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# Socio-Cultural Determinants of Maternal Health Seeking Behaviour Among Young Women in Remote Pastoral Communities of South Omo, Afar and Somali Regions of Ethiopia

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**ABSTRACT**

The episodes of maternal mortality and reproductive health complications among pregnant adolescent and young mothers in pastoral communities of Ethiopia are numerous and complex. Access to maternal health service utilization is limited. ANC service utilization by these pastoralist women is negligible. This paper is an outcome of critical review and synthesis of selected research articles in addition to empirical case studies on adolescent pregnancy and reproductive complications undertaken in some selected kebelles of the sample woredas. The maternal mortality and morbidity frequencies among agro-pastoralist communities of Ethiopia are high mostly from preventable causes. A great chunk of these women does not receive skilled health care during pregnancy and during delivery. Community birth attendants conduct deliveries at home in more than 80 % of cases. The socio-economic and cultural factors influence on the reproductive behavior of pregnant adolescent and young women and decision of the place of delivery. The negative perceptions of women on quality of maternal services provided at health facilities often restrict their preference for utilization of health facilities. The factors such uncomfortable health facilities coupled with disrespect for women's modesty, delivering babies at hospital making her full naked, separation from family during delivery create negative motivation for preferring home deliveries than institutional deliveries. This paper has outlined a number of actionable interventions for promoting a robust maternal health platform and making accessible the maternal health services, ANC and family planning services to pregnant adolescent and young women in agro-pastoralist communities of South Omo, Afar and Somali regions of East Africa.

***Keywords: Maternal Mortality, Agro-Pastoralist, Actionable Intervention, Women's Modesty, ANC Coverage.***

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## Introduction

Ethiopia is one of the six countries of the world with alarmingly high episodes of maternal death accounting for fifty per cent of maternal deaths at global level compared to other African countries. The maternal morbidity and mortality multiply in rural and pastoral regions of this country due to inadequate health personnel and ill-equipped health service facilities. In rural regions of Ethiopia, the health services are scarce, inaccessible and inappropriate to rural and pastoral way of life. The existing health centers in these regions are not equipped with trained health workers, physicians and midwives apart from existence of poorly supplied with basic medicaments, equipment and supplies. The maternal health service utilization by pregnant mothers is adversely influence by prevalence of inimical cultural practices, social taboos and customary rules determining decision for obtaining services of trained birth attendants and health facilities. The reproductive health of women in these pastoral communities is affected by cultural practices of tonsillectomy, female genital mutilation, abduction, early marriage and milk teeth extraction. These cultural practices not only damage the reproductive behavior of women but also adversely affect their sex desire and dream for leading a healthy sex life. The maternal health is influenced by poor use of antenatal care service, service of skilled birth attendants, T.T immunization and periodic visit for ANC (antenatal Care). It is reported by different studies conducted among mothers of pastoral communities in these regions, the utilization of antenatal services along with T.T immunization have been inappropriately accepted. The pregnant women in these regions prefer to services of traditional birth attendants who are culturally relevant, accessible and affordable. The absence of appropriate delivery practice is major contributing factor for high maternal morbidity and mortality of pastoral communities of Ethiopia. The illiterate women in these regions are not properly sensitized and educated about ANC service utilization which will facilitate them detection of high-risk pregnancy and availing timely referral to the health facilities. The mothers who fail to provide regular ANC visits to health facilities are deprived off the knowledge in determining delivery process and outcome as well as initiating preparedness for combating obstetric complications that may arise. (Fikre et.al, 2012, Mekonnen et.al, 2012)

## Methods and Materials

This piece of research paper is based on review of published research articles on adolescent reproductive health issues in pastoral communities of South Omo, Afar and Somali regions of Ethiopia. A framework of research questions, key hypothesis and socio-cultural variables influencing fertility behavior and sexual activities of adolescent and young mothers in pastoral communities has been designed to be validated through content analysis, synthesis of research findings of different scholars and empirical case studies conducted in some selected villages of Somali and Afar region by the researchers. The study has validated that inadequate and poor quality of maternal care coupled with poor post-partum care, poor antenatal care, high percentage of home delivery conducted by untrained community midwives, forced pregnancy and forced abortion of pregnant adolescent mothers compound high maternal mortality and morbidity prevalent in pastoral communities of South Omo,

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Afar and Somali regions of Ethiopia. This piece of micro study has suggested a good number of recommendations towards prevention of high maternal mortality burden in pastoral communities keeping in view the National Adolescent and Youth Reproductive Health Strategy, 2007 of Government of Ethiopia.

