

Report 10



HEALTH CARE SEEKING BEHAVIOUR IN SOMALIA

A Literature Review



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Acronyms

ANC	Antenatal care
ARV	Antiretroviral therapy
CSZ	Central South Zone, Somalia
FGD	Focus group discussion
FP	Family planning
HIV	Human Immunodeficiency Virus
HP	Health Post
IDP	Internally displaced person
KAPB	Knowledge, attitude, practices and behaviour
MCH	Maternal and child health centre
MICS	Multiple indicator cluster survey
MSF	Médecins Sans Frontières
NEZ	North-East Zone, Somalia (Puntland)
NWZ	North-West Zone, Somalia (Somaliland)
OPD	Outpatient department
PNC	Postnatal care
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid

Acknowledgements

The authors would like to thank all agencies for making their surveys and unpublished data available to the consultant. In particular we would like to acknowledge the assistance of Grainne Moloney (FAO) for assistance in collecting prime material and Dr. Ingvil Sorbye (WHO), Dr. Chiara Pierotti (UNICEF) and Farhana Zuberi (UNICEF) for their reviews and inputs on essential parts of the document.

1

BACKGROUND

1.1 The population and the health system

Somalia has an estimated population of eight to ten million people and is amongst the least densely populated countries in the world. Only two percent of its 600,000 square kilometres constitutes arable land. Settled populations are largely confined to the southern river basins and urban centres, while the rest of the population remains nomadic or semi-nomadic. In 2002 it was estimated that just over a third of Somalis are living in urban areas, although this is reported to be on the increase. In addition, over one tenth of the population is currently internally displaced as a result of nearly two decades of conflict and instability.

The majority of people are ethnic Somali (85 percent), rural or nomadic (65 percent), and illiterate (80 percent)¹. Just over half of people are economically active and the predominant sectors of economic engagement are livestock and agriculture. The overall economy remains severely under-developed and under-diversified.

It remains a challenge to imagine an effective, affordable and equitable strategy to bring essential health services closer to populations which have, on the whole, low levels of expendable income, are

thinly spread and inaccessible as well as nomadic. Meanwhile, these stark operational challenges have to be faced by a society with limited diversification, availability of skilled personnel, infrastructure development and public financing.

While conflict has seriously impaired the health system, problems relating to access and equity were ongoing during Siad Barre's regime. By the end of his dictatorship, an estimated 80 percent of Somalis were estimated to have no access to basic health care, particularly in rural areas². Both past and present realities have no doubt affected Somalis' expectations of health services and their utilization behaviour.

The private sector is highly active and it is very likely that this sector provides the majority of modern health services on the ground, while varying by region and in degrees of development of the public and private sectors. The vast majority of private services are offered through basic pharmacies or drug shops. By many accounts, private health services seem popular amongst the population, although costs involved in accessing them may be prohibitive to large segments of the population. The services of traditional and religious healers are also commonly sought.

¹ **World Bank/UNDP. *Socio-Economic Survey 2002: Somalia*.** Somalia Watching Brief 2003. The International Bank for Reconstructions and Development/The World Bank, Washington DC; and the United Nations Development Programme, New York NY. 2003.

² **Joint Needs Assessment Somalia.** Cluster: Social Services and Protection of Vulnerable Groups. Sub-Cluster: Health. Draft April 21 2006

1.2 Health care seeking behaviour and utilization patterns

Models of health care seeking behaviour are complex and dynamic. People do not seek one source of care, and differ in their behaviours according to who is affected and what diseases are experienced. Behaviour is also affected by beliefs of causation behind certain diseases, such as evil eye, infection or accident.

Furthermore, the decision to seek care is mediated by opportunities to seek care, especially concerning time and cost. These decisions are not isolated to individuals but are embedded in a broader household and social organizational decision process and the capacity to allow seeking of care.

This paper seeks to collect and review available literature and evidence, to take a first step in understanding constraints Somalis face in accessing modern health care. It is hoped that understanding health care seeking behaviour and health care utilization patterns will allow a better appreciation of how the Somali population interacts with health service providers, both formal and informal, and skilled and unskilled. Research into health

care seeking behaviour can provide insights into why some people opt out of certain services, why people are late in attending services and/or why some levels of health facilities are bypassed by intended users. These behaviours should be taken into account in organizing the provision of health care, thereby reacting to demand-side considerations to maximize utilization and utility of health services to the people.

Studies on health care seeking behaviour can open opportunities to respond with strategies promoting a more desirable interaction between populations and health systems, and efficiency in meeting public health goals.

Utilization patterns give an indication of current preferences amongst people already deciding to seek care. These data shows where populations, given options available to them, feel they receive services most suited to them in terms of cost, convenience, quality and acceptability. Utilization patterns can help inform where a target population already goes for health management, allowing services and referral to be built up and to maximise their impact. They can also indicate where they do **not** go and where services may be downgraded.

2

METHODOLOGY OF THE REVIEW

This literature review is a first step in adequately exploring the issues mentioned, consolidating what various stakeholders have already documented about healthcare seeking behaviour in the three zones of Somalia and noting gaps in the literature for consideration in designing future studies. Findings of this review aim to stimulate ideas on increasing interaction with health facilities, as well as development of strategies to adapt health facilities to community behaviour and demand.

This report reviews multiple sources, nearly all of which are grey literature and not specific to the topic of health seeking behaviour or utilization. In fact, most are nutritional surveys which only touch on the current subject of interest. There is a marked lack of peer-reviewed research in the context of Somalia. Sources of information were obtained by contacting major health stakeholders in order to access their documentation, health-related surveys and health programme evaluations. Organizations contacted were: FSAU/FAO, UNICEF, WHO, Somalia Support Secretariat, World Vision Somalia, Somalia Red Crescent Society, ACF, Horn Relief and MSF. Most studies located were from UN agencies, despite efforts made to diversify sources. In addition, internet search engines were used to search the net³.

³Keywords: 'Somalia' and 'health seeking behaviour', 'healthcare/service utilization', 'barriers to healthcare/service', 'health behaviour change' and 'treatment seeking'

Data were drawn from both quantitative and qualitative assessments, including key informant interviews and focus group discussions (FGDs). Where possible, information indicating differences by zones or regions were noted.

While health seeking behaviour is complex, multidimensional and dynamic⁴, most of the data reviewed were static, one-dimensional and simple. It is thus difficult to construct a full picture of the varied choices facing individuals, families and communities regarding how and when they decide to seek care. It is also difficult to interpret much of the information as it is not grounded in the broader context and does not present a valid range of options. That is, an individual may opt for traditional care but this may have been due to it the only option available, rather than a choice; he or she may have chosen modern health care solutions if they were accessible. Finally, much of the data collected are not consistent, telling different stories without sufficient information to assess their validity or general application.

⁴ Decision-makers will react to the kind of problem (acute or chronic) and interpretations of causation. They may wait and see (depending on barriers to seeking care) and may use a combination of responses (seeking advice of elders, traditional healers, pharmacies and private and public clinics) as opportunities arise or as the disease progresses and advice is gathered. Responses therefore differ over time and space.

Findings are presented in three parts:

- Chapter 3 assembles the trends in utilization;
- Chapter 4 examines what is known about determinants of health seeking behaviour; and
- Chapter 5 presents findings on behaviours specific to reproductive health needs.
- Chapter 6 then concludes with a discussion and recommendations.

3

HEALTH SERVICE UTILIZATION: WHERE DO SOMALIS TURN FOR CARE?

The following chapter presents the overall research findings, identifying final decisions of health care seeking behaviour rather than behaviour determinants. These provide perspectives on where, when and to which sector people most often present themselves and their family members for health care services (given current levels of operating quality and cost).

3.1 Seeking care for recent illness in a child

Since 2000, FSAU and its partner organizations have conducted over 100 nutritional assessments within various Somali livelihood groups. Each survey has explored elements of health seeking behaviour at the target location, namely on whether and where caretakers seek assistance for their sick children. These surveys have never attempted to be representative of the population as a whole, but they offer a chance for comparison by virtue of the fact that the questionnaire has been consistently implemented over time, in a wide variety of locations and across all three zones.

In 2006 the FSAU changed its nutritional assessments to reflect patterns in defined livelihood zones rather than in the administrative districts or regions alone. This sampling frame has allowed for insights on different health seeking behaviour trends of pastoralists, agro-pastoralists, riverine and IDP communities, as well as comparisons between zones.

According to FSAU nutritional surveys between 2006 and 2008, the vast majority of caretakers with sick children reported seeking care to treat them. Overall, surveys in NWZ reported more consistent and frequent care seeking than surveys conducted in other zones (with usually about four out of five caretakers of sick children seeking assistance). Among the surveys in which fewer than half of caretakers reported seeking care, most were conducted in the pastoralist zones of CSZ⁵.

Higher use of the private sector was more frequently reported in the surveys. Surveys that found higher proportional use of the public sector were commonly conducted in parts of CSZ (Gedo, Middle Juba, Bakool), or alternatively in urban/IDP areas of all zones (Bossaso, Burao, Galkayo, Berbera). It is not clear whether the higher use of public sector facilities in parts of CSZ is due to a less-developed private sector, or whether these public facilities are offering better quality services as has been elsewhere suggested⁶. However, other parts of CSZ (Lower/Middle Shabelle and Bay) showed higher use of the private sector than in the other zones.⁷

⁵ Bibliography #40--83

⁶ **UNICEF Somalia Support 2008**. National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

⁷ Bibliography #40-83

Figure 3.1: Summary table of trends: Averages from FSAU nutritional survey findings 2006-2008⁸

Healthcare seeking for recent child illnesses, 2006-2008 averages (% of caregivers)					
Cross-sections of Somalia	Private	Public	Own medicine	Traditional	Not sought
South Central Zone	25.8	24.7	11.6	8.3	27.3
North West Zone	33.1	14.7	5.5	12.9	18.2
North East Zone	36.1	29.6	6.1	4.4	33.4
Pastoral – all zones	32.0	19.5	9.6	8.5	30.1
Agro-pastoral – all zones	22.4	25.1	12.0	9.0	31.3
Riverine – SCZ	29.1	32.0	10.2	5.4	23.5
IDP - all zones	27.4	41.7	7.7	1.95	24.9

Note: Not all populations are represented in these averages. This table serves only to register trends and comparisons. Figures cannot be used to describe any actual population group.

