Why invest in reproductive health in Cameroon?
Why invest in Reproductive health in Cameroon?

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On May 16th, 2012, four international health agencies, namely the WHO, UNICEF, the UNFPA and the World Bank presented their report, "Maternal Mortality Estimates" in Geneva, which provided information on the new maternal mortality estimates at the global, regional and local level. Analyses are without ambiguity: globally the maternal mortality is losing ground throughout the world, even if that tendency is minor in some countries or practically non-existent in others. In Africa, the maternal mortality rate has dropped from 870 deaths for every 100,000 live births in 1990 to 630 in 2008, a remarkable 27 per cent drop off between 1990 and 2010. The number of mothers who die per year across the continent has thus decreased from 250,000 to 180,000.

The heads of the four quoted agencies estimate the fall in maternal deaths in developing countries by 70% and those of new-born babies by about half if the world could double the investment in family planning and pregnancy-related health care. Presently 358,000 maternal deaths are occurring yearly in the world, many of which could be easily prevented in developing countries.

In Cameroon, we are regrettably in a position where the Millennium Development Goals number 5 (MDG5)—which aims at reducing the maternal mortality, remains the one that the country is the most far from reaching. According to the methodology of the study quoted above, the estimated maternal mortality rate is around 600 per 100,000 live births in Cameroon. In other words, every two hours, a woman is dying through birth giving.

The MDG 5 is the focal point of the entire Millennium Development Goals. In fact, the quality of the maternal health care system reflects the quality of the whole health care system. The MDG 5 is not only about health, but it is also about gender equality and women empowerment alongside the actors and decision makers of the state education, the youth, public finances, economy and planning, communication, transport and public works as well.

The present document shows where Cameroon stands as concerns the Millennium Development Goals number 5b.

Improving the reproductive health is a major concern for the Cameroon Government as it is clearly stated through the documents orientation framework on strategic development which are the 2035 vision and the Growth and Employment Strategy Papers (DSCE), that’s why in the Growth and Employment Strategy Papers, the Government has shown their intention to invest in the health sector, with emphasis on the youth and women, as well as the guidance and support for the socially fragile groups.

It is now admitted that investing in a small number of basic health services, such as family planning and routine health care at delivery, could save millions of women and babies. For most, these are low-cost simple services that can be provided locally, supplemented with urgent health care or treatment if need be. Recent studies have demonstrated that it was profitable to invest in the maternal health care and family planning.

It is our greatest wish that through this publication, the multifaceted investments in the women and infants health would increase, since investing in maternal and the reproductive health, investing in the youth and gender equality will allow us to “...bring about a world where each pregnancy would be desired ... each birth without danger ... and the potential of each young person would be achieved”. Vision translated from the Growth and Employment Strategy Papers, DSCE, on 1.3.1. Health.
INTRODUCTION

The conceptual evolution in the fight to reduce the maternal mortality has evolved since the independences with the International Conference on Population and Development (ICPD) held in Cairo in 1994, as the concept of Maternal and Child Health and Family Planning (MCH/FP) was replaced by the broader concept of Reproductive Health.

The Cairo conference has defined the Reproductive Health as the general wellbeing of an individual, which includes the physical, mental and social wellbeing a person as regards the genital organ, its functions and its functioning, not only the absence of diseases or infirmities.

During the National Symposium on the Reproductive health held in Yaoundé from the 14th to the 17th December 1999, Cameroon, with regard to the resolutions of the Regional Forum held in 1996 in Ouagadougou and workshops held in Bamako and Libreville in 1998, defined eight (08) priority sectors taking into account its own national specificities, namely:

i. Maternal and infant health (MMR, new born health care, pregnancy termination related health care, IMCI);
ii. Family planning
iii. The fight against STDs, HIV/AIDS
iv. The fight against infertility and Sexual Dysfunction
v. The fight against Harmful Practices (excision, domestic sexual violence, early marriage)
vii. The Health of the Teenager
viii. Coverage of the Reproductive Health of the Elderly (ECA, Male menopause, Menopause, Sexuality)

The main targets selected are: women, children, teenagers and young people, men, elderly people, handicapped people, refugees and moved. On this basis, four elements were retained: :

• The health of the woman ;
• The health of the child ;
• The health of the teenager and youth ; and
• The health of the man.

One prime reproductive health indicator, the maternal mortality rate, has increased in an unacceptable way in recent years, despite many decades of international and national agreements and actions: 430 (1998), 669 (2004) and 670(2012) births for 100,000 live births. Various world economic crises, the reduction of Family Planning measures by certain countries among which Cameroon, and the reorientation of priorities towards the fight against the HIV, partly accounts for the present degradation in maternal health.

In order to implement retaliating measures, the government of Cameroon has signed up to international agreements (ICPD, MDG, Declaration of Paris, Declaration of Abuja, Maputo Agreement,…) with the support of the partners to the development and set up political strategic tools and programs aiming at reducing the maternal and infant mortality in the long run.
The Sectoral Health Strategy - SHS(2005-2015), the National Reproductive Health Policy, the National Strategic plan on the Reproductive Health, the CARMMA plan are as many documents which strategically are set up to meet this goal.

However, in spite of the efforts made by the authorities to inflect this rising curve, changes on various strategic levels are not yet perceptible, and it should be thought of undertaking new initiatives aimed at reducing drastically maternal mortality for a great and lasting impact on the development.

Writing the present document aims at following this purpose, which focuses on rallying the general opinion, particularly decision makers, planners and various strategists of the public and private sectors and civil society at different levels of the social pyramid, for more commitment and investment in the reproductive health in general and for the reduction of maternal mortality in particular while repositioning the Family Planning by giving priority to the more vulnerable population such as the women, the children and the teenagers, particularly young girls.
Why invest in Reproductive health in Cameroon?

POTENTIAL DEMAND IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN CAMEROON
1-POTENTIAL DEMAND IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN CAMEROON

The Reproductive Health is a concern of any age through the life cycle and represents more than 80% of health issues. The forecasts on the reproductive health services must take into account the population’s structure (its age), its diversity and its dynamics for specific needs within the various groups. The teenagers are a priority target, because 43.6% of the population is less than 15 years old.

1.1 Vulnerable and health hazard populations in reproductive health

As regards the reproductive health, vulnerable and at risk populations form the priority targets of the interventions. Vulnerability refers to the limitations and disadvantages of certain groups among the population, or their precarious reproductive health, which reduces the protection guarantees for them. These risks refer to a set of behaviors which a person would display, endangering himself/herself or others.

Groups of people generally considered at risks as far as reproductive health interventions are concerned are: women, the young girl, teenagers and the youth. Moreover, the demographic weight of the women (15-49 years), of the teenagers (10-19 years) and the young people (15-24 years and 15-34 years) in procreation age in comparison with the total population of the country will remain important during the next decades.

It is in these groups that the highest levels of sexually transmissible infections (including HIV/AIDS) and the greatest number of unwanted pregnancies are generally recorded, ending up sometimes in clandestine or dangerous abortions. Women, teenagers and the youth often have little or not information on sexual and reproductive health issues and hesitate to take necessary measures to protect themselves.

This global view should not mask the fact that within these groups, there are sub-groups more vulnerable or more at risks. The rural woman or family is more vulnerable as far as RH is concerned than the urban or suburban woman. The teenager living in the cities such as Yaoundé and Douala has a more hazardous behavior than those of the countries.

Demographic forecasts have estimated that the population increased from 17,463,836 inhabitants in 2005 to 20,636,954 inhabitants in 2012, and will probably reach 22,179,707 inhabitants in 2015 and 24,910,305 in 2020. The demographic weight of the women (15-49 years), of teenagers (10-19 years) and of the youth people (15-24 years and 15-34 years) in procreation age compared with the total population of the country will remain important during next decades.

