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Global Livestock CRSP

Preliminary Perspectives on the Health Needs of Pastoral Women on the Borana Plateau Using Participatory Approaches

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Since 2000, the PARIMA project has conducted participatory research and outreach among pastoralists in southern Ethiopia. This has led to notable achievements in terms of forming collective-action groups dominated by women, stimulation of sustainable micro-finance and micro-enterprise activities, and improving linkages of pastoral producers to livestock markets. Despite such gains, there are many other challenges to be addressed. One is poor human health. PARIMA researchers used participatory and qualitative methods to conduct a preliminary assessment of women's health problems among members of six, well-established collective-action groups from the Borana and Gugi zones in the Oromia Regional State during 2008. Conventional wisdom from local public-health authorities suggested that malaria and diarrhea would be the most common ailments in the area. Results, however, indicated that women are most concerned with challenges related to their reproductive health (pregnancy-related problems, sexually transmitted diseases, etc.) Community-action plans have been developed for implementation and include prioritizing attention to training skilled local birth attendants and investing in awareness-raising, prevention, and treatment of sexually transmitted diseases. Improved health could have major effects on the welfare of pastoral women and the economic performance of collective-action groups.

Background

The PARIMA project has operated in southern Ethiopia since 1997. Its efforts to engage semi-settled pastoralists using participatory approaches began in 2000. The 59 collective-action groups that were created over seven years have proven to be sustainable, and nearly all have been transformed into legally recognized producer cooperatives. This process has involved at least 2,300 people overall, of whom over 75% have been women. The primary goal of collective action has been defined by the people themselves, namely improving incomes and well-being via capacity building and livelihood diversification.

Despite such notable successes, many challenges remain. One is poor human health in the region. Knowledge concerning the health needs of pastoralists in general, and that of pastoral women in particular, is lacking for southern Ethiopia. Most health statistics for rural Ethiopia are aggregated over vast areas, and participatory rural assessments are rarely, if ever, undertaken.

The main objective of the work reported here is to identify health problems that are most perceived as priorities by pastoral women in the PARIMA study area. Researchers also wanted to explore related issues of the accessibility and affordability of local health care. In the process, they assisted women to identify intervention priorities and develop sustainable community-based action plans to address health issues. PARIMA has also secured funds to begin the implementation of these action plans, but that part of the process is still underway and not reported here. The intent is to develop the capacity of collective-action groups to establish community-based health service mechanisms using their own capabilities and growing financial resources.

Researchers started with a general review for five districts (Yabelo, Dugda Dawa, Dire, Moyale, Liben) covering the Borana and Gugi zones to see what local health officials felt were the greatest health needs among pastoralists. Officials from zonal and district government health offices and clinics—as well as non-governmental organizations involved in health care—were interviewed. Results from these interviews indicated that malaria and diarrhea were viewed as the major health problems overall. Delivery of health services was uniformly regarded as very poor for pastoralists overall and particularly ineffective for pastoral women.

On the basis of this review, researchers then focused on engaging some of the collective-action groups in three of the five districts, namely Yabelo, Liben, and Moyale. Two settlements were selected in each for a total of six study sites. Potential partners were also involved in the engagement process, including some of the district health officials noted above as well as zonal and district representatives from the Oromia Women's Affairs and Cooperative Promotion Offices. Researchers wanted as many potential stakeholders involved from the beginning.

Sixteen of such partners were trained for five days in Participatory Rural Appraisal (PRA) techniques with a focus on the health sector (Lelo et al, 2000.) The participants had no previous exposure to participatory concepts and methods.

