general point in the case of Ethiopia is that the spread and living environment of many groups does not allow easy access to information, education or health. It also means that there is no one-fits-all type of intervention programme, which can be applied to all communities, as vary immensely in terms of custom, tradition and culture. Pastoralist communities, such as the Afar, pose the authorities with particular challenges, as they are unable to regularly attend the community dialogue sessions to get enough information on FGC. This makes it difficult to monitor progress at the community level.<sup>103</sup>

<sup>97</sup> IRIN 'ETHIOPIA: Female circumcision declines in southern region', 31 July 2007, <http://www.irinnews.org/report.aspx?reportid=73509> (accessed 11 August 2011).

<sup>98</sup> The Maputo Protocol came into force in November 2005 and is an African initiative that prohibits and condemns FGC.

<sup>99</sup> IRIN 31 July 2007.

<sup>100</sup> NORAD 2007: 11.

<sup>101</sup> Dawit Seyum et al. 2010: 16-17.

<sup>102</sup> NORAD 2007: 11.

<sup>103</sup> UNFPA 8 April 2010.



It appears that some of the programmes both of the government as well as the non-governmental organisation are having an effect, but the change remains slow. Issues such as a lack of education and access to health will continue to form barriers to decreasing the FGC prevalence in Ethiopia. An integrated approach, such as has been successfully adapted in rural communities in Egypt, may be the way forward. In 2007, UNFPA and UNICEF jointly initiated a rights-based approach to adolescent and youth development in the Oromiya, SNNP, Amhara, Afar and Addis Ababa regions.<sup>104</sup> FGC forms part of a larger picture, in which human rights values, empowerment and education are promoted. Activities include youth and community conversations, advocacy against gender-based violence and FGC and build legislative and law enforcement capacity. Part of the joint program also entails monitoring and evaluation in a more scientific manner, seeking best practices and indicators, and financial assistance for development of, for instance, Demographic Health Surveys (DHS). It will be worthwhile assessing the impact of this programme, after its conclusion at the end of 2011.

An example of a project that is particularly targeted at nomadic populations is AMREF's Nomadic Youth Reproductive Health Project (NYRHP), which ran from 2007-2010. This project was aimed at improving reproductive health care and rights of nomadic youths in the Afar region in Ethiopia, Kenya and Tanzania. Reducing FGC was one of its goals. The main focus of the project was on the training of people involved in the different aspects of reproductive rights, including traditional birth attendants, teachers, health extension workers, health service providers and health managers on various reproductive health issues and on strengthening the health system in the region.<sup>105</sup> Seeing the important role, which TBAs play in the continuation of the practice, a project, which specifically targets their practices and traditions, seems essential. In chapters 8 and 9 of this book the projects are described in which TBAs and also health extension workers are central focus, but also local practices are addressed

Recent experiments in Kenya with 'alternative rites of passage' may also provide a useful starting point for anti-FGC projects in Ethiopia. The Maendaleo Ya Wanawake Organisation, for example, organizes by yearly-classes for young girls and a subsequent ceremony, as a replacement of FGC. In the course of the passage, girls spend time away from their families, being taught about basic skills in life such as cooking and basic medication, after which a final ceremonial event welcomes the girl into the state of womanhood. The idea of alternative rituals seems successful, as prevalence in some Kenyan communities has declined.<sup>106</sup> Alternative rituals may not be applicable to the younger girls who undergo FGC, but in communities where FGC is regarded as a rite of passage, it could certainly lead to change in a long-standing tradition.

<sup>104</sup> NORAD 2007: 18.

<sup>105</sup> Dawit Seyum et al. 2010: 7-8.

<sup>106</sup> See <http://mywokenya.org/research.html> (accessed 17 October 2011).



## Pathways to childbirth

For pastoralist communities where the formal health care services are hardly accessible and obtainable, especially in Eastern Africa in Tanzania, Kenya and Ethiopia the existing informal (e.g. traditional birth attendants, community-based health management information system and formal health care services (e.g. health extension workers, skilled professional health care providers and others) have to be linked and these linkages need to be strengthened and integrated somehow in maternal health care services and other health related community-based health services. This cannot be realized without the commitment of pastoralist men, women, young people and those representing them. Strong leadership and responsiveness to local mechanism ensure that childbirth becomes a safe enterprise for mother and child.



## 8 The contribution of health extension workers in the formal maternal health care service in Afar, Ethiopia

Jemal Yousuf Umer

Health Extension Workers can significantly improve maternal health care services for pastoralist communities in collaboration with local leaders, Traditional Trained Birth Attendants (TTBAs) and professional health care providers in a holistic, integrated approach to service provision.

Ethiopia is faced with a shortage of health workers at all levels, especially in rural areas, in which 85% of the population lives.<sup>107,108</sup> To overcome this, in 2003 the government introduced the role of Health Extension Workers (HEWs) in primary health care services, although not all the Ethiopian regions have actually reached the targeted number of health extension workers yet. According to the regional health bureau report, the region where this study took place, Afar, only reached the targeted number of HEW placements with the last round of staff graduating as HEWs in August 2010.

The HEW training programme was developed and is being implemented by the Federal Ministry of Health in collaboration with the Ministry of Education. The first step was to expand the number of tutors, teachers and trainers and develop relevant and appropriate educational materials, focused on Ethiopia's priority health problems. To provide space for HEW training, the Ministry made use of Training Centres.

In the national HEW scheme, female (in these programmes, priority is given to female applicants) high school graduates who had completed grade 10 in school, were from the community where they intended to work and spoke the local language were trained for one year.<sup>109</sup> For the pastoralist programme the training is for six months, as the national strategy to access the pastoralist community and admission to the programme only requires completion of grade 4 or above, since very few individuals have completed high school. As a result of the higher grade requirements there are no more educated females in the pastoralist communities of Afar, due to a lack of basic education facilities in the former government infrastructures.

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<sup>107</sup> Yarehyirad, K, Yemane et al. (2007). Assessment of the Training of the First Intake of Health Extension Workers, *Ethiopian Journal of Health Development*, Volume 21, Number 3, 2007: 232.

<sup>108</sup> Awash Teklehaimanot, Yarehyirad K et al. (2007). *Study of the Working Conditions of Health Extension Workers in Ethiopia*. Ethiopian Journal of Health Development, Volume 21, Number 3, 2007: 246.

<sup>109</sup> World Health Organization and Global Health Workforce Alliance (2006). *Country case study: Ethiopia's human resource for the health programme*.

In the training, HEWs learn to deliver a package of 16 preventive and basic curative services (see BOX 1 below).

### Box 1. Package of services offered by HEWs

1. Family health service component:
  - Maternal and child health
  - Family planning
  - Immunization
  - Adolescent reproductive health
  - Nutrition
2. Hygiene and environmental sanitation:
  - Proper and safe excreta disposal system
  - Proper and safe solid and liquid waste management
  - Food hygiene and safety measurements
  - Healthy home environment
  - Anthropoids and rodent control
  - Personal hygiene.
3. Disease prevention and control:
  - HIV/AIDS prevention and control
  - TB prevention and control
  - Malaria prevention and control
  - First aid
4. Health education and communication

Staff at the local health post supervises the HEWs and ensures that they are doing their jobs appropriately. Technical supervisors periodically visit the health posts to follow the HEWs' planning, implementation, monitoring and follow-up, and to record and report developments in the community's health status.

## The HEW programme

In May 2010, a qualitative study was carried out to explore factors contributing to the (lack of) use of maternal health services among the pastoralist community in Afar. The study found that, while the community was largely aware of the intentions of the HEW programme, there are still major barriers obstructing its proper functioning.

The HEWs themselves noticed changes in their community as a result of their training and health outreach efforts, as an HEW from Awash District said:

"I have observed big changes. Many in my village have started implementing the lessons that I have taught. Through Dagu [the traditional information exchange], women even ask other women about my teachings. This progress motivates me to push forward. When I learned that some women were sharing my lessons, I felt really satisfied. I am most encouraged when I see pregnant women visiting a health centre or coming to talk to me about their pregnancy. In an effort to help more pregnant women in my village, the regional health bureau has given me additional training on antenatal care and delivery. Now I can assist deliveries and provide postnatal care support."

Not only was the HEW influencing the health of the people she directly reached, but she also felt that the messages were being shared among community members. *Dagu*, the system of information exchange among the Atari people, is a tradition in which any two people who meet are obliged to inform one another about themselves, where they are coming from, where they are going and any significant news or events they have observed or heard of along the way. The inclusion of health information in *dagu* suggests that it is valued by the community. *Dagu* is regarded as a highly efficient way of spreading information in Afar, which implies that the messages may reach an even wider audience than initially intended.

The presence of HEWs in the pastoralist community creates a vital link between the community and the formal health system, as an Awash local leader confirmed:

“During antenatal care the HEWs tell the mother about her condition and the status of the foetus. If the case is beyond their capacity they will refer them to Awash health centre or Merti health centre. In our kebele, especially on the antenatal care most of the women seem satisfied with the service of HEWs.”

Thus, when formal health services are available, HEWs can play an important role as an advisor providing input into when to seek more advanced medical care. In light of this, the HEWs are working with Trained Traditional Birth Attendants (TBAs) and TBAs in their catchment areas in an integrated approach to access the pastoralist community, because they are working according to the community lifestyle.

HEWs recognize the local leadership as key partners in their daily business and health post management. Local leaders are the only entry points for community work, including health interventions, in the pastoralist community. The local leaders are helping and supporting HEWs in coordinating the community for mass education and other health-related issues. Because health interventions in the pastoralist community are different from others areas of their lifestyle, they need the commitment of the community leaders and HEWs.

## Challenges

The design of the programme, in which short training courses allow for quick mobilization of HEWs, also has its drawbacks. On the one hand, some respondents indicated that the HEWs attempted to perform work that was beyond their mandate, for which they were not qualified or properly trained. A health manager from Dalifage said, *“HEWs also consider themselves as clinical nurses in most cases; they are providing drugs which they have no practical knowledge about.”* At least some of the HEWs are aware of this competence gap, and would like to have the opportunity to receive additional training and become more skilled. One of the HEWs in Dalifagi said:

“After I graduated from school I was deployed in the kebele without the availability of a health post. This often disappointed me in conducting routine tasks, and also I cannot learn to develop skills; because of that my working interest decreases from time to time.”



Because this HEW is not affiliated with a health post, she has limited resources for carrying out her work and does not have the opportunity to improve her skills by working with other health professionals.

Another HEW from Awash district expressed a similar desire:

"My only remaining concern is my education. I want to continue my study to eventually become a physician. I want to continue my education, though I am happy to work as a Health Extension Worker."

On the other hand, when HEWs do have the opportunity to pursue continuing education, this often takes them to the district capital, so they are not able to perform health services in the community. A health service provider indicated that the health extension programme is weakened when the HEWs are not available in the kebele because they are undertaking continuing education. One HEW reported that he works only on weekends, since he is attending his formal education on weekdays. A woman of reproductive age also shared her concern as follows:

"Previously there was a skilled health professional in the nearby health post. But now he's left, and another woman came; she is skilled too, but she is not available at the health post. Sometimes there are no drugs, and no car to take labouring mothers to better facilities. I have tried to report this to the concerned body [Wereda health office and kebele leaders], but they did nothing. And I can't do anything else."

– Adult woman key informant, Awash

While there are challenges in implementing the HEW scheme, there are also promising stories. We interviewed Asya Mohammed, 20, who was very positive about her work as an HEW. Asya is the third child in a family of three girls and four boys. She was born and raised in Doho village, Afar, and went to Doho elementary school, where she completed the fourth grade. She was one of the young women selected by the district to become an HEW and participated in the six-month training programme at Aba'ala Health Extension Training Centre. For five months she followed courses in the classroom before heading to the field for one month of practical experience.



Asya learned a lot about health in the training. As she said: *"I had very limited knowledge about basic health care issues. I was the one who took the little children into hiding when there was a vaccination campaign in our village. I had such a bad feeling about it just like the mothers."*

After completing training, Asya was very eager to return and teach her community. She is now working in her own village, Doho, as well as the nearby areas. Her services include house-to-house visits to women and children, vaccination, family planning and hygiene education. She uses her own approach to educate the women in her community:

"I teach the women while working with them on their house chores. This way they will save time and also get some help."

Adopting this approach to education made the community more receptive to her messages. Additionally, the kebele administrator convinced the community that Asya was their own girl and that she had taken the health extension training for the benefit of the community.

Although HEWs are based in their own village, every day is not easy. They face many challenges. For instance, they have to travel as far as 10km to visit neighbouring villages, crossing the bush alone. When they feel unsafe and must travel long distances, the local kebele administrator assigns someone to accompany them. Cooperation with the kebele administrator has proved essential to HEWs' positive experience of their role.

The training of HEWs in basic and field practice has been done well, because they are involved in theory and practical field work with close follow-up from their instructors. However, as the key informants said, different HEWs have different levels of knowledge and skills in antenatal care, delivery and postnatal care in each of their districts. This creates some difficulty for the HEWs who have not yet received training on antenatal care and delivery skills after their training.

