EDITORIAL

Triad limiting the provision and uptake of reproductive, maternal and neonatal health services in the pastoralist communities of Afar, Ethiopia

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In recent times, impressive gains have been recorded across the world in reproductive, maternal and neonatal health (RMNH). For example, the maternal mortality ratio (MMR) fell by nearly 44%, from an estimated 385 maternal deaths per 100,000 live births in 1990 to 216 maternal deaths per 100,000 live births in 2015 (1). Similarly, between 1990 and 2017, the global under-five mortality rate dropped by 58%, from 93 deaths per 1,000 live births (12.6 million) to 39 deaths per 1,000 live births (5.4 million), and the neonatal mortality rate fell by 49%, from 34 deaths per 1,000 live births to 18 deaths per 1,000 live births (2). Nevertheless, such positive gains are characterized by disparities in the quality of RMNH services (3).

Ethiopia has shared in the global success of reducing maternal, neonatal and child deaths. Child morality was reduced by two-thirds, from 204 per 100,000 in 1990 to 68 per 100,000 in 2012 (4). Similarly, although the target for reducing maternal mortality was not achieved, Ethiopia reduced the maternal mortality rate by almost 72%, from an estimated 1,250 per 100,000 live births in 1990 to 353 per 100,000 live births in 2015 (1). Nevertheless, progress has been marred by poor-quality services and disparities among different groups of populations in the country (5-7).

More particularly, the use of RMNH services in pastoralist regions of the country, such as Afar and Somali, is very low. The Ethiopian Demographic Health Survey (EDHS) 2016 showed that the uptake of modern contraception at the national level was 35%, while it was just 12% in Afar and a mere 1% in Somali. The uptake of skilled delivery service is strikingly low among women from the pastoralist communities of Afar region compared to other regional states in Ethiopia. Afar has the lowest percentage of women whose births were delivered by a skilled provider or in a health facility (16.4% and 14.7%, respectively), while Addis Ababa has the highest percentages for both indicators (97% each), further illustrating the dimension of disparities regarding maternal health in Ethiopia (8). The country cannot afford to ignore this alarming disparity between its regions and different population groups. Achieving the country's targets of reducing maternal, neonatal and under-five mortality – as indicated in the health sector transformation plan for the years 2015 to 2020 and the SDG targets for 2030 (3,9) – will be impossible unless high-impact interventions are put in place in the pastoralist-dominated regions of the country.

Afar is one of the nine regions in Ethiopia and is located in the north east of the country. The region is characterized by a predominantly pastoralist way of life. According to the 2007 census projection, in 2015 the total population of the region was estimated at 1,816,304, of which the majority (85%) were pastoralists (10). The pastoralist communities of Afar region are challenged by chronic poverty, food insecurity, poor health status, a high burden of communicable diseases, high levels of malnutrition, and poor access to safe water and sanitation. Limited access to health services coupled with diverse barriers have led to the poor utilization of basic RMNH services, including antenatal care, postnatal care, institutional delivery, and family planning services (8,11,12).

The low uptake of RMNH services, coupled with the peculiar contexts of the pastoralist communities of the Afar region, call for a thorough investigation and understanding of the multifaceted barriers that result in low utilization of RMNH services, as well as the design of high-impact and contextualized solutions. However, there is a paucity of data from in-depth investigations and documentation in relation to the socio-cultural barriers that hinder the pastoralist communities of Afar from accessing and utilizing RMNH services. More importantly, the interventions

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and programs that are in place to improve access and utilization of RMNH services in the region – implemented by the Ethiopian government, and its international, national and local partners – are simply a 'copy and paste' of the programs that have worked in the agrarian regions of the country. For instance, the way in which the health extension program and women development group approach have been cascaded or implemented in Afar region mirror those that have been cascaded and implemented in the agrarian regions, with no consideration of the specific context of the Afar region.

Although health care services during pregnancy, delivery and after delivery, and for limiting or spacing births, are important for the survival and wellbeing of both the mother and the infant, the studies in this special issue reaffirm the low levels of utilization of RMNH services. The proportion of babies delivered at home in the pastoralist communities of Afar stands at 85%. Almost nine out of 10 (87%) post-partum women from Afar do not get postnatal check-ups within the first two days of giving birth. Nearly half (48%) of the women do not receive antenatal care from a skilled provider for their most recent birth.
A number of demand-side challenges and socio-cultural barriers that limit the uptake of reproductive health services by Afar women were identified. These were categorized as: 1) lack of awareness; 2) lack of male involvement and husband objection; and 3) cultural values and religious beliefs.

Although the primary focus of the specific studies in this special issue was to examine the demand-side socio-cultural barriers, several supply-side issues emerged as major barriers. In the Afar context, supply-side barriers hinder pastoralist women from accessing and using RMNH services. Supply-side barriers were categorized as: 1) health facility-related barriers, including distance to health facility, ill-equipped health facilities; 2) provider-related barriers, such as a lack of friendly providers, health communication problems for providers who don't speak the local language; and 3) leadership-related barriers, including unresponsive and non-accountable leadership. By overcoming these demand- and supply-side barriers, a greater number of women can utilize RMNH services and improve the low coverage of RMNH services in the Afar region.

Demand- and supply-side barriers are compounded by development and livelihood challenges. Development activities in the region have been neglected over the past few decades Poor road infrastructure and a high rate of illiteracy are typical characteristics of the region. The region is also affected by cyclical drought that aggravates the availability and use of RMNH services.

The challenges of Afar pastoral communities are not unique. Similar studies in the agrarian regions of Ethiopia report a range of barriers with different levels of manifestation (13,14).

There is no magic bullet to solve the triad of challenges: demand- and supply-side barriers and development challenges. A holistic development approach may help. Endeavors to address the health challenges of the pastoralist communities of Afar should not only focus on improving access to, and the uptake of, reproductive health services, specifically antenatal care during pregnancy, institutional delivery, postnatal care and family planning services. There should be an integrated approach to implement high-impact interventions that focus both on resilience building and a tailor-made development package that addresses the chronic levels of poverty and poor health faced by the pastoralist communities of Afar.

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