## Main findings and Observations

The protocols of United Nations Millennium Development Goals **(MDGs)** have been endorsed and adopted by Federal Government of Ethiopia towards reduction of maternal mortality by three quarters by 2015. As a follow up measure, the Government of Ethiopia has not only envisaged the mechanism for continuum care of mothers, new-born through targeted maternal health care in rural and urban areas of the country, but also demonstrated its political commitment to enforce attainable standard of health policies to curb maternal mortality across urban and rural regions of the country. Greater emphasis was given on strengthening the maternal health-care system for carrying out Basic and Comprehensive Emergency Obstetric Care. Priorities were given on conducting training of non-clinical physicians and midwives along with supply of essential and basic equipment, and by regular monitoring and supervision by staff competent in emergency obstetric work. Federal Democratic Republic of Ethiopia, Ministry of Health has launched an innovative scheme, Health Sector Development Plans (HSDPs) initiated in 1996 for achieving multi-sectoral health challenges across urban and rural areas of the country. Under the umbrella of this program, a wide number of packages were provided such as family health service, prevention and control of communicable diseases, prevention and control of non-communicable diseases, integrated disease surveillance and public health emergency, hygiene and environmental health, health extension program, medical service, nutrition, health sector reform, human resource development and pastoralist health service. A Pastoralists' Health Promotion and Disease Prevention Directorate was established. An innovative Health Extension Program (HEP) was launched in 2003 to deliver community-based health packages through trained Health Extension Workers deployed in pastoral regions. The irregular service of these health personnel, physical inaccessibility of health facilities, poor monitoring and supervision, fear or disrespect and abuse among conservative pastoral women, gender inequality, negative cultural practices and absence of NGOs for gearing up the implementation process have drastically hindered the percolation of these schemes at pastoral villages.

The NGOs are encouraged to join hands with Government Agencies for facilitating maternal health services in rural areas focusing the shift of services from facilities to household and villages. The Government of Ethiopia has launched an innovative Health Extension Program (HEP) in 2003 that not only integrate community based primary health care and intervention on maternal health services utilization but also facilitate rural mothers equitable access to promotive, preventive and curative maternal health care. Not less than 30, 000 female health extension workers have been trained and deployed in rural areas for delivering pastoral families with basic maternal health care and spearhead