The HEWs need career training for their further education, because they were enrolled in HEW training from grade 4 and above, which encourages them to learn more for the future. Unfortunately, this drive for education needs to be balanced with the need for HEWs to be present in their communities to deliver health services. To make the HEW activities strong and significant, commitment and leadership from both the HEWs and local leaders are essential, with collaboration, regular supportive follow-up and monitoring from nearby health centres and district health office supervisors. All HEWs need to receive additional practical training on antenatal care, delivery, postnatal care and family planning services. In addition, further training is required to retain HEWs in remote areas but should be carefully implemented, perhaps in a rotating scheme, to ensure that health services remain consistently available.



## 9 The role of traditional birth attendants in perinatal care among the nomads: A case study of the Maasai of Magadi, Kenya

David Kituku Kawai

Traditional Birth Attendants (TBAs) play a unique and important role in the time around delivery in the Maasai community in Kenya. The community holds them in high regard, and they are one of the only groups of women who are vested with decision-making power in a society that is typically run by men. Considering the high esteem in which these women are held, they should be engaged to provide advice and care around delivery and refer women to skilled birth attendants for the birth itself.

It is not easy to take away the perinatal care obligations from the TBAs in nomadic settings. This is despite the World Health Organization's recommendations to ban them from practising. Governments have enforced the ban, purporting that the TBAs are a major contributor to maternal mortality. The Kenyan government has followed this trend and banned TBAs.<sup>110</sup> The rate of maternal mortality in Kenya stands at 414/100,000 live births.<sup>111</sup> This is even higher in nomadic settings, where it stands at 516/100,000 live births. Is the higher maternal mortality in nomadic areas exacerbated by services offered by TBAs?

The Maasai are a nomadic community living in arid and semi-arid areas of eastern Africa. In these areas resources are scarce and health facilities are few, far apart and away from the community. Health services are inaccessible. The community has, for a long time, relied on traditional medicine men and TBAs for health services. They migrate with the community and are easily accessible and affordable. TBAs are held in high esteem because of the work they do in this community. They provide antenatal care, conduct normal deliveries, make referrals for complicated maternal cases, and offer postnatal care services to mothers in an area where maternal health services are hard to access. It is this cadre of Community's Own Resource Persons (CORPS) which the government has banned from offering maternal health services.

Instead, women are expected to deliver at a health facility with the support of medical practitioners.<sup>112</sup> In the nomadic areas there are few roads, and where there are roads, most are impassable during the rainy season.<sup>113</sup> People mostly walk from place to place,

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<sup>110</sup> Anyangu-Amu, S (2010). *Jury Still Out on Traditional Birth Attendants*. IPS News, 26 July 2010: <http://ipsnews.net/africa/nota.asp?idnews=52274> (accessed 4 September 2012).

<sup>111</sup> Kenya National Bureau of Statistics (KNBS) and ICF Macro (2010). *Kenya Demographic and Health Survey 2008–09*. Nairobi and Calverton, MD: KNBS and ICF Macro.

<sup>112</sup> Government of Kenya (2009). *National Reproductive Health Strategy 2009–2015*. Nairobi: Ministry of Public Health and Sanitation and Ministry of Medical Services.

<sup>113</sup> Blair, P (2009). *Crossing the road in Loitokitok*, (28 December 2009). <http://superkeen.com/peacecorpsweblog/2009/12/28/crossing-the-road-in-loitokitok/>. (accessed 4 September 2012).



as transport is either unavailable or unaffordable.<sup>114</sup> Distances to the health facility are too long for an expectant mother; let alone a mother in labour. Most health facilities are operated by only one member of staff, who may not be able to meet the needs of the people because of exhaustion. The health personnel are mostly male, and Maasai women do not like to be assisted by males during delivery, as it is culturally unacceptable.<sup>115</sup> But the TBAs are not allowed to conduct a delivery. How can they assist?

## A piece of evidence

In a qualitative exploratory study carried out among the Maasai of Magadi, Kenya, it was found that Maasai women were still holding TBAs in very high regard, and thus putting a ban on their services was complicating a problem rather than offering solutions. Data for the study were collected through focus group discussions and in-depth interviews with TBAs and women and men considered knowledgeable in the community. An inventory of services provided by health facilities was also undertaken to establish the availability of maternal health services in the area. The study found out that the TBAs provided a variety of services during the perinatal period. These included:

- Observing activities performed by the pregnant mother to ensure her safety and that of the child;
- Giving advice on diet for pregnant mothers;
- Advising pregnant women on prevention of illnesses such as malaria during pregnancy and;
- Checking on the pregnancy and curing any detected diseases using herbs.

Other responsibilities included assisting the woman in preparing for birth (developing a birth plan and collecting necessary items such as a razor blade and a clean string), palpating the pregnant woman's abdomen, cutting the umbilical cord, cleaning the mother and the baby after delivery, and assisting in the removal of the placenta. In case of complications, they are key decision-makers in referring the woman and the baby to a health facility. Their decision is respected in a community where men make most decisions. The TBA suggests a specific diet for the new mother and informs the family.

According to respondents, TBAs have various characteristics which make them preferred and well-known. These characteristics include wide experience (having attended to several women who have given birth successfully), the ability to identify complications in a pregnancy, ability to estimate the size of the baby, ability to palpate and position the baby well during birth, cutting the umbilical cord, and removing the placenta. A young man from Musenke sub-location alluded to these qualities by saying:

"TBAs are perfect in their work; they can identify normal and abnormal baby presentation when the mother is in labour."

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<sup>114</sup> AMREF (2007). *Baseline assessment for the manyatta-based delivery for MCH services, Magadi division, Kajiado District* (unpublished).

<sup>115</sup> Ibid.

The TBAs are also friendly, reliable, available, and punctual when called upon. Their services are not expensive and can be paid in kind. In some instances a TBA can be paid with money; for instance, if the woman comes from a different household this is a way of cleansing the TBA for 'touching blood'. According to one of the TBAs from Murantawa:

"We love and understand each other. If she is from a different home I am paid something small for touching blood".

Women prefer traditional maternal care because they believe that people attend a hospital when they are sick, but pregnancy is not a sickness. Pregnant women's fear of caesarean birth in the hospital, high costs, and being left on their own in hospital explain why women prefer traditional maternal care. An old woman from Saideny sub-location echoed this by saying:

"It is only sickness that will force you to go to the hospital. If you are not sick... there is no need to go to the hospital; instead, you should deliver at home."

A young woman from Komiya in Magadi location affirmed this:

"At home you are given good care, unlike in the hospital where they wait for a short time and take you for caesarean birth."

In hospital, after delivery women are told to bathe themselves and clean the baby, while at home TBAs clean the woman and the baby. An old woman from Oloshaika in Magadi location had this to say:

"TBAs come to the house and massage the woman; when she delivers she is bathed with hot water, and the baby is cleaned. She is then given hot soup to drink."

There is plenty of food at home, coupled with celebrations and festivities to mark the beginning of a new life in the community, unlike in the hospital where there are restrictions on when and what to eat, especially after birth. According to a TBA from Entasopia:

"You get better care at home than in hospital. They provide food or meals mostly in great quantities compared to hospital, which takes long for you to be fed again."

At home, the mother is with a lot of people including her other children, whom she can monitor. Fear of isolation from other women makes pregnant women opt for home care and delivery. A woman who delivers in the hospital is regarded as a coward and held in low esteem, and other women do not like to associate with her. The use of TBAs during pregnancy and childbirth is then a culturally accepted way to follow up on a pregnancy, labour and delivery.

When a woman is about to deliver and labour has set in, a TBA is summoned by a family member to assist. An elderly woman who is a member of the family should assist the TBA

during the birthing process. The elderly women in the family, and especially the mother-in-law, also assist the new mother to clean herself and the baby during the first days after delivery.

The task of a TBA is regarded as noble and is extolled after a successful delivery. To some families, a TBA will be regarded as a family member and a friend who is accorded high respect. To some, this relationship becomes too intense so that it leads to intermarriages between the two families. According to a TBA from Murantawua sub-location:

“In African traditional concept or religion, apart from blood relations, relationships are enhanced when a TBA assists a woman to deliver. Sometimes a woman might undergo difficulties since the time of conception till delivery period. As a perfect and responsible TBA in the community, you are expected to take up the role of assisting her till birth. Through that, good relations are enhanced between the two families.”

The respect is enhanced if the child becomes successful or prominent in life – for example, a political leader.

## Collaboration is possible

It is important to note that some of the TBAs work in collaboration with health providers through community health workers (CHWs). Some have been trained on modern maternal care and midwifery offered in the past at the health facilities with a given curriculum from the Ministry of Health, where they are also provided with gloves to use during delivery. If a TBA is unable to handle a pregnancy, delivery or a complication arising after a delivery, she makes a referral to Entasopia Health Centre. They mostly carry the woman using shukas (clothes), and sometimes, if lucky, they can access a private vehicle or motor bike, as public transport is rare and unreliable. TBAs are allowed to accompany and visit the woman at the health facility if the woman is admitted.

Contrary to the common perception that TBAs and skilled birth attendants would regard each other negatively, it is not the case with TBAs in this community. TBAs acknowledge that skilled birth attendants maintain high levels of hygiene at delivery since they use gloves as they assist mothers to deliver, and they have skills that enable them to handle complications before, during and after delivery, such as retained placenta, caesarean sections and excessive bleeding, which a TBA cannot handle or offer. They have equipment and medicines to deal with these types of complications. In addition, they offer treatment for any disease a mother could be suffering from as well as transfuse blood and cater for dehydration through a drip, as a TBA from Olchoro Olepo in Entasopia sub-location stated:

“A doctor is also a small god, because he/she can identify a particular disease one is suffering from and know exactly the type of medication to be given. He can also give a drip to a woman after delivering, avoiding dehydration that always causes fainting of women at home.”

Unlike at home, where many people are around during delivery, skilled birth attendants offer privacy at health facilities. In addition, skilled birth attendants offer advice to the



mothers before and after delivery on how to care for themselves and the new-born baby. However, TBAs dislike the fact that some male skilled birth attendants assist women during delivery, which is contrary to their culture. As one of the TBAs from Entasopia said:

“In our culture, it is an abomination for a man to assist a woman to deliver a baby, but in hospitals some of the male skilled birth attendants are assisting women to deliver, and we don’t like it.”

As indicated earlier, women in health facilities are told to shower or take a bath and also clean their babies immediately after birth, unlike at home where they are cleaned by a TBA or other women. They are also given hard (solid) foods to eat in the health facility at specific times of the day, unlike at home where they have plenty of soft foods such as porridge and soup to take throughout as they prefer.

## What can we learn from the evidence?

This study shows that TBAs are still a preferred source of maternal health services. Their role in providing antenatal care, conducting deliveries, referring expectant mothers and providing postnatal care is unquestioned by society. Banning TBAs from conducting deliveries means that many Maasai women will suffer in childbirth, because most are unable to reach or afford modern health services.

Childbirth is a natural process but sometimes not without complications. Other than assisting in making a referral to a health facility, what else should a TBA do if she sees a mother in labour and far away from a health facility and there are no means of transport? Should the TBAs in a nomadic setting be banned from offering antenatal care and postnatal services that are in huge demand by the society? Should their capacity not be enhanced to recognize danger signs in pregnancy and identify high-risk mothers to make timely referrals?

This paper does not suggest that TBAs should be allowed to conduct deliveries, but the opportunity to offer advice to an expectant mother using her longstanding experience is worthwhile. A TBA would easily recognize certain danger signs in pregnancy and offer assistance in good time. She would also give advice to a mother regarding taking good care of herself and the child after birth. This would help in ensuring the general health of the mother and baby before and after delivery. If TBAs were not appreciated in the nomadic settings, their fame would have diminished to a level of extinction. But evidence points to a rising popularity.

This is an indication of the value of the services they provide. This study provides evidence that TBAs offer much-needed antenatal and postnatal care services in addition to referring expectant and high-risk mothers to health facilities. Maternal health services are improving elsewhere, but in nomadic settings the situation is still bleak.

To ensure that deliveries are not clandestinely conducted at home, this study recommends that there is a need to enhance the skills of TBAs to be able to offer antenatal and

postnatal services. They should also be trained on how to recognize danger signs in pregnancy and identify high-risk mothers for timely referrals. The antenatal and postnatal care package should also include family planning.





# 10 Community-based health information: A key to harmonizing tradition and formal health systems

Henerico Ernest Malagi

To harmonize informal and formal health systems, a community-based health management information system (HMIS) was introduced as an attempt to bridge the gap between the community and formal information systems. The community was trained to collect and record information about marriages, pregnancies, births and maternal deaths. This mobilized the community to seek funding for a dispensary and provided the Ministry of Health with valuable information about reproductive health in the community. This information is crucial for determining the role played by Traditional Birth Attendants (TBAs) in the health of nomadic communities.

