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EDITORIAL TO

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The editorial board of Nigerian School Health Journal is proud that with this volume we are now comfortable to produce journals not in arrears. We also congratulate Bayero University, Kano or better still Kano State for hosting our 2000 national conference where this journal is presented and launched.

Journal production is expensive and we solicit financial support to enable us to continue to publish good health related papers for the advancement of knowledge. We want to assure readers that this edition contains position/empirical papers on diverse issues relating to population, sexuality education etc. that will broaden one's mind.

We commend this millennium edition to all.

- Editors

APPRAISING THE ROLE OF REPRODUCTIVE HEALTH, FAMILY PLANNING, MATERNAL AND CHILD CARE IN THE CONTEXT OF POPULATION STABILIZATION IN AFRICA

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Abstract

In a world of about 5.6million people, growing by nearly 100million more every year, the future of the planet and especially the portion of it known as Africa, depends on promoting population stabilization. The roles reproductive health, family planning, maternal and childcare can play in the achievement of these population stabilization form the focus of this paper. Factors affecting population stabilization can be classified into two groups; namely: background variables and intermediate or proximate variables. The former includes cultural, psychological, economic, social, health and environmental factors. The proximate determinants are those factors that have direct effect on population stabilization. The background factors operate through the proximate determinants to influence the stabilization of population since they do not have direct influence. This paper assesses the relative effects of four proximate determinants on population stabilization namely, reproductive health, family planning, maternal care and child care, illustrating different effects of each factor.

Introduction

Reproductive health, family planning, maternal and childcare are all issues linked up with the family. It is the aim of every African government to strengthen the family and for this purpose concentrate on the physical well being of all family members.

The population of any nation is that nation's most valuable asset, serving as both the agent and the beneficiary of national development. The realization of the above usually prompt many governments to embark on a series of development programmes aimed at improving the quality of life of the population. Quality of life can be situated in the quality of reproductive health, family planning, maternal and child care that the relevant strata of the population enjoy.

Population Stabilization

In demographic terms population stabilization or better still, optimal population refers to a situation where the available resources are in direct and corresponding relation with the number of people needing or making use of the resources. While certain of the resources needed in a

Table 1: Cause-Specific Probabilities of Dying by Board Age Group and Sex

	Cape Verde 1980		Bamako, Mail 1974-1985		Western sierra Leone 1972-1975		South Africa "Colored" and "Asian", 1971	
Cause of death	15-44	45-64	15-44	45-64	15-44	45-64	15-44	45-64
Males	10..3	35.1	46.5	118.1	64.1	137.3	33.1	86.5
Communicable/reproductive	0.6	1.3	7.2	64.1	6.7	24.5	1.9	3.1
Diarrheal	4.8	12.9	10.9	6.7	13.6	19.5	15.3	31.7
Tuberculosis		0.0	6.5	13.6	-	-	-	0.1
Non-communicable	4.2	19.3	8.3d	-	22.3a	53.5a	13.5	47.6
Neoplasms	20.5	123.0	89.3	22.3a	76.5	248.5	65.5	303.3
Cardiovascular	3.5	27.5	9.5	76.5	1.6	18.5	11.3	67.8
Digestive	7.9	63.7	11.8	1.6	13.8	69.0	25.1	157.1
Senile/defined	1.7	8.1	19.1	13.8	11.5b	29.0b	5.6	19.9
Injuries	2.1	7.3	27.1	11.5b	-	-	6.7	17.9
Unintentional	29.2	17.9	21.1	19.5	16.4	12.3	93.5	44.2
Suicide	18.7	13.1			-	-	60.0	32.4
Homicide	1.6	1.1			-	-	5.1	2.8
Total	8.9	3.7			-	-	28.4	9.1
	60.0	176.0	157.0	401.7	157.0	398.0	192.0	434.0
Females								
Communicable/reproductive								
Diarrheal	13.2	14.4	45.2	75.6	72.4	108.5	36.3	36.9
Tuberculosis	0.4	0.8	5.8	17.7	7.3	23.4	1.2	2.1
Malaria	4.2	3.4	4.8	11.7	8.5	9.3	11.7	8.7
Respiratory			4.2	9.1	-	-	-	-
Maternal	4.8	8.8	6.1a	21.0a	15.0a	30.0a	13.5	22.5
	2.8	0.2	11.4	0.7	19.8	0.6	7.7	0.6
Non-communicable								
Neoplasms	24.4	80.5	72.9	220.5	68.7	272.6	67.9	206.1
Cardiovascular	4.6	14.6	7.1	36.0	2.4	26.2	12.9	37.4
Digestive	9.4	48.5	15.9	61.5	10.4	85.1	26.2	124.1
Senile/defined	0.8	2.5	10.2	21.7	5.6b	20.7b	2.2	6.4
Injuries	2.6	3.7	21.3	62.4	-	-	7.4	9.4
Unintentional	9.4	5.1	6.8	11.0	5.9	4.9	6.2	13.0
Suicide	5.9	3.8	-	-	-	-	16.5	9.8
Homicide	0.8	0.3	-	-	-	-	2.2	0.7
Total	2.8	1.0	-	-	-	-	7.7	2.6
	47.0	100.0	125.0	307.0	147.0		131.0	256.0
Number of deaths								
Death registered (%)	432		15.801		4.542		11384	
Medically certified (%)	90+		77c		80		90+	
			60c		56		42+d	

