ORIGINAL ARTICLE

Assessment of Barriers to Reproductive Health Service Utilization among Bench Maji Zone Pastoralist Communities

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ABSTRACT

***BACKGROUND:** The reproductive health (RH) needs and challenges in pastoralist area are different from elsewhere. People in this area live in very traditional settings and adhere strongly to traditional cultural values and beliefs. Some of these beliefs are known to lead to poor sexual and RH outcomes. Thus, the objective of the study was to identify barriers of RH service utilization among pastoralist communities of Bench Maji zone.*

***METHODS:** This study was conducted in pastoralist communities of 5 woredas in Bench Maji zone. Qualitative study was conducted through FGD, IDI and KII. For this study 15 FGDs, 5 IDI and 5 KII were conducted. Recorded data was first transcribed in to local languages and translated to English by experts. The data was coded and themes were identified. Finally the result was presented narratively.*

***RESULTS:** The major challenges of RH service utilization identified in this study were preference of female professionals, preference of home delivery, cultural influences, lack of knowledge, decision maker related barriers, and health facility related barriers. Husband disapproval was significant challenge for utilization of services. Family disapproval for adolescent RH service utilization and judgmental approach of health professionals for contraceptive utilization were also common barriers.*

***CONCLUSIONS:** Preference of female professionals, preference of home delivery, cultural influences, lack of knowledge, decision maker barrier, and health facility related barriers were identified barriers. Therefore, awareness creation to the community, and capacity building to health professionals are recommended.*

***KEYWORDS:** Reproductive health, Barriers, Pastoral, Ethiopia*

INTRODUCTION

The reproductive health (RH) needs and challenges in pastoralist area are different from those elsewhere. People in these areas have limited access to information and services. This is not simply due to the mobility that pastoralist communities have. But other factors also play a role. They live in very traditional settings and adhere strongly to traditional cultural values

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and beliefs. Some of these beliefs are known to lead to poor sexual and reproductive health (SRH) outcomes (1).

In Maasai (Kenya), traditional values are that a woman's social worth is largely determined by how many children she gives birth to (2).In pastoralist areas of Tanzania, there is low attractiveness of remote posts and difficulty in recruiting health workers to these areas. Long distances to facilities and poor infrastructure are challenges of access (1).

The results of studies conducted on Ethiopian, Kenyan and Tanzanian pastoral communities are generally characterized by poor RH outcomes. Low access to RH services, low education levels and the high prevalence of potentially harmful traditional practices are important contributing factors (3).

In addition, the capacity of the formal health care systems in pastoralist settings is generally very weak. Service providers show limitations in their ability to provide services and generally lack the knowledge and skills required to address the traditional pastorals' SRH needs effectively(4).

Maternal and neonatal morbidity and mortality rates in Ethiopia are among the highest in the world and are attributable to a range of socioeconomic, political and demographic factors. The dangers associated with giving birth at home are ever-present in communities throughout the country (5).A high proportion of women in Afar experience high-risk pregnancies and deliveries. Utilization rates of RH services are low, few births (6%) are attended by skilled personnel and services are not equipped to provide emergency care. Moreover, uptake of contraception is among the lowest in the country (6.6%) (1).

Understanding the context of such beliefs and practices is central to developing strategies to ensure positive outcomes for both the mother and the infant.

Bench Maji Zone is one of the zones in Southern Nations Nationalities and Peoples Region (SNNPR). The zone contains 10 woredas and five of the woredas have pastoralist kebeles. There is no previously conducted study on barriers of RH services in the pastoralist areas of the zone. Therefore, this study is intended to show the barriers of RH service utilization in Bench Maji Zone pastoralist areas while understanding this will have an important value for informing policy-makers in designing appropriate strategies for providing RH services for pastoralist women and youths.

METHODS

Study area and period: This study was conducted in pastoralist communities of five woredas (districts) in Bench Maji Zone. These woredas are Surma, Bero, Maji, MenitGoldia and MenitShasha. Bench Maji Zone has 838,235 people in 247 kebeles (smallest administrative units) and 10 woredas. Among these 10 woredas, the five woredas mentioned above have pastoralist kebeles. The study was conducted from October to November, 2016.

Study design: Qualitative study was conducted through FGD (Focused group discussion), IDI (In-depth interview) and KII (Key informant interview).

Study population: For FGDs of youths population of 18-24 years were involved. For FGD of mothers women who ever gave birth were included. For FGD of male men who are married and have children were included. For IDI religious leader/clan leader and for KII health professionals were included.