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frontline referral for pregnant women with obstetric complications to appropriate hospitals and health facilities. These services have not been appropriately utilized by pregnant women in remote pastoral communities of South Omo, Afar and Somali regions of Ethiopia. The pastoralists occupy 10 % of total population of Ethiopia and hold a very significant pillar in country's economy. The reproductive health issues of adolescent and young women of pastoral communities are severely influenced by socio-economic and geographical factors. The pastoral communities in Ethiopia are most vulnerable and marginalized due to their geographical remoteness and low investment by government in pastoral development. Government derives not less than 40 % of agricultural GDP from livestock which accounts for more than 20 % of total GDP of the country. But Government allocates very insignificant recurrent expenditure in agriculture and livestock compared to allocation in other sectors. The pastoral communities are exposed to frequent droughts, herd depletion, diminished of grazing land, adverse effects of climate change and insurgencies in economic stability of households. The pastoralists living in remote regions of South Omo, Afar and Somali depend on market not only sale of livestock and animal products such as meat, skin and dairy products but also for food, clothes, veterinary drugs water and other livelihood necessities. Inappropriate livestock policies for marketing coupled with geographical remoteness and poor infrastructure compound barriers to accessing marketing network for these communities. The implementation of new schemes and modernization of pastoral economy have led to breakdown of traditional governance system in these communities and disrupted traditional coping mechanism mitigating animal disease and shrinkage of grazing land. Indigenous institutions have been handicapped to enforce customary rules, norms and values ensuring sustainable use of dry lands and application of indigenous knowledge for combating epidemics, drought, animal and human health insurgencies. The common property regime upholding community's ownership on vast area since time immemorial has been replaced by new laws and polices promoting individualization of land tenure. This is a great threat towards livelihood of pastoral communities. The changing land tenure security and land expropriation have posed key challenges to household food security among these pastoral communities. The shrinkage in dryland not available for grazing, reduction in communally owned grazing reserves and growing individualization of land use rights have undermined total autonomy and sustainable community-based management protocol of grazing reserves. The restriction on use of grazing resources has forced these communities to adopt diversified livelihood activities such as wage labor, small business and fishing and out migration to urban areas. This has led to drainage of potential labor force from livestock raising sector to other sector of economic activities. The women play a very important role in household food security of these pastoral communities. The reliance on livestock, shocks of drought and floods, shrinkage of grazing land has not only posed to serious threats for their living conditions but also to the health of women in these communities. Under Health Sector Development Program (HSDP-II), greater emphasis was given on reduction of maternal mortality to 267 per 100,000 live births, promotion of antenatal birth service coverage (ANC), service of skilled birth attendants and Postnatal Care (PNC), Tetanus Toxoid (T.T) vaccine uptake, screening of syphilis, provision of deliveries and referral centers for high risk pregnancies; post abortion care, addressing sexual and reproductive needs of adolescents, appropriate nutrition education to mothers and children,

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provision of family planning services were targeted for delivery among women in theses pastoral communities. But the enforcement of these components of HSDP-II in these pastoral communities have not yielded any visible results.

The pattern of maternal health seeking behavior among pastoral women have been determined by various socio-cultural and demographic factors such as birth order, women education, place of residence, mothers age at birth, cultural beliefs, economic conditions, physical and financial accessibility, religion and household decision making autonomy.

The Millennium Development Goals (MDGs) targeted to reduce maternal morbidity and mortality and promoting universal access to reproductive health care has grossly failed to achieve target in these pastoral communities of Ethiopia as evident from the Fourth Demographic and Health Survey, 2017(CSA, 2017).

The nomadic pastoral region of Somali has accounted for highest percentage of human genital mutilation (99 %) compared to 24 % in Tigray, 54 % in Addis Ababa, and 33 % in Gambella. It indicates the sexual and reproductive behavior of women in nomadic pastoralist settings are governed by customary rules, traditional beliefs and taboo that determine their choice for making pregnancies, child birth and availing services of health providers. Poor understanding of cultural practices revolving around sexuality and reproductive health behavior of women in these communities has created barriers for non-acceptance of current reproductive health program of the Government and restrict the adolescent girls and young women of these communities accessing reproductive health counselling and services. The enforcement of The Millennium Development Goals (MDGs) and provisions of National Adolescent and Youth Reproductive Health Strategy, 2007 of Government of Ethiopia in pastoral communities of South Omo, Afar and Somali regions failed drastically as efforts were not taken to engage male members for decision making for creating suitable environment that enables reproductive rights and improved child birth outcomes. (Tsegay et.al, 2013)

Somali women exhibit highest rate of child birth accounting for 7.2 children per woman in entire country. It is evident that the fertility behavior of women in reproductive age cohort is highest in these nomadic communities of Ethiopia. Similarly in Afar region, the women show fertility rate in terms of 4.9 children per women. The health indicators of these regions are worst. In Afar region, the maternal mortality is alarmingly high accounting for 801 for 100000 live birth compared to national figure of 673 for 100000 live birth. A high proportion of women in Somali, South Omo and Afar are exposed to high-risk pregnancies, deliveries and unsafe abortion attributed to early marriage, female genital mutilation, heavy work load and unhealthy practices during pregnancies. These regions have very limited health infrastructure and resources and health care system with inappropriate number of health professionals not matching to WHO standard of one doctor to 10,000 population and one nurse for 5,000 population (WHO, 1992, 2004, 2012, 2014). The health personnel and health infrastructure