Following the PRA training, collaborative PRA demonstration exercises were conducted in the six settlement locations. These six sites were chosen based on their ethnic diversity, distance from health centers, and ability to effectively implement community-action plans. The local community participants in each PRA assessment numbered 10-15 volunteers each. Of the 75 participants overall, 12 were men. Ethnic groups included Boran, Arsi, Somali (Gurre), and Gabra. The Gurre, Arsi, and Gabra are Muslims, while the Boran practice other traditional forms of spirituality. The PRA process relies on intensive forms of dialogue created between the practitioners and community assemblies. Each PRA took about six days of continuous effort at each site. Team members used different PRA tools including health-facility mapping, creating seasonal-health calendars, rankings of important ailments using a pair-wise matrix, development of community action plans, and formulating frameworks for participatory monitoring and evaluation. To supplement the PRAs focus-group discussions were held in four sites that involved male and female elders and traditional healers. The average size of the focus groups was eight and these discussions lasted for an average of one hour. Prompts for these meetings dealt with women's health problems and potential solutions.

Basic aspects of pastoral society and culture in southern Ethiopia are reviewed in Coppock, 1994. Social norms regarding sexual behavior and marriage provide an important backdrop for understanding women's health challenges in the region. In particular, there is a general emphasis on early marriage for young women. Pastoral men today typically have one spouse, but there are several traditions involving extensive extramarital partnerships, especially among non-Muslims (Tezera and Desta, 2008; Coppock, 1994). Researchers have observed an apparent increase in the prevalence of mosques in small towns on the Borana Plateau over the past decade, and this may reflect a growing influence of Islam.

Findings

The focus group discussions with the elders and traditional healers indicated a decided lack of public health-care facilities in local towns. Health service delivery was regarded as very poor and expensive when available. The distance between pastoral settlements and town-based clinics was viewed as a major challenge. The focus group discussions indicated that considerable reliance is still placed on traditional healers to deal with health problems. Many diseases are still thought to be caused by supernatural forces. Women are also perceived to be confronted with malnutrition and overburdened with household chores during pregnancy. It was stated that women have less chance to obtain medication to treat illnesses because money has been traditionally controlled by men.

The results from the six PRA exercises were similar in terms of how women ranked their major health problems. The participants were very open about related issues of culture and health. The ranked order, from higher to lower importance overall, was as follows: (1) pregnancy-related problems; (2) sexually transmitted diseases (STDs); (3) malnutrition; (4) malaria; (5) diarrhea; (6) gastritis; (7) skin diseases; and (8) anemia.

Pregnancy-related problems include bleeding, still-birth, premature delivery, sterility, abortion, female genital cutting, and fistulas associated with birthing processes of young mothers. The STDs were dominated by gonorrhea and syphilis; STDs were regarded as rampant. Malnutrition was related to poor food intake in conjunction with heavy workloads. Mothers often feed themselves last in families where food is in short supply. Maize, whether locally grown or coming from food aid, is the dominant source of calories, and women reported that a shortage of animal-source foods, fruits and vegetables in diets also leads to malnutrition. Threats from malaria are perceived to be reduced due to recent campaigns that have distributed protective nets and sprays. Diarrhea is often associated with unclean drinking water.

The results from the PRA exercises also revealed that a general lack of health care access, and as well as the high expense of available medicines and services, compels many people to rely more on traditional healing and traditional medicines. Places other than clinics were also recognized as sources of health care and information. Muslims noted that mosques are regarded as direct and indirect contributors to physical and mental health; mosques are sanctuaries where prayer and religion soothes the spirit, relieves anxiety, and improves health. Public schools are regarded as indirect contributors to health and basic hygiene via education of children; the pastoral children in turn pass new knowledge on to their parents. Boreholes and pumps are regarded as indirect contributors to improved pastoral health via their provision of cleaner drinking water. Otherwise, people are compelled to procure water from ponds and wells that are also accessed by animals.

