

HEALTH BENEFITS OF FAMILY PLANNING

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FAMILY PLANNING MANAGEMENT TRAINING WORKSHOP
BY COLLABORATIVE EFFORTS OF BENDEL STATE
MINISTRIES OF HEALTH, LOCAL GOVERNMENT,
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INTRODUCTION

One of the most dramatic demographic changes in the last three decades of population transition has been the ability of the sexually active woman whether married or not, to exercise control over family size. The mass availability of highly effective contraceptives, has made possible this new dimension of fertility control. Unfortunately, however, while the developed countries of the world have used family planning as a strong and important check on their population, contraceptive practice is still very low in the Sub-Saharan Africa, with attendant high fertility and growth rates.

Population increase and the need for family planning must be seen in its biological perspective. Malthus (1798) in his now famous essay, postulated that population was limited by disease, war and famine. This was true perhaps in many parts of the world particularly in Africa, when man's success to rear children depended largely on his capacity to reproduce and make good his losses from war famine, disease and slave trade. The situation has now changed dramatically due to better international understanding and improvement in medical science since the last century. Now that natural checks on population are being removed, more children survive to maturity and in turn have their families, resulting in a more rapid growth of the human species than ever before.

African women are pregnant for 18 - 20 years of their lives, as compared with 3 - 5 years for women in developed

countries (Sai 1987). It will not surprise anybody therefore, that the African women, particularly in West Africa, including Nigeria, are the most prolific in the world, rivalled only by those of South West Asia. The average West African woman bears 6.8 children in her reproductive years compared to 6.6 in East Africa, 6.0 in Central Africa, 5.2 in South Africa and 1.9 in most industrialised countries (Peope. 1PPF 1981). This has been confirmed recently by Makinwa (1982) who found the fertility rate in Lagos metropolis to be 6.7, and by a team in Benin-City, where the prevalence of grand-multiparity was about 20 percent (Diejomaoh Omene and Omu 1977). Unfortunately, very high morbidity and mortality accompany child-birth in Sub-Sahara Africa, especially in Nigeria. Much of the maternal morbidity and mortality is attributable to high-risk pregnancies that could be avoided through effective use of family planning.

In this article therefore, there will be a state of problem of non-utilisation of family planning in Nigeria and the attendant health implications of the continuum adolescent pregnancy to grand-multiparity. A catalogue of health benefits of fertility will be delved into. Solutions will then be suggested to achieve the dream.

STATEMENT OF PROBLEM AS NEED FOR FAMILY PLANNING:

The greatest problem facing many countries of the world today in general and individuals in particular is population. The resources and infrastructure available are not conveniently

adequate for the teeming population especially in our great country, Nigeria. Growth in utilisable resources in terms of food, housing, education and employment potentials are not keeping pace with contemporary population growth trends. Since 1953, the population of Nigeria has almost tripled. The Gross Domestic Product has shown no improvement whatsoever.

It is well known that changes in the population of any locality is a determinant of four interacting factors, namely, births, death, immigration and emigration (Brown and Selznick). Of these factors, birth has the greatest influence because it is to a greater extent determined by the personal decision of the individual. It is obvious therefore that if the population of any country like Nigeria needs control, it is the birth rate that should have the searchlight.

According to the Fourth World Food Survey, 28 percent of the population of the whole African Continent was underfed in 1972-1974. My modest projection is that about 60 percent of Nigeria are underfed 1986-1988. Between 1974-1983, Nigeria was dependent on food imports. Every food item became an essential commodity. With the FEM and SAF, we have got mixed blessings. Dependence on food imports is now compulsorily over. However, the common man cannot afford the high costs of the local food like garrri, rice, beans and maize. How do we feed our large families, cloth and house them, and give them the opportunity of a sound education.