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in these regions needs to be renovated and upgraded in order to effectively implement the provision of National Adolescent and Youth Reproductive Health Strategy, 2007 of Government of Ethiopia. The young women in pastoral communities of South Omo, Afar and Somali are exposed to multiple reproductive health challenges such as high-risk fertility behavior, poor health and nutritional status, pervasive inequality in maternal mortality and inappropriate use of essential maternal health care services. The Federal Government of Ethiopia has initiated path breaking initiatives and multifaceted and integrated intervention approach to encounter not only high-risk pregnancies and prevention of malnutrition among nourishing mothers and facilitating access to quality maternal health care, clean delivery and post-partum care services. Unfortunately, the benefits of these interventions are available to women living in urban area like Addis Ababa. A very little attention has been given to address the reproductive health care of adolescent and young mothers living in pastoral communities of these regions (Amano et.al, 2012). These women are affected by different categories of pregnancies such as too early, too old, too soon and too many pregnancies and births. They are highly malnourished and not facilitated to use antenatal care, delivery care, post-partum care and family planning care which otherwise would have improved their reproductive health status. Antenatal care and post-partum care are interrelated with safe delivery and safe motherhood. It is reported from Ethiopia Demographic and Health Survey (DHS, 2011), the adolescent and young women of these three regions exhibit lowest number of antenatal visits and lowest percentage of deliveries conducted by trained workers. The number of antenatal visits by pregnant mothers not only facilitated the services of skilled birth attendants but also influences the institutional deliveries. More a pregnant woman visits health facilities for ANC, more opportunities she will get to know about the status of the pregnancy and preparedness for selecting the place of delivery and handling complicated pregnancies. The Ethiopia Demographic and Health Survey (DHS, 2011), reveals that the urban area like Addis Ababa accounts for availing highest ANC coverage compared to their sisters in these pastoral communities. Similarly, a greater percentage accounting for 83.1 % of young and adolescent women in urban region of Adis Ababa availed post-partum care as compared to their sisters in a remote Afar region 9.2 %, Somali region 9.3 % and South Omo 8.4 %. The women suffered from malnutrition and anemia is highest in Somali region accounting for 49.4 % compared to Afar 44.4 % and South Omo 9 %. It is evident from above statistics that reproductive health status of adolescent and young mothers in pastoral communities is worst which needs an integrated nutrition intervention for pregnant and post-partum women. These women are not provided with iron tablets and proper screening for their anemic status. This may be due to shortage of iron tablets in the health facilities and negligence of health workers reluctant to visit remote and inaccessible pastoral villages in these regions. The adolescent and young mothers of these regions are highly affected by under nutrition and anemia which needs immediate intervention by Government and Health Policy makers of Ethiopia (EDHS, 2011, CSA, 2008, CSA, 2008).

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**Reproductive Behavior of Adolescent and Young Women in Agro-Pastoral Communities**

