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REPRODUCTIVE HEALTH SITUATION IN CONTEMPORARY NIGERIA BY ANTHONIA IROEGBU

ABSTRACT

Reproductive health covers various areas of concern and needs of the health of women moving beyond the narrow confines of family planning and contraception. Reproductive health has become the centerpiece of development and it encompasses safe motherhood and the prevention of STDs and AIDs.

Safe motherhood initiative introduced in 1987 was seen by many sub-Saharan African countries as a solution to the very high rate of maternal mortality in the continent. However, it is paradoxical that since that time, maternal mortality rate have increased rather than declined in much of sub-Saharan African countries.

The World Health Organization identifies four fundamental strategies that support the safe motherhood initiative, family planning, antenatal care, clean/safe delivery, and essential obstetric care. Family planning helps women avoid unwanted pregnancies and abortions. Certain contraceptive methods, condoms for example, also helps women avoid high risk births, usually defined as births to very young women, births spaced less than two years apart, and births to older women who already have many children. Antenatal and obstetric care help to improve a woman's overall health and nutrition and prevent complications. Such health care can help identify and treat complications and risks before and during pregnancy and after delivery. Clean and safe delivery practices can help recognize and respond to complications during child birth.

Key Words: *Reproductive health, family planning, safe motherhood, maternal mortality, obstetric care.*

INTRODUCTION

Safe motherhood is an important policy initiative that recognizes the existence of high levels of maternal mortality and sickness and identifies strategies to reduce them. At the same time, in sub-Saharan Africa, where governments often spend less than $10 per person for the entire health sector and where many countries are being ravaged by the HIV/AIDS epidemic, it will take time to develop the necessary political commitment, mobilize sufficient resources, and implement programs. Meanwhile maternal mortality rates in sub-Saharan Africa remain the highest in the world. The United Nations population fund (UNFPA) reports that the maternal mortality ratio (the number of maternal deaths for every 100,000 births) is between 600 and 1,500 for most sub-Saharan countries (see Table 6)

Maternal Mortality Ratios in Sub-Saharan Africa, 1990s (Table 6)

	Maternal deaths per 100,000 lives births			
Region	1,200 to 1,800	800 to 1,199	500-799	less than 500
Eastern African	Burundi, Eritrea, Ethiopia Mozambique, Rwanda Somalia, Uganda	Zambia	Kenya, Sudan, Tanzania Zimbabwe	Madagascar
Middle Africa	Angola Chad	Congo (former Zaire), Congo Republic	Cameroon Central African Republic, Gabon	
Southern Africa			Lesotho, Swaziland	Bostwana Nambia South Africa
Western Africa	Guinea, Mali, Niger Sierra Leone	Benin, Burkina Faso, Cote d'Ivoire Ghana, Guinea-Bissau, Mauritania, Nigeria	Liberia Togo	

Source: UNFPA, The State of the World Population, 1997:67; and (for Swaziland) Carl Haub and Diana Cornelius, Population Reference Bureau 1997 World Population Data Sheet.

There is no evidence yet that maternal mortality has fallen since the adoption of the Safe Motherhood Initiative.

By contrast, maternal mortality rates have declined systematically in other parts of the world. This state of affairs is attributed to macroeconomic policies which have worsened socio-economic and living conditions in many African countries.
In Nigeria for instance, the number of people who live below the poverty line is 55 million.

The first is the increasing poverty in many African countries. Africa is rich in natural resources but poor technologically. The gap between the world in terms of technological development is nearly 3-fold. In the last 10 years, while rich countries grew 3 – fold economically, the middle income

countries grew one and half times while low income countries grew only minimally. There are nearly 47 poor countries in the world, out of which 29 are in Africa, with Nigeria being one of them.

Statistics indicate that 23 percent of the world's population earns less than 6 dollars per month. The poorer the families are, the higher rates of maternal mortality. The mass literacy campaign embarked upon by these low income countries is the major factor responsible for the low rates of maternal mortality.