Despite differences, it is clear that the private sector are a major source of health services in the three zones of Somalia, and is likely to be surpassing public service figures at most locations. The private sector are particularly used in urban centres by populations with the financial means to use them (big towns demonstrate greater diversification in the range and sophistication of private services) and private pharmacies are particularly used in major urban centres⁹.

3.2 Trends in livelihood zones and minority groups

3.2.1 Riverine

When examining trends in FSAU nutritional surveys (2006–08), it was clear that riverine or sedentary populations tended to use the public sector more often, when care was sought for a sick child.

In a survey by MSF it was observed that Somali Bantu

were more likely to use traditional healers at onset of illnesses and present to a (public) health facility later. Meanwhile, other groups in the community relied on prayer and drugs purchased at local pharmacies, in the initial phases of illness. Distance combined with the time-consuming nature of Somali Bantus' agricultural activities were said to negatively affect their health-seeking behaviour¹⁰.

3.2.2 Pastoralists

According to FSAU nutritional surveys (2006-08), nomadic pastoralists tended to predominantly use the private sector when they sought care. The only surveys (3/14) to find that pastoralists turned more to the public sector were conducted in Gedo and Middle/Lower Juba, where the use of public facilities was seen to be proportionally higher overall¹¹.

Pastoralists face the greatest obstacles in terms of dis-

⁸ See bibliography #40-83

⁹ UNICEF Somalia. *Somaliland Private Pharmacy Situation Analysis*. May 2009

¹⁰ Medecins Sans Frontieres Holland. *Nutritional Survey Report: Lower & Middle Juba, Somalia*. Medecins Sans Frontieres. November 2004

¹¹ Bibliography # 84 - 127

tance and transport to both public and private facilities¹²
¹³. In a 1998 NEZ study, they reported lower use of almost all types of health facilities and were more likely than all other groups to do nothing when a child fell ill¹⁴. In NWZ they were similarly more likely to do nothing about malaria, diarrhoea, cough or colds in children, and they also relied much more on outreach services for vaccinations than urban or rural caretakers¹⁵.

One study described how pastoralists in CSZ turned primarily to health facilities in the home vicinity, opting to not use another closer facility when seeking grazing away from home. This suggests that distance to a health worker was not the only consideration: pre-established social contact also played a role. However, it was noted that the hesitation to visit unknown facilities did not apply to pastoralists visiting pharmacies to purchase drugs. Nomads were said to carry a range of drugs for self administration.¹⁶ By way of contradiction, other studies noted that they use pharmacies less frequently than other groups^{17 18}.

3.2.3 Agro-pastoralists

Not surprisingly, FSAU nutritional surveys on agro-pastoralist populations described behaviour patterns falling between findings on riverine and pastoralist populations. The private and public sector were equally used, and proportional use seemed more related to location (in Middle Shabelle, agro-pastoralists used the private sector more, while in Middle Juba the opposite was true), potentially reflecting what is available and trusted in the area¹⁹.

3.2.4 IDPs

The FSAU surveys showed the greater tendency of IDP populations to turn to the public sector, with the exception of IDPs in Garowe. Use of traditional healers appeared less evident²⁰. Urban non-IDP and IDP groups often showed similarities in health seeking behaviour, characterized by the high use of modern medicine and pharmacies, especially²¹. However, one qualitative survey found that IDPs in Hargeisa were more determined to preserve a traditional culture than other city residents, making them more likely to reject the health clinic/MCH and other modern health services²².

In general, IDPs may be served to a greater extent by accessible and quality NGO programmes (public) while having lower access to private services that may not serve a temporary market such as an IDP settlement.

12 **Food Security Analysis Unit.** *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices.* FSAU Somalia. Dec 2007

13 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

14 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

15 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

16 **Helander B.** *Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia.* University of Uppsala. Nomadic Peoples, No 25/27, p. 122-132, 1990

17 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

18 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

19 Bibliography #40-83

20 Bibliography # 84 - 127

21 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

22 **Korong A, Mbuvi D.** *KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland.* Health Unlimited. September 2008

3.3 Dominance of the private sector, especially pharmacies

In addition to findings from eight years of FSAU nutritional surveys, other literature reports higher overall reliance on the private sector when seeking care for ill children, family members or self^{23 24 25 26 27}. The exception to this in some parts of CSZ has also been noted and supported by other evaluations^{28 29 30}. The differences may represent the degree to which quality public services are provided (for example, if an area is well served by NGO programmes) and conditions for establishment and growth of the private sector (available economic resources and security).

Studies which separately capture the reported use of pharmacies as opposed to other private facilities tend to show that pharmacies account for the lion's share of

all private sector health care seeking^{31 32 33 34 35 36}. It is admittedly challenging to draw the line between the two, since many clinics, laboratories and pharmacies exist under one roof. Nevertheless, it has been repeatedly found that the majority of all private facility visits take place at the pharmacy or drug shop, and this is not only an urban phenomenon^{37 38 39}.

Findings from the following two studies demonstrate the higher use of the private sector (particularly pharmacies) to manage recent illness in various parts of Somalia.

23 **Meyer CD/Horn Relief.** *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia.* Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

24 **Save the Children (UK).** Health Baseline Survey for Togdheer Region, Somaliland. Draft report, September 2008

25 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

26 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

27 **UNICEF Somalia.** *Somaliland Private Pharmacy Situation Analysis.* May 2009

28 **World Vision Somalia, Oirere BO.** *End-of-Project Evaluation Report: Waajid District Primary Health Care Project.* Consultant's report, July 2006

29 **World Vision Somalia, Omanga P, Okeyo-Owuor JB.** Household Livelihood Security Assessment Middle Juba, Bay & Bakol Regions of Southern Central Somalia. Final Report, 2007

30 **UNICEF Somalia Support 2008.** National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

31 **Meyer CD/Horn Relief.** *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia.* Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

32 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

33 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

34 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

35 **Save the Children (UK).** Health Baseline Survey for Togdheer Region, Somaliland. Draft report, September 2008

36 **UNICEF.** *Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006.* UNICEF Somalia 2006

37 **Save the Children (UK).** Health Baseline Survey for Togdheer Region, Somaliland. Draft report, September 2008

38 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

39 **UNICEF Somalia.** *Somaliland Private Pharmacy Situation Analysis.* May 2009

Figure 3.2: Findings of a three-zone cluster malaria KAP study⁴⁰

Type of facility sought when household member was ill in past two weeks	Percent of respondents (n=688)
Private	49.7% (44.8% pharmacy alone)
Public	30.2%
Nothing/other	20.1%

Figure 3.3: Findings of a Togdheer health baseline study⁴¹

Type of facility where treatment was sought for a child's fever/cough in past two weeks	Percent of respondents (n=210)
Private	65% (52% pharmacy alone)
Public	24%
Other	11%

The literature has also indicated that giving modern drugs is the most common response to children's illnesses (for example, malaria), and that acquiring pharmaceuticals through private pharmacies far outweighs visits to health facilities or workers^{42 43 44 45}. As a result, many of these surveys have expressed concern at how few caretakers present their children to public facilities when they are thought to have malaria, and some have pointed out that pharmaceutical treatment is taking place without adequate testing to confirm cases⁴⁶.

This trend seems to be particularly associated with health seeking behaviour in urban areas^{47 48}, but the degrees to which pharmaceuticals are purchased also depend on location and perceived seriousness of the disease. Urban areas showed high rates of drug purchase to treat childhood diarrhoea, and studies in NEZ showed high rates of drug purchase to treat childhood malaria⁴⁹.

In 2006, children aged 0-59 months with suspected pneumonia were overwhelmingly taken by their caretakers to pharmacies for treatment, in all zones of Somalia⁵⁰.

40 Lynch C. *Report on Knowledge Attitude and Practices for Malaria in Somalia*. UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

41 Save the Children (UK). *Health Baseline Survey for Togdheer Region, Somaliland*. Draft report, September 2008

42 Ezepue G/ World Vision. *Knowledge, Practice and Coverage Survey Report: Middle Juba, Somalia*. World Vision Somalia. March 2001

43 Food Security Analysis Unit. *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices*. FSAU Somalia. Dec 2007

44 UNICEF. *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

45 ACF (Action Contre la Faim). *The KAP Deyr 2006. Wajid Zone: Bakool, Bay and Gedo regions, Somalia*. 2007

46 ACF (Action Contre la Faim). *The KAP Deyr 2006. Wajid Zone: Bakool, Bay and Gedo regions, Somalia*. 2007

47 Save the Children (UK). *Health Baseline Survey for Togdheer Region, Somaliland*. Draft report, September 2008

48 Food Security Analysis Unit. *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices*. FSAU Somalia. Dec 2007

49 UNICEF. *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

50 UNICEF. *Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia*. UNICEF Somalia, April 1998

Figure 3.4: Percentage of children 0-59 months with suspected malaria who were taken to health providers, Somalia 2006⁵¹

Zone	Gov't hospital	Gov't health centre	Gov't health post	Village health worker	Private hospital/ clinic	Private physician	Pharmacy	Traditional practitioner
NWZ	1.1	0.9	0.0	0.0	6.9	6.9	13.8	0.0
NEZ	8.5	3.0	1.2	2.8	5.5	2.4	10.3	0.0
CSZ	1.8	4.6	0.3	1.1	1.8	3.4	18.1	1.3
Total (n=935)	2.0	4.2	0.3	1.1	2.4	3.7	17.3	1.1

3.4 Low use of public facilities

Low utilization rates of the public sector have been noted by many studies, especially in NEZ and NWZ^{52 53 54 55}. One calculation of available public outpatient service numbers indicated that the average Somali (of any age group) visits an health clinic/MCH service about once every eight years, with the lowest utilization rates seen in NWZ, followed by NEZ and the best in CSZ⁵⁶. Figures are slightly higher when calculating only for children under the age of five. It has been noted that people turn to public facilities when they are either extremely ill or when they have experienced physical trauma such as fractures (hospitals), underscoring the limited interaction between communities and the public

sector and the particularly limited use of lower tiers of the public sector (health clinic/MCHs and Health Posts)^{57 58}.