For people to have good health, they must have a strong, comprehensive and functioning health system with the appropriate administration, management, infrastructure and human resources. To strengthen people's health, the health system must meet the needs of poor and vulnerable communities, and local people must form the basis of the system. This also requires cooperation between different health development partners including the government and non-governmental organizations.

HMISs collect information about the health of the community that can be used to monitor, evaluate and eventually improve health services. Community-based information such as deaths and illnesses are rarely collected at the health facility and so frequently go unreported. This is particularly noticeable in rural areas, such as Kilindi District in Tanzania. These observations indicate the weakness of the HMIS; a community-based HMIS may be able to fill the gap.

Involving communities in gathering information on their own health creates awareness of their own health as they review and share their own information. By using this information, they can prioritize their health plans and become more able to demand appropriate health services from the government and other stakeholders.

According to the National Bureau of Statistics (NBS) Tanzania Demographic Health Survey (TDHS) 2004–2005,<sup>116</sup> maternal mortality has been constant at 578/100,000 live births for a period of 10 years. It is important information to inform health development partners' implementation activities to achieve Millennium Development Goal 5: improvement of maternal health. The information has to be accurate and comprehensive, and it should include the maternal deaths occurring in communities, which are not normally recorded.

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<sup>116</sup> National Bureau of Statistics (NBS) (Tanzania) and ORC Macro (2005). *Tanzania Demographic and Health Survey 2004–05*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.

## Creating a community-based HMIS

Through the Nomadic Youth Sexual and Reproductive Health project, AMREF in Tanzania played its part in bridging the gap in the HMIS, in particular for community-based information. The process started by making a visit to the existing district HMIS to identify whether a community-based HMIS existed. Since nothing was found to exist, it was decided that the system would be implemented in villages of Kilindi District in Tanga, Tanzania. The project focused on collecting sexual and reproductive health (SRH) information, including documenting the role currently played by TBAs in maternal health service provision. The tools for collecting SRH information were developed in a workshop which involved Council Health Management Team (CHMT) members, Community Own Resource Persons (CORPS), local leaders, youth, health care providers, teachers and respected traditional leaders. All groups involved in the task of collecting data were oriented to the basics of monitoring and evaluation. They were also taught about types of data, methods of collecting data and the use of data, including how data can be stored for future use.

Collection of SRH information in the community was started by volunteers in May 2009 in all 27 villages. The information collected by CORPS was compiled by Village Executive Officers who are government employees. Copies of information from each village are shared with the respective wards and finally sent to the District Reproductive and Child Health Coordinator and AMREF, who both implement SRH programmes in the area. This information has been used by the District health Authorities to direct their resources and services to where they are most needed. Community health workers analyse the information and present it to their community, educating them in health issues common in their village and empowering them to take control of their own health. The fact that the information is being compiled by local government leaders is promising for the sustainability of the system established in Kilindi.

## Making changes in Ludewa village

As a result of the process, some villages progressed very well in terms of collecting new information on teenage pregnancies, home deliveries, sexual abuse and violence, community referrals and maternal deaths. Here we discuss the example of Ludewa Village in Kikunde Ward, where the information gathered prompted the community to take action.

Community-based information from Ludewa village showed that 53 mothers delivered their babies at home, assisted by TBAs, between May 2009 and June 2010. All of these women survived delivery. Thirty-two girls became pregnant while still teenagers and most of them were still in school. The number of people who got married before the age of 19 has also been tracked: in the same period 26 males and 19 females were married. The collected information is strictly for events occurring in Ludewa, so the difference in the numbers of young married males and females reflects the fact that people often marry outside their village. The recorded deaths, if any, are those related to delivery, as reported by CORPs who communicate with TBAs.



After gathering this information, the community realized the magnitude of the problem of not accessing SRH services. They determined that teenage pregnancies and marriages were common because young people did not have a place to go for information and education on SRH, but a health facility can offer preventive, curative and information and education services to people of different ages and sex. As a result, they took the action of raising funds from themselves and other stakeholders to construct a dispensary in their village. Without information on reproductive health in their village, they could not have identified the need or developed the idea of building their own dispensary. The Ludewa Village Executive Officer (VEO) said:

“We saw the importance of community information after seeing the problem that a big number of mothers deliver at home assisted by TBAs...This information made us realize the importance of constructing our own dispensary.”

The study done in Kilindi on factors influencing the uptake of family planning and maternal health care services has found that traditional healers/herbalists, TBAs and community health providers are an important and reliable source of health services for the community. Information on what these informal health providers are doing needs to be tracked and shared with the formal system; this pilot is the first step towards enhancing communication between the community and health services in Ludewa.

## **How does this information enable health development partners to respond adequately?**

This study concludes that implementation of a community-based HMIS is a very useful system for appraising a community's health status and a useful tool for planning health development programmes. Sharing information with the district authority through the DRCHCO harmonizes the formal and informal health systems and strengthens the overall health system. It is also a useful system for recognizing the role of TBAs in nomadic communities; and involving communities in generating information on their own health is believed to create awareness of their own health through reviewing and sharing their information. By using this information, they could even prioritize their health plans and become more able to demand appropriate health services from the government or other stakeholders.

Communities easily identify their health needs, are able to prioritize them and take relevant actions towards improving their reproductive health, as has been done in Ludewa Village, Kilindi District. Real community sensitization and awareness was created just by having evidence owned by the people themselves, so it becomes easy for communities to contribute resources voluntarily for their own development. If development partners have evidence of people's problems, they can easily consider requests made by communities for them to invest in a particular project and justify their investments.

From this process we learned that it is important to involve the community in all matters pertaining to their health. It is also shown that CORPs, volunteers from the community



appointed and accepted by the community to work for them, are key people in the collection of community SRH information and even sharing it in the relevant forums at village and ward levels. In particular, this information can be used to bridge the gap between TBAs and the formal health system. The direct sharing of information with the district authority creates more recognition of TBAs and may lead to a willingness to build their capacity to offer skilled assisted delivery for the benefit of the community.

## Recommendations

Home deliveries occurring in the community should also be recorded and reported to relevant stakeholders to measure the work done by TBAs.

A call is made to governments and other health development partners to join informal and formal health systems by establishing a community-based HMIS. This will make information available for a positive response by communities and other health development stakeholders.

The service offered by TBAs should now be tracked through community information and incorporated into the formal HMIS for appropriate actions, as is done for other health issues.

More investment on health development should also be directed to the community for them to own their health. That will allow them to build capacity to collect, manage and share information among themselves and with health development stakeholders, to create high community awareness and sensitization towards improving their own health.





# 11 Developing the capacity of traditional birth attendants in nomadic communities, Afar region, Ethiopia

Mazengia Ayalew Mekonnen

It is critical to recognize and support Traditional Birth Attendants (TBAs) in nomadic communities because they meet a vital community need by supporting women throughout pregnancy, childbirth and the postpartum period. They are the backbone of the health sector at the community level.

TBAs remain the primary resource for maternal health care in nomadic communities, where modern maternal health services are unavailable. Because of the high level of trust the community places in TBAs, the health system should be willing to work with them to improve maternal health. However, barriers remain on behalf of both the formal health workers and the TBAs – in particular, both sides need to be willing to make compromises and trust and respect the competencies of the other.

The World Health Organization<sup>117</sup> defines a TBA as a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other TBAs. Individual TBAs and their roles vary. However, certain characteristics are commonly seen across continents and regions.<sup>118</sup> TBAs tend to be older women, respected in the community for their knowledge and experience. They are often non-literate and have learned their skills from older, more experienced TBAs. They may work independently, in collaboration with an individual provider or facility or they may be integrated into the health system. Their role may include, in addition to birth attendance, bathing and massage, domestic chores, and provision of care during the later postpartum or postnatal period. TBAs may perform other roles depending on local custom, their own interests and expertise. The number of births TBAs attend each year ranges from a few births to as many as 120 births per year typically; TBAs attract clients by reputation and word of mouth. Usually they receive some remuneration for their services.<sup>119,120</sup>

Today, TBAs remain an important provider of maternity care in developing countries. Secondary analysis of the 1995 to 1999 Demographic and Health Surveys<sup>121</sup> found that TBAs (trained and untrained) assisted at 24% of 200,633 live births (ranging from less

<sup>117</sup> <http://whqlibdoc.who.int/publications/1992/9241561505.pdf> (accessed 18 July 2012)

<sup>118</sup> Fortney, JA and JB Smith (1999). *Measuring maternal mortality*. In Berer, M and TKS Ravindran (eds.) *Safe Motherhood Initiatives: Critical Issues* pp43–50. Oxford, UK: Blackwell Science Ltd.

<sup>119</sup> Sibley LM, Sipe TA, Brown CM, Diallo MM, McNatt K, Habarta N (2009). *Traditional birth attendant training for improving health behaviours and pregnancy outcomes* (Review). The Cochrane Library 2009, Issue 2, <http://apps.who.int/rhl/reviews/CD005460.pdf> (accessed 18 July 2012).

<sup>120</sup> Ofili, AN and OH Okojie (2005). *Assessment of the role of traditional birth attendants in maternal health care in Oredo Local Government Area, Edo State, Nigeria*. *Journal of Community Medicine and Primary Health Care* June 2005; 17(1): 55–60.

<sup>121</sup> Central Statistical Agency and ORC Macro (2005). *Ethiopian Demographic and Health Survey*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro.

than 1% to 66%) in 44 developing countries in five regions of the world. Reporting on attendance at birth does not clearly distinguish between a TBA, a family TBA (one who has been designated by an extended family to attend births only in that family) or a relative who occasionally attends birth. When these categories are combined, TBAs, relatives and others assisted at 43% of all live births, ranging from less than 1% to 89% of live births. Up to 12% of births are unassisted in some settings.<sup>122</sup> There is little doubt that they are very important to the community because they know and respect cultural practices, are a part of the community, and understand the care, empathy and psychosocial support that a woman needs and desires during delivery. For families, TBAs are a cheaper option than midwives and will often accept payment in kind, for instance goat meat or skins.

The Demographic and Health Survey of Ethiopia 2005 described that an overwhelming majority of births (94%) were delivered at home, while 5% were delivered in a public facility and less than 1% in a private facility. In the Afar region home delivery is 95.8%, with the other births in either private or public health facilities attended by health workers.<sup>123</sup>

According to this 2005 survey, only 6% of births are delivered with the assistance of a trained health professional – that is, a doctor, nurse or midwife – and 28% are delivered by a TBA. The majority of births are attended by a relative or some other person (61%), and 5% of all births are delivered without any type of assistance at all. This information tells us that the majority of births are assisted by a relative or another person who has no skill of attending delivery, but when we compare the assistance of delivery with trained health workers, the majority of the deliveries are carried out by TBAs nationally. In the Afar region 4.5% of mothers are assisted by health professionals, 42.5% by TBAs, 50.2% by a close relative with no training on attending delivery, 1.3% with no assistance, and for the remaining 1.5% is not known who assisted the delivery. It is estimated that between 60% and 80% of all deliveries in developing countries occur outside modern health care facilities, with a significant proportion of this attended to by TBAs.<sup>124,125</sup>

## Delivering our own children

In Ethiopia community members have great respect and recognition for TBAs. The women are willing to share their secrets with them, and they are highly respected. The community feels that religion is an important part of pregnancy and values the TBAs because they have the same religious beliefs and practices.<sup>126</sup> The majority of the respondents perceive TBAs as the primary health educators at the community level.

<sup>122</sup> Sibley Lynn, Theresa Ann Sipe (2004). *What can a meta-analysis tell us about traditional birth attendant training and pregnancy outcomes?* Midwifery (2004) 20, 51–6. <http://www.eldis.org/vfile/upload/1/document/0708/DOC18154.pdf> (accessed 18 July 2012).

<sup>123</sup> Ibid. 121

<sup>124</sup> Yousuf Jemal, Tedla Mulatu, Tilahun Nigatu, Dawit Seyum (2010). *Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia*. Discussion Paper No. 003/2010 AMREF.

<sup>125</sup> UNFPA (2008). *Maternal health care seeking in Ethiopia. Findings from the EDHS 2005*. Ethiopian society of population studies, In-depth Analysis of the Ethiopian Demographic and Health Survey 2005 <http://ethiopia.unfpa.org/drive/MaternalHealth.pdf> (accessed 18 July 2012).

<sup>126</sup> Yousuf Jemal, Tedla Mulatu, Tilahun Nigatu, Dawit Seyum (2010). *Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia*. Discussion Paper No. 003/2010 AMREF.