1.2 Women in procreation age (15-49 years)

The amount of the female population in procreation age in comparison with the total population will increase from 24.3% in 2005 to 24.6% in 2012, and finally reach 25.0% in 2020. The initial 4,248,727 figure in 2005 will be multiplied by 1.2 in 2012, that is to say 5,085,135, then by 1.5 to reach 6,229,914 in 2020. The structuring is aimed at facilitating international comparison, so let us not forget the young girls of less than 15 years old (12-14 years) which are already exposed to pregnancies risks, as showed by the 3rd General Census of the Population and Housing (RGPH): at 15, 100 girls already have more than 7.1 children with all the early fertility related risks (obstetric fistula for instance).

Rural women are also a vulnerable group, due to their poverty.
1.3 Teenagers and youth

With regard to teenagers and the youth, it appears clearly that the Cameroon population is young and will remain so for a long time. The percentage of the people of less than 15 years which was 43.6% in 2005 would regress by only 1.3 point over the 15 coming years (2005-2020).

The percentage of the teenagers aged 10-14 which was 12.4% of the total population in 2005 is at 12.2% in 2012 and will not change significantly until 2020 (11.9%).

The relative importance of the teenagers aged 15-19 years old ranges from 11.2% of the total population in 2005 to 11.4% in 2012 to reach 11.6% in 2020. Among these teenagers, the young girls are a priority target for Reproductive Health services, in view of their vulnerability; according to the demographic and health census (EDS-MICS), 23% of women are aged 15-19 years old, a group where early marriages, early sexualities and other sexual violence are recorded.

The population of youth of 15-24 years which was 3,606,696 people in 2005 will be multiplied by 1.2 and 1.5 respectively in 2012 and 2020. All in all, the population of the young people aged 15-34 will increase at the same rhythm as that of those belonging to the 15-24 group, therefore increasing from 6,061,263 in 2005 to 7,274,284 in 2012 and reach 8,911,891 in 2020.

<table>
<thead>
<tr>
<th>Year</th>
<th>Women in procreation age</th>
<th>10-14 years</th>
<th>15-19 years</th>
<th>15-24 years</th>
<th>15-34 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>2005</td>
<td>4,248,727</td>
<td>1,107,716</td>
<td>1,053,890</td>
<td>2,161,008</td>
<td>961,639</td>
</tr>
<tr>
<td>2010</td>
<td>4,845,514</td>
<td>1,221,236</td>
<td>1,166,550</td>
<td>2,387,788</td>
<td>999,065</td>
</tr>
<tr>
<td>2012</td>
<td>5,085,315</td>
<td>1,282,669</td>
<td>1,225,249</td>
<td>2,507,958</td>
<td>1,348,646</td>
</tr>
<tr>
<td>2015</td>
<td>5,506,148</td>
<td>1,362,549</td>
<td>1,301,532</td>
<td>2,664,081</td>
<td>1,403,799</td>
</tr>
<tr>
<td>2020</td>
<td>6,229,914</td>
<td>1,511,291</td>
<td>1,444,571</td>
<td>2,956,682</td>
<td>1,407,294</td>
</tr>
</tbody>
</table>

Source: *Année de base, 3rd RGPH, 2005

1.4 Family planning

The potential demand for family planning is in regular growth in Cameroon since 1991. In 2004, it was 40.6%. It is higher in urban (55.7%) than in rural environment (37.1)

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children spacing</td>
<td>31,5</td>
<td>28,9</td>
<td>38,4</td>
</tr>
<tr>
<td>For children limitation</td>
<td>17,2</td>
<td>18,8</td>
<td>17,3</td>
</tr>
<tr>
<td>Total</td>
<td>48,7</td>
<td>47,6</td>
<td>55,7</td>
</tr>
</tbody>
</table>


The potential demand for family planning is in regular growth in Cameroon since 1991. In 2004, it was 40.6%.
Why invest in Reproductive health in Cameroon?

USE OF REPRODUCTIVE AND SEXUAL HEALTH SERVICES
II - USE OF REPRODUCTIVE AND SEXUAL HEALTH SERVICES

Despite the development of the Sectoral Health Strategy and subsequent frameworks, and in particular those relating to the RH, a lot is still to be done for the use of the existing infrastructure. According to the study on the Emergency Obstetric and Neonatal Care (EmONC) conducted in Cameroon in 2010, the use of the Health Facilities-HF by the beneficiaries is very low, with only 6.1% of childbirth recorded in the HF EmONC, and 65.2% of the estimated reproduction-related complications remain in the community, far from the health system. Dystocia, abortion-related complications and hemorrhage being the most frequent ones. The Caesarean intervention rate is very low (2.3%).

2.1 Use of contraceptive methods

The proportion of women aged 15-49 years who have already used a contraceptive method has increased from 16.1% in 1991 to 26% in 2004. However between this period and 2011 there is a reduction (23.4%), observed both in urban (33.4%) as in rural environment (14.4%). However, regular increase among women using modern contraceptive methods (4.3% in 1991 to 14.4% in 2011 of women population), suggests that the observed flex should require a thorough analysis, in particular as adequate data are rare. The proportion is more important in urban (20.8% in 2011) than in the rural environment (8.7% in 2011).

Among the most commonly used modern contraceptive methods, in the decreasing order there is male condom (7.6%), Injectable contraceptives (3.0%, compared to 1.6% in 2004) and the pill (1.9%). The other modern methods are used only in less than 1% of the cases. The prevalence of traditional contraception is low and has decreased from 13% in 2004 to 9% in 2011; could this decline, resulting from the decrease in the practice of calendar-based methods (10% in 2004 to 7% in 2011) be partly the consequence of the improvement of the education of women and girls? Only a thorough analysis will be able to confirm this hypothesis.

Table 3: Socio-demographic use of contraception by women aged from 15 to 49 years old (in %).

<table>
<thead>
<tr>
<th></th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other contraceptive method</td>
<td>24.9</td>
<td>34.6</td>
<td>36.2</td>
</tr>
<tr>
<td>Modern contraceptive method</td>
<td>7.1</td>
<td>13.1</td>
<td>19.3</td>
</tr>
<tr>
<td>Traditional contraceptive method</td>
<td>17.9</td>
<td>21.5</td>
<td>16.9</td>
</tr>
<tr>
<td>No contraception currently</td>
<td>75.1</td>
<td>65.4</td>
<td>63.8</td>
</tr>
</tbody>
</table>

1-Female or male sterilization, pill, DUI, injectable contraceptive, implant, male and female condom (more MAMA in 2011).
2-Calendar based methods, withdrawal, MAMA (except for 2011) and , others.


2.2 Unsatisfied family planning needs

Though small, some changes are observed, if compared with 2004: the proportion of women who do not want more children have increased from 20% to 26% between 2004 and 2011, while the proportion those who wish to space the next birth have increase from 32% to 35% during the same period.

The proportion of women who want to limit The number of their children is quickly increasing with the number of children alive: less than 1% among childless women, it passes to 3% among women having a child alive, 9% to those having two children alive, 20% among those having three children alive, to reach the maximum 65% among women having six children or more. However, the proportion of women who wish to space births (waiting two years or more before the next child) is important almost everywhere, except for women without a child (19%) and those having six children or more (14%).