In one study, over 600 interviewees were asked how they would respond to a hypothetical episode of illness of a family member, and were later asked how they did respond to a specific incidence of fever within the previous two weeks, if applicable. Reported behaviour was different for the two questions. In the hypothetical case, respondents said they would generally use the public health facility, much more than they actually did for the reported incidence of fever. Instead, those with a family member with fever overwhelmingly attended a private pharmacy⁵⁹.

51 UNICEF. Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

52 UNICEF Somalia Support 2008. National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

53 Meyer CD/Horn Relief. *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia*. Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

54 Save the Children (UK). Health Baseline Survey for Togdheer Region, Somaliland. Draft report, September 2008

55 UNICEF. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

56 UNICEF Somalia Support 2008. National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

57 Helander B. Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia. University of Uppsala. Nomadic Peoples, No 25/27, p. 122-132, 1990

58 UNICEF. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

59 Lynch C. *Report on Knowledge Attitude and Practices for Malaria in Somalia*. UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

Figure 3.5: Health seeking behaviour in NEZ, by population grouping ⁶⁰

Where to get treatment when child is ill	Percent of Households *1			
	Urban (n=372)	Rural (n=452)	Nomadic (n=209)	Total (n=1033)
Hospital/MCH	41 %	28%	6%	20%
Health post/CHW	1%	1%	2%	1%
Private doctor/Private clinic	18%	NIL	NIL	4%
Traditional healer	4%	4%	17%	11%
Pharmacy	78%	79%	50%	64%
Nothing done	2%	8%	26%	16%
Other	1%	NIL	6%	3%
'Public' facility/worker *2	41%	29%	8%	21%
'Private' facility/worker *2	86%	81%	65%	75%

*1 Percentages do not add up to 100% as multiple answers were allowed.

*2 'Public' facility/person = Hospital, MCH, Health Post, community health worker.

'Private' facility/person = Private Doctor, private clinic, traditional healer, pharmacy.

The percentages concern the proportions of households who mentioned at least one public or private facility.

Figures 3.4 and 3.5 both show very infrequent use of health posts by the population, although this is the lowest tier of public care and theoretically should be the most accessible and most frequently used. Health centres/MCHs and hospitals fare only slightly better.

3.5 Trends in accessing immunization

Immunization rates give an indication of the level of interaction between the population and the public health system, as immunization services are not offered by the private sector⁶¹.

According to the 2006 MICS, overall immunization rates tend to be disastrously low in comparison to most other countries (5% fully-immunized children).

Coverage rates are higher in NWZ when comparing percentages of children between 12-24 months who have received single dose vaccines, but CSZ shows much lower drop-out rates for multiple vaccine courses. If looking at DPT1 coverage as an access indicator, NWZ and CSZ are roughly tied at 25.3 and 25.5 percent respectively of children having received the vaccine, while NEZ lags behind at 16 percent. However, the percentage of children who received all recommended immunizations by 24 months is highest in CSZ (15.9 percent, compared to 3.3 percent in NWZ and 5.2 percent in NEZ)⁶². The 2008 EPI survey of NWZ found similar but slightly higher coverage rates, with marked improvement in coverage of DPT3 (i.e. reduced dropout rates) than the 2006 MICS NWZ figures⁶³.

60 UNICEF. *Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia*. UNICEF Somalia, April 1998

61 UNICEF/WHO. *Somaliland Immunization Coverage Survey Report*. July, 2008

62 UNICEF. *Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006*. UNICEF Somalia 2006

63 UNICEF/WHO. *Somaliland Immunization Coverage Survey Report*. July, 2008

Figure 3.6: Immunization coverage, 2006⁶⁴

Zone	DPT1 coverage in children 12-24 months	All recommended vaccinations by 24 months
NWZ	25.3%	3.3%
NEZ	18%	5.2%
CSZ	25.5%	16%

A 1998 NEZ study showed that urban and rural women usually took their children directly to the MCH for immunization, while far more than two-thirds of nomad mothers relied on outreach services⁶⁵. In a 1998 NWZ study, many respondents said that their main source of health information is from vaccination campaigns, which emphasize the importance of the link beyond vaccination, reinforcing the importance of campaigns and outreach in ensuring services in hard to reach rural and pastoralist communities⁶⁶.

It is clear from many surveys that urban children are more likely to be immunized and that immunisation status strongly correlates with levels of mothers' education⁶⁷
^{68 69}.

According to FSAU surveys, riverine zone children show relatively high vaccination rates compared to survey findings for any other group, while pastoralists tended to demonstrate the lowest vaccination rates for children⁷⁰. The findings that populations in CSZ have

higher rates of overall coverage and much higher rates of completion (multi-doses of vaccine) suggest that some communities in CSZ have more regular contact with public facilities (riverine/sedentary populations) and regular outreach, than occur in the other two zones. This is coherent with how these groups reported using public or private sources of treatment for recent child illnesses.

The behaviour reported above (mainly focussing on purchase of drugs through private pharmacies) indicates the degree to which health services are commoditised. Somalis tend to want rapid service and drugs in response to a consultation. Overall demand for preventive and promotive services is low, especially among the less educated, and rural and pastoralist communities. The 2006 MICS indicated that negative perceptions and misconceptions relating to vaccinations were strongest in NEZ and accounted for a higher percentage of failed immunization than in other zones.

3.6 Traditional healers

Overall, the FSAU nutritional surveys did not demonstrate high use of traditional healers compared to modern sources⁷¹.

Low use of traditional healers was found in the three zones of Somalia by the 2006 MICS survey. Just 1.1 percent of caregivers reported taking children with suspected pneumonia to traditional healers (Figure 3.4)⁷².

64 UNICEF. *Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006*. UNICEF Somalia 2006

65 UNICEF. *Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia*. UNICEF Somalia, April 1998

66 UNICEF. *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

67 UNICEF/WHO. *Somaliland Immunization Coverage Survey Report*. July, 2008

68 UNICEF. *Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia*. UNICEF Somalia, April 1998

69 UNICEF. *Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006*. UNICEF Somalia 2006

70 Bibliography #40-83

71 Bibliography #40-83

72 UNICEF. *Multiple Cluster Surveys (MICS) and Millennium*

However, other studies have described the particular use of traditional healers for ARI cases, including chest burning^{73 74 75}. It is not clear how widespread these practices might be, compared to reported low use of traditional practitioners in the MICS survey.

An extensive 1998 survey in NWZ noticed that traditional healers did not account for much of reported health care seeking in the quantitative assessment, while the qualitative component of the assessment established that they are in fact commonly used⁷⁶. The literature occasionally indicates that families turn to traditional medicine prior to seeking modern care and alternatively when modern medicine has not been deemed to be effective^{77 78 79}.

This suggests that many Somali communities use both concomitantly, sometimes for the same illness. It is possible that quantitative studies underestimate the use of traditional healers, as they are not an alternative source of care but are instead a complement to modern medicine.

Reasons for turning to a traditional healer have been suggested, relating to differential perceptions of the bout of illness for example, with the perception either that the illness is minor, is of a spiritual nature (such as convulsions) or when modern methods seem to have failed^{80 81 82}.

Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

73 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

74 **Ezepue G/ World Vision**. Knowledge, Practice and Coverage Survey Report: Middle Juba, Somalia. World Vision Somalia. March 2001

75 **World Vision Somalia, Oirere BO**. *End-of-Project Evaluation Report: Waajid District Primary Health Care Project*. Consultant's report, July 2006

76 **UNICEF**. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

77 **UNICEF**. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

78 **Helander B**. Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia. University of Uppsala. Nomadic Peoples, No 25/27, p. 122-132, 1990

79 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

80 **UNICEF**. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

81 **Helander B**. Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia. University of Uppsala. Nomadic Peoples, No 25/27, p. 122-132, 1990

82 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

4

WHY? DETERMINANTS OF HEALTH SEEKING BEHAVIOUR IN SOMALIA

This section explores study findings which have sought to establish determinants of health seeking behaviour in Somali populations.

4.1 Access determinants

Availability, affordability and acceptability of health services all compound to determine access. These are complex and interconnecting issues that can make it decidedly difficult to isolate the single greatest barrier for a population. While this can be a source for debate, there is little doubt that access to health services is low for Somali populations.

There are an estimated 625 health posts and 225 MCHs in Somalia. Assuming a population of eight million people, this implies one health post per 13,000 people and one MCH per 35,000 people. These ratios are far from reaching WHO international standards and imply a severe lack of facilities.

4.1.1 Cost

Cost is often identified as a formidable obstacle in accessing health care in Somali contexts, extending to

both the private and public sectors^{83 84 85 86 87}. Most of these studies have referred to the cost of transport and consultation or treatment fees as being equal barriers to healthcare seeking.

One 2005 study requested public facility users to break down the costs involved in accessing the health services they had sought. This exercise found that respondents' expenditure on transport far outweighed that of health care. Transport cost was in fact named as the greatest barrier to health care seeking, especially amongst nomads. However, the sample population was remote (with only 30 percent of respondents living within an hour of a health facility)⁸⁸.

⁸³ **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia*. UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

⁸⁴ **UNICEF.** *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

⁸⁵ **Helander B.** *Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia*. University of Uppsala. *Nomadic Peoples*, No 25/27, p. 122-132, 1990

⁸⁶ **Meyer CD/Horn Relief.** *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia*. Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

⁸⁷ **Save the Children (UK).** *Health Baseline Survey for Togdheer Region, Somaliland*. Draft report, September 2008

⁸⁸ **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia*. UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

Another study in Sanaag found that respondents were, on average, 130 kilometres distant from their *preferred* health facility. This distinction raises the question as to whether *available* health facilities are actually used by the target community. It is likely that the decision to bypass certain facilities increases the strain of distance on the population to a greater extent than is suggested by the socioeconomic survey proximity figures.