More recently, TBAs have also been mobilized to educate the community about female genital cutting and discourage them from practising it. In Afar, TBAs are seen as social capital, a resource that has been grown, harvested and utilized by the beneficiary community. This has been the case for over decade, when the modern health system was non-existent in the region. Trained TBAs are perceived by the community as competent and perhaps even better at delivering babies than trained health workers. In a study on TBAs, a trained TBA relayed the following case:

“Three years ago I went to the health centre with a woman in labour. I referred her due to prolonged labour. At the centre, the health service provider did the pelvic examination to measure the dilatation. He told the woman that her child would not be expected soon, so he left after preparing the room. But soon after his departure, I discovered the foetal head crowning. I quickly put on my gloves and delivered the baby. When the health service provider heard the new-born cry, he returned to the delivery room and asked who delivered this baby, and I replied, ‘God did’.”

In this example, the woman telling the story clearly thought that the services she was providing were meeting the needs of the pregnant woman, while the health service provider was absent. The statement that God delivered the baby reinforces the connection between the TBA, mother, child and religion. TBAs usually attend a delivery free of charge, but the mother’s family provides incentives either in cash or in kind, which they do not refuse, because they assume that they did a great job in strengthening family ties. In the health facility the delivery service is ideally provided free of charge, but the women are exposed to extra costs such as for food, transportation, accommodation, drugs and other necessary materials.

In Ethiopia, more than 90% of childbirths take place in homes with the aid of only family members or TBAs.<sup>127</sup> Ethiopia’s fledgling Health Extension Programme is designed to bring health services, including maternal and new-born health care, closer to where people live. The effort, however, has been stymied because Health Extension Workers (HEWs) receive limited training in maternal and new-born health care and people do not understand their value or roles.

“It’s a self-sustaining cycle, HEWs haven’t received enough training to feel confident in providing maternal and new-born health care services, while women and families don’t see them as having roles in pregnancy and delivery, and therefore do not seek them out.”<sup>128</sup>

- Hadley, a researcher from Emory University, Atlanta

HEWs have their own roles and responsibilities to implement a package of 16 preventive and basic curative services for which they receive training. They go house to house to train, demonstrate, and educate families to create role models in line with the Health Extension Programme and to disseminate it for the community. These activities can

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<sup>127</sup> Central Statistical Agency and ORC Macro (2005). *Ethiopian Demographic and Health Survey*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro

<sup>128</sup> Source: MaNHEPs Research conducted in September 2010: *Making Childbirth Safer in Ethiopia*.



facilitate and increase mothers' needs for family planning, antenatal care and institutional delivery, and prevention of malaria, HIV and AIDS and harmful traditional practices, which has a subsequent effect of reducing maternal mortality. The HEWs provide services at health posts and in the community. For family planning services they distribute oral contraceptive pills, injectable contraceptives and condoms. HEWs are also responsible for supervising community health workers, TBAs and Community-based.

Reproductive Health Agents (CBRHAs) also participate in the distribution of oral contraceptive pills and condoms and educating families about child spacing. Antenatal care is another main activity for the HEWs. This is carried out by providing health education on birth preparedness, early detection of abnormal pregnancies, educating mothers about prevention of bleeding, danger signs, prevention of infection and safe delivery, immunization, women's nutrition, early transportation (referral), prevention of HIV and AIDS, iron supplementation and the use of insecticide-treated nets during antenatal care.

Another reason why mothers prefer TBAs is that hiding a pregnancy is a common practice in Ethiopia in general, including the Afar community, especially during the first pregnancy. This wish for secrecy is usually respected by TBAs but not the health workers; this is because TBAs have the same culture and habits as the pregnant mother.

## Training of Traditional Birth Attendants

The role of the TBA started to be taken seriously in the early 1950s when high maternal mortality rates became a concern in many developing countries. A number of studies, surveys and reviews generated international interest in the traditional health care provider, and several countries started training TBAs in clean and safe home delivery and some other health care-related roles. For more than 20 years, bilateral and international donor agencies and non-governmental and local organizations poured resources into TBA training programmes, with the expectation that TBAs would contribute to reductions in maternal mortality. Studies of the effectiveness of these training programmes, however, showed that reductions in maternal mortality occurred only in areas where the TBAs had skilled back-up support. The studies found that the majority of the programmes were ineffective because TBAs did not have sufficient literacy or general knowledge when they started their training. Without supervision and back-up support, they tended to slide back into their old ways and were not able to prevent death when life-threatening complications arose during childbirth.<sup>129,130</sup>

Rigorous evaluation of TBA training is methodologically and logistically challenging. The distinction between a trained TBA and an untrained TBA may be blurred because untrained TBAs are exposed frequently to biomedical concepts and practices. Moreover, TBA training is often one component of comprehensive interventions – for example, community mobilization and upgrading of referral facilities. Both behavioural and health outcomes such as

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<sup>129</sup> Fortney, JA and JB Smith (1999). *Measuring maternal mortality*. In Berer, M and TKS Ravindran (eds.) *Safe Motherhood Initiatives: Critical Issues* 43–50. Oxford, UK: Blackwell Science Ltd.

<sup>130</sup> Weil, O and H Fernandez (1999). *Is safe motherhood an orphan initiative?* *The Lancet* 354(9182): 940–943.

maternal and neonatal morbidity are typically based on self-report and suffer the limitations of this method.<sup>131,132</sup> Measuring the magnitude of the impact of TBA training on maternal mortality requires special studies with large bio-statistical denominators. As a result, while donors, governments and non-governmental organizations have invested heavily in TBA training programmes over the years, they have not invested equally in the systematic evaluation of training effectiveness.<sup>133</sup>

The African Medical and Research Foundation (AMREF) used TBA training based on the former Ministry of Health regulation, which is one month of new training plus refreshment training once they have trained with a TBA kit provided by AMREF, which includes materials such as gloves, cord tie, scissors, gauze and alcohol. However, the Ministry of Health has stopped new TBA training because it is now adopting an approach of basic and comprehensive obstetric and new-born care.

TBAs themselves recognize that the training serves purposes other than simply acquiring skills, including 'modernization prestige'. One TTBA said:

"After I attended a one-month TBA training on safe delivery, I became a modern attendant like a nurse because I use the appropriate materials and supplies for the safety of mothers, new-borns and myself."

This quote shows the pride the TTBA takes in her work now and how much she appreciated receiving the training.

Previously, the Ministry of Health recognized the role of TBAs in improving maternal health, under the Safe Motherhood initiative. However, without sufficient evidence to support the use of TBAs, the enthusiasm for them has waned and their role has been delegated to skilled birth attendants – a category which does not include TBAs. The term 'skilled attendant' refers to an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns.<sup>134</sup>

A skilled attendant should have the necessary equipment and medicines and adequate referral means to be effective in reducing maternal mortality, and current data do not indicate whether these requirements were met.<sup>135</sup>

Globally, it is estimated that 34% of mothers deliver with no skilled attendant; this means there are 45 million births occurring at home without skilled health personnel each year.

<sup>131</sup> Ronsmans C, Vanneste AM, Chakraborty J, van Ginneken J (1997). *Decline in maternal mortality in Matlab, Bangladesh: a cautionary tale*. Lancet 350(9094), 1810–4.

<sup>132</sup> Campbell, Oona MR, Wendy J Graham, on behalf of The Lancet Maternal Survival Series steering group (2006). *Strategies for reducing maternal mortality: getting on with what works*. Lancet 2006; 368: 1284–99.

<sup>133</sup> Bergström Staffan and Elizabeth Goodburn. *The role of traditional birth attendants in reduction of maternal mortality*. <http://www.jsieurope.org/safem/collect/safem/pdf/s2933e/s2933e.pdf> (accessed 18 July 2012).

<sup>134</sup> World Health Organization (2005). *The World Health Report 2005 – Make every mother and child count*. Geneva: World Health Organization, pp65–67: <http://www.who.int/whr/2005/en> (accessed 14 August 2008).

<sup>135</sup> World Health Organization, the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics (2004). *Making pregnancy safer: the critical role of the skilled attendant*. Geneva: World Health Organization: [http://www.who.int/making\\_pregnancy\\_safer/documents/92415916692/en/index.html](http://www.who.int/making_pregnancy_safer/documents/92415916692/en/index.html) (accessed 14 August 2008).

Skilled attendants assist in more than 99% of births in developed countries compared with 62% in developing countries.<sup>136</sup> In five countries including Ethiopia the percentage drops to less than 20%.<sup>137</sup> However, poorly developed infrastructure and an inadequate number of health workers is still hampering the attainment of expected results on maternal and child health, and TTBA's fill an important gap where the health system cannot reach pregnant women. Thus, it is possible that the TTBA's are playing an unacknowledged role in preventing the maternal mortality situation from worsening.

## Traditional Birth Attendants and the health system

TTBA's indicated that they were not structurally excluded from the health system, but there was very limited synchronization and collaboration between themselves and formal health workers. However, the training they receive from non-governmental organizations helps them to work together with the health system. TTBA's and the health facility communicate about case referrals, organizing transportation for the referred woman, the follow-up of critical cases and information about the TTBA's activities in the community. Ideally, TTBA's refer pregnant mothers to a health facility whenever a danger sign or complication occurs, and the health facilities are able to manage these complications. The TTBA is responsible for the referral itself and organizing the referral, including transport. Lubaba Mufti, a TTBA from Adaar District said that whenever the case related to delivery is difficult and beyond her capacity, she refers pregnant women to Adaar Health Centre. However, this process has not always gone well. She pointed in particular to the case of Fatuma Ali. Fatuma Ali, who is 17 years old, lives in Ledi kebele of Adaar District. She is married, and it was Lubaba Mufti who was following her pregnancy. At the time of delivery, there was a prolonged labour, so Lubaba Mufti referred Fatuma to Adaar Health Centre. However, because the complication was beyond even the capabilities of the health centre, Fatuma was referred to a higher health facility, a hospital in Dessie. Although Fatuma's life was saved through instrumental delivery, it was a dead foetus that was expelled. This complication resulted in Fatuma developing a fistula, which deeply troubled Lubaba Mufti. Because Fatuma could not afford the expense of the fistula surgery, she has not received treatment yet, even though she was referred to the fistula hospital in Addis Ababa. Lubaba Mufti expressed her frustration with the lack of appropriate services:

"When I refer mothers to the health centre and if there are no health professionals, I accompany the mothers up to the hospital. And sometimes if we don't get proper service, we take the mother back home and await her fate."

When the necessary care is unavailable, TTBA's are left with no choice but to return home and do the best they can with the knowledge they have. Although the majority of TTBA's

<sup>136</sup> Yalem Tsegay Assfaw (2010). *Determinants of Antenatal Care, Institutional Delivery and Skilled Birth Attendant Utilization in Samre Saharti District, Tigray, Ethiopia*. Master thesis, Umeå University Sweden [http://www.phmed.umu.se/digitalAssets/50/50462\\_yalem-tsegay---revised.pdf](http://www.phmed.umu.se/digitalAssets/50/50462_yalem-tsegay---revised.pdf) (accessed 18 July 2012).

<sup>137</sup> World Health Organization (2005). *The World Health Report 2005 – Make every mother and child count*. Geneva: World Health Organization, pp65–67: <http://www.who.int/whr/2005/en> (accessed 14 August 2008).

refer mothers when they get complications, they do not always do so. In the study on maternal health, a TTBA mentioned in the research report that the majority of TBAs refer the pregnant woman to the health facility if a complication is beyond their capacity; however, a few TBAs still manage the pregnant women by themselves without referring them and bring drugs from the nearby health facility. As one TBA said:

“Some of the problems that occur during pregnancy are back pain, abdominal pain, swelling of the face, hands and legs; during this time we advise them to take milk and milk products. Sometimes the placenta and blood vessels may be retained in the uterus. At this time my role is to manage it by myself, and sometimes I bring drugs from the hospital and give her (the mother) them and give her foods. If all these things do not work, the fate of the mother is to die at home.”

The conclusion from these quotes from TBAs from the in-depth interviews and focus group discussions is that not all TBAs refer pregnant women to health centres, but those who do not refer when complication arise are few.

## Discussion

Since the work of TBAs is adapted and strictly bound to the social and cultural matrix to which they belong, their practices and beliefs are in accordance with the values of the local community. Consequently, most deliveries take place at home in the hands of TBAs. Designing a maternal health care strategy around the existing maternal health care-seeking behaviour of a population is key to achieve normal deliveries. TBAs can play an important role in linking the community to health services, particularly if they are willing to refer women with complications to a health facility where basic emergency obstetric care is available. In nomadic communities where there is poor health infrastructure, newer, formal approaches for reducing maternal mortality are difficult to implement. Therefore, providing standard training, equipping complete TBA kits, monitoring and evaluation are critical to achieve Millennium Development Goal 5.

Furthermore, it is equally important that the health system is aware of and responsive to the needs of TBAs. The World Health Organization has joined the global discussion on the role of TBAs and has advocated for a reduction of their role in childbirth. Based on the findings of our research, this position is difficult to accept. Especially in the case of nomadic communities, where distance, mobility and traditional lifestyles all influence pregnancy outcomes and where traditional values and practices are so deeply valued, we think that TBAs will continue to be a central part of the childbirth experience. The best way forward would seem to be to form working partnerships with trained and skilled TBAs.