Sample size and sampling technique: For this study, 15 FGDs, 5 IDIs and 5 KIIs were conducted. Five FGDs were on youths, 5 were on fathers, and 5 were on mothers. The IDIs were conducted among religious/clan leaders, and KIIs were conducted among health professionals. The sample size was decided based on saturation of data. The study participants who could actively involve in the discussion were selected for group discussion. For FGDs of youths, people who were 18 to 24 years old were selected through purposive sampling technique by local Family Guidance Association of Ethiopia (FGAE) focal persons. Among the five FGDs conducted on youths, three were among females and the remaining two were among males. The

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discussions were conducted separately. For FGDs conducted among fathers males who were married and have children, were selected purposively by FGAE focal persons. For FGDs conducted among mothers women who ever gave birth were selected purposively by FGAE focal persons. For IDIs religious or clan leaders who know the local culture and were acceptable by the community were selected purposively. For KIIs, senior health professionals who had worked in the study area were selected purposively.

Data collection technique: The data collection was conducted by using FGD, IDI and KII guidelines which were developed by the principal investigators. The guides were first developed in English and later translated into respective languages (Menit language for MenitGoldia and MenitShasha woredas, Dizzi language for Bero and Majiworedas, Suri language for Surma woreda) by language experts. Data collection was done by health professionals who were fluent in the respective local languages. The FGDs were facilitated by BSc (Bachelor of Science) nurses who fluently spoke the local languages and trained on FGD facilitation. Training was provided on data collection for two days. Separate and silent rooms were selected for discussions and interviews. All interviews were tape-recorded and notes were taken.

Data analysis procedure: Recorded data were first carefully transcribed in local languages by fluent local language speakers and translated to English by experts. The data were coded, and themes were identified. Finally, the results were presented narratively.

Data quality assurance: The quality of the data was assured by training the data collectors, by using experts to translate into local languages and by translating back to English to assure consistency. Private and silent rooms were selected for data collection. In addition, interviews were recorded and notes were taken.

Ethical considerations: Ethical clearance was approved by Mizan-Tepi University, College of Health Sciences. Before enrolling any of the eligible study participants, the purpose and benefit of the study were discussed with all the study participants. Informed consent of the respondents was obtained.

RESULTS

Sociodemographic characteristics of study participants: Among the study participants, nearly equal numbers were taken from each of five woredas. Half of the participants were females. Regarding age of the participants, nearly one-third were in the age group of more than 35 years. More than half of the study participants (52.4%) had no formal education (Table 1).

Table 1: Sociodemographic characteristics of study participants

Characteristics	Frequency	%
Woreda		
Surma	26	20.9
Maji	24	19.4
Bero	26	21.0
MenitGoldia	25	20.2
MenitShasha	23	18.5
Total	124	100
Sex		
Male	67	50
Female	67	50
Total	124	100
Age (years)		
<25	42	33.9
25-35	38	30.6
>35	44	35.5
Total	124	100
Educational status		
No formal education	65	52.4
Primary education	41	33.1
High school	12	9.7
10+3	6	4.8
Total	100	100

Challenges of reproductive health

***Preference of female professionals**:* Due to topography and security issues of pastoralist communities, most health professionals and health extension workers were males. However, many women do not want male professionals for utilization of FP, ANC and delivery. They do not want to be exposed and let male professionals see

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their body parts. Their husbands also highly hate such things. If they are examined by male professionals, their friends will try to ridicule them. This challenge extends to issues of adolescent RH. The problem raised from the adolescent FGD was that it is considered shameful to take counseling and do pregnancy test from male health professionals.

"In our culture, women should expose their body only to their husbands. It is shame to be naked in front of others especially males…" (Men FGD participants from Surma)

"Females in our community are shy to take counseling from males, especially outside their ethnic group. Therefore, this is a challenge for us to utilize reproductive health services." (Female FGD participant from MenitShasha).

Preference of home delivery: Most women who prefer to give birth at home because they think it is a better place to expose their bodies to fire and make them hot. In addition, they can easily obtain different types of foods from home. Women also think that the food they get around health institutions is unusual food that they do not prefer to eat. Some people who prefer to give birth at home because when they face abdominal cramp during labor, local *Areke*(local alcohol beverage) is available at home. However, it is not obtainable at health facilities.Women also believe that if they give birth in health institutions, the professionals either cut or evacuate their womb and they may not give birth in subsequent times.

"There is one woman in our community. She gave her first birth at health institution, but now she can't give birth to another child. Therefore, we don't want to go to there…" (Women FGD participant from Maji)

*"We do have a lot of cultural values practiced when a woman gives birth. We lose all those cultures if a woman gives birth at health institutions." (*Women FGD participant from MenitShasha)

Cultural influences: Regarding the issues of ANC, the misconception is that there are some people who believe that women should not follow ANC because their mothers and foremothers did not have such follow-up, but they and their children were healthy. The great burden of women in homes is the challenge to move to health institution for ANC. They usually give more emphasis to the work in a home than to their health. There are misconceptions among the community members regarding institutional delivery. Sometimes, women refuse to sleep on delivery coach; rather, they prefer to sleep and give birth on the ground.

