

# **REPRODUCTIVE HEALTH IN DEVELOPING COUNTRIES**

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# DEFINITION

- "Reproductive health" is defined as the overall well-being, both physical and mental, as well as spiritual and social of the human being for every aspect pertaining to the genital organs, its functions and functioning, and not only the absence of disease or infirmities.
- A reproductive health program is thus the set of methods, techniques and services contributing to sexual health and well-being.

# The components of Reproductive Health

- Women's health component.
- Child health component.
- Youth component.
- Men's health component.

# CONSTITUENTS OF THE DIFFERENT COMPONENTS

- **Constituents specific to each component**
- The constituents of a component correspond to different health programs adapted thereto.

## **A-1 WOMEN'S HEALTH COMPONENT**

This component include the following programs:

- **SAFE MOTHERHOOD:**
  - Pre-conception consultations.
  - Pregnancy surveillance.
  - Supervision of labour and delivery.
  - Post-partum, post-abortum and post-natal surveillance.
  - Emergency obstetrical care (1st , 2nd , 3rd trimester).
- **GYNAECOLOGICAL CARE:**
  - Functional disorders.
  - Genital and breast cancers.
  - Menopause.
  - Treatment of sexual disorders.

# CONSTITUENTS OF THE DIFFERENT COMPONENTS (continued)

## ***A-2 Child health component***

- The child health component is the largest, with such programs as:
  - Neonatology.
  - Common hereditary diseases and malformations.
  - Control and promotion of growth (CPG): breastfeeding, nutrition, vaccination (EPI).
  - Integrated management of diseases (IMD): diarrhoea/diseases, acute respiratory infections, malaria and malnutrition.
  - Promotion of the health of school children.

# CONSTITUENTS OF THE DIFFERENT COMPONENTS (continued)

## **A-3     *The youth health component (Adolescence)***

- Programs relating to this component include:
  - Family life education.
  - Management of youth health, including such risk behaviours as alcohol and drug addiction, delinquency and prostitution.
  - Prenuptial consultations and counselling during marriage.
  - Fight against unwanted pregnancies, self-induced abortions and early motherhood.
  - Promotion of a physical, political, legal, social and economic environment conducive for youth development.
  - Promotion of the gender approach.
  - Promotion of college and university students' health.
  - Promotion of youth literacy.

# CONSTITUENTS OF THE DIFFERENT COMPONENTS (continued)

## ***A-4 Men health component***

- This component is often forgotten. It generally consists of:
  - Responsible sexual life.
  - Management of men's sexual dysfunction and pathologies.
  - Control of genital cancers.
  - Management of andropause.

# B-CONSTITUENTS COMMON TO THE FOUR COMPONENTS

- These are programs involving all 4 components. These are mainly:
  - Family planning: contraception, STD/ AIDS control
  - Infertility prevention and treatment
  - Protection against disease caused by the administration of health care
  - Prevention of infections
  - IEC in reproductive health with special emphasis on the gender approach
  - Fight against harmful traditional practices and sexual violence, such as:
    - Excision,
    - Nutritional taboos,
    - Forced marriage.

# C. RELATED CONSTITUENTS

- These constituents have a bearing on the four components of reproductive health, but fall under sectors other than the health sector:
  - Environmental and population education for sustainable human development.
  - The psycho-social support of orphans, the disabled, abandoned children, old persons, and refugees.
  - The promotion of a physical, political, legal, social and economic environment conducive for reproductive health activities.

## **D. SUPPORT CONSTITUENTS**

- These are major intervention strategies for implementing reproductive health programs:
  - Improvement of the management of reproductive health programmes.
  - Training in reproductive health.
  - Research in reproductive health.

- **BASIC CRITERIA FOR THE SELECTION OF PRIORITIES**
- Magnitude and urgency of the problem.
- Its impact both on the family and nation at large.
- Availability of interventions, workable solutions with regard to their impact on the improvement of health.
- Cost-effectiveness.