The second factor contributing to the high rate of maternal mortality in Nigeria is the high incidence of un-booked emergencies in health institutions. These are women who during pregnancy did not receive antenatal care but who are seen for the first time during labor with complications. Such women were often exposed to the consequences of prolonged labour leading to uterine rupture, obstetric fistula and fetal death. They are also more likely to suffer postpartum neglect leading to blood loss and infection. These patients are poor risks for anesthesia and surgery, and are significantly more likely to suffer maternal mortality.

The Structural Adjustment Programme (SAP) introduced into Nigeria in 1985 is one economic policy that has ruined the health sector. In Nigeria, social problems started to surface in the early 1980s when a deep economic recession occurred. Debts were increasing while commodity prices were declining. The attempts of the International Monetary Fund (IMF) to restore fiscal discipline through the instrumentality of SAP, was a complete failure. To attain the objectives of SAP, workers were retrenched, subsidies were removed, the currency was devaluated and government owned parastatals were privatized or commercialized. Because the government could not totally finance health care delivery system, user fees were introduced and this led to a massive fall in hospital attendance. Thus, women began to resort to self treatment and to the utilization of cheaper but evidently more dangerous traditional forms of treatment. The increasing prevalence of unbooked emergencies in our hospital is a consequence of the economic difficulties suffered by Nigerians under the Structural Adjustment Programme.

The increasing economic hardships occasioned by SAP have encouraged the practice of prostitution thereby encouraging the spread of STDs/HIV.

Unfortunately, the name SAP has not encouraged the wide spread availability of modern facilities for the prevention and treatment of STDs. SAP has also adversely affected the Nigerian educational sector with the result that primary school enrollment has declined significantly over the last few years. This trend has both short as well as long term implication for the health of women and children in Nigeria.

These problems can be avoided if the right priorities are created, literacy and contraceptive use are widespread and equity in health care usage including antenatal, intrapartum and postpartum care takes place.

Female education is the fulcrum on which efforts to promote safe motherhood would revolve. Other essential conditions for safe motherhood in Nigeria are the following:

- Provision of satisfactory living standards leading to good general health.
- Basic essential antenatal care made universal; and
- Prompt and effective treatment of emergencies including operative procedures.

The Sub-Saharan African AIDS epidemic is a heterosexual epidemic and that sexual networking is influencing its spread. Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

HIV destroys the ability of the body to fight infection. In the developing world, nearly all HIV – infected persons dies from AIDS – related illnesses. A person infected with HIV may show no symptoms of AIDS for several years, but can transmit the virus to uninfected people through sexual contact, to an unborn child, to an infant through breastfeeding or through blood.

In Africa, heterosexual transmission is the major mode of transmission, followed by transmission from mother to infant before, during, or after birth. Contact with contaminated blood through

medical procedures or use of unsanitary needles are relatively unimportant means of transmission in sub-Saharan Africa.

The HIV/AIDS epidemic is a serious problem in many world regions, but it is especially severe in Africa. The United Nations Programme on AIDS (UNAIDS) estimated that sub-Saharan Africa has 20.8 million people infected with HIV, two-thirds of the world total for 1997. UNAIDS estimated that about 7 percent of sub-Saharan adults ages 15 to 49 were infected with HIV in 1997, a percentage several times higher than in any other world region.

The extent of the epidemic is difficult to gauge because most AIDS cases are never reported. National estimates of HIV prevalence and the number of AIDS cases reflect data from sentinel surveillance systems, as well as any other available data.

Why are levels of HIV higher in Africa than elsewhere? The epidemic has probably lasted longer here than in other parts of the developing world. The first cases were reported in the early 1980s. Although the origin of the disease has never been established, many assumed it came from Africa. Many African political and health leaders bristled at reports that HIV originated in Africa, believing that the continent was being unfairly held responsible for the epidemic. In the late 1990s , leaders were more concerned with the effect of the epidemic than with determining its origins.

Several factors contribute to the high level of HIV in sub-Saharan Africa and in specific areas within the region.

The high prevalence of other Sexually Transmitted Diseases (STDS) such as gonorrhea or cancroids. The presence of a sexually transmitted disease greatly increases the chances of HIV transmission during an unprotected act of sexual intercourse. The high incidence of multiple concurrent sex partners, wives may be infected by their husbands if their husbands have outside sex partners. The age and sex profiles of reported AIDS cases suggest that many young women are being infected with HIV from older men.