"Many women in Menit community give birth in standing position outside their home by themselves. There is effort by health extension workers to avoid home delivery. But, when they come to health center they don't want to be in delivery coach." (Health professional from MenitGoldia)

FGD participants explained that both boys and girls are reluctant to seek RH services in health posts and health centers. This is because, culturally, it is a taboo to talk about sexual issues for unmarried youths. In addition, they discussed that it is considered as a shame to use contraceptives for unmarried girls.

In some members of community family planning is considered as enhancing factors to practice adultery.

"If women use contraceptives, they may have contact with other male, we do not know that. But if she is not using contraceptive, she will be pregnant and their husband will know it." (Male FGD participant from Maji Woreda)

There are different malpractices which the community undertakes. When the mothers give birth at home, they apply butter and cow dung at umbilicus of the new born. Abdominal massage with butter, shaking of mother forward and backward and closing her mouth and noses to facilitate labor are among the cultural malpractices. Giving birth without being assisted by anyone outside the home can be considered as malpractice during labor and delivery.

"In our community, women give birth in the forest. You know what? The great fear is that many women are being eaten by hyena in forests while giving birth." (Woman FGD participant from Dizi Woreda)

"In Menit community, women keep issue of pregnancy and delivery as mystery, and they do

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not tell to anybody. When labor starts, she leaves her home to forest. There, she finishes everything by herself including cutting of umbilical cord. Then, she returns to home with her baby." (Male FGD participant from MenitGoldia)

Lack of knowledge*:* Women in the community have poor planning for birth and delivery. Due to this, labor starts at unexpected time and they give birth at home. Most women in their province do not know the time when they are pregnant because they do not register or remember their menstrual cycle. When their menstruation is missed, they wait for a long time hoping it to come. In the meantime, their belly becomes enlarged, and they notice that they are pregnant.

"*You know, our women, unlike women from town, do not know whether they are pregnant or not. They do not know their menstrual period, and therefore they do not do pregnancy test when they miss their menstruation."* (Health professional from MenitGoldia).

"We usually notice our pregnancy when our belly becomes enlarged. It is at this time that we start to think about our pregnancy."(Female FGD participant from Bero)

Decision maker barriers*:* Study participants discussed the highly influential negative attitude of men towards ANC. Women are overloaded with different kinds of activities, and husbands are unwilling to send their wives to health facilities for ANC.

"There are some husbands who say that 'it is God who supports you, to whom do you leave all the tasks in the house?'…." (Male FGD participant from Bero)

The husbands usually claim that there is no problem if they give birth at home. They say that we all were born in forest and that there is no need to go to health institutions. In addition, the discussants noted that husbands are not involved in planning for delivery. The men FGD participants also added that many husbands say that it is God, not a man, who supports a laboring woman. They believe that there is no difference whether she goes to health facility or not. Men also do not support their wives to stay at maternity waiting rooms.

"In previous times, women would immediately return to home after giving birth at health center. But, now they stay more than one month there. This imposes a great problem in the house." (Male FGD participant from Bero)

Husbands do not want their wives to use family planning. This is because husbands want many children and they claim that the money paid during marriage is to have children from her. Husbands, especially in previous times, imagined as if health professionals were giving drugs which make their wives infertile. Therefore, they usually discouraged family planning.

Sometimes, husbands even hit their wives if they start to use contraceptives. Fear of side effect was also raised as a barrier to utilization of contraceptives.

"There is one family that I remember. The woman has one daughter. Health professionals gave her injection and now she could not conceive for nine years. So, we fear that our wives may face the same problem." (Male FGD participant from Bero)

Women noted that education should be provided to husbands.

"When health extension workers provide home-to- home education, they just told us to go to health institution and they say nothing to our husbands about going with us." (Woman FGD participant from Goldia)

The FGD participants who discussed issues of RH explained that it is not possible to discuss freely with family members on adolescent RH problems. Due to this, they have no enough information on service available, and therefore they do not utilize it.

On the aspect of adolescent RH barriers listed in FGD, includes disapproval from families. Open discussion between adolescents and their families on issues of RH is not considered as a good practice. This is culturally unacceptable in the community. This discouragement of open and free discussion on RH issues imposes a huge problem on adolescents.

"Talking about sexual issues with families is considered as bad behavior. We do not have such

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communication with families and friends….” (Male FGD participant from MenitGoldia)

Health facility related barriers*:* As to challenges, the health professionals discussed that the topography of the area was a problem to them to reach to households so as to address different health issues and provide health education. Women FGD participants discussed that most of those who give birth at home usually due to lack of transportation and long distance from home to health institutions. Most of the time, health posts are closed.