## Recommendations

It is important to avoid developing dual systems where there is competition and tension between TBAs and formal health workers including HEWs.

Because pregnancy is understandably seen as a normal process, antenatal check-ups are not routinely sought and complications are often detected too late, if at all. Many presentations occur at a late stage when the health of the mother and child has been severely compromised.

TTBAs can be trained to identify complications earlier in pregnancy, since they already have access to pregnant women and experience observing the progression of pregnancies.

There is a need for further research into the effectiveness of training for TBAs to provide maternal health care, as little evidence currently exists regarding their role in nomadic communities.

Special measures need to be taken because of the lives that nomadic communities lead – they are remote, mobile and live by traditional values and practices. Programmes will need to be consistent with these lifestyles, and to be sustainable they should seek to work with the existing societal structure (for example, mobile health care services and outreach).

Finally, cost is an important factor in keeping TBAs and, in some cases, religious leaders involved in the management of childbirth. Not only are they often a more convenient and lower priced alternative, but if they are to become involved in the formal childbirth sector compensation will be an important consideration.







# 12 The role of decision-makers in health among the Maasai of Kajiado district, Kenya

Lepantas Charles Leshore

For Maasai nomadic communities, decision-making about health and health-related issues is complex and intertwined with cultural and traditional practices. The cultural elders have a strong influence in the community, and what they say often goes unquestioned. The main decision-makers, according to this study, are the men. Paradoxically, the men are often unavailable when decisions need to be made, because they are responsible for attending to their animals, and this can take them far from home. In such a situation, pregnant women are sometimes forced to wait for their husbands to return before decisions can be made. This can be the case even in circumstances where the life of the woman and her unborn child is at risk. In decision-making terms, women in this community are afforded status similar to that of dependent children: according to participants in this study, women commonly lack the authority to make sound and responsible decisions. This status effectively excludes them from the decision-making processes and the groups that take decisions. This case study seeks to contribute to a better understanding of decision-makers and decision-making processes among the Maasai community of Magadi Division in Kajiado District.

## Background

The Maasai are pastoralists who live in southern Kenya along the Great Rift Valley on semi-arid and arid lands. They are semi-nomadic people who live under a communal land management system in extended families. However, nowadays it is not uncommon to see a kraal occupied by a single family following the introduction of newer systems of land management in the Maasai region.

The Maasai community is a patriarchal society with pronounced gender disparities. Women are responsible for constructing the houses, supplying water, collecting firewood, milking cattle and cooking for the family. Warriors are in charge of security, while boys are responsible for herding livestock. The elders are directors and advisors of day-to-day activities. Every morning before livestock leave to graze, an elder who is the head of the *inkang* sits on his chair and announces the daily schedule. The schedule involves many decisions that are to be followed as directed.<sup>138</sup>

Individuals, families and clans establish close ties by giving or exchanging cattle. There is a Maasai prayer "*Meishoo iyiook enkai inkishu o-nkera*", for which the English translation is: "May Creator give us cattle and children." Cattle and children are central facets of Maasai

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<sup>138</sup> World Culture Encyclopedia (2008). *Maasai socio-political organization*. [www.everyculture.com/Africa/Maasai](http://www.everyculture.com/Africa/Maasai).

life. Traditionally, the Maasai rely on meat, milk and blood from cattle for protein and caloric needs. Blood is consumed on special occasions – for example, by a circumcised person (*o/lesipoloi*), a woman who has given birth (*entomononi*) and the sick (*oltamueyiai*).<sup>139</sup>

## Maasai socio-political organization

In East Africa, the Maasai have managed to retain their traditional way of life and to continue to move from place to place in search of pasture for their livestock. In Maasai society older men, sometimes joined by retired elders, take decisions on most major matters affecting each Maasai group. The *enkopir* are cultural elders representing different age sets of the Maasai, and they are the key decision-makers in matters of importance for the community, including marriage, ceremonies, circumcision and female genital cutting, among others.

According to Sironka Ole Masharen (2009),<sup>140</sup> a woman is referred to as *enkitok*, meaning the great one. This is a Maasai linguistic paradox, as women are not accorded the respect in everyday life commensurate with their title; they are entirely dependent on men. Once married, women are completely absorbed into their husband's clans and age sets. In terms of decision-making, they have little status.

## Decision-making

Decision-making regarding health is a complex and often poorly understood process, not least for traditional communities such as the nomadic Maasai. For example, during pregnancy, if the husband is absent, other elder members of the family such as parents-in-law, brothers-in-law and sometimes the parents of the expectant mother take over the husband's decision-making role.

In Maasai communities, discussing sexual (and reproductive) issues is a cultural taboo. This creates a dilemma for women when they need to make informed decisions about key health issues, especially sexual, reproductive and maternal health. This situation can lead the women to suffer silently and to experience adverse maternal health outcomes, some of which are life-threatening. For example, when a woman needs money to pay for health care, the only person who can decide whether and what goat or cow can be taken to market to get the necessary cash is the husband.

## Decision-makers

Wisdom and age are highly regarded and are the basis for being accepted as a decision-maker. The study<sup>141</sup> found that decisions depend on the person's age, age group or age

<sup>139</sup> Ibid.

<sup>140</sup> Masharen, SO (2009). *The Maasai pioneers: the first modern cream*. Nairobi.

<sup>141</sup> Gitimu, A, J Nduba, C Leshore, P Nguura and D Kawai (2010). Study report on decision-making processes on perinatal care at family and community level that influence maternal health among the Maasai of Magadi, Kajiado district. Unpublished research

set, gender, the decision to be made, cultural beliefs and customs, and the circumstances in which the decision is made. Maasai community political structures are embedded in age-grade systems which separate young men and older men who command great respect and power for authority, particularly in decisions that are of importance to the community. The highest body for making key decisions on behalf of the Maasai people is the 'Maasai parliament'. At family level the husband is the key decision-maker in all issues including childbirth, family planning and child-rearing practices.

The study revealed that in the event of the husband's death, other family members take over the decision-making role for the widow. The lead decision-makers are now the older son or the oldest elders in the family. Another key issue to be decided includes who should inherit the widow – including the sexual duties that accompany inheritance. Certain cultural criteria must be followed by the elders when making this decision and this can take a few months. Given that the husband might have died of AIDS (albeit unknowingly) and that his wife may be HIV-positive, this decision can have serious repercussions.

In all the focus group discussions and key informant interviews, participants were asked questions regarding decision-making about perinatal care, and who the key decision-makers are. A husband, as the head of the household/family, makes all decisions concerning pregnancy and childbirth, including when to have the next baby. The expectant woman can only make decisions in consultation with her husband. In the absence of the husband, other older members of the husband's family such as parents-in-law, brothers-in-law and sometimes the expectant woman's own parents decide on her behalf.

Maternal health care decisions include whether to attend the antenatal clinic, preparations during pregnancy, and skilled delivery. In this study, for example, older men argued that it was not necessary to make any preparations during pregnancy – presumably because this is an everyday event and a natural process. This contrasts markedly with the principles of the modern health care system which promotes planned pregnancies and antenatal care. According to the young men, decisions about antenatal preparations are to be left to the old men and the pregnant woman's parents, who are considered to be more knowledgeable and experienced in pregnancy issues and also because some of the younger men are not yet authorized to make such decisions. An important aspect of childbirth preparations is to organize the celebrations after childbirth: enough firewood should be gathered and plenty of food and beverages prepared, including slaughtering goats/sheep depending on whether the child born is boy or girl; preferential treatment is given to a male child. The study also found that decisions about whether to deliver in a health facility are made mainly by the husband in consultation with the woman's parents-in-law or older family members. A woman in this community is not supposed to make her own decisions unless this is done in consultation with her husband, and generally his wish must prevail.

## Postnatal practices and traditions

Sex after delivery is considered a cultural taboo among the Maasai, and the older men direct the older women to ensure that this does not occur. Some women are required to go and stay in their parental homes to avoid sex, particularly by younger men.

"I don't like a woman who successfully delivers a child and later destroys the same child by having sex almost immediately after birth or during breastfeeding."

– Older man, aged 50 years, during a focus group discussion

During a focus group discussion on maternal health care most participants considered the following to be good practices during the perinatal period:

- Eating enough food and having a balanced diet;
- Enquiring about how to avoid diseases such as sexually transmitted infections (STIs);
- Reducing movements, especially travelling long distances; and
- Drinking blood from cattle to avoid dizziness and anaemia.

Bad practices were also noted. According to the participants, these included eating meat from dead animals; eating cattle intestines (since these are associated with causing boils in children); and no one assisting the pregnant woman.

The study found that a pregnant woman should eat a lot of meat and animal fat to reduce heartburn during pregnancy. The young women also recommended that a pregnant woman should be made to vomit from time to time to create room for the baby and avoid a delayed or prolonged labour. Encouraging a pregnant woman and giving her support during her pregnancy is considered a good practice during perinatal care. One of the older women said:

"I remember when I was expectant my husband ensured that I got what I craved and drank enough blood, since what I was carrying took a lot of blood from me."

– Older woman during a focus group discussion

The husband, with the help of other family members, has to ensure the availability of basic needs: a razor blade, clothes, soap, and petroleum jelly, enough paraffin in case the woman delivers at night, plenty of food, and money for emergencies. A Traditional Birth Attendant (TBA) will be asked to check on the woman during pregnancy and labour and to cure diseases using herbs and animal fats. Sometimes an attendant decides to refer a pregnant woman to a health facility if she sees complications that she cannot handle.

According to the data, other factors that influence good practices include: the health of the mother and child; the presence of complications or illness; general weakness; excessive sleeping; the need for vaccination to reduce infections; the need to know HIV status; the cleanliness of the facility; and expenses. However, illness, complications during labour and delivery, such as too much bleeding, prolonged labour or retained placenta, which TBAs cannot handle, will compel them to make quick decisions and seek help from health facilities.

The procedure used by the TBAs during childbirth was described by participants in focus group discussions. A TBA should keep palpating/massaging the woman's belly, as this would ease the placenta to pave the way for the child. Hot water should also be available to clean the mother and the child after delivery.

## Conclusion

Decision-making procedures among the Maasai are complex. The decision to seek perinatal care involves many actors: immediate family members, extended family members, and the community. Traditional customs and beliefs always underlie the decisions made. The expectant woman, as a sign of respect and submission, cannot make her own decisions. The men, who are the main decision-makers, are often absent herding animals, so pregnant women are sometimes forced to wait until their husbands return for key decisions to be made. This may put the life of the woman and that of the unborn child at risk. Since pregnancy is not an illness, it is generally felt that there is no need to visit a health facility unless there are signs of illness. There are inevitably decisions with which young women disagree, but transgressing cultural norms risks leaving the woman marginalized, and many acquiesce rather than risk recriminations. These practices come at a price for maternal and child health.

## Recommendations

Education in nomadic settings should be emphasized and promoted to empower both men and women. This will enable members of these communities to make better decisions about their sexual and reproductive health, which will ultimately result in better maternal health outcomes.

Follow-up research should be undertaken into decision-making on sexual and reproductive health (including female genital cutting) and empowerment interventions to be employed in the community.

Some cultural practices that are risky should be discouraged and positive practices promoted. Since the society is patriarchal, women are not expected to make decisions on sexual and reproductive and maternal health. They can only make decisions in consultation with the husband or others.

Maintaining certain cultural practices, such as making a pregnant woman vomit until she becomes dizzy, insisting on home delivery with the help of a TBA, and abstaining from sex during pregnancy, are all detrimental to the health of the women and children. Gender analysis and mainstreaming will be critical to achieving male involvement and healthier decision-making processes with respect to the community and culture.

Community-based cultural entry points and dialogue are a key for sustainable, acceptable and home-grown solutions and processes for decision-making.



Non-governmental organizations, development partners and the government need to run more health seminars to sensitize the local cultural decision-makers on sexual and reproductive health issues.

Comprehensive sexual and reproductive health and gender services need to be offered among the community, considering the hardships they experience such as limited economic development and infrastructure, and economic marginalization.





# 13 Health-seeking behaviour and decision-making at family level in perinatal care among nomadic women: A case study of the Maasai of Kajiado, Kenya

Anne Muthoni Gitimu

In this chapter we examine how decision-making at the family and household level influences health-seeking behaviour in perinatal care. Using the findings from an exploratory study carried out in May 2010<sup>142</sup>, we were able to show that women do not have autonomy when making decisions regarding where to seek perinatal care services, when to seek care, and what type of care to seek. This study provides insights that chart the societal changes needed to make women the lead decision-makers on their own health needs. We also show that this is far from being achieved. Despite individual behaviour changes and greater knowledge among the younger generations, societal expectations routinely override personal actions towards improving one's own health, especially for women. This could partially explain why a large proportion of women continue to deliver at home instead of in medical institutions and why preventable problems continue to take a high toll.