The high incidence of commercial sex and other transactional sexual relationships in the region. The extremely low rates of condom use until recently. Anti HIV and STD campaigns and social marketing have increased the availability and use of condoms in sub-Saharan Africa in the late

1990s, but availability and use have not increased enough to show the HIV epidemic. Low rates of male circumcision in parts of the region. Uncircumcised men appear to be more vulnerable to HIV transmission. Rapid rates of urbanization. Large numbers of working age males often migrate to cities without their wives or families and become involved in multiple sexual relationships. STD rates are high in the cities because of the large concentration of people and because many of the social norms that limit sexual contacts in the country side breakdown in the city environment.

Refugee and massive population movements generated by civil unrest and war, economic distress, and environmental disasters. Poverty, malnutrition, and a generally low health status, which make individuals less able to stave off infections of many kinds, including STDS.

Adult prevalence in Nigeria is probably still below 5 percent. But the country contains a large and growing number of HIV infected individuals. In 1997, an estimated 2.2 million people were living with HIV in Nigeria, more than in any other African country except South Africa.

The HIV/AIDS epidemic in western Africa also involves a different virus, HIV 2, which does not transmit an easily as HIV-1, the virus responsible for AIDS in the rest of Africa.

AIDS experts do not fully understand why a different form of HIV exists in Western Africa, or which biomedical, cultural, and economic factors may contribute to the lower rates in this region. Nevertheless, millions of people already are infected in Western Africa, and the adult prevalence rate is higher here than in most of the world outside Africa.

EFFECTS OF MORTALITY: The most obvious impact of the HIV/AIDS epidemic will be on mortality, both directly through AIDS deaths, and indirectly through strains on the health system, the increase in indigent orphans, and the facilitation of the spread of other diseases such as tuberculosis. AIDS also will deplete the experienced labour force in some countries because it tends to strike adults in their prime working ages.

Two factors govern the extent and timing of the effect of AIDS on death rates.

First, the epidemic has not yet peaked in Africa, with the possible exception of Uganda. Experts do not know how long it will take the HIV/AIDS epidemic to reach its highest prevalence in a given country because they have no historical evidence about the cause of the disease. There are only a few areas where prevalence appears to have leveled off. Many countries have introduced intervention

programs, but they vary in effectiveness and in the population they reach. An epidemic that started in the early 1980s is not likely to peak until the late 1990s or early 2000s, delaying the most devastating mortality effects.

Second, there is a long lag time between HIV infection and the development of AIDS. On average, a person is infected with HIV for three to ten years before exhibiting signs of AIDS. Sub-Saharan Africa in the late 1990s is just beginning to feel the full mortality effects from the epidemic, and mortality is expected to increase over the next decade.

AIDs mortality is erasing the hard-won gains in child survival in sub-Saharan Africa.

The UN and U.S. Census Bureau Projections show declining life expectancy in many countries because of AIDS reversing the long-term improvements of the past 50 years. Over the next decade, 5 percent, 10 percent, or even 20 percent of adults will die from AIDS in many sub-Saharan Africa countries. Hundreds of thousands of additional adults and children will become infected with HIV, ensuring high levels of AIDs mortality well into the 21st century.

Most recent demographic studies in Africa conclude that AIDS mortality will affect the age structure and growth of the population but will not cause population decline.

SOCIOECONOMIC AND POLITICAL EFFECTS: U.S. Census Bureau projections show that there may be as many as 40 million orphans in sub Saharan region in 2010, or about 16 percent of all children. Beyond the personal tragedies, this surge in the number of orphans will be a tremendous societal burden.

The HIV/AIDS epidemic also compounds the burden carried by women, even when they are not HIV infected. When AIDS strikes a family member, the responsibility for care falls disproportionately on women and girls. AIDS widows often face the loss of livelihood because women lack property and inheritance rights in many countries.

AIDs also will have an economic impact, although the AIDS economic relationship is not straightforward. AIDS strikes hardest among the young, working-age population, especially those ages 20 to 49. AIDS mortality is likely to degrade the quantity and quality of labour and reduce

economic productivity. AIDS-related illnesses and deaths increase expenditures and reduce revenues for companies.