Include chronic respiratory disease.
Category comprises diabetes mellitus, peptic ulcer, nephritis, and nephrosis.
All ages 5 years and over.
Not known, but 42 percent of death at all ages occurred in hospital.

SOURCES: Cape Verde (United Nation, 1987); Bamako (Fargues and Nassour, 1988); Western Sierra Leone (Wurrie, 1979); South African (United Nations, 1983b).

population are mutable, certain other resources such as land space are not easily mutable,The bottom-line for population stabilization is sustained decrease in fertility, matched by an almost equal decrease in mortality rate as shown graphically below. This is the refined and humane approach to population stabilization, where the quality of life of the living is improved so as to reduce morbidity, while a strong drive is made to drastically reduce fertility with this drastic reduction maintained or sustained at some tempo.

Another alternative demographic approach which I term the fatalistic approach to population stabilization can be seen in a situation where a slow decrease in fertility rate is matched with an increase in mortality rate, with the increase affecting any stratum of the population, but especially the middle and late adult strata of the population. As mentioned, this is a fatalistic approach, but an in-depth look at happenings in the world, appears to point to the fact that this is the approach being adopted rather subtly by world powers for Africa, and ignorantly by Africa herself. Though there is absence of articulate statements to this effect, or hard empirical data, but the benefits of hindsight, as well as the knowledge of the nuclear power status of many African nations seem to indicate that all the wars, germicides and genocide in many parts of Africa which previously had high population statistics, may not have been sustained if different world powers were not supplying arms and ammunitions to the different warring factions of those countries. This is where the world power dimension of the fatalistic approach hypothesis comes in. The ignorance dimension on the part of Africa comes in the warring leaders' lack of suspicion of the "hidden" agenda in the supply of arms to them, coupled with their short-sighted vision for their countries, as well as their rather monstrous ambition to be in or cling to power. Though Africa probably is not the only continent suffering from this fatalistic approach, but Africa seems to have been greatly hit as can be imputed from the statistics earlier quoted and also below.

In twenty-four (24) African countries for which data are available, adult mortality is high (Timoeus, 1993). The estimated probability of surviving from age 15 to 60 is under 70% in half of those countries of the content, and falls to less than 60% in Liberia, Sierra Leone, Mali and Madagascar. The male adult mortality rate is even higher and male adult survivor rate lower in Liberia, Sudan, Burundi, Rwanda and such other war-ravaged countries of Africa. In Southern Africa, which has just survived the consequences of apartheid, the differential between male and female mortality among the Blacks (majority) is as large as in Swaziland or Botswana, (Timoeus, 1993) or Lesotho where the hazardous occupation of mining, a lifestyle of heavy smoking and drinking, as well as an epidemic of tuberculosis originating from the mining activities have resulted in high adult mortality (Packard, 1990). The significant thing to note is that such conditions that prevailed in Lesotho are different from the conditions of apartheid, war and homicide that prevailed in Southern Africa. Between 1970 and 1980, in Cape Verde a total of 12.6% of the male population depletion was a result of war and homicide (United Nations, 1987), and this is shared in 8.9% for the age group 15-40 years, and 3.7% for the age group 45-64 years. For South Africa, for the same period, the figure attributable to war and homicide is 37.5% (United Nations, 1982), with 28.4% carried by the age group 15-44 years and 9.1% by the age group 45-64 years. If the female population figures were included, the figure due to homicide and war would definitely be higher. (See Table 1 for other causes of death and figures for other countries of Africa). Estimate data (Coale and Demeny, 1983, Timoeus, 1993) have shown

higher female than male survivorship in most sub-Saharan Africa. This can be viewed as rather the obvious of the explanation of depletion of the adult male population due majority to war (internal).