Why invest in Reproductive health in Cameroon?
Table 4: Unsatisfied Needs for Family Planning

<table>
<thead>
<tr>
<th></th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children spacing</td>
<td>14,3</td>
<td>6,6</td>
<td>12,9</td>
</tr>
<tr>
<td>For children limitation</td>
<td>9,5</td>
<td>6,5</td>
<td>6,6</td>
</tr>
<tr>
<td>Total</td>
<td>23,7</td>
<td>13,1</td>
<td>19,5</td>
</tr>
</tbody>
</table>


2.3 Maternal and infant Health

2.3.1 maternit Health

a. Current Fertility: Women fertility in Cameroon remains high, to such an extend that at the end of her fecundity life, a woman on average has 5.1 children (2011) and it is higher in the rural environment (on average, 6.4 children per woman) than in the urban environment (4.0 children, on average). The data also reveal that fertility is earlier in the rural environment than urban. As a whole, teenagers of 15-19 years old contribute for 12% in the total fertility.

Table 5: Total Fertility Rate (TFR)- Trends

<table>
<thead>
<tr>
<th></th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFR</td>
<td>5,2</td>
<td>3,9</td>
<td>4,0</td>
</tr>
</tbody>
</table>


b. Prenatal health Care: Among the children alive born for the last five years, more than eights out of ten (83%) have gone through antenatal consultations by trained staff. As a whole, 85% of women have consulted a health professional during their pregnancy for their most recent birth and this proportion has changed little since 2004 (83%). Recourse to antenatal consultations varies little depending on the age of the woman. However, an important variation is observed while the place of residence is taken into consideration: In 2011, women living in urban environments (96%) have more frequently consulted a health professional than those residing in rural environments (76%).

Tableau 6: Percentage of women who have received prenatal care from a trained professional

<table>
<thead>
<tr>
<th></th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women who have received prenatal care from a trained personnel</td>
<td>91,7</td>
<td>92,1</td>
<td>93,8</td>
</tr>
<tr>
<td>% of women whose live birth have been protected against neonatal tetanus</td>
<td>81,6</td>
<td>79,1</td>
<td>78</td>
</tr>
</tbody>
</table>

c) Birth

Table 7: Some indicators of women health

<table>
<thead>
<tr>
<th></th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of birth assisted by a</td>
<td>83,5 84,9</td>
<td>84,2 86,7</td>
<td>51,2 48,2</td>
</tr>
<tr>
<td>trained health care</td>
<td>professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of birth in a health</td>
<td>82,1 81,8</td>
<td>81,2 84,6</td>
<td>49,8 44,0</td>
</tr>
<tr>
<td>care facility</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


2.4 HIV PREVALENCE

HIV prevalence for women and men from 15-49 years old has significantly decreased between 2004 and 2011, from 5.5 to 4.3%. The proportion of HIV positives persons has decreased more among men than women and, in 2011, the prevalence of HIV was nearly twice as higher among women as men. 5.6% of women are HIV positive, against 2.9% of men. This result confirms the vulnerability of women in this field and raises the issues of their rights as concerns the Reproductive Health.

The prevalence of HIV is lower in the rural environment (3.8%) than in the urban environment (4.8%). The situation is of more concern in the two metropolises, Yaoundé and Douala, where the prevalence reaches 5.5% women and men of 15-49 years. It should be noted that if the proportion HIV positive women is definitely higher in the urban areas than in the rural environments (6.4% against 4.6%), one notes only little variation among men (respectively 3.0% against 2.7%).

Table 8: HIV and AIDS prevalence

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
<th>Urban area</th>
<th>Rural area</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,8 5,6 4,1 2,9</td>
<td>6,7 4,8 4,0 3,8</td>
<td>5,5 4,3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: EDS-MICS 2011, EDSC 2004

2.5 - TEENAGERS REPRODUCTIVE HEALTH

The sexual and reproductive health of the youth is tackled by raising such issues as contraception, antenatal monitoring of the mother and fetus, teenagers fertility, HIV/AIDS and pregnancy termination related knowledge, attitudes and practices.

2.5.1 Contraception: non-satisfied needs among teenagers

If 86.6% of the youth have knowledge of at least a contraceptive method, only one fifth (20.2%) of the teenagers of 15-19 years, married or not and sexually active at the time of the investigation, use any contraceptive method. The use of any contraceptive method would have allowed, among other things, to reduce the maternal mortality and to improve women health through reduction of early, close or late pregnancies and therefore the abortions that follow. Lack of adequate data do not allow a reliable comparison between the two EDS. The un-met Family Planning needs of the women aged between 15-19 years are real, even if the 2011 data are not yet available. In 2004, about a woman over five (19.5%) had unmet needs as regards family planning, among which 18.8% concerning births spacing and 0.7% birth-control.
The early sexuality of teenagers exposes them to many life hazards. The number of young women that start precociously their sexual life is higher in proportion compared to that of young men: 18.0% among young girls and 11.5% among boys aged 15-19 years have already had their first sexual intercourse.

### 2.5.2 Birth planning

According to the results of the EDSC-2004, more than 9 births out of ten (94.4%) from women aged between 15-19 years were desired. Most of these births (71.2%) occurred at the desired moment. Nevertheless, 23.2% of women among them wished to have given birth later in their life. Unwanted pregnancies represent approximately 2.0%.

### 2.5.3 Antenatal care, childbirth assistance and place of childbirth

The antenatal care is essential for the protection, survival and development of the future baby as well as the health of its mother. They are all the more essential and imperatives since there is the new context marked by the HIV/AIDS pandemic. According to the results of the EDS- MICS 2011, the proportion of pregnant women of less than 20 years having received at least one prenatal health care during their pregnancy was 84.9%, only 57.7% of births took place in a health facility.

### 2.5.4 Fertility of female teenagers

Teenager pregnancies occur at an age (before 20 years) where the young girls have not yet reached physiological maturity to conduct her pregnancy to term safely. Some of these pregnancies are unwanted and often lead to clandestine abortions that can result either in the death of the mother to be, or on the aftermath be detrimental to her fertility life.

According to the results by EDSC 2004, the proportion of adolescents aged 15-19 years who had begun their fertility life is 28.4 %. The teenage girls from rural areas who have begun their fertility life are proportionately more numerous than those residing in urban areas. The starting period to embrace fertility life also varies according to the educational background: 50,2% of the teenagers who have never been to school, have already started their fertility life, 33.4% for those with primary education and 18.1 % of those who have reached the secondary education or more. The improvement of the level of education for girls is one of the key factors to their late entry into the fertility life.

#### Table 9: Socio-demographic characteristics: % of 15-19 years old teenagers who already have a child or expecting a first child

<table>
<thead>
<tr>
<th>Age (ans)</th>
<th>Mothers</th>
<th>Pregnant from first child</th>
<th>Pourcentage ayant déjà commencé leur vie féconde</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>3,5</td>
<td>3,3</td>
<td>6,8</td>
</tr>
<tr>
<td>16</td>
<td>9,5</td>
<td>5,7</td>
<td>15,2</td>
</tr>
<tr>
<td>17</td>
<td>19,9</td>
<td>4,7</td>
<td>24,6</td>
</tr>
<tr>
<td>18</td>
<td>34,2</td>
<td>8,6</td>
<td>42,8</td>
</tr>
<tr>
<td>19</td>
<td>47,3</td>
<td>5,9</td>
<td>53,1</td>
</tr>
</tbody>
</table>

**Place of residence**

- Urban area: 18,3, 4,2, 22,5
- Rural area: 29,0, 7,8, 36,8

**Education level**

- None: 41,3, 8,9, 50,2
- Primary: 26,5, 6,9, 33,4
- Secondary or more: 14,3, 3,8, 18,1

**Total (15-19 year old):** 22,7, 5,7, 28,4

*Source: INS, EDSC-III, 2004*

The proportion of the teenagers having already started their fertile life varies according to the areas. It is higher in the East, Far-North, South, center, Adamaua and North regions. It is in these same areas that one also observes the strongest proportions of teen mothers.