Some analysts speculate that the overall impact of AIDS on percapita income may be negligible. While the epidemic may depress the overall productivity of African economies, it also will reduce population growth.

TREATMENTS AND INTERVENTIONS: There is a lingering hope that the AIDS virus will mutate to a more benign form and that the epidemic will fade of its own accord. But this is unlikely. Neither are new treatments likely to help HIV-infected Africans. For example, certain combinations of drugs - referred to as combination therapy or drug "cocktails" – can inhibit the spread of HIV in a person's body and in some cases even reduce it to below detectable levels. But combination therapy requires a strict regimen of drug administration, and testing that is not affordable or practical for Africa. By some estimates, the drugs cost about US$15,000 per patient each year. Many African governments spend less than US$10 per person for the entire health sector. More promising are less expensive drugs that help prevent perinatal transmission from infected mother to infant. These may become more widely used in the sub-Saharan region.

Many health policymakers and researchers are hoping for a vaccine that can prevent HIV infection. In the late 1990s at least two dozen experimental HIV Vaccines were being tested. Some have shown promise in test animals. But vaccines are unlikely to be available for at least five to ten years, and even if an HIV Vaccine became available, African countries would face the daunting logistical problems of inoculating large numbers of people.

Halting the spread of HIV will require both immediate action by political leaders and long-term reforms and projects that attack some of the cultural factors that perpetuate AIDS, STDS and other health problems that facilitate its spread in Sub-Saharan Africa.

Public education about the risks and consequence of HIV infection are paramount. Accurate knowledge helps individuals protect themselves and encourages them to be more open about the disease by removing some of the stigma associated with HIV infection.

While most of the sexually active population knows about AIDS, that knowledge is often inaccurate.

The major task facing political leaders, health workers and administrators is to convince people to change their sexual behaviour specifically, HIV infection can be greatly reduced if individuals reduce the number of sexual partners, practice safe sex (including use of condoms) delay sexual activity (for adolescents), and seek treatment for other STDs. These behaviour changes can be promoted and facilitated through mass media, public advertising, education, and counseling, as well as by health services. Many African countries are making condoms available in an unprecedented fashion through expanded public sector distribution, social marketing program, and workplace promotion, and condom use has increased. STD prevention and treatment programs are also promising.

Counseling and testing programs can help reduce perinatal transmission. HIV – positive women, for example, many choose to avoid pregnancy. Educational programs can also disseminate practical advice suggested by new research. Public health initiatives can combat HIV infection by screening potential blood donors and testing donated blood to ensure a safe blood supply.

Each of these interventions can help control the epidemic, but none of them alone is likely to be adequate. Because people respond to different programs and be achieved by messages, the greatest impact on the epidemic can implement a broad package of interventions.

These interventions need to be complemented by structural and contextual reforms aimed at long-term changes. Efforts to improve public health, raise the status of women, and create new jobs, for example, can also help control the AIDS epidemic and reduce other health problems.

RESUME.

Reproductive health services in the country are poor. The government should pursue social policies that will alleviate poverty and improve the state of health for women and children. There is neglect of socio-cultural factors by health professionals. There is a “pathetic” situation whereby mothers and babies are held up in hospital for a long period of time because they are not able to pay hospital bills. Health professionals should always consider social issues while attending to their patients in health institutions.

SAP inflicted more damage to reproductive health than it purported to offer.

To reduce maternal mortality in Nigeria, political will is needed on the part of *g*overnment and other policy makers. On the Federal Government recommendation of a maximum of four children per couple, it has since been shown that high parity does not kill rather it is poverty and illiteracy that kills pregnant women. The increase in maternal mortality with rising parity is a feature of poverty, illiteracy and backwardness. The government must seek ways to reduce the high rate of poverty in the country.

Political will is needed on the part of the government to confront the problem of maternal mortality in Nigeria. On a short term basis, health planners should organize and work out a system of referrals for pregnant women and to target the improvement of emergency obstetric care at the secondary and tertiary levels. The government should do away with user charges. Traditional birth attendants don't have a role to play in reducing maternal mortality rate in Nigeria.

Emphasis should be placed on training midwives who could even be made to provide home-based services as done in the past. There is a need to test the relative effectiveness of these approaches in reducing maternal mortality in the country.

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