## CONSTRAINTS COMMON TO THE IMPLEMENTATION OF THESE PRIORITIES

- Verticalisation of activities.
- Weakness of the health information system.
- Lack of monitoring of activities.
- Centralisation of the health care system which has a bearing on availability of resources (human, financial and material).

# PRIORITIES-ICPD 1994

1. Safe motherhood: prenatal care, safe delivery, essential obstetrical care, care for newborn babies, post-natal care and breast feeding.
2. Family planning information and services.
3. Prevention and treatment of infertility and sexual dysfunction in men and women.
4. Prevention and treatment of abortion complications.
5. Provision of safe termination of pregnancy when authorised by law; (NOT RETAINED IN CAMEROON).

# PRIORITIES-ICPD 1994 ( continued)

6. Prevention and treatment of genital infections, especially sexually transmitted infections (STI), including HIV infection and the acquired immunodeficiency syndrome (AIDS).
7. Promotion of healthy sexual development from pre-adolescence; safe and responsible sex, and sexual equality.
8. Eradication of harmful practices like female genital mutilation, early marriages, domestic and sexual violence against women.
9. The treatment of non-infectious genital disorders, such as genital fistula, cancer of the cervix and breast, complications of female genital mutilation and menopause-related reproductive health problems.

# SITUATION ANALYSIS

## SAFE MOTHERHOOD (SM)

a) 98% of deaths (600,000) due to pregnancy-related causes occur in developing countries; morbidity x 30.

The maternal mortality rate remains disturbingly high (670 for 100,000 live births) in Cameroon despite efforts by the government and the medical corps. The rate of infant mortality stands at 74/1000. Only 62% of deliveries are assisted by a qualified personnel.

b) Causes

### **Direct 80%**

- Haemorrhage
- Sepsis
- Unsafe abortion
- Obstructed labour
- Hypertensive disease of pregnancy

### **Indirect:**

- Malaria
- Hepatitis
- AIDS
- CVS disease

MMR in Cameroon was 430 in the 1990s increased to 670 for 100,000 live births in the 2000s.

### Comparison of 1990 and 2005 maternal mortality by region and income groups (World Bank)

Region and income group	1990*		2005		% change in MMR between 1990 and 2005	Annual % change in MMR between 1990 and 2005
	MMR	Maternal deaths	MMR	Maternal deaths		
Region						
East Asia and Pacific	220	80 000	150	45 000	-30.6	-2.4
Europe and Central Asia	57	4 500	42	2 600	-26.7	-2.1
Latin America and the Caribbean	180	21 000	130	15 000	-26.0	-2.0
Middle East and North Africa	250	20 000	200	15 000	-21.4	-1.6
South Asia	650	238 000	500	187 000	-22.0	-1.7
Sub-Saharan Africa	920	212 000	900	270 000	-1.8	-0.1
Income Group***						
High income	11	1 300	9	1 000	-18.8	-1.4
Upper middle income	58	6 400	91	9 000	57.1	3.0
Lower middle income	210	104 000	180	74 000	-17.0	-1.2
Low income	730	464 000	650	541 000	-11.4	-0.8
<b>World</b>	<b>430</b>	<b>576 000</b>	<b>400</b>	<b>536 000</b>	<b>-5.4</b>	<b>-0.4</b>

# Situation analysis (continued)

- **A) ABORTIONS**
- **Over 90% of countries including Cameroon allow abortion to save the life of the mother.**
- **About 13% of maternal deaths worldwide are due to abortions.**
- **61% of world population abortion is legal; 14% to protect her life.**
- **21% only to save her life; 4% not permitted at all.**

# Situation analysis ( continued)

- B) In most health facilities in Cameroon, 20 to 40% of maternal mortality is due to abortions. About 70% of abortion cases recorded in health facilities are self-induced, which points to the failure of Family Planning programs.