Before we go on to discuss the roles of reproductive health, family planning, maternal and child care in population stabilization, let it be pointed out that strictly speaking, population cannot be stabilized, for no sooner had decrease in fertility and increase in morality been achieved, than it will be found that there is a tilt in the population pyramid after some years. This is exemplified by the case of Sweden, which decreased fertility successfully, improved the quality of life of the living, and haven discovered a tilt, is now again campaigning for and encouraging increase in fertility.

Reproductive Health

Reproductive health has been defined as:

> A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system, and to its functions and processes.
>
> **ICPD, 1994**

The term "Reproductive Health", as a distinct concept is yet to find its way into country (national) or international parameters of consideration in population discourse. A search of population literature as recent as the last one decade indicate the absence of reproductive health as a distinction in proximate determinants or other factors of population or demographic discourse, or of health surveys. However, it must be observed that a few of the issues involved in reproductive health such as contraception, abortion, pathological sterility and bacterial amenorrhea feature in discourse of fertility and population. Other issues in reproductive health include prevalence of sexually transmitted diseases (STDs) and Reproductive Tract Infections (RTIs), teenage pregnancy, rape, and female genital mutilation (FGM).

Although infertility increases as a woman ages (natural sterility), studies have revealed that much of primary sterility (inability to have any children at all) in sub-Saharan Africa is caused by STDs and RTIs (Caldwell and Caldwell, 1983; Frank, 1983). Though it is generally believed that gonorrhea is the most prevalent STD affecting the African population, more recent studies (Roberts, 1996) have shown that other RTIs and STDs like herpes, chlamydia, and genital warts are known to adversely affect the reproductive capability of those affected. They cause tubo-pertioneal damage, and increase the percentage of gynaecological consultations for infertility. This negative reproductive health issue will not augur well for population stabilization.

If reproductive health is not positively promoted, there may be a situation where infertility will overtilt the children statum of the population, so that there are only few children able to grow into middle age and adulthood to support the workforce, the reproductive need and the productivity level of the nation. When it is remembered that:

(a) no matter how good the health care is, some children will die; and

(b) that the health care status of many African countries needs immense improvement, then it becomes more imperative to note that the positive responses to reproductive health issues are germane to the achievement of population stability.

Teenage pregnancy and "out of union" deliveries which still have a high prevalence in the African region are issues in reproductive health which need be focused upon and reduced in the march of Africa towards population stabilization. Van de Walle (1993) correlating age at first marriage with number of children ever born concluded:

If the married state were the context of socially sanctioned childbearing, one would expect to find a strong positive relationship between the proportions who are single and the proportions who are childless...., however, this relationship is not strong... if age at first marriage and age at first birth were the same, one would expect marriage to preceed the first birth by a number of months, if it truly marked the start of exposure. However, birth occurs in the absence of marriage.....

In Van de Walle's (Van de Walle, pp141 & 144) study, twelve African countries, namely Botswana, Burundi, Ghana, Nigeria, Kenya, Senegal, Togo, Uganda, Zimbabwe, Liberia, Sudan and Mali had high prevalence figures of teenage pregnancies and out-of-union deliveries. Apart from absolute population figure implications, teenage pregnancy also has health and economic implications. Some of the pregnancies end up in abortions, some end up in Vasico-Vaginal fistula complications. All these conditions have implications on resource use, which is part of general population implications.

The incidence of HIV/AIDS has had its toll as a reproductive health issue on the population of greatly affected East and middle African countries of Uganda, Kenya, Zimbabwe, Zaire and Burundi. Other African countries, in fact every African country has had its share of the HIV/AIDS pandemic, but the East and Middle African countries have been worst hit. It has been reported (Stoto, 1993) that as many as 5-10% of infants born in many of the cities of Africa, on the average, are HIV sero-positive. The estimated prevalence among adults (Chin, 1991) in urban areas is 20-30%, about 10 times that in rural areas. Rural areas along heavily traveled roads, however, tend to have higher rates. All told, the World Health Organization (1992) estimated that about 8 million people in sub-Saharan African are infected with HIV. This figure, which has serious implications for population stabilization, is expected to have increased, if increased figures noticed in some countries like Nigeria, and Ghana (Emeke, 1996) in the last three years can be used as reliable yardstick. A lot of information, awareness creation and behavior change programmes need to be mounted in many countries of the African region to combat this devastating, population reducing, health and economic draining epidemic.