Some studies show cost and distance as separate barriers to attending or delaying a visit to a health facility⁸⁹, but they are often two ways of looking at the same barrier. Costs of seeking care include transport, food and lodging not only for the sick person, but in many cases for the accompanying individual as well⁹⁰.

Direct costs of consultation and treatment have also appeared as a barrier in the literature. In a 2002 socioeconomic survey, all percentages of people who said that a public facility was available to them were lower when they were asked if it was affordable⁹¹. The 2005 malaria KAP study showed a wide range of monies spent to access services at public facilities⁹². Meanwhile, a study in Togdheer found that almost a third of mothers said they could not afford any of the drugs they felt their children needed⁹³. While cost is clearly a barrier, an evaluation in Waajid still recommended carefully

considering whether free services cause communities to perceive the services to be of low value⁹⁴.

However, there is a high degree of reliance on external funds to finance public health facilities. Cost-recovery mechanisms contribute little to any financial recuperation, while overall levels of public facility utilization are low. Taken overall, it might be argued that charging user fees is a factor which ensures that public health services are both inequitable and inefficient (not cost-effective). Given the large subsidies to the public system, it would be more *efficient* to reduce user fees if this were to result in a major increase in utilization, and more *equitable* if the reduction of fees was to lead to inclusion of poorer segments of society.

4.1.2 Distance

Physical inaccessibility to health facilities is a major obstacle to treatment seeking behaviour, and it is again clearly related to the possibility of and costs of transport. Several studies have determined lack of availability to be the most important reason why Somalis fail to seek health care^{95 96}.

Information presented in the previous chapter also highlights the particular difficulties with regularly accessing health care for rural populations in low population density areas, especially in the northern zones and for pastoralists and nomads.

However, all data on utilization show that while there is greater use of health services in urban areas, this is largely consumption of private services. It is also increasingly evident from FSAU surveys that there is

89 **Meyer CD/Horn Relief.** *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia.* Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

90 **Helander B.** *Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia.* University of Uppsala. *Nomadic Peoples*, No 25/27, p. 122-132, 1990

91 **World Bank/UNDP.** *Socio-Economic Survey 2002: Somalia.* Report no. 1 Somalia Watching Brief 2003. The International Bank for Reconstructions and Development/The World Bank, Washington DC; and the United Nations Development Programme, New York NY. 2003.

92 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

93 **UNICEF.** *Somali Health Knowledge, Attitude and Practices.* North-West Zone. UNICEF Somalia. 1998

94 **World Vision Somalia, Oirere BO.** *End-of-Project Evaluation Report: Waajid District Primary Health Care Project.* Consultant's report, July 2006

95 **Food Security Analysis Unit.** *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices.* FSAU Somalia. Dec 2007

96 **World Vision Somalia, Omanga P, Okeyo-Owuor JB.** *Household Livelihood Security Assessment Middle Juba, Bay & Bakol Regions of Southern Central Somalia.* Final Report, 2007

a growing population of urban poor unable to access private or public health services due to cost constraints.

Prior to 2006 over thirty FSAU nutritional surveys asked caregivers why they did not seek care for a sick child. Half mentioned distance and unavailability of facilities as the most significant obstacles in seeking care, while the other half found that lack of money was the most significant factor⁹⁷.

During a World Vision post-intervention evaluation in Waajid, utilization of services did not increase despite increasing physical access to health facilities. Instead, health seeking behaviour remained apparently affected by other determinants⁹⁸.

4.1.3 Low reliability of point of care

Mothers in a study in Togdheer reported that costs for both transport and consultation were the biggest problems in accessing health care, but they also expressed the fear of finding no health care provider present at the facility⁹⁹.

Public facilities are open for approximately two hours per day, compared to private pharmacies which open for 11 hours per day. The short opening hours in the morning (when most women typically have other work) is without doubt a barrier to access for potential users^{100 101 102}. In addition, despite many facilities having professional staff on their rosters, professional staff is reported to be frequently absent in order to run their private interests, in many cases leaving volunteers to man public posts.

Somalis do not trust health workers at many of the lower-level facilities, preferring to seek higher-level advice from genuine professionals such as MDs and nurses in the private sector¹⁰³. As an indication, MCHs in the vicinity of Hargeisa typically see fewer than five patients per day. One initiative spearheaded by the Somaliland Ministry of Health and Labour, organized for medical doctors to serve one day per week in the MCHs around Hargeisa. On those days there were queues of patients waiting for consultations.

Concerns regarding reliability of opening and presence of professional staff were similarly expressed in discussions during a study in Sanaag¹⁰⁴. It is easy to imagine how this might impact on decisions to pay transport money or other costs involved in care seeking.

An evaluation of MSF OPD services in Marere (CSZ) also showed what happens when access is not assured at an existing facility. Due to overwhelming workloads during their intervention, MSF were forced to reserve patient consultations for either small children or emergencies. The evaluation noted that this restriction apparently had a negative impact on communities' health seeking behaviour: people no longer bothered to come when sick because they saw no guarantee of treatment¹⁰⁵.

These examples all show that fear of not being seen by a health professional and not finding the service available, have a substantial impact on motivation to seek care.

97 Bibliography #84-127

98 **World Vision Somalia, Oirere BO.** End-of-Project Evaluation Report: Waajid District Primary Health Care Project. Consultant's report, July 2006

99 **Save the Children (UK).** Health Baseline Survey for Togdheer Region, Somaliland. Draft report, September 2008

100 Bibliography # 84-127

101 **Food Security Analysis Unit.** Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

102 **Korong A, Mbuvi D.** KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

103 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

104 **Meyer CD/Horn Relief.** *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia.* Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

105 **Medecins Sans Frontieres Holland.** *Nutritional Survey Report: Lower & Middle Juba, Somalia.* Medecins Sans Frontieres. November 2004

4.1.4 Drug supplies and stock outs

In similar vein, an analysis in one report indicated dramatic changes in utilization rates at MCHs depending on availability of drugs. Stock-outs mean that fewer patients come as they know there is reduced utility of the service. Overall, repeated experience of stock-outs impact trust of the facility offering care, reduce demand and increase delays in seeking care¹⁰⁶. For example, in one study men placed a low value on ANC visits, as they believed the MCH would only be able to offer women vitamin tablets, such as iron, without any other services¹⁰⁷.

It is also clear that children under five attend MCHs proportionally more often than the rest of the population. This thought to be because the MCHs are supplied with kits of drugs that cater to illnesses of those in the under-five category, and do not have sufficient drugs to offer a full range of services to the entire population¹⁰⁸. This fact certainly contributes to adult preference of the private pharmacy sub-sector.

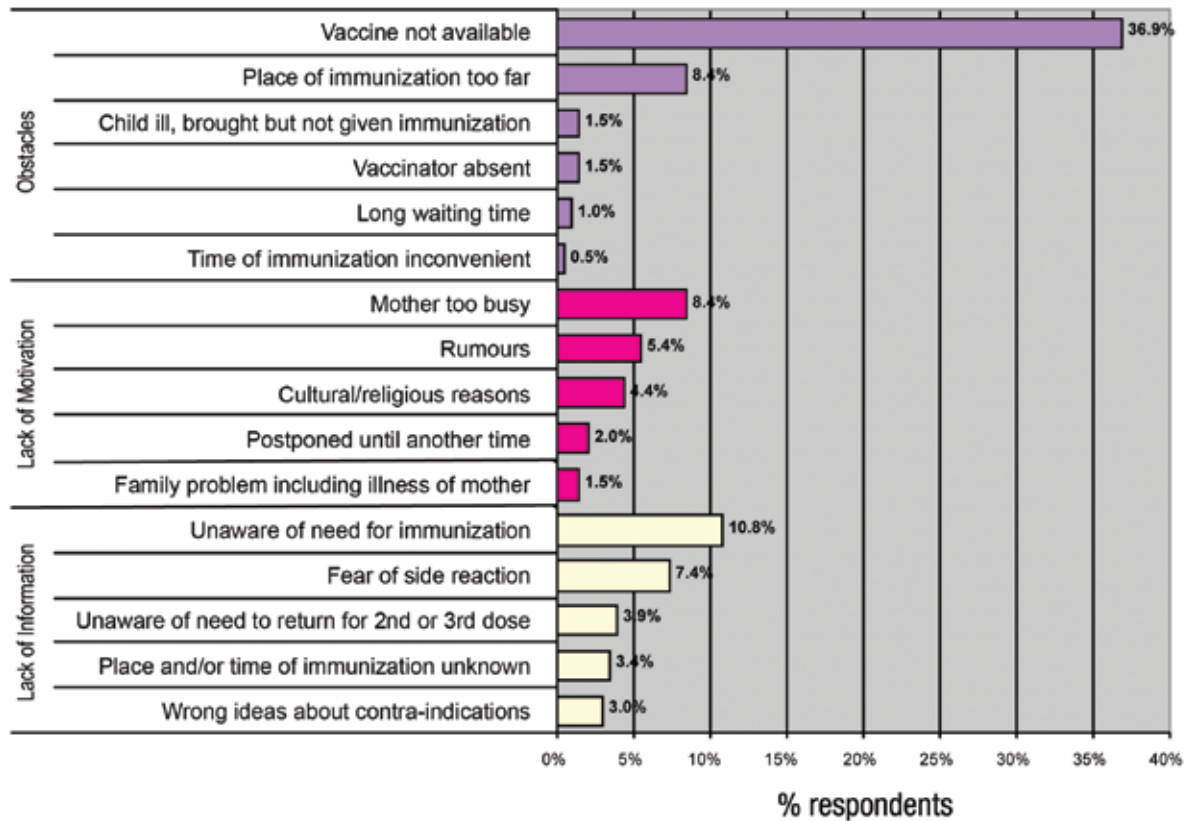
EPI/vaccination services are only provided at MCHs and through outreach (public facilities with a cold-chain). As such, vaccination is one of the real value-added services of public facilities. A 2008 NWZ survey investigating vaccination coverage (and reasons for failure to vaccinate children properly) found that there were many barriers to accessing vaccination services, ranging from religious contradictory advice to distance and cost. But by far the commonest reason for failed immunization of children was reported lack of vaccines at MCHs.