**During the investigation, each mother was asked, for each child born for the last five years and for the current pregnancy (if the inquired was pregnant), if she had wished to be pregnant at the current, moment, later, or if it was an unwanted pregnancy.**
In Cameroon, pregnancy termination (IVG in French), which is intentional evacuation of the fetus, is forbidden by the article 337 of the penal code, which punishes by imprisonment and a fine any woman, or girl who has committed abortion as well as the health care professional who has carried it out. Legally, IVG is accepted only in two specific cases: if the pregnancy poses threat to the life of the mother (therapeutic termination) or in case of proven rape (article 339).

In spite of the prohibition, intentional abortion is carried out clandestinely by adults and teenagers. According to the results of the 1998 and 2004 demographic and health surveys in Cameroon 1.7% of teenagers (15-19 years) having carried out sexual intercourses had carried out intentional abortion. A study carried out by the Cameroon National Association for Family Welfare (CAMNAFAW), the International Planned Parenthood Federation (IPPF) and the Ministry of the Public health reveals that 23.1% of abortions in Cameroon are deliberately planned and that the rate of abortions for women of 15-35 years in Cameroon is between 30 to 40%, with cost varying between 31 000 FCFA and 70,000 FCFA.

The consequences of these abortions are usually infections, perforation of the uterus or bladder (leading, in some cases to vesiculo-vaginal fistulas), ectopic pregnancy (located out of the uterus), and dysfunction of the fallopian tubes.

2.5.5 Termination of pregnancy

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2.6 HIV/AIDS and STIs

The propensity of the populations to resort to services offered for prevention, test and subsequent coverage allows to measure the degree of sensitization of the population. However, coverage depends among others on the availability of the products including the ARVs products.

2.6.1 Knowledge of HIV/AIDS, and transmission/prevention methods

According to the results of the various field surveys carried out since 2004, knowledge of HIV/AIDS is today almost complete within the population of Cameroon. The last demographic and health survey (EDS-MICS) carried out in 2011 estimated to 96% the level of knowledge of the HIV/AIDS among women and at 98%
among men. However, the residential environment and educational level present some disparities. As concerns the transmission and prevention means of HIV/AIDS, it is important to note that the use of condom and limitation of sexual intercourses to only one non infected faithful partner are two most important mottos to know and live by. In fact, multi partnership in sexual intercourses increases the risk to contract the HIV, and that risk is important because the use of condom as a means of prevention is not enough. Men are slightly better informed than women on the precautions (68 per cent and 60 per cent respectively in 2004). This knowledge increases with the level of education.

Multi partnership (which spreads the pandemic) is more common in urban areas than in rural areas (8.0 per cent and 4.0 per cent) and frequent as the level of education increases (2.0 % among women without education to 14.0 % among those with the higher education level). Among women having had more than one sexual partner for the last 12 months, 37.0% said to having used a condom during their latest sexual intercourses. Among men aged 15-49 years, 29.0 % testified to have at least 2 sexual partners for over the past 12 months. Among those who had had more than one sexual partner for the past 12 months, 43.0 % said they had used a condom during their last sexual intercourse.

2.6.2 HIV/AIDS prevalence

Between 2004 and 2011, the total prevalence rate of HIV has significantly decreased, with a feminization of the pandemic: in 2011, the HIV prevalence has increased to close to twice as much for women as men: 5.6% women are HIV positive, for 2.9% men. The strong prevalence of HIV among women could be explained by their greater biological vulnerability, their poverty which exposes them to precarious living conditions and the gender inequalities which limits their power of decision.

Strong variations of the prevalence are recorded as per the region of residence thanks to the quality of the Sexual and Reproductive Health services -SRH and population sensitization. Compared with the national average (4.3%), the total prevalence is definitely lower in the Far North region (1.2%), the North (2.4%) and the West region (2.8%). It is definitely higher in the Center region (6.1%), East (6.3%), the North-West (6.3%), in Yaoundé (6.4%) and in the South (7.2%).

Why invest in Reproductive health in Cameroon?

Some figures on HIV/AIDS

- In 2010, the HIV prevalence among people aged from 15-49 years is 5.1%;
- Approximately 570,000 people are living with the HIV and 33,000 deaths in 2010 were linked to AIDS;
- 305,000 children are orphan because of this disease;
- 102,000 people living with HIV over 249,000 people eligible to the antiretroviral treatment were on treatment by the end of September 2010, i.e. a cover rate of 39%.
- 60% of the infected people are women.
2.6.3 PREVENTION OF MOTHER TO CHILD HIV/AIDS TRANSMISSION (PHCT)

Access to PHCT services is linked to several other interventions and services, namely:
(i) Pregnant women actually going to the health facilities/services; (ii) CPN HIV test; (iii) the rate of withdrawal of results; (iv) service availability (technical equipment, inputs and trained staff). Also, a particular emphasis must be placed on reinforcing neonatal and infant maternal health services including the PHCT and pediatric coverage of HIV/AIDS.

The investigation of HIV/AIDS monitoring for pregnant women carried out by the National Committee for Fight against Aids, CNLS in 2011, and shows that the HIV/AIDS prevalence rate is 7.9% for pregnant women, against 7.6% in 2010. This proportion which is above the national average predicts a higher number of new infections cases among children if effective prevention interventions are not implemented.

According to the place of residence, it was observed in 2010 that in the urban environment, the prevalence among pregnant women was 8.21%, against 6.59% for those in the rural environment.
Research carried out in 2011 on HIV monitoring among pregnant women shows the prevalence for HIV infection for CPN1 is 6.5% for those of less than 25 years and 5.1% for those aged 15-19 year old. These data are worrisome because in these immediate post-pubescent age brackets, there could be new infections.

### 2.7 Condom availability and accessibility

Increasing the availability and accessibility to condoms for the population in general, and for those most at risk, reinforcing the promotion of correct use of the condom, and improving the perceived quality and safety of the condoms are the support activities for preventing the transmission of HIV/AIDS and STI.

For 2011 specifically, the PNS annual evaluation report indicates that 21,645,424 male condoms and 486,417 female condoms were distributed by l’Association Camerounaise pour le Marketing Social, ACMS over the 35,000,000 targeted in the action plan, e. i. 63.23% coverage of the estimated demand for the year. It is therefore worth noting that 51% of these condoms are freely distributed with the help of UNFPA and 49% are sold within the framework of PPSAC project. Condoms distributed by the CENAME and those distributed by wholesalers such as LABOREX or others distributors were not reported, they would improve these figures.

Despite the reduction of HIV/AIDS prevalence rate in Cameroon, the pandemic is far from being eradicated. AIDS continues to be one of the leading causes of death in Cameroon. New cases of infections are discovered, especially among young people at the start of their sexual life. Increasing the use of condoms, delaying sexual activities among youth, and reducing the use of multiple sex partners are the principal measures taken to prevent the transmission of HIV. A more sustainable support and proper follow-up of the already infected people should be carried out so as to curb the impact of the pandemic in the long term.
SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES IN CAMEROON

Why invest in Reproductive health in Cameroon?
III- SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES IN CAMEROON

The sexual and reproductive health care services in Cameroon are still tenuous and insufficient: decrepit technical installations which are sometimes in the process of degradation, insufficient infrastructure, mostly territorial unequally distributed, degrading medical staff coverage of the population, particularly as far as reproductive health services are concerned. The budgetary constraints hinder such offer.

