International Journal of Social Sciences and Scientific Studies (2023)

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ACCESS TO REPRODUCTIVE HEALTH CARE FOR DISPLACED WOMEN AND GIRLS LIVING IN URBAN TOWNS AN ANTHROPOLOGICAL PERSPECTIVE☆

Nfondoh Blanch WANCHAMBI [a], Fosso Simun Reine [b]

A. Ministry of Scientific Research and Innovations. Cameroon
B. Ministry of Scientific Research and Innovations. Cameroon

Received 29 September 2023; Accepted 15 February 2024
Available online 18 March 2024

ARTICLE INFO

Keywords:
Reproduction Health
Displacement
Women
Perception
Practice

ABSTRACT

This paper seeks to show the stakes faced by displaced women and girls from conflict-affected areas as they try to seek reproductive health care services in their new setting. Normally, reproductive health possess defies to both health providers and consumers in pre conflict settings due to some social and cultural norms. The displacement of women from the Northwest and Southwest regions of Cameroon as a result of the on-going conflict has worsened the reproductive health situation of these women. Reproductive health problems have always been at the centre of healthcare provision in Cameroon with much money invested in it. Since the outbreak of social unrest in the two English speaking regions of Cameroon, many women and young girls have been displaced to other towns to seek refuge. Faced with the risk of displacement, most women and girls find it hard to access health services on issues relating to reproductive care.

In carrying out this study, A qualitative research method was used. Information was gotten from 30 people who were made up of 20 women and 10 men, with the help of in-depth interview and focus group discussion. These informants were contacted at the hospital where they come for consultation and at their homes. The theory used for this study is the health system theory. Coming from different cultural background as a result of displacement, these women have different reproductive health needs and challenges. With this, they are force to deploy various culturally perceived ways to solve these problems which with time, it becomes dangerous to their health.

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I. INTRODUCTION

Access to sexual and reproductive health services are basic human rights. According to the *World Refugee Survey 2002*, nearly 37 million people worldwide are currently living away from their homes and communities because of, persecution, war, violence and crisis. Internally displaced persons (IDPs) stand a record of more than 20 million displaced persons worldwide. During 2020, several crises, some new, some longstanding, and some resurfacing after years forced 11.2 million people to flee, compared to 11.0 million in 2019 (UNHCR, 2020). People who have been forcibly displaced or who are stateless have been among the hardest-hit groups of society, facing increased food and economic insecurity as well as challenges to access health and protection services (UNHCR, 2020). Among these displaced people, approximately 80% are women and children and are vulnerable to abuses and negative health outcomes during the crisis. Women often become heads of households because they are widowed or deserted during displacement and become sole providers and caretakers of their families. This group of persons (women and girls/adolescents aging from 15-49years) faces disproportionate threats to their health, wellbeing and including gender-based violence (GBV), the risk of contracting HIV or other sexually transmitted infections as well as complications during pregnancies and childbirth. These displaced women and girls also tend to be at a greater risk of deprivation, insecurity, abuse, neglect, and a general deterioration of their well-being (UNHCR, 2020).

Whilst displacement often aggravates gendered harmful social norms that discriminate and devalue girls, education together with gender-based violence at school, home or in the community, as well as early marriage and pregnancy also create major obstacles to learning (Cazabat et al 2020). Complications of pregnancy and childbirth, such as severe bleeding, obstructed labor, and unsafe abortion, maybe more serious for displaced women, and may lead to infertility and death. (Liz Creel, 2002). Also, Pregnancy among adolescence has been associated with numerous adverse outcomes, including social, economic, and health problems for both young mothers and their children (Liz Creel, 2002). With these risks encountered by displaced women and girls, the minimal initial services package (MISP) was then developed to respond to reproductive health needs during crisis and this MISP included the following six objectives: identifying an organization to lead MISP implementation, preventing sexual violence and responding to the needs of survivors, preventing the transmission of and reducing morbidity and mortality due to human immunodeficiency virus (HIV) and other STIs, preventing excess maternal and newborn morbidity and mortality, preventing unintended pregnancies and planning to integrate comprehensive SRH services into primary health care. (Desrosiers et al 2020). In recent years, the humanitarian community has focused increased attention on the long-neglected needs of internally displaced persons who often live in non-camp settings, as they make up the vast majority of those affected (Cohens, 2010). With the cultural diversity created during displacement, this study then seeks to understand how displaced women and girls in urban settings deploy different means is dealing with their reproductive health issues.