106 **UNICEF Somalia Support 2008**. National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

107 **Korong A, Mbuvi D**. KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

108 **UNICEF Somalia Support 2008**. National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

Figure 4.1: Reasons for children's immunization failure, NWZ 2008 ¹⁰⁹



Many other surveys have found basic obstacles to be most significant to immunization, as opposed to lack of motivation or information. This typically includes the unavailability of the vaccine, that the child was not home at the time of an outreach or that a vaccination team did not arrive^{110 111}. Only two of the reviewed FSAU nutritional surveys found that unfavourable attitudes accounted for more than a third of immunization failure.

4.1.5 Poor quality

It has been frequently pointed out that low quality, especially in public facilities, has discouraged people from seeking health care in Somalia^{112 113 114 115}.

109 UNICEF/WHO. *Somaliland Immunization Coverage Survey Report*. July, 2008

110 UNICEF. *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

111 Bibliography # 84-127

112 World Vision Somalia, Omanga P, Okeyo-Owuor JB. *Household Livelihood Security Assessment Middle Juba, Bay & Bakol Regions of Southern Central Somalia*. Final Report, 2007

113 Food Security Analysis Unit. *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices*. FSAU Somalia. Dec 2007

114 Joint Needs Assessment Somalia. Cluster: Social Services and Protection of Vulnerable Groups. Sub-Cluster: Health. Draft April 21 2006

115 UNICEF. *Somali Health Knowledge, Attitude and Practices. North-West Zone*. UNICEF Somalia. 1998

Anecdotal information comparing facilities before and after international intervention has suggested that, when facilities are staffed with professionals, are open, reliable and affordable, utilization rates respond positively. For example, utilization rates increased around surgical camps at Boroma hospital, as they did at MSF-run obstetrics clinics in Jowhar.

While quantitative assessments in NEZ found that obstacles relating to availability were the most important reason why people did not attend a public facility, qualitative assessments showed that dissatisfaction with quality of services on offer figured very strongly in people hesitating to seek care. They also captured the perception that experienced practitioners are not found in the public sector as they prefer to run their own private practices and pharmacies, which is a further reflection on quality¹¹⁶.

Given low utilization rates and poor quality of services in existing public facilities, UNICEF concluded in its National Primary Health Management Information Report that simply increasing numbers of facilities is unlikely to improve access of Somali populations to the health system¹¹⁷. Quality improvements are required to bolster use and thus efficiency.

4.1.6 Security

While the effects of security on all types of decision making and behaviour are undeniable, this issue has had only a few mentions in literature on health care seeking in Somalia. World Vision in Waajid and MSF in Mogadishu both observed reductions in health service utilization caused by restricted movements in their respective intervention areas^{118 119}. In other cases, residents of one

area claimed they could not access nearby facilities due to the impossibility of crossing clan lines. In the case of MSF, client loads dropped by a third in a matter of weeks following unrest in 2007, and late presentation and related complications were attributed to security concerns. Others have recognized security as a serious limiting factor to access as facilities cannot function, disposable income diminishes and travel becomes more expensive and risky^{120 121}. A 2007 FSAU report noted that health seeking behaviour was negatively impacted as a result of conflict due to the increasing involvement of women in livelihood activities, replacing child care¹²².

4.1.7 Delay

It appears from the literature that it is common for Somali families to both pray and use home remedies to address illness, prior to seeking assistance from a health facility (at least for minor ailments)^{123 124 125 126 127}. The precise role that this may play in delaying health care seeking outside the home has not been extensively explored. In one Gebiley study, over a third of individuals experiencing any type of morbidity during the prior four weeks, only

seeking medical care. Mogadishu, Somalia. July 25, 2007

120 **Joint Needs Assessment Somalia**. Cluster: Social Services and Protection of Vulnerable Groups. Sub-Cluster: Health. Draft April 21 2006

121 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

122 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

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125 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia*. UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

126 **Food Security Analysis Unit**. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

127 **Republic of Somaliland Ministry of Health and Labour/ KEMRI Wellcome Trust Collaborative Programme/UNICEF Somalia/WHO Somalia.** *Fever Treatment Seeking Behavior in Republic of Somaliland: Results of Two Cross-Sectional Surveys in Three Rural Communities*. September 2008

116 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

117 **UNICEF Somalia Support 2008.** National Primary Health Management Information Report. Somalia and Somaliland 2007. Unpublished draft report.

118 **World Vision Somalia, Oirere BO.** End-of-Project Evaluation Report: Waajid District Primary Health Care Project. Consultant's report, July 2006

119 **MSF Field News.** New wave of violence keeps people from

resorted to prayers to resolve it. This implies prayer was not a delay, but rather a coping mechanism replacing seeking care from an inaccessible facility. Among people suffering from fever during the previous two weeks, very few visited a health facility as a first action, but those who did visit one usually did so within less than 48 hours^{128 129}.

In one three-zone study, people reported seeking treatment from facilities within at least two to three days from onset of illness. They also reported that next time they would go to a health facility sooner than they did the last time a household member fell ill¹³⁰. About 30 percent of respondents said that they never go to a health facility. This figure was highest for the nomadic respondents, at 38 percent¹³¹.

Late presentation has been proposed as being exacerbated by use of purchased drugs or reliance on traditional medicine prior to seeking a health professional's advice in a facility environment¹³³. Furthermore, some studies have documented a prevailing belief in Somalia that a patient has to be very ill to warrant taking him or her to the hospital. In one documented account a seriously ill woman who was located near to a regional hospital explained why she had not attended, using the logic: "The disease had not yet spread into the whole of my body"¹³⁴.

Figure 4.2: Findings of a three-zone cluster malaria KAP study¹³²

Time after onset of illness that a household member was taken to health facility, in the last two weeks	Percentage of respondents (n=688)
Same day	12.9
After 2-3 days	34.4
After 4-5 days	13.8
After more than 5 days	9.8
Did not attend	25

128 **Republic of Somaliland Ministry of Health and Labour/ KEMRI Wellcome Trust Collaborative Programme/UNICEF Somalia/WHO Somalia.** *Fever Treatment Seeking Behavior in Republic of Somaliland: Results of Two Cross-Sectional Surveys in Three Rural Communities.* September 2008

129 **UNICEF.** *General Morbidity and Health Seeking Behaviour in Three Villages in Gebiley District, Somaliland.* Draft report, July 2009.

130 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005

131 **Lynch C.** *Report on Knowledge Attitude and Practices for Malaria in Somalia.* UNICEF/ Global Fund Partners. Malaria Consortium. February 2005\

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133 **Food Security Analysis Unit.** *Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices.* FSAU Somalia. Dec 2007

134 **Helander B.** *Getting the Most Out of It: Nomadic Health Care Seeking and the State in Southern Somalia.* University of Uppsala. Nomadic Peoples, No 25/27, p. 122-132, 1990

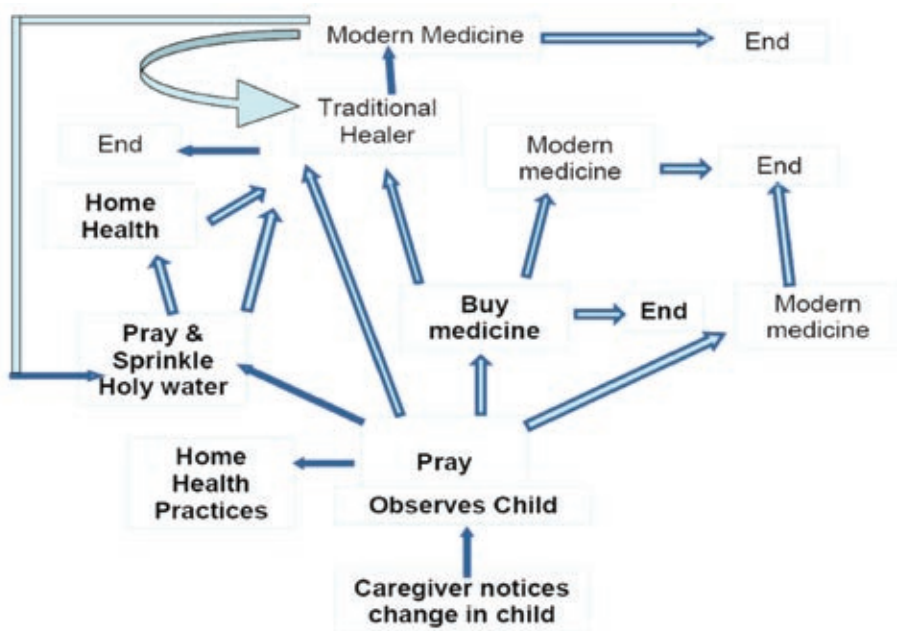
4.2 Socio-cultural determinants

A proximate health facility can still be rejected by a community due to lack of knowledge or previous exposure, low awareness of potential benefits or poor acceptability of services, on social, cultural or religious grounds.

Studies such as the 2007 FSAU KAP report have emphasized that cultural and religious beliefs significantly affect health seeking behaviour. For example, in CSZ many people see health outcomes to be in God's hands alone, which has been suggested to result in a degree of fatalism in the face of illness. It was also reported that if an illness is perceived to be caused by an evil eye, only prayer and traditional cures are deemed appropriate¹³⁵.

Not many studies have identified that people who use traditional medicine have worse modern health care seeking behaviour overall, but some have proposed the link. For example, health workers have reported seeing children with critical pneumonia being presented late to facilities following traditional chest-burning cures¹³⁶. However, the 2006 MICS survey found only 1.1 percent of Somali caregivers took their child to a traditional healer with a recent case of suspected pneumonia, which begs the question of how widespread these cases might actually be.