Abortion is a factor to take cognizance of in the discussion of reproductive health. Although reliable and comparable cross-national estimates do not exist for most parts of Africa, especially sub-Saharan Africa, there is limited evidence indicating that abortion is substantial in some regions. Cocytaux (1988), in a review of literature on abortion, notes that studies conducted in the late 1970s and 1980s show rising hospital admissions for complications related to abortions. She notes that ethnographic data suggest that a greater number of abortions are performed than originally thought. Data on adolescent and unmarried urban women indicate that

abortion may be fairly common (Working Group on the Social Dynamics of Adolescent Fertility, 1993). Makinwa- Adebusoye (1991) also highlighted the economic consequences of abortions on the Nigerian economy.

Although, induced abortion has been identified as one of the subtle factors capable of and has been influencing population growth, (Jolly and Gribble, 1993), the fact remains that abortion is negative to reproductive health, hazardous to the health of the women, and morally unjust to the urban child. In societies where abortion has been legalized, one of the intents of the legislation hinges on population dynamics among other seemingly justifiable, though morally and religiously unacceptable considerations.

Family Planning

Family planning is a term, which often encompasses two distinct concepts- contraceptive use, and family planning services (Emeke, 1998).

Contraceptive use, here used in its broad sense, refers to any means, artificial or natural, employed by an individual or couple to avoid pregnancy, thus allowing women to meet their practical and strategic needs, by enabling them to control when and how many children to have. The second distinct concept, that is, family planning services refer to organized services put in place to provide family planning methods and ensure their safe and effective administration.
The proportion of women using contraceptives to space or limit births, and the effectiveness of the contraception used, directly affects a society's fertility level, and by projection, influence the level and rate of the stabilization of the population. In sub-Saharan African, contraceptive prevalence rates are general low. In comparison with other regions of the world (Rutterberg, et al, 1991). For example, in Nigeria in 1990, survey (Nigeria, 1992) revealed that only 6% of married women were using a contraceptive method though contraceptive use among women not currently married was twice as high, 13%. By 1996 survey data reported by Akumadu (1998), indicated that though contraception awareness has increased, the actual use has not undergone any appreciable increase. In Kenya, Botswana and Zimbabwe, contraceptive use was very low in the 1960 – 1970s, resulting in high fertility, but in the late 1970s to the late 1980s, fertility fell approximately 20% to a little more than 6.5 births per women. The decrease was attributed principally to an increase in contraceptive use (Brass and Jolly, 1993). There is also substantial use of the traditional methods, which though are not as effective in preventing pregnancy as the modern artificial methods (Jolly and Gribble, 1993), still play a role in reducing fertility rate and promoting population stabilization.

There is also a very small proportion of adults that does not actually engage in artificial contraception or adopt the artificial family planning method to space births or plan family size, but engage in or use the natural family planning (NFP) method. The NFP has been found to be very effective in the small proportion using it (McSwenney, 1992). It is safe, and because it is natural, it is healthy and reproductively health – promoting , eliminating all the known hazardous side effects and health consequences of the presently available artificial methods of contraception. It is in fact a method that many more couples should adopt and use.

The Intra-Uterine Contraceptive Device (IUCD) - one of two commonly used family planning device (Emeke, 1998; Zurayk, et al, 1994), for example has been found to:

Precipitate reproductive tract infections.
Intensify cervical cell changes.
Lead to increased menstrual bleeding.
Cause genital prolapse, especially the serious form, to be more uncomfortable to the patient. and
Permit lower tract infections to be carried to the upper tract using the thread of the IUCD as a route.

The pill, the second most commonly used contraceptive – device among sub-Saharan African women, is contraindicated for women with high blood pressure, older obese women, and those with cardiovascular disease. (Zurayk et al, 1994: Wasserheit and Holmes, 1992).In fact, it is the contention of this writer, that the international donor agencies, and world health bodies should devote funds to the promotion of strategies and techniques that will bring people not only to the awareness of NFP, but also encourage the widespread use of NFP in the drive for population stabilization, via the strategy of reducing fercunality. Any population stabilization intervention that will promote life while still achieving its aim, should catch the attention and fund of donor agencies. It is to be mentioned that a lot of education, dissemination of information, and communication among all relevant people - couples, medical personnel, government, donor agencies etc., is needed to ensure the success of the use of the natural family planing (NFP) method.

Deciding to adopt a new method, which NFP will be to many people, though is a matter of individual decision, is often crucially affected by the positive nature of, and intensity of publicity and awareness creation given it. Once acceptance is secured. The individuals who make up the community and the society can gear into action many of the channels, which can translate the policy or the method to viable action. As was contained in the Washington Speech Series (1981), decisions affecting population are in the final analysis made by the millions of individual men and women. Whatever the technology employed, the most effective programme is one, which reached men and women directly through the channels, which they know and understand. So, people will accept the NFP if it can be presented to them effectively in the way they will understand the benefits therein.