2.METHODOLOGY

2.1. Study design

A descriptive study design with interviews as techniques for data collection was used.

2.2. Theoretical approach

System theory was used to demonstrate how reproductive health care are provided
to displaced women and girls irrespective of their belief systems. Individual or community beliefs are not taken into consideration before providing reproductive health care. Rather, health providers

base their focus on the National Health System policy which might not be suitable for displaced persons. This is because there are cultural dimensions in reproductive health care which is specific to each culture or community. This specificity in reproductive health provision is not noticed by health providers when providing health care to displaced women and girls.

2.3. Sample population, sample procedure and population size

This study targeted displaced women and girls from the Northwest and Southwest regions of Cameroon living in the urban center of Yaoundé. A snowball sampling method was used to enable us to identify each participant.

The sample size were attained at 30 participants both displaced women and girls and health specialist around the seven council areas of Yaoundé.

2.4. Population representation

In order to get a better grasp of the reproductive health care of displaced women and girls, the respondents were firstly identified in the different English-speaking neighborhoods in this urban town. Apart from the displaced person health specialist were also considered in the study for them to give their perceptions of reproductive health and how the situation may affect displaced person in urban areas.

2.5. Method of data collection

Data for this study was collected with the help of different tools and techniques such as interview guides and discussion guide with in-depth interviews and collective discussions as techniques. Data was then transcribed, analyzed and interpreted for better understanding and usage for this study.

2.5.1. In-depth interview

To have a better grasp of this study, in-depth interviews were conducted among the different groups of persons involved in the study. This technique helped in getting respondent views, perspectives and challenges on reproductive health to them personally and other witnessed cases. A one-on-one interview carried out with the participants gave clarity and understanding of the different perceptions and stakes of reproductive health in their previous area free from insecurity and now in an urban setting

2.5.2. Collective Discussion

For this study, a collective discussion was done. This discussion took account of their practices and their limitation in accessing health care serves as displaced women and girls. Questions were posed to respondents who have had health issues relating to their reproductive health. Direct quotes were also taken down and pseudonyms were given to the respondents.

2.6. Technique of data analysis

When data collection was finalized, codes were attributed to the data so as to ease the coding process. Content analysis was done where themes and subthemes which were generated from the findings became the principal key points for discussion in the results section following the research questions and objectives.

3. RESULTS

3.1. Financial complications

One of the most challenging factors that limit displaced women and girls from accessing reproductive healthcare services in Yaoundé is finance. Since the conflict broke out in the two English speaking regions in Cameroon, many income generating activities have either come to a stand or are not very vibrant as before the crisis. Women could easily pay for health services both in private and public hospitals from their earnings .The frustration of the conflict made it in such a way that most of the women moved out of the conflict

affected areas to Yaoundé.

To sustain their living in this town, most of them chose to engage in some income generating activities. These activities include farming on contract, baby-sitting, cooks, hair dressing, dress makers and petite traders. The income which these women get from these activities is very minimal as compared to the standard of living in Yaoundé. Hospital bills in both private and public hospital are very expensive. This was confirmed by a respondent who said

> ***"Just to consult for my pregnancy, I had to pay. If a pregnant woman has a complicated situation that requires a specialist, she needs to pay even more. This prevents many women from coming to the hospital. Even when they come, they cannot afford all what is prescribed as drugs. In this case, they end up not completing their treatment (Obili Yaoundé 10 am 2023).***

In most societies, it is known that when women are married, the decision concerning their health is taken by the husband. He determines the number of children to be born without considering the reproductive wellbeing of the women. Since most men want more children for prestige and honour in the society, even as displaced persons they continue with this practice. They do not consider the financial cost on the woman and the burden it has on the other children. In most cases, these women find themselves in a dilemma where they are breast feeding one child and are pregnant for another. In all they are not even able to provide neither for themselves and the child (children). Due to financial limitation, these women try to carry out clandestine abortions, and some of them do end up in a deplorable situation. Displaced women still find themselves challenged by their cultural values, they still hold on to their systems even when it is detrimental to their well fair.

3.2. Negligence and lack of awareness

This has been cited in both women and girls as one of the various reproductive health problems faced by these vulnerable populations. Negligence is reported to not only be from the patient but also from the hospital and or medical staffs. The high rates of maternal mortality are due to limited access to quality healthcare services, inadequate prenatal and antenatal from health services.

