

Exchange

ON HIV AND AIDS, SEXUALITY AND GENDER



Reproductive health in nomadic communities: Challenges of culture and choice

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Since the late 1980s, improving maternal health and reducing maternal mortality have been key concerns of several international meetings, including the Millennium Summit in 2000.² One of the eight Millennium Development Goals (MDGs) adopted after the summit involves improving maternal health (MDG5). Although reproductive health is not specifically named, it is widely recognised that ensuring universal access to reproductive health care, including family planning and sexual health, is essential for achieving all the MDGs, and vice versa.³



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

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

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

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Preventing needless deaths among hard-to-reach mothers

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

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

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

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

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

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

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

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

On the other hand, HIV incidence among pastoral communities appears to be relatively low; Talle relates this to the cultural identity of the Maasai. Although the Maasai value multiple sexual partners and engage in large sex networks, their sexual morals are not loose and their sexual interactions are regulated by a strict morality of prescribed sexual partners according to age-set and kinship affiliation⁴.

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

Programme in Eastern Africa

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

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

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

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

Early marriage and sexual practices

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

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

FGC because of its associations with family honour (respect), cleanliness, a woman's ability to walk for long distances and women giving birth with ease.

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

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



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

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

Local beliefs and knowledge

Despite global efforts to eliminate FGC, it remains widespread in nomadic communities, as indicated by the high proportion of nomadic youth who reported having a circumcised sister. A possible explanation for this is the belief among nomadic youth that circumcised girls are different from uncircumcised girls in important ways. For example, many justify

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



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

Fertility choices and decision making

The reproductive choices made by young women and men have an enormous impact on their health, schooling and employment prospects, as well as their overall transition to adulthood^{7,8}. Unintended pregnancy is a major health problem among young people in Sub-Saharan Africa⁹ where, it is estimated that 14 million such pregnancies occur every year, with almost half among women aged 15-24 years¹⁰.

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

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

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

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

Contraceptive use among nomadic youth was extremely low with those in Ethiopia being the least users. This reflected low knowledge of modern contraception. Enhancing contraceptive knowledge among nomadic youth seems essential to spur higher use. Deliberate efforts are therefore required to make contraceptives culturally acceptable in nomadic communities. This and awareness of decision-making structures where the men and the mothers-in-law are the most decisive in local practice, are key issues that need

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

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

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

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to be taken into account when organising awareness programmes. For example, men in Kenya kept the identity cards of their wives with them, to ensure that they could not go anywhere without their consent.

Quality of reproductive health services

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

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



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

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

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

Lack of basic training among providers was evident. Training of service providers on

reproductive health was and is therefore extremely essential.

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

Lessons learned

- Access to reproductive health care services among nomadic youth is wanting and it is recommended that this be addressed by improving attendance at formal schools; decentralisation of reproductive health services to make them closer to nomadic communities; and training reproductive health care providers to offer youth-friendly services. The introduction and use of mobile phones may help in easing communication between providers and communities.

- The involvement of traditional herbalists, local healers and TBAs could capitalise on the trust communities have in them to fight negative practices that hinder reproductive health service provision. This will also help address cultural beliefs that encourage female genital cutting among nomadic communities. ■

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