Ethiopia is a country of young people comprising of 65 % of total population under 25 years of age. The sexual and reproductive health problems of young people are numerous and complex. The Government of Ethiopia has enacted National Adolescent and Youth Reproductive Health Strategy, 2007 to address unmet needs and gaps of adolescent girls and adolescent young women and strengthening their reproductive health. The gender inequality, sexual cohesion, illiteracy, unemployment, extreme poverty, polygamy, early marriage, female genital mutilation, unplanned pregnancies, abortions, closely spaced pregnancies, sexual tract infections are major reproductive health issues among adolescent and young women. The studies have revealed that adolescent reproductive health problem is a growing problem of the country in spite of remarkable achievement in use of contraceptives and overall reduction in fertility. Out of young and adolescent married women in age group 15 to 19 years, 94 % are reported to be sexually active. The adolescent girls in Ethiopia prefer to marry only at an age of 16 years and experience first intercourse at median age of 16 years. The contraceptive use among these married women is only 3.9 %. They prefer use of pill and contraceptive injections at a very higher rate ignoring use of IUD and birth spacing methods. The condom used by young married males is 32 %, whereas, the commercial sex workers report using condom as high as 88 %. The social inequalities between male and female and within family and community level have adversely undermined the status of young women in pastoral communities. They are exposed to sexual exploitation and harassment by harmful traditional practices inflicted on girls and sugar daddy phenomenon. Premarital sex and forced sex have led to prevalence of Sexual Tract Infections (STI) among 12 % adolescent and young girls in age group 15 to 24 years. The adolescent girls in age group 15 to 19 years are most affected in terms STI infections compared to male in this age cohort. A very insignificant benefit has been derived by adolescent and young women of pastoral communities from Government program on youth reproductive health in terms of meaningful advocacy, sectoral guidance, prevention of unintended pregnancies as well as STIs and HIV. There is a very wide gap between macro-level policy formulation and micro-level intervention due to multifarious geographical, administrative, social cultural and environmental barriers. National Adolescent and Youth Reproductive Health Strategy, 2007 of Government of Ethiopia has prioritized for educating and sensitizing adolescent and youth on HIV AIDS and prevention of AIDS through abstinence, partner reduction and use of condom. The IEC (Information, Education and Communication) activities did not yield satisfactory result and reach the targeted adolescent and youth in spite of launching multifarious schemes over last one decade. Although greater emphasis is given on use of condoms by young men and women, only 32 % of young men are reported using condom as compared to only 14 % of young women being users of condom. Condom use has gone high among female commercial sex workers accounting for 88% of the same group. The gap between macro and micro level program implementation are numerous and complex which need to be screened through action research. The reproductive health issues of adolescent and young women in pastoral communities of South Omo, Afar and Somali regions of Ethiopia are worst. There is a very little

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attempt made by researchers to study reproductive health issues of these women and young girls and examine how far the provisions of National Adolescent and Youth Reproductive Health Strategy, 2007 of Government of Ethiopia have benefitted them. The socio-cultural barriers prevalent among nomadic pastoralists in these regions pose serious threats for implementation of above programs at grass roots. The policy makers and program executives failed to understand the customs, values and beliefs of these communities revolving around their sex and reproductive life. These people live in a very traditional setting and adhere strongly to traditional customary rules and values. The sex and reproductive life are regulated by customary rules. Besides, these communities move their livestock from one place to another during dry and wet season in search of fodders for which they have limited access to knowledge, information, and services provided under above national program. Different studies have validated that the pastoral communities exhibit a very poor reproductive outcome. The factors associated with poor reproductive outcomes are low education, prevention of harmful traditional practice such as female genital mutilation, pre-marital sex and sex with multiple partners, early marriage, low spaced pregnancies, poor access to reproductive health services and primary health care. It is reported that the health infrastructure and capacity of primary health care system existing in nomadic settings are very weak. Besides, the health personnel exhibit limitation in their ability to provide timely health service and fail to address the reproductive health issues of adolescent and young women in pastoral societies due to inappropriate knowledge, skill and training. Absence of skilled birth attendants has stimulated communities' reliance on traditional birth attendants who are honoured as culturally relevant maternal health service providers. (Ministry of Agriculture and Rural Development, Ethiopia, 2012, Kwagal B. 2013).