> *"When I left my village because of the crisis I came to Yaoundé I was pregnant but because I don't understand the language here and how things function here It was difficult for me to go to the hospital. Someone also told me that before I go to any hospital, I should be very careful that here nurses and doctors have a lot of work so they don't properly check patients. I am also not a first-time mother so I preferred to observed by condition by myself than go somewhere that they will talk and I will not understand". (Damas-Ebom Yaoundé 4pm 2023)*

Negligence is a major issue when it comes to reproductive health and healthcare in general in Cameroon. The mother and child health care component, was establish to take care of pregnant women, infants and child-spacing or planned and responsible parenthood with objectives to reduce maternal mortality and proper surveillance of pregnancy to detect risky cases early enough for proper management (Simon Ako et al). But because of lack of awareness from the component the death toll of maternal and child mortality is still at its rise at the Yaoundé central hospital and Yaoundé Gyneco-obstetric and pediatric hospital with main causes such as hemorrhage, hypertension and complications from anesthesia. This could also be associated with lack of follow up during antenatal or adequate follow up during labour and postpartum (Kamga et al 2021). It was also discovered that half of maternal death rate at the Yaoundé central

hospital was associated with the health service; this service suffers from limited human resources not allowing for prompt, efficient care and monitoring (Kamga et al 2021).

3.3. Limited access to proper health facilities

Most internally displaced persons have the tendency to settle in far-off neighbourhoods where housing is affordable. This keeps them away from health services which are found around the city centers and not in the suburbs. These neighbourhoods are mostly low-income and characterized by quark doctors and clinics for immediate health services. This vulnerable population turn to seek these heath services because of limited access to proper health facilities.

> *'Where I live is very far from the government and districts hospitals and I don't trust the clinics around me but the problem is, most pregnant women here have no choice than to go to those clinics and other hospitals when they are in labor especially at night because the public hospitals are far off from us'. (Mendong Derrier le Can 1pm 2023)*

Reproductive health influences a woman's quality of life and lack of access to reproductive health services can lead to unintended pregnancies, unsafe abortions, sexually transmitted diseases gender-based violence (GBV) disability and maternal death. Accessing hospitals for proper healthcare is a bone to swallow by these vulnerable populations. Health services in Cameroon are still tenuous and insufficient, decrepit technical installations which are sometimes in degradation and insufficient infrastructure which are mostly territorial unequally distributed. (Thongmixay, et al 2019). The cost of getting to these services, and or the quality of these services provided relates to some hindrances these displaced women and girls face. Most young girls are lacking reproductive health knowledge because of the stereotypes in most cultures, where sex education is not discussed with children. This put most young girls into shock when they are exposed to sexual activities for their first time. It becomes even complicated when they become pregnant especially as displaced teenagers. Due to the hardship faced by these displaced women and young girls, those who become pregnant always look for ways to terminate the pregnancy before term. This is because of the burden of raising a child as a displaced woman or as a single mother. In most cases they go far off neighbourhoods to look for clinics that provide low-cost services for abortion or try to do it clandestinely.

3.4. Lack of motivation of staffs

Motivation of health workers is associated with both individual and program performances. Effective management, training opportunities, and supportive supervision along with both financial and non-financial incentives are needed to keep them motivated and retained for a longer term (Mahmud I et al 2023). Sustainable development goal especially goal 3, 4 and 5 accessing top quality sexual and reproductive health services is essential in improving womens' lives worldwide. In most hospitals and private clinics, majority of health workers complain of minimal pay and lack of motivation. This creates a room for poor performance and alternative means of acquiring extra funds from patients. It was observed that lack of motivation push health workers to demand for extra finances from patients either to prescribe their medication or sell drugs to them. According to a respondent;

> *"Sometimes you go to the hospitals and the nurses are the one selling medicines to you especially midwives even things they know you don't need while delivering, they still sell to you. Some of the things they sell to us are things we have already paid for when doing*

the deposit for delivery but because we don't know the midwives still sell them to us" (Mendong Derrier le Can 1pm 2023)

Lack of motivation such as financial incentives have prone a lot of health workers to obtain extra finances through several means especially from patients. The cry for minimal pay, no financial motivation and work load does not reflect the pay. This does not only affect reproductive health women and girls but also all patients coming in for other health problems. Internally displaces person turn to find this situation hard to adapt with bearing in mind their financial difficulties and way of life.