Figure 4.3: Child caregiver's health seeking model¹³⁷



¹³⁵ Food Security Analysis Unit. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

¹³⁶ Food Security Analysis Unit. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

¹³⁷ Food Security Analysis Unit. Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007. Model developed by W. Kogi-Makua & R. Opiyo

The model in Figure 4.2 presents the various paths observed in health care seeking amongst Somali caregivers. It does not quantify approaches or distinguish between different types of illness or causation. However, it indicates the dynamic and pluralistic way that Somalis understand and seek redress for illness.

The role of knowledge cannot be ignored when examining motivations and barriers to health seeking behaviour. Without knowledge or previous exposure, the benefits of essential services cannot be internalized and prioritized by a community. The 2007 FSAU KAP report described Somali populations as having a generally good awareness of types of illnesses by name, signs and symptoms, as well as available management resources, but this does not necessarily translate into knowledge of appropriate actions in response to an illness¹³⁸. Preventative services are perhaps less understood, and focus group discussions in NEZ noted considerable confusion between concepts of 'preventing' and 'treating' illness¹³⁹.

Many studies have shown increased treatment seeking to be associated with educational attainment of the household head or caregiver¹⁴⁰. In a Gebiley study, 42.8 percent of individuals living with educated household heads and who complained of morbidity in the prior four weeks, turned to a modern source of care for treatment compared to 22.6 percent of those from households with uneducated household heads¹⁴¹.

4.3 Gender bias

Finally, there is evidence of slightly different behaviour in responding to male and female child sicknesses, as seen in the 2006 MICS. Male children with ARI were more likely to be taken to a health facility than girl children, were more likely to be given antibiotics for suspected pneumonia and, if having fever, were more likely to be given an appropriate anti-malarial drug¹⁴².

Figure 4.4: Treatment seeking of caregivers for male or female children, all zones, 2006.¹⁴³

	Male children	Female children
Taken to an appropriate health facility for suspected pneumonia	14.4 %	11.4 %
Taken to a pharmacy for suspected pneumonia	18.9 %	15.5 %
Given antibiotics for suspected pneumonia	35.2 %	29.0 %
Given an appropriate anti-malarial for fever	9.7 %	6.0 %

138 **Food Security Analysis Unit.** Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

139 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

140 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

141 **UNICEF.** *General Morbidity and Health Seeking Behaviour in Three Villages of Gebiley District, Somaliland.* Unicef Somali Support Offices, Nairobi Kenya. 2009 (forthcoming)

142 **UNICEF.** Multiple Indicator Cluster Survey (MICS): North-East Zone, Somalia. UNICEF Somalia, April 1998

143 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

4.4 Decision-making power

Findings on decision-making power and its relationship to health seeking behaviour have been slightly conflicting in the literature.

The 2002 Socioeconomic Survey of Somalia found that women play a major role in household decision-making, either independently or in consultation with men in the household. This included areas such as maintaining the household budget and purchasing durable and semi-durable goods¹⁴⁴. Studies in NEZ and NWZ similarly found that men and women equally, make health seeking decisions for their children^{145 146 147}. In CSZ, riverine and agro-pastoral groups showed that women held more decision-making power over their children's health, while fathers dominated in these decisions in pastoral groups, especially if modern healthcare was concerned.

Five FSAU nutritional surveys suggested that low decision-making power of women impacted negatively on health seeking behaviour in the study areas¹⁴⁸. Another study described that fathers were the predominant decision-makers regarding polio vaccinations for children in Somalia, while noting that women as caretakers are typically the ones to decide in other, comparable countries¹⁴⁹.

Men were also found to be the decision-makers for children's vaccinations in general, by the 2006 MICS¹⁵⁰.

In Maroodi Jeeh region of NWZ, discussion with female respondents shared that men dominate decisions for their wives' healthcare, while mothers hold much more power over the health decisions for their children¹⁵¹. Providers of obstetric services in Somalia have been frustrated by the extremely late delay in patients arriving in need of obstetric intervention. While much of this is due to difficult travel and other factors, many failed interventions have been explained by the necessity to get permission from the family to intervene medically to save the woman's life.

From this summary, decision-making power appears to be variable in different cross-sections of Somali populations, and overarching trends cannot be identified. However, while women may have a higher degree of influence over decisions regarding children's health care, there appears to be greater control of husbands and communities in decisions to seek care for women.

144 **World Bank/UNDP.** *Socio-Economic Survey 2002: Somalia.* Somalia Watching Brief 2003. The International Bank for Reconstructions and Development/The World Bank, Washington DC; and the United Nations Development Programme, New York NY. 2003.

145 **Food Security Analysis Unit.** Somali Knowledge, Attitude and Practices Study (KAPS): Infant and Young Child Feeding and Health Seeking Practices. FSAU Somalia. Dec 2007

146 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

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150 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

151 **Korong A, Mbuvi D.** KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeeh District, Somaliland. Health Unlimited. September 2008

5

REPRODUCTIVE HEALTH CARE SEEKING BEHAVIOUR

This section attempts to consolidate studies which have focused on health seeking behaviour in Somalia in relation to reproductive health services. While analysis of health seeking behaviour by different types of disease offered little extra insight, one area of care was different: women's and reproductive health. It is clear that there are various barriers which warrant an exploration of the issues in their own right.

Reproductive health services are weak in Somalia, inhibited by both supply and demand. This applies to modern FP services, ANC, facility-based delivery, PNC, STI and HIV testing^{152 153 154}.

While costs are high and availability and quality of services are low, service seeking is poor even where services are available. Determinants for this are likely to be highly complex, but it is suggested that Somali communities in general do not trust these services and do not see that their potential benefit outweighs the challenges they face in accessing them.

Most implementing partners in reproductive health and particularly obstetric services, report major obstacles in provision of services and genuine barriers to health seeking behaviours according to customs and beliefs. Women will not use available services, lack updated information about when and why to use services and frequently report fear of assisted deliveries and prospects for caesarean deliveries. Furthermore there appear to be convoluted paths to be followed in the decision to seek care. Social acceptability, fear, stigma, lack of information, as well as the extremely low availability of quality services, all contribute to the overall poor use of reproductive and sexual health services, which is particularly evident in preventive services. Patterns of beliefs and socially determined obstructions to the uptake of women's services are consistent with other culturally traditional societies in the eastern Mediterranean basin, where supply of services is frequently much better.

5.1 STIs and HIV

About 90 percent of Somali respondents who said they had suffered from an STI in the past had sought treatment for the infection, but only half of their partners had been similarly treated¹⁵⁵. The type of location where STI sufferers sought treatment varied between male and female respondents as well as between zones.

152 **Sorbye IK, WHO/UNFPA Somalia.** *Addressing Maternal and Neonatal Survival in Somalia: a Situation Analysis of Reproductive Health in Somalia.* Nairobi, February 2009

153 **UNICEF.** Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis. Survey Report, UNICEF Somalia. June 2004

154 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

155 **UNICEF.** Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis. Survey Report, UNICEF Somalia. June 2004

Figure 5.1: Percentage of respondents who had an STI previously and sought treatment, by source¹⁵⁶

	Private clinic	Public hospital	Drug shop	Traditional
Men (%)	30.5	32.2	20.9	11.9
Women	46.7	26.7	9.2	16.4
NWZ	8.6	63.8	17.2	5.2
NEZ	14.8	63.0	7.4	11.1
SCZ Mogadishu	55.7	15.0	14.3	8.6
SCZ Non-Mogadishu	36.9	26.2	16.8	20.1

It is interesting to note the high use of public facilities in NWZ and NEZ for STI treatment, in contrast to many studies which show overall higher use of the private sector in these two zones. It may be that public services are more anonymous or better-perceived as service providers for RH services, while private providers are seen as members of the community at large.

Figure 5.1 shows results from a study where 46.7 percent of women suffering from an STI reported using the private sector for treatment, compared to 30.5 percent of men. This finding is supported by another study's qualitative interviews with women's groups in the three zones, which revealed that women view the private sector favourably for accessing RH services, although service provision was still deemed to be poor in both sectors¹⁵⁷. Reasons for the preference have not been explored but would seem to contradict the previous explanation relating to confidentiality.

A discussion group in Sanaag identified that genitourinary infections were the most serious health concern for women, as expressed by four in five female respondents. Over a third of women had sought medical attention for genitourinary infections, but most reported that the infections returned within a few months despite

treatment. Most also felt the infections were due either to female circumcision, sex or STIs. It was further shared that women were more likely to seek treatment for a family member's health condition under their care than for their own infections¹⁵⁸.

In terms of HIV, the majority of Somalis are aware of HIV/AIDS and are fairly knowledgeable on modes of transmission, while prevalence is believed to be quite low (1 to 2 percent)¹⁵⁹. There are however significant differences between men and women, especially in rural areas. According to a Somalia-wide study, attending an HIV testing facility is rare in all zones. Just three percent of women of reproductive age reported that they had ever been tested for HIV.

In the same study, those who had tested for HIV did so more often in a government hospital (43 percent) compared to a private hospital (37 percent). In all, 16 percent of Somalis claimed to know of a place to be tested for HIV (35 percent in NWZ, 19 in NEZ and 8 in CSZ)¹⁶⁰. Most people in the 2004 KABP on HIV and STIs expressed that they would be unwilling to be tested.