3.1 TECHNICAL EQUIPMENTS

The research on the availability, the use and the quality of the Emergency Obstetric and Neonatal Care (EmONC) in Cameroon have brought out better information on the Obstetric and neonatal needs not yet covered. In spite of its national non-exhaustiveness, a certain number of conclusions regarding technical installations for Reproductive Health in general, and the Emergency Obstetric and Neonatal Care in particular were drawn.

Table 10: Distribution of potential EmONC Health care facilities per regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Potential BEmONC Health Facilities</th>
<th>Potential CEmONC Health Facilities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adamaoua</td>
<td>43</td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>Center</td>
<td>121</td>
<td>31</td>
<td>152</td>
</tr>
<tr>
<td>East</td>
<td>49</td>
<td>14</td>
<td>63</td>
</tr>
<tr>
<td>Far-North</td>
<td>66</td>
<td>25</td>
<td>91</td>
</tr>
<tr>
<td>Littoral</td>
<td>76</td>
<td>20</td>
<td>96</td>
</tr>
<tr>
<td>North</td>
<td>54</td>
<td>10</td>
<td>64</td>
</tr>
<tr>
<td>North-West</td>
<td>74</td>
<td>16</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>484</td>
<td>123</td>
<td>607</td>
</tr>
</tbody>
</table>

Source: Etude sur les SONU - Cameroun 2010

Of a total of 607 Health care facilities selected, it can be said that:

i) The geographic coverage in EmONC health care facilities is far from satisfying the basic requirement in all seven areas surveyed, with about 3 EmONC health care facilities for every 500,000 inhabitants. The North region does not have any EmONC health care facility. The key missing services are respectively the instrumental vaginal childbirth, the neonatal reanimation and parenteral administration of anticonvulsive medications. EmONC health care facilities are unequally allocated among the regions on the national territory and generally located in urban areas;

ii) The quality of EmONC health care services is poor. The intra hospital Case Fatality Ratio (CFR) due to direct obstetric causes is high (2.1%). The most frequent causes of maternal deaths in Health Facilities (HF) are hemorrhage, the dystocia and preeclampsia. As regards early intra-partum and neonatal fatality, the rate is at 3.4 ‰ in EmONC HF. Lack of standards leads to taking the considered levels as the monitoring basis. The same holds for the maternal deaths rate due to indirect causes.

The number of EmONC Facilities is an indicator of the ability to supply services compared to needs. The minimum acceptable quantity is 5 medical facilities offering EmONC services, with at least one comprehensive Emergency Obstetric and Neonatal Care per 500,000 inhabitants. As for the 7 areas surveyed, the average is 2.99 facilities, lower than what is normally acceptable. None of the 7 Regions has reached the norm and the situation in the North Region is a cause of concern; no Health care facility offers the complete services as required per type of facility

Why invest in Reproductive health in Cameroon?
The number of EmONC Facilities is an indicator of the ability to supply Complete Emergency Obstetric and Neonatal Care and Basic Emergency Obstetric and Neonatal Care.

The little availability of Emergency Obstetric and Neonatal Care facilities (EmONC) is in line with the results of a similar study carried out in 2001 by the Ministry of Public Health and confirms that the situation has not improved for more than a decade.

3.2 PROFESSIONALS OF THE REPRODUCTIVE HEALTH CARE FACILITIES

Generally speaking, by comparison with the standards of the W.H.O., supply in medical staff keeps degrading in spite of recruitment efforts by the Government with the support of their partners. The health professional/population ratio is 0.63 per 1000 inhabitants instead of the international standard ratio of 2.3. The analysis of situation of the human resources, although concerning the wages improvement of the various staff bodies (attribution of a particular position, revalorization of wages, SIGIPES health kick off...), confirms that the problems identified in 2001 remain.

These difficulties worsened while nearly 900 health professional retired at the end 2008, highly qualified for the majority of them. Recruitments were carried out in 2009 to compensate for these departures and are currently going on, without assurance to compensate for the lost expertise.

Graph 6: Gynaecologist per Region

Midwives:

Need: 5400

Current number: 129

Why invest in Reproductive health in Cameroon?

Source: Minasante, Division des Ressources Humaines
FACTORS LIMITING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES
IV- FACTORS LIMITING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The universal access to the health care in general, and the reproductive health care and services in particular stumbles on many geographical, socio-cultural and financial sluggishness. Investigating these factors fostering maternal mortality, conceptualized as the “3 delays”, better clarifies the causes which limit access to the reproductive health services

4.1 – FACTORS FOSTERING MATERNAL AND NEONATAL DEATH

women and new-born children die more within communities because of poverty, isolation, gender inequality, women dependence, multiple births, early motherhood, ignorance, poor education, taboos, tradition, insufficient and distant medical facilities, insufficient skilled staff who would take care of the woman from the pregnancy to childbirth and postpartum, the choice of traditional medicine, the lack of organization within communities, the absence of social security.

1. Delay in the decision to consult health care services:
   - The lack in knowledge of pregnancy/birth complications
   - The acceptance of maternal death
   - The low status of women;
   - The socio-cultural barriers to health services consultation.

2. Delay in arriving at health care facilities. This delay can be caused by the terrain, or the lack of organization:
   - mountains, islands, rivers – lack or organization.

3. Delay in receiving medical care/treatment
   - equipment, Staff;
   - Staff with poor training and punitive attitude;
   - Finances.

4.2 - GEOGRAPHIC ACCESSIBILITY

To analyze the geographical accessibility to the health services, the average distance separating the home from the facilities remains the commonly used indicator. This distance can be measured either in kilometers or time to reach a health care center.

Taking into account the distance measured in kilometers

Physical access to health facilities does not seem problematic in Cameroon, since on average 80.4 per cent of the households are located in less than 5 km from a health facility. However, there are some fairly clear disparities between the urban and rural areas. In fact, the proportion of households that are resident in less than 5 km from a health facility is 69.3 % in rural areas against 99.3% in urban areas. Moreover disparities persist according to the type of health facility. Thus, the average distance separating the integrated health centers, the basic health centers- is 5.6 km. Depending on regions, there are clear differences among Douala, Yaoundé (2.3 Km) and the rest of the country (from 4.2 km to 8 km). If one takes into account the place of residence, this distance is 7.8 km compared with 2.3 km in urban environment.

By considering the time to go to the nearest health facility, access to integrated health center last an average 28.1 minutes in Cameroon. The same disparities above remain, depending on the place and region of residence. By the living standard, the time to go to the nearest health facility is higher for poor people (48.8 min) than non-poor people (41.9 min). This result could account for by a reduced access of the poor to ambulances and modern means of transport. If the geographical distance seems reduced to Cameroon, such factors as the quality of health services reduces access to the health care system and maintain the populations away from the hospital. Those are:

Why invest in Reproductive health in Cameroon?
• A longer wait for the medical practitioner. According to Ecam3, the household survey, the average duration of waiting before being consulted in a Mother–Infant Health Care and Family Planning facility (MIH/FP) is 101 minutes, depending on the type of hospital and sector. The denominational private sector has the longest average wait (116 minutes). The reference hospital has the longest average duration (126 minutes). The table below illustrates the duration.

• Unavailability of drugs in medical facilities. The results of the TBS 3 survey showed that the average duration of stock depletion is 117 days. Half of medical facilities surveyed have recorded in 2008 79 days depletion on average. Moreover, 11.1% of medical facilities with a pharmacy experience a complete stock depletion, whereas 98.4% experience a partial one.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Duration in minutes</th>
<th>Workforce at the Maternal and Infant Health/Family Planning Facility (MIH/FP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>108</td>
<td>524</td>
</tr>
<tr>
<td>Secular private</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td>Denominational private</td>
<td>116</td>
<td>51</td>
</tr>
<tr>
<td>Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital of reference</td>
<td>126</td>
<td>150</td>
</tr>
<tr>
<td>Regional hospital</td>
<td>96</td>
<td>113</td>
</tr>
<tr>
<td>District hospital</td>
<td>103</td>
<td>259</td>
</tr>
<tr>
<td>CMA/CS/IHC</td>
<td>(58)</td>
<td>2</td>
</tr>
<tr>
<td>Missing data</td>
<td>68</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>628</td>
</tr>
</tbody>
</table>

Average duration of partial stock depletion on essential drugs during the latest 12 months preceding the survey.