"There is no transportation to travel to urban community. To move on foot is very challenging. It is mountainous area…." (Health professional from MenitGoldia)

The other thing raised during FGD discussion of women was unfair attitude of health professionals. Some health professionals do not examine, and they send women back to their homes by claiming that the time of delivery is not yet reached. However women give birth on the way to their homes.

*"Some health professionals have no respect to women. They don't want to examine appropriately. Therefore, we sometimes go back to our home without any gain." (*Women FGD participant from Bero)

Discussants also noted that health professionals do not give the type of contraceptive that the women want; rather, they give methods their own of choice. When women prefer to use Depo-Provera, the health professionals enforce and provide them Norplant.

"When we want Depo, they do not want to give us. They say that we may forget to come if we use injectable so better to give us the one which functions for three years." (Female FGD participant from Bero)

DISCUSSION

This study showed that the challenges of RH utilization among pastoralist communities of Bench Maji Zone were preference of female professionals, preference of home delivery, cultural influences, lack of knowledge, decision making barriers and health facility barriers.

A study conducted in Afar indicated that use of maternal health services is influenced by cultural beliefs, attitudes and practices of the pastoralist community. There are several barriers to women's use of health facilities. One of them is women's fear of male midwives touching their bodies, especially their reproductive organs. Afar women were thus reluctant to be examined by male professionals. This goes in line with our finding that women do not want to be examined by male health professionals (6).

Our finding of husband disapproval for utilization of maternal health care is also consistent with the study conducted in Afar which showed that the male decision in maternal health is crucial to permitting women to go to health facilities as well as providing money for treatment (6, 7). There was also a similar finding from Nigeria (8).

As found in our study, some community women give birth in standing position so that when they go to health institution, they do not want to be on delivery coach. There is a similar finding that the Afar women prefer semi-sitting position. However, unavailability of beds allowing for such position was considered as barrier for institutional delivery (6).

In a study done in Naroka, Kenya, the factors that influenced access to SRH services for adolescent girls included cultural beliefs, restriction by family members, shyness and fear (9). This finding is consistent with the result of our study that cultural influence and shyness of girls were considered as barriers to RH service utilization. In other study, factors affecting utilization of SRH services by young people include: limited SRH knowledge, lack of open discussion on sexual matters, low status of women, cultural and logistical barriers, competing priorities among community health professionals, limited resources for health facilities and negative attitudes of providers towards unmarried youth (10). Similarly, our study showed that lack of open and free discussion and cultural hindrances were considered as barriers to utilization of service.

Distance to health institution as barrier to service utilization was consistent with other

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pastoralist areas. Lack of transportation was also raised as a challenge to reach health institutions. This coincides with the study conducted in Kenya among pastoralist women which showed that women continue to deliver at home due to a range of factors including distance, poor roads and the difficulty of obtaining and paying for transport(11). A meta-analysis also showed a significant association between distance and institutional delivery service utilization (12).

In our study, inappropriate attitude of health professional was mentioned as a challenge to service utilization. The study conducted in Kenya also showed that the treatment and care offered at health facilities was disrespectful and unfriendly (11). A study conducted in Nigeria also indicated that utilization of ANC was subject to attitudes of health workers (13). There are also similar studies which support these findings (8).

The other cultural barrier revealed in this study is cultural values concerning delivery. The other is ceremony undertaken during birth. Many women do not want to miss this ceremony by going to health facilities. This finding is consistent with the study conducted in Tanzania which showed that women sometimes prefer to deliver at home, because institutional delivery precludes celebration in accordance with traditional cultural norms by family members and relatives (14).

Misconceptions toward contraceptives are widely seen in this study. Fear of side effect is common in different studies. However, in this study, it is beyond fear of commonly known side effects. The fact that they fear they may lose their womb is a challenge for provision of family planning methods. This goes in line with the finding from a study conducted in Kenya which revealed that fears, misconceptions or misinformation and side effects (actual or perceived) of methods were common barriers to the adoption and continuation of modern contraception (15).

Service provisions were seen to be judgmental. This approach is mentioned as a barrier to the uptake of contraception. The judgmental approach of professionals in this area indicates that there is lack of capacity building training to health professionals.

In conclusion, the major challenges of RH service utilization identified in this study are preference of female professionals, preference of home delivery, cultural influences, lack of knowledge, decision making barrier and health facility related barriers. It is recommended that awareness creation should be done in the community. Capacity building trainings need to be given to health professionals. The government should give more emphasis to pastoralist communities.

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