While Family Planning has been integrated as a National Policy in almost all developed countries of the world, only twelve governments out of 48 members of Organisation of African Unity (O.A.U) have an official policy to reduce their population growth rate namely, Ghana, Benin, Kenya, Uganda, Botswana, Lesotho, Swaziland, South Africa, Mauritius, Senegal, Burkina Fasso and Mozambique. These countries now have a better understanding that in helping with the problems of fertility through control measures, governments are actually investing in the next generation. Nigeria has recently, (early 1988) recognised the problem of rapid population and pegged the number of children a woman can have to four. This decision has generated a spate of criticism. This is a laudable decision and a first step in the right direction. It will certainly demonstrate the health benefits of family planning.

Government policies on family planning however well intentioned will fail if there is no acceptance of the idea itself at the family unit base. The problem of fertility control at the family unit level, has a spectral pattern, from adolescence to climacteric, when the ability or capacity to reproduce is in abeyance.

ADOLESCENT FERTILITY

Adolescent marriage and pregnancy have been the rule in most rural African Community (Effiong 1975 Arkutu 1979). A recent population report (1980) revealed that about 43 percent

of 15 year old teenagers were already married in Kano, in Northern Nigeria. Early child bearing is associated with high parity, short birth intervals and large completed families. The problem of adolescent sexual maturity has been compounded by the trend towards earlier menarche. The average age of menarche in Nigeria is about 13 years (Diejomaoh). The adolescent parturient is faced with problems of severe pre-eclampsia and eclampsia, anaemia, and cephalo perlvic disproportion. The incidence of vesico-vaginal fitula is highest among this group of parturients. Preventing early adolescent child-birth has benefits for the individual girl and for the society, because the place for the adolescent girl is an educational institution.

According to several workers (Ferdinard, Omu et 1981) the African School girl is prone to unwanted pregnancy because of her ignorance about the use of and lack of access to contraceptives. Omu (1981) found that 37.5 percent of the adolescents had had 1 - 3 induced abortions or live births at the time of the index admission with complication of induced abortion yet had no knowledge of fertility control methods. Illegal induced abortions are done by untrained, non-medical chalatants who use poor, septic techniques and dangerous methods. The result is that induced abortion is the common cause of death among young girls in Benin-City (Omu et al 1981).

For those adolescent girl who are lucky to get to the Hospital fairly early usually with complications of induced abortion like lacerated cervix, perforated uterus, gut injuries, acute pelvic inflammatory and endotoxic shock may survive after one to six month stay in hospital. This is usually at a huge cost to the family or state. The young lady may then loose many schooling or working hours. More seriously, is the problem of persistent ill-health and infertility caused by septic abortion. About 60 percent of women who have infertility problem later in life, may have an underlying previous induced septic abortion. There might not have been ~~overt~~ clinical infection. Sub-clinical infection from use of septic technique can also lead to tubal blockage.

Sexually active young girls are open to multiplicity of partners with attendant hazards of sexually transmitted diseases like gonorrhoea, syphilis, chlamydia and AIDS. These can be easily prevented by barrier method especially durex, diaphragm, and spermicides.

PROBLEMS OF THE GRANDMULTIPARA

In the developed countries the economic and social implications of bringing up large families, coupled with the universal availability and use of effective contraception backed by liberal abortion laws and the general improved health facilities ensuring survival of most delivered children, have led to grandmultiparity becoming a rarity (Diejomaoh, Omene and Omu). However in most Sub-Saharan countries,

there is general desire for large families reluctance to utilise contraception and inadequate health facilities. The resultant effect of this situation is a vicious circle of high perinatal and infant mortality and increasing grand-multiparity. The complications associated with grand-multiparity include anaemia, hypertension, placenta praevia and abruption placentalis. Ruptured uterus, a common cause of maternal mortality and morbidity is exceptionally high among grandmultipara (Oronsaye and Asuguo 1980). Dystocia mainly from cephalo-pelvic disproportion and malpresentation is also common (Omu et al 1981).