117 54

All these factors allow highlighting a fact: the geographical access does not always guarantee the effective use of health care facilities. The poverty in the households could explain this result.

4.3 FINANCIAL MEANS: POVERTY AND THE USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

4.3.1 Poverty: General situation

The poverty line in 2007 was 269,443 FCFA per adult-equivalent. A poor person is a person who lives in a poor home i.e. a home in which the average expenditure per adult-equivalent in 2007 was inferior to 269,443 FCFA per year (that is about 738 FCFA per day or 22,454 FCFA per month). This amount corresponds to the minimum necessary to satisfy the essential needs of the individual and include all the final consumption (including consumption in kind). Poverty remains important in Cameroon: 39.9% of the population live below the poverty line.
4.3.2 Social characteristics of the poor homes

Poverty is more evident in the homes whose head is male (41.6% of the homes led by men are poor against only 33.4% of the homes led by women), a surprising situation which could be partly explained by the responsibilities assumed by these female leaders, living alone without a spouse for most of them.

The educational level of the head of the home is also an explanatory factor of the degree of poverty in homes: the poverty rate in the homes whose head is without education is multiplied by 15.3 more than where the head is a university graduate or drop-out. Thus, homes whose head are without education hold the highest proportion of the have-not, 48.7%.

The precariousness of the homes of people working informally in the agricultural sector is even more disquieting according to the results of ECAM III. The affordability of health care and services has decreased and is especially unfair. The share of home expenditure allocated to health has decreased from 7.6% in 2001 to 3.9% in 2007 (TBS3). In Cameroon in general, according to the results of the 3rd census (the RGPH), poverty touches 36% of the homes; rural environment are much more affected by this incidence (67% for 7% in urban environment).

An analysis of the factors limiting affordability of the health services, based on the private annual expenditure per capita, shows that the rural environment is underprivileged compared to the urban environment, so that each member of the urban home spends twice as much for his health as rural homes, an average 20,583 FCFA per year for only 8,512 FCFA in the rural environment. These disparities exist at the regional level as well; in fact, the north and East regions are among the groups where the annual health expenses are the lowest. Concerning the living standard, the populations from the have spend annually on average four times as much for their health as those from the poor homes (respectively 18,311 CFCA and 4,431 FCFA). The percentage of health expenses is estimated at the national level at 3.9% of the total homes’ expenses. Except for the Adamaoua (2.4%) and Littoral (5.0%) regions, there is no significant difference for this indicator between the regions since the maximum gap between them do not exceed two percentage points.

Affordability of the most vulnerable people to the reproductive health services seems even more hypothetical. Indeed, this group, composed of women, children, teenagers and more particularly of young girls, and of people living with handicaps or in difficult situation, have the highest number of the have-not, without sufficient financial means to provide for their essential needs, particularly as regards health.
In other words, chance to use modern contraception is 5.6 times higher for the women of the have homes that those of the poor households.

### 4.3.3 Poverty and the use of Sexual and Reproductive health services.

The private annual per capita health expenses measures the total annual health expenditure of the homes per number of individuals. At the national level, the annual health expenditure per capita is estimated at 12,775 FCFA, a drop of approximately 9,262 FCA compared to 2001. Depending on the place of residence, each member of the urban homes spends twice as much for his/her health as that of the rural homes, an average annual 20,583 FCFA for only 8,512 FCFA in the rural environment.

Access to sexual and reproductive health services is dependent on the standard of living. An exclusive and marginalizing factor, poverty is, indeed, a constraint which, not only does it prevent an important number of people to have knowledge of the contraceptive methods, but it also prevent them from affording sexual and reproductive services as well.

- The awareness of contraceptive methods: knowledge of contraceptive methods is higher among women with partners of non-poor households (97.5 %) than among those of poor homes (77.0 %). With regard to the modern methods, there is about the same variation of knowledge level between the women of the non-poor households (96.9%) and those of poor households (75.8%).

- The use of contraception: as a whole, the rate of contraceptive prevalence is higher in the homes of the Have (36.8%) that in the homes of the have-not (10.5%). The prevalence of the use of modern contraception is higher among women from the have homes (18.9%). On the other hand, it is very low in the have-not homes (3.4%). In other words, chance to use modern contraception is 5.6 times higher for the women of the have homes that those of the poor households.

- Antenatal consultation: in the have homes, more than 9 pregnant women over 10 (93.9%) have paid at least an antenatal visit during their latest pregnancy. In the poor homes, the proportion is only 69.7%, which is to say less than 7 pregnant women over 10. At the national level, the proportion is 83.4%.
Place of childbirth: In Have homes, 8 births out of 10 (80.0%) occurred in a public or private health care facility, whereas only a little more than the third (34.2%) of births in health care facility are from the poor homes, the national average being 59.0%.

Childbirth assistance by a qualified health staff: in the have homes, more than 8 births out of 10 (83.4%) took place with the assistance of a qualified health professional, whereas in the poor homes, only 36.1% births were assisted by a trained health workforce. The national average is 61.8%, a little more than 6 births out of 10 assisted by a qualified health workforce.

In conclusion, it appears that poverty is the main factor limiting the access to health services. It is an obstacle to ensure the universal access to the sexual and reproductive health services. Consequently, efforts should focus on removing certain constraints which favors the exclusion of the poorest and most vulnerable among the population.

4.4 SOCIO-CULTURAL ACCESS TO HEALTH CARE SERVICES

Access to health services is also prevented by such socio-cultural factors as the low education level, cultural practices, habits and customs, and gender discrimination.

• The low level of education: the level of education appears as a determining factor in access to health care and reproduction services. The 3rd population census (the RGPH) and the EDS-MICS/2011 highlighted behavioral differences while dealing with the reproductive health. The level of education of women specifically is an important differential factor. Therefore, the contraceptive prevalence, which results from using the reproductive health services, is strongly linked to the level of education. Among women with a higher education level, 34% currently use a modern method, against 24% of women having the secondary school level, 13% of those with a primary education and 3% of those with no education.

(EDS-MICS 2011).