District location appeared to influence access to health care. For example, people living in Moyale District along the border with Kenya reported they can access better health facilities in Kenya. This involves cross-border travel and greater expense, however, as charges are higher for Kenyan health services if they are provided to Ethiopian citizens. Concern about HIV/AIDS was surprisingly low in all six

Community members from southern Ethiopia engage in a participatory mapping effort to determine the health needs of pastoral women on the Borana Plateau. Photo by Seyoum Tezera.

sites. HIV/AIDS was not mentioned as a priority problem. Most participants noted they have heard about HIV/AIDS, but as yet have not seen a person so afflicted in their communities. Given the common challenges to health and physical vigor in the area, HIV/AIDS symptoms might be difficult to detect. This relative lack of awareness poses a challenge for HIV/AIDS prevention. However, transmission of STDs is commonly recognized.

The seasonal health calendars showed that pregnancy-related problems are more apparent during the *Bonna* (long dry-season from December to March) when women face the highest workload and receive less food. Sexually transmitted diseases appear more common during the *Ganna* (main rainy season from March through May) when people have more food and are more sexually active. For one Muslim community, however, the seasonal pattern differed in that they noted that transmission of STDs is more pervasive during dry seasons when people have less food, their physical resistance is lowered, and they may endure a relapse or recurrence of symptoms. Concern about STDs appeared somewhat lower among Muslim respondents compared to non-Muslim respondents, and this might be related to a greater cultural emphasis on extramarital relations among the latter.

A generalized community-action plan (CAP) was developed for each community to deal with the top three health challenges perceived by the women, namely pregnancy problems, STDs, and malnutrition. Options to deal with each were outlined and resource requirements—both from within and outside communities—were identified. One key aspect was to improve maternal health care via investment in the training of skilled local birth attendants, as well as provision of first-aid kits. Another was to focus on awareness raising, prevention, and treatment for STDs. To carry out a monitoring and evaluation plan, community members prepared their own procedures (not reviewed here.)

Practical Implications

PARIMA's preliminary work revealed a high level of physical and mental health challenges faced by women. Poor health probably has a major effect in undermining productivity and performance of female group members. The Participatory Rural Appraisals revealed that reproductive health is currently the critical problem perceived among the women that PARIMA team members studied.

Knowledge of HIV/AIDS is minimal. Dealing with the problem of sexually transmitted diseases could indirectly mitigate the occurrence of HIV/AIDS. Awareness training and rapid intervention to arrest any spread of HIV/AIDS is essential, and PARIMA's findings suggest there is still a window of time to intervene.

There is disparity in the perceptions and prioritization of women's health problems between communities and local health officials. It is therefore essential to institutionalize participatory approaches in the rural health sector to assist in the improved identification of problems and prioritize interventions. This would involve training health extension staff on the use and application of PRA tools.

If women's health issues are not addressed, then it is likely that gains made from other development interventions associated with collective action could not be sustainable. There is a need for policy to prioritize institutional support for women's health in pastoral areas such as the Borana Plateau.

Addressing health problems based on a group or community approach is vital. It helps in implementing group decisions in addressing common health problems and assists with focusing group members to invest some proceeds from livestock sales in health care directly or through the creation of group-managed health-insurance schemes.

Traditional cultures may facilitate the spread of harmful practices and ailments among pastoral women. It is important to bring attitudinal and behavioral changes into these communities. Their openness has been encouraging. Men must also be included in the process of finding solutions for women's health problems on the Borana Plateau.

Further Reading

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The GL-CRSP Pastoral Risk Management Project (PARIMA) was established in 1997 and conducts research, training, and outreach in an effort to improve the welfare of pastoral and agro-pastoral people with a focus on northern Kenya and southern Ethiopia. The project is led by Dr. D. Layne Coppock, Utah State University. Email: Layne.Coppock@usu.edu. Work described in this brief was undertaken with additional support from USAID/Women In Development (WID).

The Global Livestock CRSP is comprised of multidisciplinary, collaborative projects focused on human nutrition, economic growth, environment and policy related to animal agriculture and linked by a global theme of risk in a changing environment. The program is active in East and West Africa, Central Asia and Latin America.

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