MATERNAL MORTALITY

Maternal mortality is one of the important indicators for comparing health standards in different countries or at different times in a community. England and Wales had maternal mortality of 0.11 per 1000 or 11 per 100,000 live births (DHSS 1985). In Nigerian studies from hospital data, have shown maternal mortality range from 5.2 to 17 per 1000 or 520 to 1,700 per 100,000 (Unuigbo et al 1987, Harrison 1986, and Feyi-waboso 1981). With a little statistical analysis and extrapolation, there is 50 to 150 relative risk of having a baby in Nigeria, compared to England and Wales. On the other, it is extremely sad to note that if there are about 4 million live births annually, 20,300 to 68,000 women actually die!

Now, although grandmultiparity accounts for about 20 percent of the maternally population in U.B.T.H., it is related to 55 percent of the maternal mortality. The first conclusion one is immediately attracted to jump into is that maternal mortality can be reduced by more than fifty percent if women have only four children. That is if they do not become grandmultipara. In other words, the high maternal mortality in Nigeria can be drastically reduced perhaps only by a conscientious family planning programme fully integrated into the maternal and child health services.

OTHER FACTORS INFLUENCING MATERNAL MORTALITY AND MORBIDITY

Complications of pregnancy and delivery are still major causes of maternal mortality and morbidity in Nigeria. These include anaemia, hypertension, disorders, cephalo-pelvic disproportion and malpresentation leading to prolonged obstructed labour. Some maternal diseases like diabetes mellitus, renal diseases, sickle cell disease, thyroid dysfunction, tuberculosis and leprosy are made worse during pregnancy. They on the other hand contribute to maternal mortality and morbidity.

The age of the patient makes tremendous to maternal if she give pregnant and delivers after 30 years of age. By the time she is 40 years, the risks are more than double.

A recent trend in the abortion issue in Nigeria is that it is no more the exclusive indulgence of the adolescent adult

women, married or not are now involved with the attendant risk of infection, haemorrhage and death. In Nigeria, more 1 in 4 married women agree to have had previous abortion.

INFANT MORTALITY

Child born to women aged 20 and younger and to those aged 30 and older are more likely to die in infancy than are children born to women in their 20s. Infant mortality is about 100 per 1000 live birth in Nigeria. These rates are 5 - 10 times those for developed countries. Children born after an interval of less than 24 months are about 50 percent more likely to die in infancy than those born after an interval of 24 - 27 months. From infancy to adolescence, children born into large, or closely spaced families experience more sickness and slower growth and attain lower levels of education.

The most common causes of perinatal mortality are birth trauma, low birth weight, antepartum haemorrhage and toxæmia. In Nigeria 2.5 percent of annual deliveries are still-births (World Federation for Health 1984). Women whose last infant survived want fewer additional children than do women whose last child did not survive.

WHAT IS FAMILY PLANNING?

According to Morris (1977) family planning covers research into normal reproduction, contraception, investigations and treatment of infertility and habitual abortion, genetic counselling and evaluation of pregnancy termination as a method of family limitation. The purpose of family planning therefore

is to limit population to the resources available and so make a better life. There are therefore, two broad components of family planning namely, Fertility control and management of problems of sterility and infertility.

INFERTILITY

Infertility is a major problem for both men and women in Nigeria, in which 10 - 20 percent of women are childless at the end of their reproductive years, with a large number of women experiencing secondary infertility. The commonest cause of infertility in Nigeria is infection (Osoba). The commonest preventable cause until recently was infection from induced abortion. Pelvic inflammatory disease due to sexually transmitted disease is increasing rapidly in proportion. The major sexually transmitted diseases causing infertility, are gonorrhoea and chlamydia.

Apart from the problem of chronic ill health these women suffer from, they are psychologically a deprived group. Divorces and abandonments are common on the basis of infertility. Free lancing or multiplicity of sexual partners is very common among infertile women. The situation is made worse by the traditional belief that a man makes no contribution to infertility. Infact, it is held by many cultures that a woman's infertility is a result of retributive justice for her infertility.

HEALTH BENEFITS OF FAMILY PLANNING

Family planning is one of the components of Primary Health Care. Tangible health and social benefits from family planning

have been exhaustively documented in medical and social science research (Kessler et al 1973). Well spaced, smaller family can bring improved health status and a better life to children and their parents, and make a positive contribution to the welfare of the family and the community.