Maternal Care

Maternal care involves such issues as ante-natal care, delivery assistance, and post-natal care. Mothers should receive good ante-natal care during pregnancy in good hospitals. Antenatal care can be more effective when it is sought early in the pregnancy, and is continuous through to parturition.

Maternal mortality, which is one of the important issues in maternal care and population discourse, is a term used to describe the death of a woman during pregnancy, labour, or the first six weeks of delivery. While developed countries like Sweden, U.S.A and Canada are now recording low maternal mortality rate, between 2 and 6 per 100,000), many of the countries in the African Region are still recording high maternal mortality rate as high as 1,050/100,000 in Nigeria and Tanzania (Okonofua, 1996) and the average of 606/100,000 for the African sub-region (Naq, 1996). Maternal mortality has its highest recording at the post-delivery period as a

result of complications of delivery, mal–nutrition, post-delivery poor medical services, economic incapacity and sheer ignorance. The result of socio-demographic risk factors and maternal mortality among a cohort of African women indicate that women who died in pregnancy were younger and of poorer socio-economic status, as compared to women who survived. Women aged 20 years or less were four times more likely to die during pregnancy as compared to those aged more than 20 years. Women's education had a strong ameliorating effect on the risk of dying during pregnancy. The higher the educational level of the women, the lower the odd ratios for dying during pregnancy. Even a primary level education significantly protected women from dying as compared to no education. The study of Okonofua, Abejide and Makanjuola, (1992) confirm the above. The health and population stabilization implications of maternal mortality make the issue demand a critical view.

There are several practices women can follow after the birth of a child, that delay a subsequent pregnancy. A woman is unable to conceive after a pregnancy until her normal pattern of ovulation returns. When she is breast-feeding primarily by the length of lactational amenorrhea is determined the duration, intensity and pattern of breast-feeding. This is why the present UNICEF promoted campaign of exclusive breast-feeding has a double-edged benefit of keeping the child healthys, thus reducing infant/child mortality as well as reducing fertility rate.

Also, in a number of African societies, sexual relationships are not permitted while women breast feed their newborn children, further reducing the chances of conception while the healthy conditions of both mother and child are increased. It would have been good if this practice is not only continuing but is on the increase, but the reality is that the practice is dying out. It was possible in the past when polygamy was the practice, but since polygamy is on the decline due to increased level of education, and socio-economic down-turn among other factors, (Nigeria 1992), many socio-cultural practices which also have population implications are either undergoing change or dying out.

Child Care

The main issue to consider in childcare with regard to population question is childhood mortality. Demographic figures available (Hill, 1992) show that childhood mortality rate for the African region between the late 1940s and the late 1970s was very high in the region. Though there appears to be a decline since World War II in all the countries for which data were available the decline cannot be said to be appreciable. Some countries like Ethiopia, Mozambique, Rwanda and Sudan had experienced periods of static or rising mortality against a background of civil war, and disruption of normal socio-economic development.

From the middle 1980s to the very early 1990, figures still indicate a rather high childhood mortality rate across the region. When, it is recalled that child hood mortality-promoting factors, like poor solid economic growth, political instability, wars and internal strifes, natural disasters as well as the global economic recession and the AIDs epidemic prevailed in many countries of the region during the period in question then the trend would not be a surprise. Countries like Mozambique, Sudan, Angola and Malawi for example , suffered internal conflicts; Uganda, Kenya and Zimbabwe did not just suffer civil wars, and economic collapse

sometime during the period, but also was badly hit by the AIDs pandemic, which killed parents which could take care of children or the children themselves, even newly born ones. Examples can be multiplied from the other nations of the region.

The main point of emphasis in the fore-going is that child care still must receive the attention it deserves when population stabilization is the goal. Nations in the African Region should borrow a leaf from Botswana, whose childhood mortality rate has been consistently declining since 1955-1985-(the period for which Hill (1992) had available data). Botswana enjoyed rapid and economic growth, erected fast-developing infrastructure and social services, and upgraded child health and nutrition to an excellent level. As a result, Botswana appears now to have the lowest child mortality in Sub-Saharan Africa, and can be reckoned with when child care is being considered as a possible ingredient for population stabilization.

Conclusion

Access to good reproductive health facilities, life and love-promoting family planning services, good and improved maternal as well as child care programmes are important proximate determinants playing crucial role in the achievement of population stabilization in any part of the world, Africa inclusive.

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