## Background

Women's access to health care is complex – it is both the outcome of women's status in society, including society's response to their health needs, and a determinant of women's health and productivity and, ultimately, of their status.<sup>143</sup>

The child-bearing functions of women, especially in developing countries, are considered normal and routine. Yet these valued and precious aspects of life are among the most hazardous experiences that women engage in, often without being aware of the risks involved. Pregnancy-related mortality is almost always preventable. Unfortunately a range of factors sustain high levels of maternal morbidity and mortality. Among these are health care-seeking behaviour patterns and decision-making at the family level, which have a huge impact on outcomes for pregnant women, especially in terms of complications that require early referral for skilled treatment at health facilities. Perinatal care – the care given to a pregnant woman five months before delivery, during labour and childbirth and one month after delivery – is essential for reducing maternal mortality caused by pre-eclampsia, obstetrical haemorrhage, bacterial infection and other complications.

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<sup>142</sup> Gitimu A., Nduba J., Nguura P. and Leshore P. (2010). *Study report Decision Making Processes in Perinatal Care at Family and Community Level that Influence Maternal Health. A case Study of the Maasai of Kajiado. Kenya*

<sup>143</sup> Chatterjee M (1990). *Indian Women: Their Health and Economic Productivity*. World Bank Discussion Paper; 109. Washington, DC: World Bank.

Over the past two decades, there have been impressive advances in reducing levels of infant and childhood mortality and in increasing contraceptive use in developing countries. In contrast, despite being a central element of the Millennium Development Goals, progress in reducing levels of maternal mortality and in making pregnancy and child-bearing safer for women has been much slower. An estimated 525,000 women, almost all from developing countries, continue to die each year from maternal causes.<sup>144</sup> Sub-Saharan Africa in general and Kenya in particular, continues to experience high levels of (mostly preventable) maternal mortality and morbidity.

Data on the maternal health status of nomadic populations is scant; however, studies among pastoralists have shown that traditional practices and geographical inaccessibility have left nomadic communities with inadequate health care. Furthermore, practices at family and community levels contribute to poor maternal health outcomes. A study by the World Bank in 2004 in Eritrea found that among the 30% of Eritreans who are semi-nomadic, the common causes of maternal mortality and morbidity included postpartum sepsis and bleeding. Various other factors have been identified as contributors to sustained high levels of maternal mortality and morbidity. Among these are health care-seeking behaviour patterns at the family level, which have a huge impact on outcomes for pregnant women, especially in terms of early referral of complications for skilled treatment at health facilities.<sup>145</sup>

Appropriate maternal health care means the difference between life and death for a pregnant woman. Ensuring that women everywhere have access to such care could save hundreds of thousands of lives a year. Common complications such as pre-eclampsia or malaria, as well as serious conditions such as obstructed labour, can be safely managed as long as skilled care is available and accessed in time. The reduction in the number of maternal deaths and morbidity is a key international development goal: Millennium Development Goal 5. Evidence-based health policies and programmes aiming to reduce maternal deaths need reliable and valid information, and this paper provides information from a study among nomadic communities that aims to provide insights that can improve maternal health in relation to decision-making at family level.

Many factors affect access to health care services. Studies have attempted to identify and measure the effects of factors that contribute to barriers to service utilisation. The utilisation of a health care system, public or private, formal or non-formal, depends on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself.<sup>146</sup> Decision-making is strongly associated with health-seeking behaviour. Making appropriate choices during the perinatal period determines maternal outcomes; however, this is not straightforward among the Maasai people.

<sup>144</sup> Koenig, MA, K Jamil, PK Streatfield, T Saha, A Al-Sabir, SE Arifeen, K Hill and Y Haque (2007). *Maternal Health and Care-Seeking Behaviour in Bangladesh: Findings from a National Survey*. International Family Planning Perspectives, 2007, 33(2):75–82.

<sup>145</sup> WHO, UNICEF, UNFPA and the World Bank (2007). *Maternal Mortality in 2005: estimates developed by WHO*. [http://www.who.int/reproductive- Geneva health/publications/maternal\\_mortality\\_2005/index.html](http://www.who.int/reproductive- Geneva health/publications/maternal_mortality_2005/index.html)

<sup>146</sup> Babar T. Shaikh and Juanita Hatcher (2004). 'Health Seeking Behaviour and Health Service Utilisation in Pakistan: Challenging the Policy makers.' *Journal of Public Health*, Vol 27 No. 1 49-54



## Methodology

This chapter is based on a qualitative exploratory study that was carried out with the aim of determining family, social, cultural and health system factors that influence decision-making on perinatal care and hence maternal health status of nomadic communities. Focus group discussions and in-depth interviews with purposively selected participants and informants were the main methods of data collection.

The study was carried out in Magadi, one of the divisions of Kajiado North district in Kenya. Magadi is 2340km<sup>2</sup>, with a projected population in 2009 of 31,571.<sup>147</sup> Magadi borders Tanzania to the southwest and Narok district to the west. It has a low population density and is inhabited by the Maasai people, who are pastoralists. There has very limited access to health care services and other social amenities. Participants included pregnant women, women with children under two years of age, men of different age sets, traditional birth attendants (TBAs) and health workers.

## Why traditional perinatal care?

In all interviews with men and women, irrespective of age, it was consistently agreed that decisions about pregnancy, childbirth, type of diet during pregnancy, the type of perinatal care, and where and when it is received is the role of the husband. Other decision-makers were only involved if the husband was absent or had died.

In all the focus groups discussions it was reported that most women receive care during pregnancy and childbirth at home with the assistance of a traditional birth attendants (TBA). In Maasai communities, both young and older women prefer TBAs for perinatal care services, as they are felt to be highly competent by virtue of their experience; they are cost-effective and have the 'right attitude'. One elderly woman said:

"They are the best because they can twist the infant in the womb to sit well. They volunteer without pride to perform the exercise with good heart, massage the woman and do not charge expensively. They are experienced."

Important reasons why women opt for TBAs include: they are supportive, good at their work, they know and can identify labour complications or actual labour time, and they volunteer to assist "without pride". Furthermore, they are more flexible and available than mainstream health workers, they can attend to a pregnant woman who is unaware of her delivery date, they assist in cases of abrupt labour, and they are preferred by women without a history of complications during earlier births.

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<sup>147</sup> National Coordinating Agency for Population and Development (2005). *Kajiado district strategic plan 2005-2010*.



From the in-depth interviews and focus group discussions family expectations or family traditions guided women when considering perinatal care. According to one elderly woman:

“Most of us here were born right at home with their assistance, so they are very important.”

One of the expectant women who had attended antenatal care at a health facility said:

“I do not see the need for hospital delivery. I am expecting my fourth child. All of my three children were successfully delivered with the help of the TBA at home. I can attend the antenatal clinic to check my blood and other sicknesses. If I am not sick then I will deliver at home.”

Some women felt uncomfortable seeking perinatal care services from a hospital because they believed that some of the practices conducted in hospitals were against their cultural beliefs:

“They [skilled attendants] are trained people, use gloves and do not restrict some of the things a woman is not supposed to be given. For example, they give women water to drink soon after delivery. In our community, a woman who has just delivered is not supposed to drink water for two months.”  
– woman aged 23 years with a child less than six months old who had no prior experience with hospital delivery

For a few participants, perceptions on modern health care were found to be a contributing factor when it came down to making decisions on seeking perinatal care services. A 26-year-old woman in a focus group discussion also added:

“I do not like some nurses. They make a lot of noise and hurl abuse at you, yet you are in pain.”

Most of the reasons given for seeking perinatal care had an inclination towards cultural and societal expectations, in zeal to fulfil this traditional perinatal care is more preferred to modern care. These decisions in the perinatal period are primarily made by men who are the custodians of culture.

## Desire for modern perinatal care

Some of the young women and men interviewed indicated that they sought care during pregnancy and childbirth from a health facility. From discussions with women and men, the circumstances that lead a pregnant women to seek perinatal care services include: feeling ill; being advised to do so during a check-up at a health facility; being forced by the husband to do so; by the desire to have a healthy baby; when there are pregnancy-related complications; and some women indicated that there were apparently many infections associated with home deliveries:

“Nowadays we have realised many complications and diseases during pregnancy and childbirth; therefore, we have to take our expectant wives nearer to the hospital because there are no vehicles.”  
– Older man from a focus group discussion

The findings made it clear that women are not autonomous in decision-making and that those societal expectations often determine their fate. However, some women, particularly those who had children in the last six months, seem to prefer hospital delivery.

Nevertheless, they would deliver at home if the husband decides that they should do so:

“A woman might want to deliver in the hospital and the husband is against that; in our tradition a woman is supposed to be submissive to her husband.”

– Woman interviewed (aged 26 years)

## The dilemma

The findings indicate that there are some decisions that young women feel are not correct, but not to acquiesce to cultural norms risks having them marginalised in their own community. As a result, despite their better judgement, women reportedly conformed to these expectations for the sake of maintaining their position in society. Traditional customs and beliefs always underlie decision making. As a sign of respect and submission, expectant women cannot take their own decisions. The men - the main decision-makers - are frequently away and preoccupied with tending their herds. In such a situation, pregnant women are sometimes forced to wait until their husbands return before decisions can be taken. The husband, as the head of household/family, makes all decisions concerning pregnancy and childbirth, and in the husband's absence, other older family members such as parents-in-law, brothers-in-law and sometimes the expectant woman's parents can sometimes take a decision-making role.

Pregnant women who were at the health facilities at the time of the interview were asked how they came to seek services there. Their reasons included: family members; other women who had already given birth; community health workers; and health seminars. However, as we already noted, these reasons can only be acted on in consultation with their husband.

## Women's decision-making: creating change on perinatal outcomes

It is clear that women are not autonomous in decision-making in perinatal care, which greatly influences their health-seeking options. Preferences are culturally and socially influenced, and women have little control over key decisions about their health or even initiating the discussions around the subject. The low status of women prevents them from recognizing and voicing their concerns about their health needs. Women are usually not allowed to visit a health facility or health care provider alone or to make the decision to spend money without permission from or consultation with the husband. Thus women generally cannot access health care in emergency situations.

Men play a paramount role in determining the health needs of a woman. Since men are the key decision-makers and in control of all the resources, they decide when and where

woman should seek health care. When they are absent from home for long periods herding animals the woman may have to wait until he returns. In other instances, the parents-in-law or brothers-in-law can take over; this is even the case for widowed women, who remain part of the family into which they marry and rarely remarry, even if they have other children from other relationships. A brother-in-law or a man from the same age group belonging to the family of the late husband is tasked with making decisions on her behalf.

Despite the fact that women are often the primary care givers in the family, they are prevented by the men in the family from going to health services. The importance of medical institutions and skilled attendants came up in the findings; however, seeking care from these institutions was not a preferred choice for many. The task, therefore, is for health programmes to create societal change through the older men and others in the society, since individual behaviour change that is not supported by structures in the communities will have little effect.

It has been established in other studies<sup>148</sup> that there is a strong relationship between men's involvement in maternal care decision-making, whether delivery is conducted in a medical institution and whether the delivery is assisted by a trained medical person. Deliveries are more likely to take place in medical institutions if the husband is aware of various pregnancy and delivery complications. Therefore, educational efforts on perinatal care with men should go beyond awareness to include specifics of perinatal services, precautions and problems. Men's involvement needs to be defined more broadly to include a husband's support to his wife or wives for them to take the lead in making decisions about perinatal care.

## What can be done?

On the basis of the findings, to improve the utilisation of perinatal care services, it is suggested that comprehensive efforts have to be made to create awareness about the benefits of health care-seeking behaviour. This research calls for continued investment in female education and enhancing women's household decision-making, which are indispensable for improving utilisation of perinatal care services. Development activities such as women's micro-credit, life-skills training and non-formal education have been shown to have a positive impact on health-seeking behaviour, morbidity and mortality, and the overall empowerment of women. Gender-sensitive strategies and programmes that address male involvement need to be developed by both government agencies and development workers. Health providers also need to be sensitized more towards the needs of the clients, especially the women, to improve interpersonal communication and be more compassionate and caring to clients. Further coordinated efforts should be made, on the part of the government and other concerned bodies at all levels, to improve access to health care services.

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<sup>148</sup> Singh A and Ram F (undated Manuscript). *Men's Involvement in Maternal care during pregnancy and Child Birth in Rural Maharashtra*. Mumbai: International Institute for Population Services.





# 14 The role of religious leaders in mothers' decision-making to use maternal health services

Kassahun Negash Yalew

The maternal mortality rate is the major health problem for Ethiopia, particularly in the Afar Regional State. Poor utilization of health services by mothers is not a result of a single factor but is linked to multiple factors. However, the role of religious leaders has a significant impact on the utilization of the services. According to our study findings, religious leaders play a pivotal role in women seeking appropriate care in appropriate places.