Research has shown that birth defects, mental retardation, prematurity, maternal and infant deaths, infectious disease in both parents and children, the chance of child abuse and various other adverse outcomes like malnutrition and domestic injuries increase when when family is large, when births are closely spaced, when pregnancy occur very early or unusually late in a woman's reproductive life (Barnes 1978). Eugenic benefit of family planning is to stem the perpetuation of a seriously harmful genetic trait like the down's syndrome, sickle cell disease, klinefelter's syndrome and Pheny Ketonuria.

Family planning improves children's health by helping women to space their births, have smaller families and avoid pregnancies and unfavourable age or with chronic medical disorders. The resulting changes in child-bearing inevitably contribute substantially to dramatic decline in infant mortality. Family planning can also reduce the number of high-risk pregnancies and subsequently reduce maternal mortality therefrom. In Bangladesh, it was estimated that the number of maternal deaths would decline by over 25 percent if all pregnancies were confined to between 20 and 35 years.

The situation is likely to be the same in Nigeria. The greatest impact of family planning on maternal and child health in Nigeria, will be through prevention of grandmultiparity.

PREVENTION OF GRANDMULTIPARITY BY FAMILY PLANNING

The health hazard nature of high parity can be reduced by an interplay of a number of factors that can be sustained by the bedrock of family planning, to assuage the sexually active group.

(1) Age at marriage and first child birth:

Postponing first birth until 20 years or later would significantly reduce maternal and infant mortality and morbidity, slow population growth and contribute to improvement in the quality of life. According to Morris et al twenty-seven percent of the reduction in the U.S. infant mortality rate for 1965-1972 was attributable solely to shift in age of mother and birth order. A recent Chinese policy recommended that women delay marriage until their middle to late 20s. This policy has been recognised as a means of slowing population growth and improve maternal and child health.

(2) Education:

There must be emphasis on women's development as to their role in Nation building. Institution scholarship will further enhance the postponement of age at marriage and first maternity. The experience

in Benin-City was that those with Primary School education only had an average anticipated family size of 7.8 child while those with Secondary School was 4.1. It was found that even where some of them with Secondary to University opted for crash programme to make up lost ground, there was found to be generation gap, which has a positive impact on population control. In parallel with education should be infrastructure that will create gainful employments.

(3) Birth spacing:

Spacing pregnancies will improve the health of both the mother and her children. This will permit the first infant to be independent of breast milk, able to walk before the next arrives. A shorter interval will give rise to protein-calorie malnutrition and of course there is the burden of carrying two children (Saxton and Saxton 1966, Jelliffe).

(4) Ideal Family Size:

In line with the thinking of many researchers in reproductive health, the Nigerian Military Rulers have recently pegged the family size at four children. If this policy is sustained, maternal and infant mortality will certainly tumble to low levels. This dream can only come true if there

is a bold fertility control measures that will recognise family planning as a component of Primary Health Care, using available methods like the hormonal contraceptive pill, and injectable intracetrerine contraceptive device, barrier methods, natural methods like breast feeding and surgical contraception.

CONCLUSION

It gives one a hopeful feeling to note the great progress being made in Nigeria to implement strategies of health for all through Primary Health Care. Family Planning should be carried along with these efforts.

2. Contrary to unwarranted propoganda, the concept of family limitation and birth spacing is not new to Nigeria. The women had hitherto resorted to various natural and medicinal contraceptive methods in an attempt to limit family size and space birth. Prolonged breast feeding and temporary separation of the wife from the husband, was also used (Network 1981).
3. Maternal and infant mortality and morbidity are still very high in Nigeria. Adequate attention and resources should be given to reproductive health care and to family planning in particular. A situation where scarce resources are used to care for high risk pregnancies and complications of sexually transmitted disease should be prevented through

better education and family planning services.

4. Government should implement population and maternal child health and Family Planning Policies that will improve health and enhance the quality of individual and family life, by providing accessible, affordable and effective services for reproductive health Management, including counselling and a choice of temporary and permanent methods.