• As regards gender: observable disparities are due to the quality of services and treatment offered, which does not always take into consideration the specific needs of women and men of various age groups. Women have insufficient access to treatment and drugs; that is why many still die while giving birth. Their low level of activity and strong unemployment rate, worsen the situation. As regards employment, formal activity remains dominated by men (16.2% against 8.2% for women) (3rd census RGPH). Most of the actives people are in the less remunerative informal sector; 90.4% of whom are women.
NEED FOR INVESTING IN SEXUAL AND REPRODUCTIVE HEALTH CARE SECTOR
V - NEED FOR INVESTING IN SEXUAL AND REPRODUCTIVE HEALTH CARE SECTOR

The financial and economic crises which have been shaking Western countries for some time and are causing economic and social damage in these countries, have also had a great impact on the rather fragile economies of the African countries, of which Cameroon. Le Government has accepted, within the DSCE framework, to implement vigorous strategies over the 2010-2019 periods so as to rev up growth and employment to:

• attain an annual average growth of 7% during that period;
• reduce the under-employment from 75% to 40% in 2019, by creating ten thousand formal employment per year;
• bring back the monetary poverty rate from the 2007 39.9% to less than 25% in 2019;
• achieve the whole Millennium Development Goals (MDG), specifically the MDG 3,4,5 and 6 by 2019, if not achieved by 2015;

- to promote the gender equality and women autonomy by suppressing the gender disparities in the primary and secondary educations – MDG3;
- to reduce by two thirds the mortality rate of the children of less than 5 years between 1990 and 2015 – MDG4;
- to improve maternal health, by reducing maternal death by 3/4 – MDG5;
- to fight HIV/AIDS, Malaria and other diseases with its 3 targets – MDG6;
- to have stopped the propagation of HIV/AIDS and to have started to reverse the current tendency
- to ensure to all those in need access to the treatments against HIV/AIDS;
- to have subdued malaria, controlled and other serious diseases and start to reverse the current trend

On the whole areas under development, the maternal mortality rate have dropped by 34% from 1990 to 2008, ranging from 440 maternal deaths for 100,000 live births to 290; In Cameroon, this indicator has increased, moving from 430 to 669. Thus, in the country, one is still very far from the global target figure

To what extend can Cameroon vis-a-vis the persistent financial and economic crisis, consolidate her social assets, continue improving the living conditions of the vulnerable population and achieve the 4 Millennium Development Goals as listed above?

The mitigated and non-inclusive economic growth of these last years, due amongst other causes to the sluggishness of the international economic environment and issues related to the governance in the country, has remained too low; It has failed to impact positively the living conditions of the homes, as well as the health of the populations in general, and the poorer, among which women, the youth and young girls in particular

Between 2001 and 2008, the average annual growth rate of the GDP of Cameroon oscillated between 3% and 3.7% and gradually slowed down to be at 3.3% in 2010. The estimates for 2011 give it a 4.0 percent while the forecasts for 2012 are at 5.9 percent.
Why invest in Reproductive health in Cameroon?
5.1 The summary of the conclusions of some studies on the advantages to invest in RH

Faced with these challenges, the studies carried out by the Guttmacher Institute in collaboration with the UNFPA, highlight the advantages of investing in Family Planning and maternal and neonatal Health. Conclusions are applicable in Cameroon:

a) Reducing the number of unwanted pregnancies;

b) Mother and children in better health;

c) Increased savings and productivity within families;

d) Better perspective concerning education for children, reinforcing economies, and reducing pressure exerted on the natural resources in developing countries;

e) Accelerating the achievement of the Millennium Development Goals (MDG) set in 2000 for 2015 but reported in 2019 in Cameroon;

f) It is estimated that 222 million women wish to avoid a pregnancy but do not use an effective contraceptive method, in spite of an increase in its use these last years; 46.9% women living with a partner are concerned by this indicator in Cameroon

g) Among the 123 million women giving birth every year, only half receives prenatal, birth and neonatal care and treatment (both routine and complications care/treatment included) and, for those who do, many do not receive all the required treatment/care;

h) Approximately 20 million women per year carry out pregnancy termination without medical assistance, and of the estimated 8.5 million who undergo complications requiring medical intervention, three million do not receive medical intervention.

New analyses also reveal that if an integral answer was given to the need for family planning and maternal and neonatal health services, the direct advantages on health would be extremely huge:

- Unplanned pregnancies reduced by more than two thirds per year
- Seventy percent of maternal death avoided
- Forty-four percent of neonatal death avoided
- Abortions not provided by health professionals decreased by 73%, and the number of women requiring medical help for complications following use of unhealthy procedure would fall from 8.5 million to two million.
- Healthy life lost due to incapacity and premature death among women and new-born babies would be reduced of more than 60%.

Other less quantifiable advantages, nonetheless important, either in the health sector or the society in general are:

- The improvements of the health care systems indispensable to the survival of women and their infants would spread to other urgent medical needs.
- The increased use of the condom for contraception purpose would reduce the transmission of HIV and other sexually transmissible infections, thus helping to curb the AIDS pandemic.
- The reduction of unplanned births would help cut the expenditure of the public sector to benefit positions in the health, water, decontamination and social services. It would lift the pressure exerted on scanty natural resources, thus facilitating the access to the social and economic development.
- The reduction of un-wanted pregnancies, particularly for teenagers, would improve the chances for women education and employment, which would contribute in improving female condition, increasing family savings and economic growth.
Drop of unplanned pregnancies, a result of an appropriate answer to the need for family planning would allow to save 5.1 billion dollars, which would contribute to the recommended treatment and care necessary for pregnant women and new-born babies.

Service needs are greater among the under privileged populations. Although the governments of the world have committed themselves in making these services accessible to all, the public and donors contributions proved quite lower than the amounts promised for the reproductive health sector.

The progress made in reducing maternal and neonatal mortality is extremely slow-paced, in particular in the two poorest areas in the world: South Asia and sub-Saharan Africa. These regions, together with the under privileged people of other regions, have everything to gain for an investment increase, because they suffer disproportionately from the pangs of pregnancy and childbirth related ill health.

Investing in FP and RH is impossible to circumvent, as the key factors to the human development are longevity (health), knowledge (education) and the standard of living (production of the goods and of wealth). The quality of the health services in general and Reproductive Health in particular is one of the elements which strongly influence the three development factors.

5.2 Potential profits that result from investing in the reproductive health sector in Cameroon

The health care system in general, of which approximately 80% represent the reproductive health, currently suffers from multiple insufficiencies; the most palpable are the human and material resources.

On the country’s global level, the investments carried out to save lives by reducing maternal mortality generate invaluable profits (savings on the expenditure for instance) which are re-orientated towards other development priorities.

According to estimates by the Ministry of Public Health in 2007, quality maternal and neonatal health services would reduce 16500 mothers and 70,000 newborns including disability of 431,000 during the 2007-2015 period, the equivalent of 245 billion Francs CFA

Investing in the reproductive health will directly improve more than ¾ of health care and health services in general; if coupled with reducing cultural inertia, it will promote their use and increase people longevity and therefore upgrade actions towards sustainable development.

All in all investment will improve the quality of supply and stimulate the demand for the reproductive health services

In Cameroon, women of childbearing age (12-49 years) are 4,871,9431, among which, 22.2% no longer want more children while 35% would like to space two years between children. So 1,705,180 do not want any more children and 1,276,449 want to wait for two years.

On the one hand, providing a modern quality contraceptive method in 2012 would cost approximately 3 SUS (about 1500FCFA at 500 FCFA a US dollar). About SUS 8,944,887 contraceptive are needed per year to cover the national needs.

On the other hand, each dollar spent to improve the current contraceptive needs- so as to cover the unmet needs- has a return of $1.40 in maternal and infant health care.

Therefore, if SUS 8,944,887 are invested, the profits in term of health care amount to SUS 12,522,842. The profit would make it possible to support other aspects of the human development. In addition to this financial profit, direct advantages in terms of well-being are recorded:

-Reduction of 77% of the unplanned pregnancies

-Reduction in hazardous abortions

-Reduction of 69% of maternal deaths and 45% of infants’ death,

-Reduction of the number of years of lost healthy life due to incapacity and premature deaths of about 2/3

The reduction of mother through child and partners through partners’ HIV and other STIs’ transmission, due to the use of condoms as a means of contraception.

RGPH III, 2010

RGPH III, 2010

2 Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012. GUTTMACHER and UNFPA

3Investir dans la planification familiale et santé maternelle et néonatale : coût et bénéfices. UNFPA-MINSANTE-SYNERGIES AFRICAINES, 2010
5.3 The levels of investment in reproductive health:

Investing in the reproductive health is a necessity at the families, communities and countries levels.