In general, women in Ethiopia are exposed to danger of reproductive health and high risk of death due to pregnancy and delivery related issues. The adolescent and young mothers in pastoral communities of South Omo, Afar and Somali are more prone to delivery related mortality in absence of well-functioning health care infrastructure and maternity care in pastoral regions of the country. On average, in every 14 Ethiopian women one dies due to pregnancy and delivery related causes. In spite of support and intervention of numerous international NGOs, Government led community health service delivery program and NGO driven health care delivery program could not be streamlined in low lands of this country. Less than 28 % of pregnant women avail prenatal care from doctors, nurse and midwives. The situation is worst among adolescent and young mothers of pastoral communities. Because, the infrastructure challenge is a great threat to maternal health care delivery in these regions. The barriers for utilization of maternal health services in these regions are numerous and complex. The inadequacy of primary health facilities coupled with shortage of trained health workers, unreliable supply of medicines, deteriorating transport infrastructure and weak health information have compounded the bottlenecks for optimal utilization of maternal health services in these regions. (Mekonnen et.al, 2012) The weak health infrastructure promotes uneven distribution system and complicate mothers access to maternal health and supervision.

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**Interventions By International Donors for Reduction of Maternal Mortality**

The International Organizations like USAID, DIFID, Packard Foundation and Government of Netherland have launched a massive reproductive health program and promotion of contraceptive social marketing all over Ethiopia. DKT International has taken a lead role for branding oral contraceptives and condoms in the country and recorded distribution of 90 % of condoms across urban and rural regions of Ethiopia. These donors supported bilateral reproductive health intervention program has been created a landmark in health sector of Ethiopia but unfortunately, the benefits of these massive program have not reached to adolescent and young mothers of pastoral communities of South Omo, Afar and Somali. Packard Foundation plays a very vibrant role for integrating effectively family planning within maternal health program at community, health facility and policy framework level. The family planning program is key to prevent high risk pregnancy and integrate into antenatal care, delivery care, post-partum care as well as nutrition services. In other words, the family planning program provides a basket full of maternity care services to pregnant women. The adolescent and young mothers of South Omo, Afar and Somali are prone to high-risk pregnancies, unsafe abortions and are required prevention of high-risk pregnancy episodes through effective family planning coverage. It is advocated that men should be encourage as partners in creating awareness program and influencing fertility behavior of women apart from preventing closely spaced pregnancies. The Packard Foundation has adopted adolescent young mothers under maternity service packages of not less than 96 private franchise clinics established across the country and providing general medical and reproductive and maternal health care to women. Greater emphasis is given on reproductive health and training on contraceptive provision and post abortion care. The intervention of Packard Foundation in sector of reproductive health care involving private profit health sector has created a visible landmark in the health sector of the country. The greater focus is given towards addressing prevention of high risk of pregnancy and reproductive health challenges of adolescent and young mothers in urban regions of the country. No efforts have been taken reportedly so far to control anemia on malnutrition highly prevented among adolescent and young mothers of Afar and Somali regions. There is an urgent need to enroll these critically undernourished women under available supplementary and post-partum Vit-A supplementation program. The health workers of these pastoral regions are required to support iron intake, control of worms and malaria for pregnant women which is drastically missing. The studies have revealed that the supply of iron tablet is not adequately available in all the health facilities. As per recommendation of WHO, four antenatal visits by pregnant women to health facilities is mandatory not only for pregnancy screening but also availing information for preparedness of healthy delivery and managing pregnancy complications apart from nutrition counselling. ANC visits by pregnant adolescent and young mothers of these lowlands are very insignificant compared to their sisters in urban areas for which they are exposed to high-risk pregnancies and maternal mortality. There is an urgent need to expand IEC activities in these areas not only to educate them about benefits of antenatal care but also to create preparedness for addressing pregnancy complications. The health workers working in these regions have not well trained to initiate proactive counselling to adolescent and young

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pregnant women requiring adequate care and necessary information, counselling for maternity care. (Mekonnen et.al, 2012)