¹⁵⁶ UNICEF. *Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis*. Survey Report, UNICEF Somalia. June 2004

¹⁵⁷ Musinguzi J, WHO Somalia. *Assessment Study of the Quality of Reproductive Health Care in the Private Health Sector in Somalia*. Consultant's Report. January 1998

¹⁵⁸ Meyer CD/Horn Relief. *Addressing the Health Needs of Settlement Residents in the Eastern Sanaag District of Northern Somalia*. Consultant Report. Columbia University School of International and Public Affairs, Mailman School of Public Health. July 2006

¹⁵⁹ UNICEF. *Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis*. Survey Report, UNICEF Somalia. June 2004

¹⁶⁰ UNICEF. *Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006*. UNICEF Somalia 2006

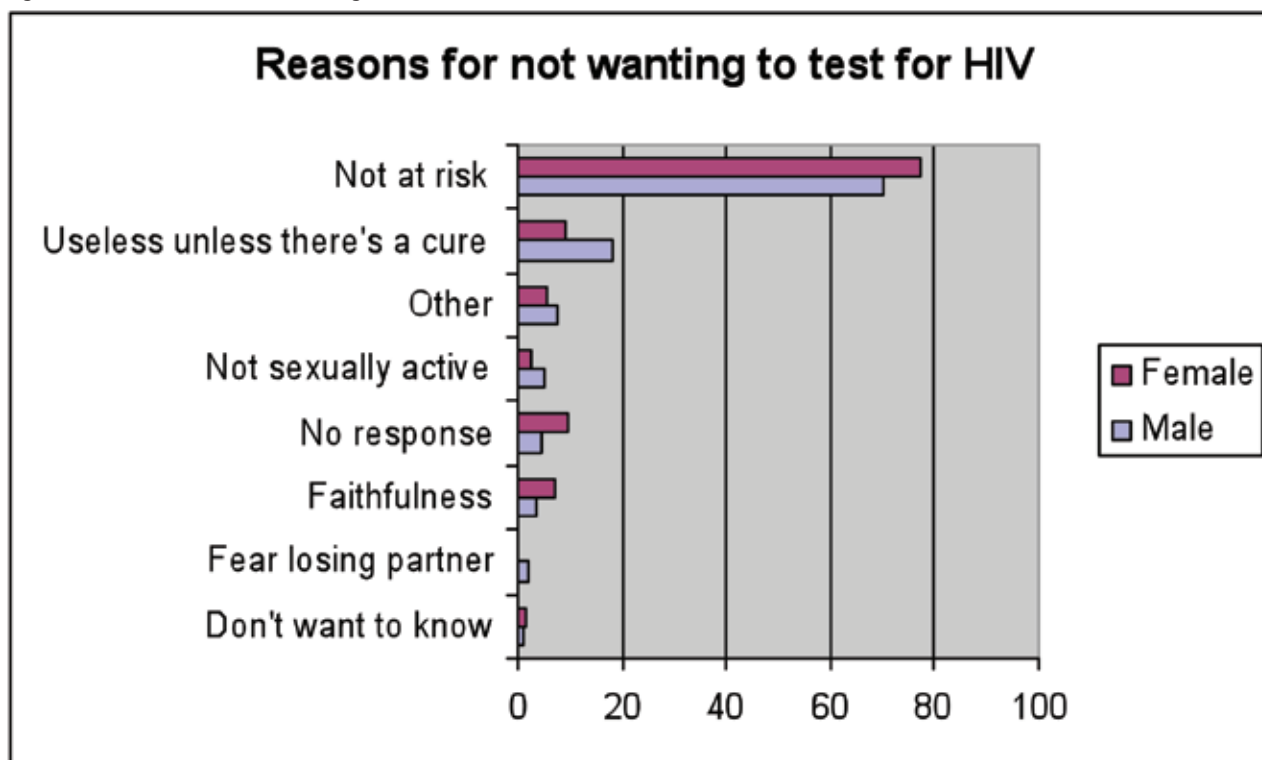
Figure 5.2: HIV awareness, attitudes and practices in Somalia by gender¹⁶¹

	Men (%)	Women (%)
Ever heard of HIV	67.1	57.1
Ever tested for HIV*	4.8	2.5
Willing to take an HIV test*	28.9	16.0
Consider self at risk of HIV*	5.2	5.5

* Of those who had ever heard of HIV

While most people are aware of HIV, there is a low perception of self-risk in Somalia, which affects health seeking behaviour for testing services.

Fig 5.3: Reasons for not wanting to test for HIV



161 UNICEF. Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis. Survey Report, UNICEF Somalia. June 2004

162 UNICEF. Knowledge, Attitudes, Behaviour and Practices (KABP) on HIV/AIDS and Sexually Transmitted Infections (STIs) among Somalis. Survey Report, UNICEF Somalia. June 2004

There is reasonable coverage of HIV testing sites across Somalia. In the period 2004-08, sites tested 13,071 (7,387 male, 5,684 female) patients of whom 1,571 (715 male and 856 female) were identified as positive. From those identified as HIV positive, 1,291 (82%) were referred to pre-ARV treatment services and 578 patients are currently on ARV treatment. Given the limited capacity for provision of any higher-level medical services in Somalia, there have been some demonstrable successes in the following: development of testing, linkages between test results and enrolment on a treatment regime, and compliance with ARV treatment. In December 2008, 75 percent of known people with HIV were still receiving treatment twelve months after initiation of anti-retroviral therapy.

This contrasts starkly with Prevention of Mother to Child Transmission (PMTCT). There are only eight sites testing pregnant women for HIV. During the period June 2007 to October 2008 these eight sites tested 2,832 pregnant women, of whom 18 were HIV positive. Only eleven women in a period of four years received PMTCT treatment¹⁶³. The lack of linkages between available testing and response to a positive test reflects the extremely weak provision of reproductive health services. The near-complete lack of PMTCT in Somalia is congruent with the limited offering and limited utilization of services for pregnant women generally, as seen in following sections.

The combination of these findings suggests that there is both hesitancy to seek services and a weak service delivery chain for reproductive and sexual health.

5.2 Family planning

Unmet demand for FP has been calculated at 26.6 percent of currently married women of reproductive age in Somalia, of whom only 1.2 percent currently use a modern method of FP¹⁶⁴. Natural methods, especially lactational amenorrhea, are by far the most used amongst women desiring birth spacing, although low frequencies of exclusive breastfeeding throw into doubt the effectiveness of the practice in this setting. Determinants related to low use of modern FP have not been well explored in the literature, but are assumed to be social-culturally and religion-based, combined with low awareness of potential benefits.

In a survey of 74 Somaliland pharmacies, two-thirds of pharmacy staff respondents reported that clients ask about FP in the pharmacy. However, fewer had any methods for sale (about one-third) and by far the most common reason given for not selling FP was the low demand for the products¹⁶⁵.

Figure 5.4: Clients requests and pharmacy sales of FP methods in Somaliland¹⁶⁶

	Yes	No
Do clients ask about FP?	62 % (n=46)	38 % (28)
Do you sell any FP methods? (including condoms)	31 % (n=23)	69 % (n=51)

164 UNICEF. Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

165 UNICEF Somalia. Somaliland Private Pharmacy Situation Analysis. May 2009

166 UNICEF Somalia. Somaliland Private Pharmacy Situation Analysis. May 2009

163 All data on ARVs and PMTCT from UNICEF

In addition, the great majority of pharmacies indicated that they refer clients to public facilities (MCH) when they request FP services. This was more common than referral for other health needs, which typically sent clients to private sources. A separate study in Hargeisa amongst IDP women also indicated that women perceive MCHs to be the main source of FP¹⁶⁷.

While women may perceive MCHs to be the main source of FP services, the MCHs are not well seen as an overall service provider and overall use of private pharmacies is much higher. There may be a disconnect between where women prefer to seek FP services (private sector, pharmacy) and where they are currently most able to access them (MCH).

5.3 Antenatal care

According to the 2006 MICS, just over a quarter of all women who gave birth during the prior two years was attended by skilled personnel at least once during pregnancy. Skilled ANC visits were associated with urban locations, education and economic status of the mother, as well as being in NWZ¹⁶⁸. An analysis of MCH utilization rates across Somalia showed that about half of women in target populations do make the effort to attend at least one ANC visit, and also indicated that ANC services are in highest demand around large urban areas (50 percent of urban women attend ANC whereas less than 20 percent of rural women do so)¹⁶⁹.

Interestingly, while TBAs play a dominant role in delivery, they are rarely sought to provide ANC services anywhere in Somalia. The same trend is true for nurse-midwives

or auxiliary midwives¹⁷⁰. When ANC is sought it is most often from a medical doctor (private) or from public facilities/MCH^{171 172}. There is a disconnect between ANC and delivery care, and limited opportunities for creating a continuum of care.

Some evaluations have asked women why they did not seek any ANC during pregnancy, if they failed to do so. In a 1998 NWZ study, respondents in group discussions expressed the belief that if a woman is healthy or did not experience any problems in the previous pregnancy, ANC is not necessary. In qualitative assessments for the same study, obstacles such as time and distance figured most importantly. Amongst urban respondents, lack of awareness of the need for or benefit of ANC was the second most important reason given, after lack of time. This indicates that even when the physical barriers are diminished, ANC services remain hindered by low demand and low prioritization¹⁷³.

Another, smaller study in Maroodi Jeeh, NWZ, showed differing reasons for not attending ANC when comparing findings of quantitative versus qualitative assessments. In focus group discussions, women expressed a lack of interest in ANC because they were busy and furthermore, pregnancy and childbearing were seen as natural processes in the hands of Allah. However, when asked why they did not attend ANC during the last pregnancy, the women most often named obstacles such as unavailability of the service or lack of money¹⁷⁴.

167 **Korong A, Mbuvi D.** KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

168 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

169 **UNICEF/WHO.** Somaliland Immunization Coverage Survey Report. July, 2008

170 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

171 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

172 **UNICEF.** Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

173 **UNICEF.** Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

174 **Korong A, Mbuvi D.** KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

It is uncommon in the literature to explore what motivates women to seek ANC services when they do so. Only two surveys reported that most women who sought ANC did so as a result of another illness, such as an infection or clear danger signs they exhibited during the pregnancy¹⁷⁵¹⁷⁶. This indicates that ANC is not well-conceived as a preventative service and is sought with more curative intentions.

Low awareness of specific benefits of ANC visits, such as tetanus toxoid vaccination has been reported in the literature. There were also reports of negative perceptions regarding intent¹⁷⁷¹⁷⁸¹⁷⁹. An analysis of MCH data indicated that, while reasonable numbers of women came for ANC, very few received the services or commodities that should be given during an ANC contact (for example, less than a quarter of those attending received Vitamin A)¹⁸⁰. Furthermore, amongst women who did go to ANC, very few sought four ANC visits as recommended by WHO, averaging just two visits¹⁸¹. Most women who attend ANC do not receive the TT vaccine or many other potentially beneficial services¹⁸²

¹⁸³¹⁸⁴. Women who were not vaccinated usually claim it was either unavailable or unnecessary¹⁸⁵¹⁸⁶¹⁸⁷¹⁸⁸. Low demand for ANC cannot be particularly unusual where the quality of an ANC visit is also so low.