According to the study, different informants had different perspectives on the role of the religious leaders. The community recognized their role as the best to support maternal health at community level, and the officials disagree with those members of the community who think that this is due to a lack of awareness of the appropriate care available at formal health facilities. The study also identified that there is a different approach between local religious leaders and the *sharia* leaders at a higher level. Some local religious leaders (*mullahs*) mix up the *sharia* law with traditions and guide community members in the wrong direction.

The collaborative efforts of government and religious institutions can play an important role in changing the behaviour of the local religious leaders to influence the community towards positive health care-seeking behaviour.

Furthermore, given the institutionalization of the information exchange system (Dagu) and its acceptance, the role of religious leaders can be significant in improving maternal health in Afar communities.

## Background

'Maternal health' refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Ethiopia's rates of maternal morbidity and mortality are among the highest in the world.<sup>149,150,151</sup>

<sup>149</sup> Central Statistical Agency, Addis Ababa (2006). *Ethiopian Demographic Health Surveys 2005*. Calverton Maryland, USA 2006

<sup>150</sup> FMOH, Ethiopia (2006). *National Reproductive Health Strategy 2006-2015*, Ethiopia.

<sup>151</sup> Family Health Department (2006). Federal Democratic Republic of Ethiopia Ministry of Health (2006). Report on Safe Motherhood Community-based Survey, Ethiopia, March 2006



Maternal mortality in the pastoralist community is 801/100,000 live births<sup>152,153</sup> compared to a national average of 673/100,000. Given the low level of health infrastructure, human resources for health and underutilization of health services in Afar in general, this number may be even higher among nomadic communities. Afar has a high fertility rate (4.9%)<sup>154,155</sup> and low contraceptive prevalence (3.2%) and an average age of 16.2 years at first marriage. Recent evidence indicates that 80% of men and 87% of women have no education at all.<sup>156</sup>

Availability of services and their accessibility (both geographic and economic) are important factors which determine maternal HC utilization and they are usually determined by women's household income, place of residence and its distance from health services, costs (direct fees as well as the cost of transportation, drugs, supplies) and multiple demands on women's time.<sup>157,158</sup> On the other hand proper medical attention, hygienic conditions during delivery, availability of essential obstetrics instrument to conduct delivery, proper training and lack of mentorship mechanism can be mentioned as the factors of maternal mortality rate.<sup>159</sup> Access to comprehensive maternal health care services is essential to reduce the maternal mortality ratio.<sup>160,161</sup>

The federal government in Ethiopia and several non-government organizations, including AMREF, have shown a strong commitment in recent years to delivering maternal health packages. Emphasis has been placed on providing basic community-based maternal health services in rural areas, primarily through Health Extension Workers and mid-level service providers. The rationale for this focus on community-based services is that rural communities have limited access to health facilities due to the scarcity of adequately equipped and staffed facilities, long distances to travel and poor infrastructure.<sup>162,163,164</sup>

The Ethiopian Demographic Health Survey (EDHS) 2005<sup>165</sup> indicates that long distances to health facilities and the associated transport are important factors that prevent women from seeking medical care. However, experience shows that even when maternal health facilities

<sup>152</sup> Family Health Department, Federal Democratic Republic of Ethiopia Ministry of Health (2006). Report on Safe Motherhood Community-based Survey, Ethiopia, March 2006.

<sup>153</sup> FMOH, Ethiopia(2008). Health and health related indicator, FMOH, 2008.

<sup>154</sup> Yousuf, Jemal and Samuel Hailu (2009). *Sexual and Reproductive Health Status of Nomadic Youth :The case of Afar Pastoralist*. Ethiopia, March 2009.

<sup>155</sup> FMOH, Ethiopia (2008). Health and health related indicator, FMOH, 2008.

<sup>156</sup> Central Statistical Agency, Addis Ababa (2006). *Ethiopian Demographic Health Surveys 2005*. Calverton Maryland, USA 2006.

<sup>157</sup> World Health Organization (1997). *Safe motherhood technical consultation*. Sri Lanka, Colombo.

<sup>158</sup> Nigussie M. (2003). *Assessment of safe delivery utilizations in the Amhara region*. University of Addis Ababa, Ethiopia.

<sup>159</sup> World Health Organization (1997). *Safe motherhood technical consultation*. Sri Lanka, Colombo.

<sup>160</sup> Central Statistics Authority, ORC, MACRO (2000). *Ethiopian Demographic health survey, 2000*. Addis Ababa and Mary Land, USA; CSA and ORC MACRO.2001

<sup>161</sup> Federal Ministry of Health (2009). *Health and Health Related Indicators*, FMOH, August 2007, Addis Ababa.

<sup>162</sup> Mrisho M, Obrist B, Schellenberg JA, Haws RA, Mushi AK, Mshinda H, Tanner M, Schellenberg, D. (2009) *The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania*. Ifakara Health Institute (formerly Ifakara Health Research and Development Centre), PO Box 78373, Dar es Salaam, Tanzania. <http://www.biomedcentral.com/1471-2393/9/10/> (accessed 18 July 2012).

<sup>163</sup> John Nuduba,(2006) AMREF ETHIOPIA Reproductive health programme for Nomadic Youth of 202 Afar Regional State, Summary of project proposal, December 2006.

<sup>164</sup> Azmerav Tayelgn Desalegn T Zegeye, Yigzaw Kebede (2011). *Mothers' satisfaction with referral hospital delivery service in Amhara Region, Ethiopia* <http://www.biomedcentral.com/1471-2393/11/78>, (accessed 18 August 2012).

<sup>165</sup> Central Statistical Agency, Addis Ababa (2006). *Ethiopian Demographic Health Surveys 2005*, Calverton Maryland, USA 2006.

are nearby, the use of these facilities remains low among the pastoralist women in Afar. Moreover, our study shows that women's education, wealth, residence and region affect the use of maternal health services. In addition, it can be assumed that community actors – for instance, religious leaders and the pastoral community's perspective on pregnancy, childbearing and motherhood – also influence decision-making on the use of maternal health facilities.

To increase the use of maternal health services and thereby contribute to a reduction in the high maternal mortality ratio in Afar, there is a need for greater understanding of why communities do not utilize the services available to them. What is the role of community leaders – particularly religious leaders – in influencing the community on decision-making about modern health facilities? The Federal Ministry of Health's health indicators for 2008 show the differences between regions and show the position of Afar compared to national average. This can give a basic insight into the number and quality of health services available to the pastoral Afar communities.<sup>166,167</sup> However, information about the pastoralist community's perspective on the services provided to them, and how different actors – particularly religious leaders – influence them is lacking.

These findings are important to policymakers and programme implementers in formulating programmes and policies and in designing appropriate strategies and interventions to improve maternal health care services and delivery models for the nomadic communities in Afar.

## Methodology

A community-based qualitative study was conducted among pastoralist communities in the Dalifage zone 5 and Awash zone 3 districts of Afar, to assess the role of religious leaders in the use of maternal health services. A total of 47 in-depth interviews were conducted with health workers, health extension workers, religious leaders and health sector representatives at different level as well as beneficiaries. The main study targets were 47 in-depth interviewees. In addition to that, 4 focus group discussions, 2 per study site. The participants for the FGDs were defined by their shared characteristics. In each site, the FGD was conducted with women of reproductive age (1 FGD per district) and with TBA's and circumcisers (1 per district). Each FGD involved six to eight people and lasted approximately one hour. The topics of discussion were their understanding and opinions around pregnancy, childbirth and the availability and quality of maternal health services in the area. Data collection techniques included a desk review, in-depth interviews and focus group discussions. Data was analysed manually at field level and at the country office level.

<sup>166</sup> Tedese Kitilla (year unknown) *Reason for referrals and time spent from referring sites to arrival at Tikur Anbesa Hospital in emergency obstetric: prospective study*. Department of Obstetrics & Gynecology, Faculty of Medicine, Addis Ababa University.

<sup>167</sup> Fantahun M (1992). *Factors affecting ANC attendance and preference of delivery by pregnant women in Gulele woreda*, Ethiopian Journal of Health development - 1992, vol 6 (2): 17-22).

## Results and discussion

According to all key informants and participants in focus group discussions, pregnancy is considered to be normal and safe unless there are signs of complications. The pregnant women therefore do not seek modern health services until they are facing complications. Although health workers agree that pregnancy is a normal phenomenon, they feel that the health of the mother has to be kept an eye on until she gives birth. This should not be overlooked, since complications can occur at any time during pregnancy and could threaten the life of both mother and new-born. Health workers therefore advise pregnant women to regularly visit the health facilities.

From the community's perspective, maternal health care is not restricted to antenatal care, delivery and postnatal care, but also includes health care more broadly and the well-being of the mother and her family. There are many factors that affect utilization of maternal health services. The most pervasive and commonly shared opinion is that pregnancy is normal and is expected from any married women. Our research suggests that this idea has been widely misinterpreted by decision-makers (husbands, men, and traditional leaders) to mean that there is no need for special care during most pregnancies. As a result, unless women exhibit symptoms such as vaginal bleeding, pain, or prolonged labour, it is widely held that they do not require any health care services and that they can safely do without antenatal care.

Compounded by the geographical, economic and political marginalization of the region and the arid environment, the Afar community relies predominantly on traditional knowledge and practices to address health problems in both general and maternal health. Several traditional care and support options are available for pregnant women. The role of community members is very important; they take over tasks such as carrying heavy objects during pregnancy. They are further involved in decision making on health seeking behaviour and traditional transport options to seek for health care at facility level.

In nomadic areas, communities are the centre of health and health care. In Afar the neighbours are responsible to provide home based care mostly focusing on nutrition – milk and others. Based on the disease classification communities discuss with the husband and decide where to seek treatment. Daggu, the traditional information exchange system, helps the community to get and provide up-dates on social, political, and environmental aspects. Communities take the woman (the sick) to the traditional healer or to the health service provider. Taking a woman to a health facility may include travelling long distances carrying her on *weeseka* (a traditional group/stretchers) or if fortunate enough using vehicles from district administration or NGOs. It is very common to see that while carrying the patient, men members shout and cry both to mobilize more support and in the meantime to inform they are taking a sick woman to health facility.

The study illustrates the potential strong influence of religious leaders on the utilization of health services. Religious leaders in Afar can be seen from the perspective of the community and the law of the Islamic religion. Any Muslim who makes rituals in Afar at

community level is called a *mullah* and works and lives close to the community. These people usually mix religion and traditional ways of problem-solving at community level.

However, those who are at the level district and above are called *sharia* leaders and are responsible for the implementation of *sharia* law in line with the rules and regulations of the Quran. Usually, the traditional way of solving problems outside *sharia* law is not tolerated by the *sharia* law.

Moreover, the influence of religious leaders is easily spread to any part of the community through the traditional way of communication called *Dagu*. This traditional way of communication is based on providing information to any Afari people wherever they meet. Not sharing information when people meet may bring bad consequences for the source of information.

The *Dagu* system is used extensively by the community, government workers, health workers and religious leaders and has an important impact on maternal health as well as great potential for health promotion. As one participant said:

"The role of religious leaders is significant in maternal health. They are the ones who worked a lot to decrease [female] circumcision. I have contributed a lot to raise the awareness of religious leaders and male groups in relation to circumcision through *Dagu*."

The study showed that the *mullahs* in Afar are highly regarded by the community, and as a result they exert considerable influence over health care and pregnancy. In this regard, in-depth interviews and discussions were undertaken to explore the role of religious leaders in the delivery of health care. This analysis examines the current role that religious leaders play as well as the potential they have to use their influence to improve pregnancy outcomes.

Despite different views of the role of religious leaders influencing the community in seeking modern health services, the women in the study agreed that the religious leaders influence them to utilize the health services in Afar. Most of the time, the community is making first contact with religious leaders. Their advice is critical in the decision to either go or not go to the health facility seeking modern health care. An in-depth interview with a mother of child-bearing age indicated that:

"Religious leaders provide Quran-based advice to the community on giving care to pregnant mothers."

Despite the community believes that the religious leaders are the one who know about the situation, the staff of Women Affairs believes religious leaders cause delays in patients getting appropriate and timely care, strongly affecting the health of the women. An interview with staff from the Women's Affairs Office showed that they do not agree with religious leaders having a supportive role in the decision-making of the community. They do not always make right decisions on the use of modern health services:

“The role of religious leaders is not as such visible in improving maternal health and securing women’s rights. They do not lend dignity to females as such. The solution is that every community member should focus on what care and support is given to females, whether by a health worker, the cabinet, elders, youngsters and everyone.”

One of the key informants also supported these comments. She argued that religious leaders contribute to pregnancy-related complications by mixing religious and traditional beliefs such as *jinni* (evil spirits), which this contributes to delays in seeking appropriate health care when complications arise (for example, by attempting to manage pregnancy with herbs and spiritual prescriptions). According to the study, in a pastoral community the median patient delay is 60 days, with a mean of 130 days, ranging from 10 days to 1800 days. This is one of the longest patient delays reported so far from developing countries.<sup>168</sup>

A Health Extension Worker (HEW) also reported that the religious leaders often resent them because they believe that the HEWs influence people to take a different path from the one the leaders recommend. One of the HEWs said:

“There is a great suspicion by the religious leaders when external partners take part in the teaching/awareness-creation activities related to health. When we start to teach the community, religious leaders do not acknowledge us and rather hate it if we bring in external partners like you.”