**Socio-Cultural Barriers in Utilization of Maternal Health Care Services**

The Government of Ethiopia has promoted a very robust network of health infrastructure across the rural area of the country with not less than 15000 health posts and 30,000 health workers. But, the adolescent and young mothers in lowlands of Somali, Afar and South Omo are far below in accessing to clean, safe delivery and post-partum care. A great chunk of them prefer to home delivery attended by traditional birth attendants without birth preparedness and information about danger signals of pregnancies. The socio-cultural barriers and reliance on services of traditional birth attendants have compounded high risk pregnancy outcomes in these regions. Ethiopia Health Sector Development Program – IV 2006-2015 (HSDP-IV) has envisaged innovative strategies and outlined specific action for reduction of maternal mortality and promotion of enabling supportive environment for safe motherhood and new born. But the strategies targeted towards reduction of maternal mortality and addressing high risk pregnancies among adolescent and young mothers of these pastoral communities failed to achieve to desired results. The poor service quality and inappropriate health infrastructure in low lands of Somali and Afar not only obstructed to provide adequate benefits to pregnant women from ANC coverage but also in addressing the severity of the problem at the community level, delays in starting the decision-making process to seek health care and providing timely obstetric referrals. . The strategies targeted to empower men and women, families and communities in identifying high risk pregnancies and initiate appropriate preventive measures fail to be implemented at grass roots due to inadequate information, surveillances and untrained health personnel deployed in these regions. Efforts to facilitate adolescent and young mothers of these regions in accessing to core packages of maternal and neonatal health services could not be materialized due to diversity of socio-economic environment, climate and geographical remoteness of these regions. (Kwagal B. 2013, Mekonnen et.al, 2012.)

The pregnant adolescent and young mothers are culturally rejected and stigmatized in pastoral communities of South Omo, Afar and Somali. A section of them is forced to early marriage and pregnancy and forced abortion which lead to pregnancy related deaths owing to unsafe abortion conducted by untrained community midwives. A negative community branding is labelled on pregnant adolescent mothers owing to prevalent community belief systems, norms and cultural practices that reject sexual activities of adolescent girls. Besides, inappropriate sanitary habits coupled with disempowerment, harmful traditional practices such as genital mutilation and forced marriages, poor knowledge on reproductive health, pregnancy complications have led to a section of pregnant adolescent mothers experiencing post-partum hemorrhage, eclampsia, obstructed labor and ultimately death during pregnancy or during delivery. The Federal Government of Ethiopia has envisaged an innovative adolescent friendly reproductive health program under National Adolescent and Youth

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Reproductive Health Strategy, 2007 which has provided space for creating awareness of community on elimination of harmful cultural norms and practices about adolescent pregnancy which has not effectively reached nor appropriately enforced in pastoral communities of these regions. The studies have validated that the main factors of maternal mortality among adolescent and young mothers in pastoral communities are forced pregnancy, closely spaced pregnancies, post-partum hemorrhage and hypertension disorders, sepsis experienced during pregnancies and deliveries as life threatening health hazards. The reproductive health issues and complications experienced by pregnant adolescent of pastoral communities are numerous and complex which created serious damage on their conjugal life as well as their career options. The entire life cycle of these young girls has been disturbed and forced them to lead a highly disorganized social life prone to prostitution and trafficking. (Kwagal B. 2013).

## Conclusion

A good number of international donors have come forward to provide support to Government of Ethiopia not only for reduction of maternal and child mortality but also for boasting up a robust reproductive health infrastructure and facilities across the country. But it is observed that different donors work adopting their individual strategies and agenda without coordination with one another. There is an urgent need for creating robust platform to harmonize various donors focusing on integrated maternal health care package for improving maternal, neo-natal and adolescent reproductive health in remote lowland areas of the country. Strengthening evaluation and monitoring framework in the arena of reproductive health is grossly missing in terms of alignment with national health policy. The review of literatures has indicated that there is an urgent need for initiating periodic supervision and audit, semi-annual review at woreda, regional and national level apart from regular annual revision of progress and conducting independent evaluation by third party on the achievement of reproductive health programs in rural and pastoral communities of Ethiopia. There is an urgent need for strengthening the system wide interventions covering improvement in human resource, supply chain, health information system and management of public and external financing in urban and rural regions of the country. The training and capacity building of health personnel will improve quality of reproductive health services whereas improvement in the management and supply of medical drugs and governance will promote a robust reproductive health delivery system. The health information system in grass roots needs to be reorganized for updating the data base and vital statistics on birth registration for monitoring ANC coverage and pregnancy complications at village level.

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