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Access to Health Services: Challenges Faced by Women and Girls living in Pastoral Communities of Bauchi and Gombe States

By

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PROJECT PROFILE

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PREFACE

This policy brief is the fourth in the series of communication to policy and decision makers as well as other researchers on the on-going research project of the Centre for Population and Environmental Development (CPED) titled "Empowerment of Women in Pastoralism and Agriculture in Nigeria's Sahel Region" funded by Supporting Pastoralism and Agriculture in Recurring and protracted Crisis (SPARC) under its Advancing gender equality in fragile food systems in the African Sahel programme.

CPED's policy brief series is designed to draw attention to key findings and their policy implications as projects are being executed. This edition presents challenges faced by women and girls living in pastoral communities of the Northeast region of Nigeria.

We are very grateful to SPARC and IDRC for the support in implementing this project. We are particularly grateful to the Officer in charge of our project, Dr. Pauline Njiriani for her support to CPED which has enabled the Centre to continue the implementation of the action research project and the publication of this policy brief. We also appreciate the cooperation of policymakers in Bauchi and Gombe States for their collaboration with CPED in the on-going implementation of the project.

Introduction

Pastoralists all over the world generate income and create livelihoods in remote and harsh environments where conventional farming is limited or not possible. Despite this and increasing recognition of pastoralism as a valuable and sustainable natural resource management system, pastoral communities remain socially and politically marginalized. Pastoralists' livelihoods are frequently undermined by unfriendly policies and laws and by competition for resources from more politically powerful neighbours and other interest groups.

Pastoralist populations face more inequities and inequalities due to their seasonal migration which is carried out as they manage their livestock. These hinder efforts to include them in demographic information and health services planning (Gammino et al., 2020). They inhibit the most remote and harshest terrains on earth while migrating with their livestock in search of grazing grounds and water sources. This prevents them from accessing healthcare services that sedentary populations have access to. As a result, the efforts made toward universal health coverage (UHC) in many low-and-middle-income countries do not reach the pastoralist communities Wild et al. (2020).

Pastoral women are key agents in livelihood development. They engage in socioeconomic and cultural activities, and in the conservation and management of natural resources. Despite the many challenges they face, pastoral women are resourceful in finding ways to ensure that their households' basic needs are met.

Pastoral women in Nigeria are particularly disadvantaged by the limitations they face within their own societies. They face numerous socio-economic barriers and unique health challenges that are often overlooked. As a result, women, and girls in these communities' experience disparities in accessing essential health services, leading to poor health outcomes, and exacerbating existing gender inequalities. Understanding and addressing these health challenges is crucial for achieving sustainable development and ensuring the well-being of all individuals within these communities.

Methodology

This study is based on action research being implemented by Centre for Population and Environmental Development (CPED) with funding from International Development Research Centre (IDRC), Canada, through the SPARC program to support women and girls in Pastoralism and Agro pastoralism in Nigeria's Sahel region. This is a mixed study that combined both quantitative and qualitative technique in data collection in Bauchi and Gombe States of the Northeast region of Nigeria.

The data for this study is derived from Key Informant interviews and Focused Group Discussion conducted with respondents in Gombe and Bauchi states.

A total of 37 key informants, comprising 57 percent females and 43 percent males were interviewed across 6 local government areas (LGAs). Majority of those interviewed were between the ages of 40 – 59 years accounting for 51 per cent of the total respondents followed by those who were 60 years in age and older.

Table 1:
Percentage distribution of Key Informant Respondents by Sex

Sex	Count	%
Female	21	57
Male	16	43
Grand Total	**37**	**100**

Table 2:

Percentage distribution of Key Informant Respondents by age

Age (Years)	Count	%
20-39	7	19
40-59	19	51
60 and above	11	30
Grand Total	**37**	**100**

A total of 12 FGDs were conducted comprising female only groups and male only groups in each target LGA. Participants selected for the FGD were people of similar background or experiences and have lived in any of the target communities for more than 3 years. Each group whether male only or female only groups was made up of between 10 to 13 participants.

FINDINGS

Almost all the key informant respondents agreed to the fact that girls are given free access to health care where such services are available. They however lament that very few primary healthcare centres have nurses and healthcare staff. The hospitals and health centres lack personnel to attend to patients which makes many people not to visit the health facilities in the locality.

Some respondents noted that women/ girls have limited access to health services because they depend on their husbands. It was stated as follows:

> *"Before the women/girls can have access to basic service such as education and health they usually depend mostly on the income of their husband which is not enough to cater for the household needs."* ...***Dass mixed FGD***

Another respondent highlighted that lack of facilities at the heath center reduced access to healthcare. They lamented that very few primary healthcare centres have nurses and health care staff. The hospitals and health centres lack personnel to attend to patients which makes many people not to visit the health facilities in the locality.

> *"Lack of medical facilities. Lack of hospital staff. No drugs"*...***Kaltungo Female FGD***

Another issue raised by respondents as a factor that reduces Women and girls' access to health care in the study area is the distance of health centers that can conveniently manage complicated cases. It is summarized as follows.

> *"Access to health facility is an issue because when there is serious gynecological case it must be on referral to the state capital hospital of which it is far and expensive to them in the community. In respect to that they have cases of women dying during labour (childbirth)"*...***Alhaji Umaru Amadu (M), Billiri LGA, Gombe state.***

Other issues raised by the respondents include the lack of medical equipment such as Ambulance in emergency situations and lack of drugs.

> *"Pregnant women do not get basic care they need. The hospital staff are not sufficient. Moreover, there is no emergency medical help, especially at night" …**Ture Kaltungo Female FGD***

> *"The hospital is in a poor condition. They Lack medical facilities, drugs, equipment, and hospital staff. They don't accept pregnant women or take childbirth." …**Purmai, Kaltungo Male FGD***

Recommendation

Advocacy and training

There is need to have community conversations with the men in pastoral communities on the need to allow their women to venture into income generating activities that could make funds available to them when there is need for medical services as well as eradicate traditional gender norms that makes the women to be financially dependent on the men.

Well-equipped Health Centers

Health and well -being should be treated as a top priority that it is by Government and relevant stakeholders. Equipment necessary for emergency situations such as ambulance and oxygen should be readily available. It is also important that essential supplies and medicines are available at all times. This will make the end users have increased trust in the health centers as well as patronage.

Qualified and well-trained staff

There is a need for more staff to be deployed to health centers in pastoral communities. These staff could be encouraged to remain there by means of incentives. There is also the need for staff to be trained on how to relate to the people in pastoral communities, putting their culture and traditions into considerations. This will encourage the women to go to the health centers.

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