The study also revealed that the religious leaders provide advice to the community in line with the Quran and some conduct rituals. Informants indicated that religious leaders often prepare and prescribe a *“written piece of prayer drawn from the Quran”* that aims to heal the women in need. If she does not survive, the religious leader says prayers over her body. However, the study indicated that the religious leaders often charge for this function and this charge impacts on the amount of money that is ultimately available for health care expenses at household level. Some informants also indicated that traditional healers receive goats or sheep in lieu of cash for the service. Seeking care at an inappropriate facility actually delays access to appropriate treatment and reduces the household’s capacity to pay for it.<sup>169</sup> Even in this case (unless long travel distances are required) these costs are not significantly higher than what communities pay a herbalist or religious/traditional healer (sometimes a goat or a sheep). All in all, the role of religious leaders and their spiritual authority influences pregnancy outcomes.

The representative of the Regional Health Bureau argued that religious factors play very little role in decisions to have institutional childbirth support. Rather, the belief is that it is the culture that makes things difficult for pregnant women. This opinion was shared by the district health officials. However, there are some religious leaders who mix sharia law with traditional beliefs, and sometimes this can adversely affect pregnancy outcomes. Since traditional culture is considered responsible for decision-making on the use of

<sup>168</sup> Gele AA, Bjune G and Abebe F. (2009). *Pastoralism and delay in diagnosis of TB in Ethiopia*. <http://www.biomedcentral.com/1471-2458/9/5> (accessed 5 June 2012).

<sup>169</sup> Ibid. 170

maternal health services, the role of religious leaders in bringing change in this culture should not be undermined. The district health office stated that the mix of sharia and traditional beliefs enable the local religious leaders to be accepted by the community, and their service provision remains a source of income.

These findings demonstrate a distinct difference between the perspectives of the government officials and the community on the role of the religious leaders in influencing the use of the formal health delivery system. Government officials at different levels strive to follow the regulations of the government to achieve the country goal. The government officials appreciate the role of religious leaders that are strict with their respective holy book. However, those religious leaders at local level and close to the communities usually use their respect for individual's advantage. The *sharia* leaders at a higher level than the *mullahs* deal only with strict implementation of *sharia* law and have very limited involvement with other programmes, so the higher-level officials have less recognition of their role in decision-making at district and higher level. However, the role of these religious leaders at national and regional level to influence government policy is well recognized. According to the study findings, religious leaders were very effective advocates, reaching over 900,000 people in Ethiopia and over 17,000 community members in Kenya. The religious leaders also made more than referrals for Counselling and Testing services.<sup>170,171</sup>

## Conclusion

Religious leaders can be effective community educators and have a positive influence on seeking and using appropriate health care, thereby reduce maternal morbidity and mortality.

Mothers delaying their use of modern health services are a major cause of mortality in Ethiopia. Moreover, the role of religious leaders is important in deciding when to seek appropriate care. According to this study, the local religious leaders, *mullahs*, are widely accepted by the community and can influence women to utilize the services. The most important thing is that the relationship between the formal government sector and the *sharia* leaders at a higher level was found to be very poor. As a result, government officials could not understand the role and responsibilities of the local leaders and the *sharia* leaders. Generally, due to lack of coordination at higher levels, the role of the local religious leaders tended to have a negative influence on the decision-making of mothers seeking appropriate care on time.

The traditional way of communication called *Dagu* was found to be the best way to prompt positive health behaviour in the communities of Afar.

<sup>170</sup> Yousuf, Jemal and Samuel Hailu (2009). *Sexual and Reproductive Health Status of Nomadic Youth :The case of Afar Pastoralist, Ethiopia*. March 2009.

<sup>171</sup> Population Council (2008). *Community and Religious Leaders Are Effective Advocates for HIV Testing for Young Couples, Kenya, Ethiopia Integration*. December 2008. [http://pdf.usaid.gov/pdf\\_docs/PNADP411.pdf](http://pdf.usaid.gov/pdf_docs/PNADP411.pdf) (accessed 5 June 2010).



## Recommendations

The Regional Health Bureau and Women's Affairs Office need to work together with *sharia* leaders so that they influence the local religious leaders to support the government health system. A plan needs to be put in place to influence the local religious leaders to work in line with *sharia* law and to not mix it with traditional beliefs. Providing health education and monitoring these local religious leaders are of paramount importance to change their behaviour and work for the health of the general population and particularly for the health of mothers.

All decisions made by the joint efforts of religious leaders and the government need to be promoted through the well-established community information system called *Dagu*.





# 15 Environmental health – a gateway to sexual and reproductive health programming among nomadic communities: A case study of AMREF projects in Kajiado, Kenya

Joris van Oppenraaij

The greatest successes in public health are typically environmental health improvements, such as the increased awareness and improved technologies in the fields of water, sanitation and hygiene.<sup>172</sup> Prioritizing hygienic practices by using clean water and sanitation has resulted in unprecedented longevity and markedly improved quality of life.<sup>173</sup>

Access to safe water is considered the first priority of traditional nomadic communities. Men are highly involved in environmental health programmes, as water is a key resource and has a direct link to animals, which is their key livelihood. In a 2010 article, Family Health International (FHI) reports that reproductive health experts have long recognized that involving men in family planning yields benefits such as client satisfaction and the adoption, continuation and effectiveness of contraceptive use. Men play a central role in reproductive health decisions – and even more so in traditional communities like those of the Maasai.<sup>174</sup>

Environmental health programmes have been identified as an opportunity in sexual and reproductive health programming. AMREF has implemented comprehensive health programmes in Kajiado since late 1980, in which water, sanitation and hygiene interventions play a key role.<sup>175</sup> This case study identifies three capacity-building strategies that have been implemented by AMREF in Kajiado over the last three decades and have realized interesting entry points for capacity-building in the field of sexual and reproductive health and rights:

- Use of water and sanitation committees in communities. These committees are entrusted with the supervision, operation and maintenance of the rural water scheme in Kajiado. The water committee potentially aims at empowering communities, and especially women, at the community level to increase participation in decision-making.<sup>176</sup> This is a key community structure that has been successfully used as an entry point for sexual and reproductive health issues.

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<sup>172</sup> Faria, MA Jr, MD (2002). *Medical Sentinel* 2002;7(4):122–123.

<sup>173</sup> Ibid.

<sup>174</sup> See chapter 10 by Charles Leshore in this book.

<sup>175</sup> AMREF (2010). *Assessing 50 years of AMREF's intervention in Kajiado District, Kenya*.

<sup>176</sup> <http://www.guardian.co.uk/katine/katine-chronicles-blog/2010/jun/24/empowering-women-grace-mukasa> – (accessed 23 September 2010).

- Use of school health clubs. School teachers are being trained to teach their pupils about Personal Hygiene and Sanitation Education (PHASE). This health education module for schools has been successfully practised throughout Kenya. It consists of training teachers in education about environmental health by means of establishing school health clubs that create health awareness with their peers and their parents. The school health clubs could also be very useful for raising awareness in the field of sexuality.
- Use of community volunteers in health promotion. The community volunteers, both men and women, are trained to create awareness at household level in the field of water, sanitation and hygiene. Hygiene in relation to childbirth is extremely important in reducing maternal mortality due to puerperal fever.<sup>177</sup> Community health promoters, if equipped well with information on hygiene during menstruation and child delivery, have been found to be very useful in improving sexual and reproductive health outcomes.

In Kajiado it has been observed that through environmental health interventions, communities can be educated and persuaded to 'buy in' to other interventions such as sexual and reproductive health and rights. Environmental health interventions and access to safe water, in particular, form an appropriate entry point to communities to address other health issues, because they are more concrete and perceived by communities as more directly necessary than more sensitive issues such in sexual and reproductive health.

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<sup>177</sup> Hanninen O, M Farago and E Monos (1983). *Ignaz Philipp Semmelweis, the prophet of bacteriology*. Infection Control 4 (5): 367–370, September–October 1983.







# Conclusions and recommendations

Experiences drawn from implementing development interventions in nomadic settings in Eastern Africa arrive at a conclusion that all nomadic communities have similar cultural practices expressed through taboos and beliefs pertaining to maternal and child health care. For example, pregnancy care and child birth are community concern and not a woman's preserve. However, key decisions regarding the pregnancy and child birth are made by the men and other close but senior community members. In the three countries of Kenya, Tanzania and Ethiopia, men, religious leaders and traditional birth attendants (TBAs) are the key players in influencing seeking and using appropriate maternal and child health care services.

Although there has been a lot of research on the subject of TBAs and the health-seeking behaviour of women in the three countries, there seems to be little of such research among the nomadic communities. Evidence from research to guide in policy formulation and planning for maternal services is lacking. Since the work of TBAs is adapted and strictly bound by the social and cultural matrix to which it belongs, their capacity is highly appreciated as it addresses the needs of the local community.

There is a strong relationship between the husband's involvement in maternal issues and delivery at a health facility. It has been shown that deliveries are more likely to take place under a skilled medical person if the husband is supportive. Decision making is predominantly a preserve of men and their mothers and there is evidence that young women often lack independent decision making power among the nomadic communities. They have to consult others for them to take a certain action pertaining to their health especially maternal health. Only when women are older and become mothers in law and grandmothers they gain more respect and have more authority to make decisions. In general women of course have their strategies to navigate in the nomadic landscape but most of the time they have to consult others for them to take a certain action pertaining to their health especially maternal health.

The local religious leaders and respected traditional leaders play a pivotal role at the grass root level. In Ethiopia, for example, the traditional leaders have more power than the religious leaders and they have an influence on the delays in seeking maternal health services from health facilities. However some of their roles are not recognized by high level religious leaders (in charge of religious matters affecting regions) and government officials.

The policy environment in the region is varied. In Ethiopia, for example, there is a fully fledged programme to support TBAs, while in Kenya and Tanzania there is an express decision to prohibit TBAs from conducting deliveries and reassign them new roles. Nevertheless, even in areas where there is support for using cultural structures in health

care, the implementation of the support is poor. Perhaps this situation results from inadequacy of data on the nomadic communities' sexual and reproductive health to enable governments to understand their situation.

The existing health information system only collects information from existing health facilities and does not involve health events occurring in the community. This leads to a wrong presentation of maternal health outcomes. The community-based health management information systems in the three regions are still underdeveloped, and this has aggravated the situation.

Among the nomadic communities, the flow of sexual and reproductive health information to the youth is hampered by tradition, culture and gender relations. There is more lateral communication among peers themselves who have similar experiences and little knowledge than inter-age communication. It is taboo for young people to discuss sexuality issues with older men and women. However, it is allowable among peers to discuss these issues. Such discussions are likely to be guided by little knowledge and inexperience in sexual matters. The structures expected to pass on sexual and reproductive health information like schools, skilled health personnel, guardians or parents have not actively taken this role. The youth get such important education through experimentation as they are influenced by peers with similar experiences and with low knowledge.

Addressing maternal and child health issues of nomadic communities in Eastern Africa requires harmonization of salient policy issues touching on research, service delivery and information collection and sharing.

Policymakers and development practitioners should invest in understanding the cultural beliefs and values that have an impact on maternal outcomes in nomadic communities. Specifically, local health posts and women empowerment groups need to have close cooperation in ensuring that cultural structures that positively address women's health are adequately engaged in the health system.

A functional community-based health information management system should be set up in the communities to gather data and help to develop evidence-based policies. They should also identify capacity building opportunities and use cultural structures as entry points for designing policies that are sensitive to the plight of nomadic communities.

Development partners need to broadly define the concept of male involvement and develop tailor-made programs to directly involve men as partners – and not decision-makers – in maternal and child health issues. There is need for governments to have a curriculum for educating men on antenatal and post natal care issues for them to be able to make informed decisions. Women have a right to be involved in decision making. This will ultimately contribute to improving maternal health care.

There is need to design strategies for up-skilling TBAs using the existing maternal health care seeking behaviours to enable them attend to normal delivery and recognition of the

complicated labour including high risk mothers and make early referral. Provision of essential equipment, extensive training on emergency obstetric care, and frequent supportive supervision are important to ensure the work of health care providers is in line with government policy. Since the traditional and religious leaders have strong influence on maternal health care, governments should ensure that their influence is in line with Government policies. Religious norms should not be confused with the traditional health care. There is need for more research and investment in traditional health care systems targeting the providers and actors in Sexual and Reproductive health to build a strong evidence for policy formulation.

Strengthening the link between formal and informal health system is important. It ensures that information is collected from both systems and used in planning for health issues. For change to be sustainable, it needs social support. In this respect, the underlying social and traditional/cultural structures impacting on maternal and child health need adaptation. There is a need to take advantage of these structures and work with them.













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