# FAMILY PLANNING

- Global contraceptive prevalence has increased from 14 % in early 1960s to 60% in 1998. Unmet FP needs are estimated at 22%, modern methods are inadequate for 1/3 of women.
- With only 7.5% of women and 13% of men using modern contraceptive methods, contraceptive prevalence in Cameroon remains low. The increased use of condoms by men has been noted of late. With the inclusion of traditional methods, 23% of couples use a contraceptive method. Modern methods are used more in urban areas (13%) than in rural areas (4.5%). 80% of women and 83% of men know at least one contraceptive method. The same percentage of men approve the use of contraceptive methods by their wives. Only 49% of birth attendants (nurses/midwives) use a modern contraceptive method.

# FAMILY PLANNING ( continued)

- The desired family size in Cameroon is 5.0 children per woman. It has dropped slightly compared to 1991 figures which stood at 6. This size is still large, if we want our development efforts to have a positive impact on living standards. While the average duration of breastfeeding is 18 months, 53.1% of women would like to space pregnancies by less than one year. A full range of Family Planning methods is offered in health facilities in most cases, but long duration methods are available in only 40% of health facilities (IUD, Norplant, VSC). There is often a shortage of commonly used methods.

# Situation analysis ( continued)

- More than 90% of health institutions offer most of the routine vaccines to children and anti-tetanus vaccines to pregnant women. Vaccination coverage for children stood at about 70%. A good proportion of child mortality is caused by infectious and parasitic diseases which can be prevented through vaccination and/or an efficient but cheap intervention like deparasitation.
- About 4 million children were deparasitized in 2006.
- Culture, religion and tradition can significantly affect women's and children's health.

# Situation analysis ( continued)

## ADOLESCENT HEALTH

- The average age for the onset of sexual intercourse is 15 for girls and 18 for boys. However, in some communities, girls have their first sexual intercourse at the age of 12 or 13. About 60% of youths have regular sexual intercourse at the age of 16, and very often, they have more than one sexual partner with all the risks this involves. One girl in two has at least a child at the age of 19. At the Principal Maternity, 40% of septic abortions are committed among adolescents. Although they account for more than 30% of the population, only 7.8% of youths use Family Planning methods. Only about 35% of youths know at least one modern contraceptive method, compared to 85% for their parents. Female genital mutilation is a common practice in certain parts of the country, especially the South-West, East and Far North provinces. 18% of reported AIDS cases in Cameroon between 1985 and 1996 were found among youths aged from 15 to 24. 48% of AIDS patients are aged 23 to 34 which imply that they acquired the infection during their adolescence.

# STDs / HIV / AIDS, INFERTILITY

- 40 to 50% of gynaecological consultations are for pelvic infections or infertility.
- More than 80% of infertility cases are due to STDs, with a sizeable proportion attributable to post-partum and post-abortion infections.
- STDs and HIV/AIDS are on the rise.
- More than 50% of new, HIV infections occur in individuals aged between 15 and 24 years.
- Adolescents and youths are the most affected. The most common STDs are chlamydia, gonorrhoea, syphilis, genital herpes, bacterial vaginitis, candidosis, trichomonas etc. About 45% of women infected by gonorrhoea are asymptomatic.
- HIV prevalence in Cameroon is 5.5% but as high as 25% in some Southern African Countries.

# OTHER REPRODUCTIVE HEALTH-RELATED PROBLEMS

- 95% of women in developing countries have never had a Pap smear.
- Cancers of the cervix and the breast are very frequent and together cause close to 22% of tumours among Cameroonian women. 70% of patients consulting for gynaecological malignancies suffer from cancer of the cervix. Most patients arrive late (>80%).