3.5. **Wrong Prescriptions**

It is estimated that each year, 12 million adolescent girls and women give birth, and 3.2 million have an unsafe abortion in humanitarian setting (Singh NS, et al 2018). These unsafe abortions practices are challenged due to poor reproductive health education. Sexual and reproductive health (SRH) is one of the most important health challenges among displaced persons in Yaoundé. This is because most of the patients look for health care services in areas where health care providers are not well trained. Furthermore, most of this health providers have stores where they do consultation and provide medication for displaced women at a very rate. In most cases these women find themselves being referred to other hospitals as a results of wrong drug prescription. According to this respondent;

"Because we don't have enough money, we can't afford an expensive hospital and my husband instructed we go to the one closest to us which is cheaper and affordable. It is a private clinic very small and I have been there once and the way I was treated scared me off. One of the nurses on duty prescribed a medicine for me and later another nurse came in and changed it they were exchanging words so I suspect something was wrong with the first prescription" (Etoug ebe 10am 2023).

Another respondent added that;

"Some hospitals especially the clinics we have around us, mostly employ people who are not really competent. There is a clinic beside my house they don't even have a lab I wonder the type of consultation and drug prescriptions they give to people who go there. The fact that people are poor and need cheaper health facilities, they turn to go there" (Etoug ebe 11;30am 2023)

Sexual and reproductive health among women and girls from conflicts affected zones should be a top priority as these people faced not only challenges from reproductive health but also mental health from the trauma of surviving and displacement. Insufficient funds and no financial assistance force them into poor choices of health services.

3.6. **Lack of follow up**

Moving from a conflict zone to a high-income area means change and adapting to the standard of life in that area. Most displaced persons suffer from adjusting in their new setting and exposing their medical history to new health care providers. Young girls and women who are pregnant or infected with sexually transmitted diseases and or trying to acquire proper family planning, turn to find it difficult in adjusting to new health care services in Yaoundé. Language barrier and little knowledge of the functioning of activities scare these groups of persons from continuing their health care plan. Also, the work load of these health staffs grants them little time for proper follow up of patients especially new cases presented to them without proper identification. Most displaced persons because of the conflicts turn not to have any health records like hospital books because of the rush for survival. This respondent made us to understand that

"It's difficult adjusting to a new space, we barely have where to stay what to eat and I have to be thinking about my health and that of my young girls, my husband died due to the crises so it's not easy for me, everything got burnt while we were still in the Southwest Region. In all of these, I have to start consulting all over again. It is not an easy thing, life is very hard for us" (Simbock 5pm 2023)

Another respondent added that;

> *"Things here in Yaoundé are not the same as in the village, there I could speak to someone even in my dialect and they will understand. Here everything is in French and what they are saying is very difficult. How do you think I can continue with my health checkup if I don't understand them or know my way around?"*

Health maintenance of women of reproductive age 15 to 44 years comprises of counselling, regular screening test with the goal of preventing and early detection of common diseases such as cancer and infections (*Heather L et al 2021).* This has not been the case as most displaces women do not follow up their health situation. Recent data illustrate the extent to which the current lack of sexual and reproductive health care puts many people at risk (*Sophia Sadinsky 2021).* Proper follow up will go a long way to improve reproductive for displaced women and reduce mobility at all levels.

4. Conclusion

Conflict poses a direct impact on the way health care services are consumed by displaced women and girls. Their needs and wants in this situation are even more as a result of displacement. Living as displaced persons in Yaoundé forces these women to take health care options which are harmful to their well-being. Even though health providers are aware of the challenges faced by these women and girls to access health services in matters relating to reproductive health, they cannot remedy the matter. This is because, these displaced women come from different socio-cultural backgrounds where issues of reproductive health are handled differently. For example, some tribes in the Southwest region oblige a woman to carry out belly massage after birth while this is rarely done in the Northwest region. The cultural backgrounds of displaced women seriously affect their access to reproductive health because not all cultural practices are accepted by displaced women from particular culture. Though some displaced women maybe living in a precarious situation, they will still prefer not to explain their health condition to a male health provider or someone they do not trust. Humanitarian assistance to displaced women and girls have been abused in that, these women do not follow the prescriptions given to them. Instead of following family panning rules provided, they prefer to hold on to cultural practices which gives the woman the latitude to have as many kids as possible without considering the dangers it poses on her health. However, one can say that systems of beliefs affect the way displaced women and girls access reproductive health care services in Yaounde because all the displaced persons are not from the same cultural background.

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