5.4 Delivery and post-natal care

Health service utilization rates for deliveries vary greatly from ANC utilisation. While ANC care is sought from MCHs and the private sector, there are very low numbers of facility-based births (less than 10 percent of all births). A large majority of women give birth at home with assistance from a Traditional Birth Attendant (TBA), who assist in half of all births but provide less than three percent of women with ANC services¹⁸⁹.

175 **UNICEF**. Somali Health Knowledge, Attitude and Practices. North-West Zone. UNICEF Somalia. 1998

176 **Korong A, Mbuvi D**. KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

177 **Sorbye IK, WHO/UNFPA Somalia**. Addressing Maternal and Neonatal Survival in Somalia: a Situation Analysis of Reproductive Health in Somalia. Nairobi, February 2009

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189 **UNICEF**. Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

Figure 5.5 Attendance during delivery¹⁹⁰

	Person assisting at delivery						
	Medical doctor	Nurse/Midwife	Auxiliary midwife	TBA	Relative/friend	No attendant	Delivered in health facility
Zone							
NWZ	19.5	1.5	20.4	37.0	18.5	1.2	21.4
NEZ	5.3	1.6	29.9	47.1	13.1	2.0	7.9
CSZ	3.4	2.7	23.7	55.9	9.4	3.2	5.8
Residence							
Urban	15.3	5.4	44.3	29.5	3.8		
Rural	2.3	0.5	11.8	63.3	16.4	3.8	3.0

Overall, women seek accompaniment during delivery. It is clear that for some with the power to pay there is demand for a medical doctor. However, the vast majority of women use a local health worker (auxiliary) or TBA and deliveries take place at home. There are therefore limited opportunities for intervention in the case of complication, which might otherwise have saved a woman's or newborn's life.

Rates of both facility-based births and skilled attendance at births are positively associated with urban locations, education, economic status of mothers, and being in NWZ¹⁹¹. It has been reported that facility-based birth is considered to be a last resort and that referral centres for caesarean section are currently underutilized¹⁹². This relates as much to ability to pay for quality assistance, as to stigma and cultural norms.

The particular issues surrounding acceptability of facility-based births have not been well-explored in the literature. One major evaluation discusses the role of the TBA. While the TBA may assist at birth if there are complications, there are likely to be elaborate paths of consultation for further decision making involving the husband, other family members and the sheikh, amongst others. This often results in significant delays in seeking care until it is too late, and many maternal deaths occur in higher level facilities¹⁹³.

Two evaluations indicated that the same women visiting the MCH or other health facility for ANC do not return to the facility for delivery^{194 195}, indicating that ANC is not necessarily an entry point. In reality, the majority of MCHs do not offer options for facility-based deliveries, or else offer very poor quality care.

One of these studies has suggested that seeking assistance from TBAs in Maroodi Jeeh is preferred by many women and is not merely the result of obstacles

190 UNICEF. Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia 2006

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195 Korong A, Mbuvi D. KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland. Health Unlimited. September 2008

to seeking assistance from skilled attendants. This was attributed to prevailing cultural beliefs, values and practices, but was not explored further¹⁹⁶.

It has been reported that many women do not trust TBAs to recommend medication, and as previously stated they do not seek ANC assistance from them¹⁹⁷. This suggests that the TBA fills a very specific niche in a pregnant woman's health care seeking needs and is perhaps unlikely to facilitate a continuum of care approach encompassing ANC, delivery and PNC.

The 2006 MICS clearly indicated that many women experience major health problems during the postpartum period, while only 10 to 12 percent of Somali women report having sought any post-natal care. This low percentage shows little variation across zones and urban or rural locations¹⁹⁸. The literature review did not find any qualitative surveys which deepen understanding in this regard. There is very low quality of PNC and very low uptake.

It is probable that there needs to be gradual improvement and outreach of reproductive health services that offer more, and build trust. Only after improving the availability of services can more complex decisions influencing seeking reproductive health care be better understood.

196 **Korong A, Mbuvi D.** *KAP Baseline Survey Reproductive Health and EmOC Intervention in Maroodi Jeex District, Somaliland.* Health Unlimited. September 2008

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6

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Health seeking behaviour is important in understanding, planning and providing health services. Decisions to seek care are complex and depend on a range of factors:

- nature of the illness or injury and its perceived severity and consequences
- understanding of disease and communicability
- understanding causation of disease (spiritual or infectious)
- availability, affordability and acceptability of services

These factors interact in a dynamic way within and across social groupings to determine how actively people seek modern health care in response to a health threat or bout of illness.

Health seeking behaviours will therefore be different, being dependent on individuals, their knowledge and prior experience with services, the social perspective in which they live and exist, and perceived and/or real obstacles they face in accessing services (time, distance, cost, quality, and acceptability).

Despite the obvious fact that there is low understanding of modern concepts of disease, and major social and behavioural barriers to the uptake of certain services, it remains difficult to quantify the importance of such behavioural barriers given the extremely low levels of quality service delivery.

In study after study, it is clear that the major obstacles to seeking care are:

- ✓ distance
- ✓ cost
- ✓ trust in the services being open, or skilled staff being present
- ✓ insufficient quality, and
- ✓ stock outs of medicines appropriate for treatment.

It is also clear that there are real social barriers to uptake of preventive and promotive services. There is a need for mass communication programmes and programmes of behavioural change to educate the population on the utility, safety and desirability of correct and timely engagement with preventive and promotive services and practices (such as breast feeding, household hygiene, vaccination, and ANC).

Clinical services currently require less emphasis on changing beliefs and behaviours, with a greater need to focus on reducing supply-side barriers to utilization. It is imperative that services on offer are appropriate and acceptable in meeting the needs of people, and that they are financially accessible. If cost, quality and medical supply questions are answered, health facilities will undoubtedly start to see an increase in utilization. As the positive impact of trustworthy services is realized, demand for services should grow – leading

to increased trust and further increased demand. Only in later stages will it be important to expand the network of facilities and work on reducing cultural and behavioural barriers to the uptake of clinical care.

Conclusions:

- 1) Overall, there is high use of private services, particularly pharmacies and/or drug shops. Drug shops are numerous and open, welcoming, accepted and trusted. That said, the patterns of use are not universal and there do appear to be higher levels of use of public services among IDPs, riverine communities and some regions of CSZ.
- 2) The use of private services is particularly high in northern zones where there has been relative stability. Either stability has afforded the growth of a competitive private sector, or private services might be more acceptable to more rural and nomadic populations.
- 3) Urban populations also show high use of private services, both pharmacies and clinical, despite access to public services. The fact that urban populations choose to access the private sector when both are available, suggests preference for and higher trust and convenience of private services.
- 4) Rural populations overall consume fewer modern health services. Their patterns of consumption are determined by their locations (proximity to town, roads, public or private services).
- 5) Pastoral communities have the lowest overall use of modern health services and the lowest use of public health services. They also have the highest proportional use of private services, such as the purchase of medicines from private pharmacies.
- 6) There is very little information on use of health posts. Health clinics/MCHs are too expensive to be established all over Somalia, which requires a functioning HP level to bridge gaps in access.

However, most evidence indicates that HPs are not valued by consumers and they do not generally use them.

- 7) In terms of vaccination uptake (offered only through the public sector), there are far higher coverage rates in urban populations, followed by sedentary or riverine populations and lastly by rural and nomadic populations. As isolated rural populations and nomadic populations rely far more heavily on outreach campaigns for their provision of vaccination services, these populations have lower overall vaccination coverage but also much lower coverage of repeat dose vaccinations (such as DPT).
- 8) In the field of reproductive health there is an urgent need to offer higher quality of services, building referral and a continuum of care. While there may be a need for BCC to improve understanding and demand for preventive services such as ANC and TT vaccination, the major need in terms of provision of clinical services is working to ensure timely accessibility of quality services. Despite this being a first priority, more work will be required in this field to find ways to ensure uptake.

Recommendations:

- a) There is a need to recognize the important role of the private pharmacy in the Somali health system. Interventions should be designed to promote the contribution of the private pharmacy network to public health, such as training, subsidies and social marketing of important commodities.
- b) There is a need to investigate the role and effectiveness of the health post. There is currently insufficient information to be able to make suggestions about what to do with this level of care. However, HPs are likely to be the only affordable way of offering public services in the medium term. Ways should be found to

make HPs useful, providing services that are in demand. This would involve staff training and management, increased supervision and oversight, as well as expansion of services and linking HPs to higher-level care.

- c) The Health Clinics/MCHs are not operating according to the needs of the population. They are not trusted in terms of staff, drug supply and opening hours, nor do they provide a full range of services. The capacity of MCHs must be upgraded to offer a full range of required services, even if this means reducing numbers of Health Clinics/MCHs. Reducing cost barriers at the point of care should be considered to contribute to improved access to public care. While the public system is heavily subsidized, the consultation fee ensures that the subsidy is targeted to the few who can afford to pay and is regressive and inequitable.
- d) In the field of reproductive health there is an urgent need to improve quality of services in hospitals and to lessen barriers to use of those services. Such higher-level services need to be linked up to functioning MCH services within a referable distance. Antenatal Care services need a major boost in terms of quality and completeness of care and services they provide, and also in encouraging a link between mothers and effective assisted delivery options.
- e) There are distinct supply and demand-side barriers to acceptability, access and affordability between different population groupings in Somalia. *Different delivery solutions need to be developed for urban, rural sedentary and rural nomadic populations, with reference to population densities and ease of access to clinics.*
- f) There is a need to sustain vaccination outreach and campaigns in order to cover nomadic rural populations. These contacts are important beyond the acceptance of vaccination and each contact should be used to promote effective use of health services.

7

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