At the family’s level, the family head or those in charge should provide for essential resources to acquire quality RH (contraception, antenatal consultations, management of pregnancy and birth related issues, etc). Children, whether boys or girls should be sent to school without gender discrimination, so as to have boys and girls able citizens, men and women capable of easily reading and understanding health related messages which aims at instructing on healthy behaviors and improve longevity.

At the Community level, the local government agencies should be the first persons in charge who must to make sure that in the council’s budgets, the health item is valued and money raised to improve the quality of health services in general and reproductive health in particular. The different associations for the community development should make it a goal in their plans of actions to support reproductive health activities and follow-up on the quality of services in their targeted areas.

At the health districts and health facilities levels, training staff and good health equipment must be the priorities in medical expansion and operational plan. The technical equipment in RH is one of the prerequisite to guarantee quality health care.

At the national level, parliamentarians, the public and private administrations as well as the civil society must ensure that investments in the health and reproductive health are meaningful and consistent with international recommendations and standards. Partners to development must make sure that their contributions are geared towards the Reproductive Health sector and actually carried out operationally.
Why invest in Reproductive health in Cameroon?

Access of the whole population of Cameroon to the reproductive health care has always been a concern. Only a part of the country’s population has access to the HR services.

The consequences of this insufficient access are serious and challenge all the RH stakeholders in the country: maternal death increases,-contrasting with the Millennium Development Targets-, the neonatal mortality is still a concern despite all the actions taken to develop the Emergency Obstetric and Neonatal Care facilities –EmONC, the harm done by STIs- particularly the HIV/AIDS- on the social, medical and even economic level, even if a light fall has been recorded by the EDS-MICS in 2011. The consequences of unwanted pregnancies such as the unhealthy abortions could have been avoided if the needs in contraception were met and if Family Planning could be use for health planning in Cameroon.

The data from various studies suggest that the maternal and child health programs implemented by the Government after 2000, with the help of partners to development, were not entirely adapted or sufficient to efficiently solve the issues resulting from the economic crisis, the root cause of the degradation of the mother and infant health in Cameroon. Other social, cultural and environmental factors should be taken into consideration for a better understanding of the reasons and causes of maternal and infant-child mortality in Cameroon, to better set up policies and programs aimed at reducing maternal and infant morbidity and mortality.

The causes of maternal and neonatal death, under the general expression known as “the three delays”, include economic, infrastructural, environmental, socio-cultural and medical factors. (I) delay in deciding to resort to a suitable health care; (II) delay relating to the means of communication and of transfer to reach a health care center; (III) delay related to the speed and the quality of health care given to the patient in medical facilities.

In spite of their rather particular nature, data drawn from the EDS Cameroon and 3rd census RGPH illustrate rather well the persistence of many significant maternal and neonatal morbidity and mortality risk factors in Cameroon, such as:

- persistence of a high total fertility (Total Fertility Rate = 5.0 children in average per woman according to the results of the 2004 EDS); the following facts are to be considered:
  - Early maternity and important teenagers’ fertility; II) Early sexual intercourses and early marriages
  - high fertility at late birth age;
  - important regional variations regarding differences in procreative behaviors;
  - persistent pro-birth behaviors and absence of family planning;
  - low contraceptive prevalence;
  - importance of men and women who have never been tested for HIV;
  - important home childbirth;
  - important childbirth without medical help;
  - important number of women who have never done post-natal visit in health care facilities;
  - relatively alarming nutritional state of women in procreation age, particularly persistent importance of anemia and chronic malnutrition;
  - low education level of the women;
  - low level access of women to the media;
  - A high percentage of active women who are in an agricultural or manual activity.

The causes of the low access to the RH care and services are multiple: insufficient quality reproductive and health services, unequally allocated on the national territory; reduced knowledge on and a somewhat stimulated service request; sector slightly know by decision makers and planners, reluctant to invest in the field. As the Executive Director of the UNFPA has said so well in an interview, “the number of maternal deaths is often inversely proportional to the status of girls and

CONCLUSION
women in the family and the society, and it is obvious that the poorer the homes, the higher the risk of maternal death…).

The reproductive health contribute several ways to improving the human development by increasing longevity, improving education and production of goods and services.

The benefits of investing in the reproductive health are multiple: economy on the health care expenditure and services, health, increase in potential actors to development, responsible for creating goods and services. To reduce the maternal and neonatal death is possible.

If the general annual number of maternal death has dropped by 47% between 1990 and 2010, this progress is not seen everywhere, not in Cameroon where it is rather a rise of mortality that has been noticed during the same period. Every day in the world, nearly 800 women still die while giving birth. Forty countries still have the highest mortality rates. Sub-Saharan Africa and the South Asia alone have 85% of the maternal deaths of the world.

Efforts from the government, the private sector, the civil society and support from different partners to development are a potential of hope to improve access of all to the reproductive health care and services.

International commitments (CIPD 1994, Beijing 1995, Declaration of Paris, Declaration of Abuja, Declaration of Maputo, etc…) are a call to all the decision makers, planners and actors of development for a new consideration, new attitudes and actions on the reproductive health so that everybody should have access to these services.

« ...It is possible to rid the world from a great deal of maternal deaths, with appropriate health care, timeliness and already known solutions. ...No woman should be dying from childbirth...”
ACRONYMS AND ABBREVIATIONS

ACMS: Cameroon Association for Social Marketing
ARV: Antiretroviral
CNLS: National Committee for Fight against AIDS
CPN1: First antenatal consultation
IHC: Integrated health centers
HF: Health care Facility
FHC: Family Health Care services
EDS: Social Health Survey
EDSC: Social health Survey in Cameroon
EDS-MICS: Social Health Survey Multi-purpose Survey
LFE: Life and Family Education
OF: Obstetric Fistulas
HF: Health Facility
IEC: Information, Education, Communication
IRESCO: Institut pour la Recherche, le Développement Socio-économique et la Communication
STI: Sexually Transmissible Infections
MICS: Multiple Indicators Cluster Survey
MINEDUC: The Ministry of National Education
MINSANTE: The Ministry of Public Health
MINESEC: The Ministry of secondary Education
MDG: The Millennium Development Goal
WHO: The World Health Organization
PDSD: Community medical expansion plan
FP: Family Planning
PMA: Minima health care services
PPSAC: Professional Programs and Services Advisory Committee
NPA: National Plan for Fight against Aids
CBS: Community-based Services
MIH/FP: Maternal and Infant Health/Family Planning Facility
UNS: United Nations Systems
EmOC: Emergency Obstetric Care
BEmOC: Basic Emergency Obstetric Care
CEmOC: Complementary Emergency Obstetric Care
RH: Reproductive Heath
TRH: Teenagers Reproductive Heath
SHS: Sectoral Health Strategy
UNFPA: United Nations Fund for Population Activities
UNICEF: United Nations International Children's Emergency Fund
HIV/AIDS: Human Immunodeficiency Virus/ Acquired immunodeficiency Syndrome
VSBC: Volunteer worker for Community-based Services

Why invest in Reproductive health in Cameroon?
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With the multiform support of the United Nations Population Funds – UNFPA
Why invest in reproductive health in Cameroon?

Because every two minutes in the world and every two hours in Cameroon, a woman dies as a result of complications during childbirth.

Because more than 222 million women have unsatisfied contraceptive needs.

Because in Cameroon, 61% of women of reproductive age wish to avoid/postpone their future pregnancy.

Because implementing the interventions measures for the survival of mother and child over a period of ten years will enable Cameroon to achieve a productivity increase of 245 billion FCFA.

Because greater collective efforts are necessary to ensure that no woman dies during child birth, which will help maintain the sustainable development of Cameroon.