- **Obstetrical fistulas** still exist in the northern provinces, where early marriage is a widespread practice. Case management is inadequate, due to the lack of qualified staff, especially surgeons.
- **Female Genital Mutilation (FGM)**
  - World prevalence estimated at 85-114 millions.
  - Annual incidence 2 millions.
  - 6000 girls “circumcised” every day.
  - Practised in approximately 40 countries mainly in East and West Africa and Arabian Peninsula. Returning in Europe and Americas via immigration; existed in these countries before the 19th century to cure “nymphomania” and prevent masturbation.
  - Human rights violation.
  - Harmful procedure: bleeding, infection, scars, psychological trauma.
- **Menopause/andropause-related problems** are neglected and not addressed by our health system, whereas presently many men and women are entering into that age group.

# THE SITUATION OF HEALTH FACILITIES IN RELATION TO RH

- Close to 89% of the health facilities in the country are managed by the government, 10% by religious organisations, and only 1% by private or para-statal institutions. Yet, during the 1995-1996 financial year, a mere 2.2% of State expenditure was devoted to health care. The State spent less than four dollars per capita per year, whereas the saying goes that 'health is wealth, or that "health is priceless". About 62% of these health facilities offer primary health care, 36% provide secondary health care and close to 2% provide tertiary health care. 48% of these health facilities are found in urban areas and 52% in rural areas; whereas only 40% of the population live in urban and peri-urban areas.

- There are about 14,500 inhabitants per doctor, and 2,100 inhabitants per nurse/midwife. Presently, there is 1 hospital bed for 400 inhabitants. Health facilities are financially inaccessible to many Cameroonians. Health insurance schemes have only barely started (Health social protection).
- There is general lack of equipment and infection prevention practices are not observed.

# CO-ORDINATION, INTEGRATION, COLLABORATION

- Many RH programmes have up till now been run vertically, without any networking with other programmes. Youth and women especially are conspicuously absent from the planning and execution phases of programmes.

# STRATEGIES AND SOLUTIONS ENVISAGED

## SAFE MOTHERHOOD (SM)

- There are two methods for curbing maternal mortality:
  - reducing the number of children per woman;
  - making pregnancies safer.
- Obstetricians should train and supervise their personnel. They should request for enough equipment; our clinics and labour rooms are ill equipped.
- Many among them need to undertake refresher courses.

# STRATEGIES AND SOLUTIONS ENVISAGED

- We should set up an efficient referral system with adequate transportation means. Traditional birth attendants should be trained in the practice of normal and safe delivery and their training programme must be standardised. They should be supervised and taught when to refer cases to hospital. In the long run, this brand of midwives should be totally replaced.

## **What can be done to improve access to adequate maternal care?**

- Bringing health centres and hospitals close to the people.
- Improving our communication infrastructure.
- Cutting down on service costs.
- Increasing the number, and upgrading the quality of personnel.
- Enabling women to make decisions on their health (education).
- Ensuring skilled attendance at birth.
- Political commitment to improve services.
- Correct the “three delays”. Most deaths occur around the delivery period.
  - Delay in deciding to seek appropriate medical help for an obstetric emergency.
  - Delay in reaching an appropriate obstetric facility.
  - Delay in receiving adequate care when a facility is reached.

# STRATEGIES AND SOLUTIONS ENVISAGED

## ABORTION

- The legal situation notwithstanding, the humane treatment of incomplete and septic abortions, post-abortum care, contraception service and counselling should be made available.
- The population and health officials should be sensitised on the seriousness and the magnitude of the consequence of risky abortions on health.

- FP information and services should be made available to all, in order to avoid unwanted pregnancies. However, even in countries where the practice of contraception is widespread, where abortion is authorised by law and is financially accessible, it still remains a serious public health problem. Thus, intensive and increased research must be carried out in this domain.
- Post-abortion care is crucial: better surgical techniques, counselling, FP.

