

Access to health care among transhumant Fulani pastoralist in Mauritania

Using the Health Access Livelihood Approach

Summary

Transhumant Pastoralists in Sub-Saharan Africa are more and more under the pressure of limited resources. In addition to this, as marginal groups, they are often excluded from political decisions and social services, like for example health care services. Research was conducted among transhumant pastoralist of Fulani ethnicity living in rural areas near Rosso, a regional Capital in the south of Mauritania. The focus of this study was set on pastoralist's livelihood capitals as well as qualitative dimensions of access. Results from the explorative, qualitative study include both the perspectives and reasoning of Fulani men and wives as well as from the health care personnel. The question was which assets are mobilised on the household level when accessing health care, and which are major constraints encountered by men and women when doing so.

Resources

The pastoralist's main capital was livestock. But this, along with other resources, was not always mobilised in the way that could be expected. What were the reasons why certain assets were not used to access health care? Possible impeding factors contributing to this phenomenon could be identified. They were influenced by resources (e.g. education, language, and financial resources), rules and structures (e.g. social and economical structures, disciplinary power) and individual strategies (e.g. previous experiences, presumptions). Uncertainty about the outgoing of certain undertakings seemed to stand behind many a decision taken by pastoralists. Uncertainty thereby pointed towards insufficient own resources or insufficient resources of the health service providers. This could be insufficient transport, information in the hospital, effectiveness of treatment, demand on the market or insufficient rain and fodder for their income generating livestock, for example. The financial means for health care were found to be limited, according to pastoralist themselves. Despite the possession of cattle and a milk selling contract to a dairy plant, pastoralists claimed the health services to be too expensive for their budget, as most income had to be spent to feed the cattle during the dry season. It also seemed a great problem not to have cash at hand, but instead having to sell a goat or a cow beforehand. People often were reluctant to quickly sell livestock for health reasons without having enough time to bargain, since they feared the economic loss in the markets seasonal price changes. Women who could sell their own cattle rarely did this on their own account, but depended on their husband for this. Women's

direct access to livestock resources was generally limited because of social rules and cultural norms. Pastoralists owning agricultural land could not always cultivate it due to lack of seed or irrigation money, hence they could not valorise their cash crop. Money borrowed from a friend or a credit could cover health care costs, but were a taboo in Fulani society. Social capitals and information exchanges were not used to the extent they could have been. Although friends and neighbours were welcome for a chat or moral support, they were not actively asked for help concerning health care costs, among other reasons simply because they were not expected being able to give anything. Young women did have very few occasions for social contacts at all, while men probably had more personal contacts with relatives and friends and benefited from such a broader network when ill. Phone calls were useful for reaching family members when geographically separated, but were expensive, conversations not intimate enough and could make people dependent on an operational phone network. Transportation opportunities existed to some degree to reach Rosso, but there was little comfort and reliability. Many people avoided a journey if they were sick due to bad experiences, fear and the belief that they will get healthy soon with gods will alone. The lack of appropriate roads and regular transportation was not met by the government and is a structural and organisational deficit.

Relevant resources for accessing health care were gendered in so far as within Fulani culture, it is usually the husband who is responsible for decision making regarding resources and health seeking behaviour. But in fact, women were also in possession of livestock and should receive their own part of the generated income through milk selling. However it did not become transparent in how many household this ideal was actually realized. The only other resource that was perhaps gendered were social networks, as many young women no longer had regular contact through milk selling on the market and therefore had only few changes of accessing social networks outside of the household. Assets like transportation, knowledge and other human capitals were essential for accessing health care but were not subject to gender inequality.

Quality of service

Whether and how the health services were used depended much on the quality of service provided. The social code of conduct named *pulaaku* had obviously a great influence on everything. It was a very strong impeding factor for the use of health care, being based on a strong feeling of shame to show weakness in front of others as well as personal pride in handling with difficulties on their own, respectively to silently bear them. The possibility to have assisted birth at the hospital was often rejected, not only because of the alleged lack of finances or adequate transport, but also because of the cultural norm, the lack of health knowledge and lack

of privacy. At the health facility, long waiting hours and lack of supply resulted in patients having bad experiences. Spiritual illness concepts impeded utilisation too. The lack of trust, communication and orientation was according to health staff something that would improve automatically with a general education and the ability to open one's mind towards the benefits of the modern town and its services. But it could also be improved through better service, which is subject to the organisation and structure of the government. According to health staff, compliance of patience could be improved if people would understand the medical meaning and reason behind instructions given out by health staff. This would require education and good conversation in a commonly spoken language among pastoralists and health care personnel, and hence schools and education for both sides provided by the state. Previous health care or travel experiences had a great influence on the health seeking behaviour during a following illness episode. Penchansky and Thomas (1981) mentioned that waiting hours and travel time for example are strong predictors for users' satisfaction (which determines access to health care). Negative experiences concerning those factors along with others in that section were certainly expressed many times within the households, and made it understandable that health services were not always immediately sought out. Krönke (2001:15, 128) also noted that users satisfaction was one of the main obstacles concerning access to care in for pastoralist in Chad.

Conclusion

According to Fulani pastoralist, it is the lack of financial means, transport and the quality of health services, like lack of privacy, communication and transparency which are impeding them from using health services. The health care staff saw this slightly differently, agreeing on the lack of transport, but naming pastoralist's "mentality" and the lack of education and health information as major impediments. It seemed that communication and mutual understanding between health care users and providers is not very well establish, and probably poses one of the main problems regarding access to health care.

To improve the Fulani pastoralists general income, provide credit possibilities, better transport and education, and improve the quality of health services would certainly help to increase access to health care. This could be done for example through a better milk price, the constructions of paved roads, "soft skill" training and sensibilisation for health staff, and incentives for teachers and health personnel to take up work in rural areas. This would require the involvement of the state and the region as well as openness for and willingness to try out new concepts on both the pastoralists and the health personnel's side. Fulani pastoralist themselves are not to be seen as

passive actors solely in need of help. Their willingness to change and try out unfamiliar concepts is already given within many households.

Concerning the health services itself, closer collaboration between human and animal health services are suggested by Schelling et al. (2005), as infrastructure can be shared and acceptability raised. According to them, joint vaccination campaigns for livestock and people among nomadic pastoralists in Chad were very successful. They also suggest that social mobilization, community participation and principles of equity can strengthen the relationship between policy makers, service providers and users (Randolf et al. 2007). Rass (2006:46) suggests instructing women as so called community based human and animal health care workers, as they are at the interface of human and animal diseases. To recruit female community based health care workers has now just been taken up by the regional department of health care in Traza and might lead to an actual improvement of access to health care in rural areas. For further concepts, it would be worth trying to combine the work of these women with the work of auxiliary veterinarian workers from the villages, in a sense of implementing the concept of one medicine, being gender wise accepted by everybody.

The field experience with the narrow focus on the daily lives of very few individuals didn't permit to perceive and penetrate social structures and networks within the short time given, but theoretical knowledge points out that there must exist such ones.

The households and the Fulani society seemed to be very individualized. De Sardan (2006:75) points out that most decision in the health domain are made at the individual and not the community level, however they are subject to interests and influences within such a community. Further research certainly is needed on the topic of social networks, concepts and structures as well as the role of the community and the acquiring of knowledge within it for the Fulani society living near Rosso. The new role of the mobile phones is also an interesting one and could be elaborated further. If by any chance resources could be distributed towards a rural hospital being built in between those villages, it would increase mutual trust, compliance and user's satisfaction to an essential degree.

Literature

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