# STRATEGIES AND SOLUTIONS ENVISAGED

## FAMILY PLANNING

- **The people should be able to determine the size of the family by choice, not by chance.** The population should be the main actor, not only the target of FP policies and programs. If the 22% of FP unmet needs were covered, this would increase the rate of contraceptive prevalence by 40%. FP practices should be intensified, especially in rural areas, and child spacing (more than 2 years) should be encouraged.

- A well implemented FP program can result in the reduction of abortion needs.
- Programs should include all the activities mentioned in the strategies for adolescent health care. Health services for adolescents should be established at all levels, and FP activities intensified.
- FP activities should be part of post-abortion care.

# STRATEGIES AND SOLUTIONS ENVISAGED

- The campaign against STIs should be intensified. The population should be encouraged to adopt responsible sexual behaviour. Men and women should also be encouraged to use condoms, which must be available in public places, shops, etc.
- The use of prophylactic ART during pregnancy among HIV seropositive women to reduce transmission to the newborn.
- Information, education and communication (IEC) and access to care especially for young people.

## **HARMFUL PRACTICES**

- The priorities in health and family planning programs should be to take steps to postpone the age of the first pregnancy to 18 years at least. In the northern provinces where early marriages are a common practice, significant efforts must be made in order to enable local communities to understand the risks involved in early pregnancies and child bearing.
- The practice of female genital mutilation and/or breast ironing in young girls must be condemned and banned. To achieve this, the support of traditional authorities must be sought. NGOs play an important role; RENATA in Cameroon.

## **CANCERS**

- Gynaecological cancers, especially cancer of the cervix and the breast are increasingly becoming a public health problem. The people and especially public authorities must be informed. Screening for these 2 cancers feasible and cost effective.

## **FISTULAS**

- Fistulas should be prevented by avoiding the marriage of teenage girls and the provision of prompt obstetric care.
- Physicians should be trained in the management of fistulas. Garoua and Maroua could be reference centres .

## **MENOPAUSE**

- The proportion of women in the group of aged persons is increasing. Women will need RH care throughout their lifetime .
- The Government of Cameroon, **NGOs** and the private sector should strengthen the family insurance system, which is vital to the survival of old persons.

# CONCLUSION

## **Social and Economic development**

- In a world where resources are disproportionately divided, medical facilities are bound to be disproportionately available. The gap between the developed world and the developing world is widening more and more. Maternal morbidity and female life expectancy is a good indicator of the state of health services directed towards women, and reflects the level of social and economic development of a country.
- There is both historical and contemporary evidence to show that maternal mortality can be reduced without first attaining high levels of economic development. The reduction of maternal mortality and morbidity should be used as an indicator of success in health reform.

# Integrated health care

- Integrated health care services (IHS) should use a « comprehensive approach » in providing primary/basic health services. Apart from providing basic care, such IHS can identify serious ailments such as cancers at early stages and refer them to tertiary services.

# Quality of care(QOC)

- QOC is an issue that is appropriate to all service settings. QOC includes ethical, professional and technical standards besides informed choice in the context of privacy, confidentiality and respect. Socio-cultural considerations should not lead to unacceptable levels of care through locally-defined standards.
- Gender: women issues and concerns should be given, more attention in service planning, implementation and monitoring. Men should support RH programmes/activities.

# CONCLUSION

**Operationalising RH has a number of pre-requisites including:**

- Human rights approach in service delivery; gender sensitive.
- Legislation and policies
- Health service restructuring (SWAp; avoid verticalisation of programs; personnel training and motivation)
- Role of NGOs: advocacy, limited service provision,
- Collaboration North-South; South-South)
- Monitoring progress
- Role of the obstetrician –gynaecologist: advocacy, training, development of national standards and guidelines, technical services.
- Refugee situations: they have RH needs and these should be provided.

- Reproductive Health in developing countries is a complex issue, involving interaction between Demographic and Socio-economic factors, perhaps all in turn influenced by poverty and ignorance. Current interventions are adequate if applied as they have given good results in developed societies. What is needed is the political will to apply them.

Thank you for listening