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The National Reproductive Health Programme in Cape Verde: scope, limits and challenges

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Abstract *Cape Verde is an archipelago on the African coast, with 538,535 inhabitants living on nine islands. Since it gained independence in 1975, the country has experienced rapid economic and social growth, with significant gains in education as well as a reduction in maternal and infant mortality deaths. In 2001, following the guidelines of the International Conference on Population and Development (ICPD, Cairo, 1994), the National Reproductive Health Program (PNSR) was launched aiming to provide sexual and reproductive health (SRH) services to adolescents, young people and adult men, in partnership with the education sector and youth centers. However, the continuance of unplanned pregnancies, illegal abortions and HIV infections has indicated that there are gaps in the program`s implementation. Studies conducted in the country point to socio-cultural aspects as well as aspects covering organizations and the services on offer, as some of the reasons for the identified problems. This paper aims to reflect on the scope and limits of the PNSR in Cape Verde with consideration being given to the challenges of implementing health policies that affect cultural practices related to gender and sexuality. Consideration is also given to the specifics of Cape Verde`s demographics, economic and cultural aspects as well as the importance of the SRH services to its development.*

Key words *Public Policy, Sexual and Reproductive Health, Adolescents and Youth, Cape Verde*

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Introduction

Cape Verde is an archipelago on the west coast of Africa. In the last years the country has registered a rapid development and increase in its population. Fifty five per cent of resident Cape Verdeans fall into the age range of 15 to 49 years old with 20% between 15 to 24[2]. So, an important part of the population is adolescent, young people and is in reproductive age.

After the independence, in 1975, a concerted effort was made to organize a health system that could tackle the high rates of maternal mortality. One of the first measures taken was the creation of the Infant/Maternal Family Planning Vaccination Program (PMI/PF/PAV). In 2001, following the International Conference on Population and Development Programme of Action the PMI/PF/PAV was widened to reach teenagers, young people and adult men. Its name was switched to the National Program for Reproductive Health, PNSR[3.] Reproductive Health Centers (RHC), for teenagers and young people were created , thematic programs on sexual and reproductive health (SRH) were incorporated as educational activities in the Youth Centers and sexual education was included in the scholar curriculum[3].

In 2007 an evaluation of the PNSR[4] showed the difficulties of implementing the RHC. Moral postures adopted by the professionals, doubts in relation to confidentiality and the fear of the girls being seen in these services were identified. Other studies confirmed the lack of qualified human resources to deal with the issues arising from SRH with teenagers and young people, the low turnout of men attending these services and the infrequent use of the Youth Centers[5].

Also, aspects of the organization and the functioning of the health system were referred to as obstacles to the performance of the PNSR[6]. The health care system was centered on the hospital, and primary health care and the health promotion activities in the communities need to be improved.

Socio-cultural characteristics in the country were noted as another barriers for the PNSR success . In Cape Verdean society, strict moral standards co-exist with contemporary and globalized lifestyles[7]. The mix of concepts and practices related to sexuality, reproduction, and women autonomy produces ambiguity and contradiction in the way to think about SRH and the PNSR operationalization.

The Cape Verdean context

Since 2008 Cape Verde has been considered a country with an average income. In 2015 the country was ranked as 122 amongst 188 countries in the Human Development Index[8].

However, Cape Vert faces a lot of structural problems, as the need to import food, and the scarcity of drinking water and natural energy sources[2]. The availability of job vacancies has not been enough to absorb the increase in the population and the subsequent demand for employment. In 2011, 49.9% of the people between the ages of 15 and 25 were not in gainful employment nor were they studying[9]. Urban violence, youth gangs, sexual commerce and the use of substances all permeated the lives of Cape Verdeans[10].

The distance and the diversity amongst the islands difficults the access of the population to the health services. General hospitals are only available on two islands; small hospitals are located on the islands more densely populated. Health centers (HCs), health clinics and primary care units are scattered around the islands owing to the concentration of the inhabitants. Just the HCS has doctors and nurses. The health services are provided on a co-participatory basis. Ante-natal care, the provision of contraception guidelines and the supply of condoms are provided for free. Services such as cervical smear tests and the application of injectable contraceptives require the payment of a small fee[11].

A non-governmental organization connected to the *International Planned Parenthood Federation* also supplies services covering SRH on five islands[11].

According to the Demographic Inquiry into Reproductive Health in 2015[12], the prevalence in the use of contraceptives was 43.9% amongst women as a whole. The fall in the fertility rate from 2.9 children per woman in 2005 to 2.3 in 2015 suggests an expansion in this practice. The fall in the number of children being born was noted amongst all age groups including those under the age of 19. However the number of pregnancies amongst young people is considerably high. In 2013 20% of those who were pregnant and received ante-natal care were aged 19 or under[4]. Data for 2010 showed that 26.2% of young people between the ages of 15 to 19 and 0.5% that were under the age of 15, had previously become pregnant at some point in their lives[12].

The law permits the abortion up to the twelfth gestational week. The consent of the family is needed in the case of girls under the age of

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18. However, it is estimated that 60% of abortions that take place in the country, occur outside of the official health system[13,] . Difficult to .meet the requirement on the gestational period, no family consent, the payment of the fee and the lack of a health care service on the island where the pregnant woman lives and accounts of poor treatment for the services personel respond to the clandestine abortions[13].

The standard that sets out an interruption in studies during pregnancies is referred to an important reason to abortion among teenagers. In spite of not having accurate data on the extent of abortions,their very occurrence is one of the alleged reasons for looking to improve the PNSR[4].

The prevalence rate of HIV/AIDs in Cape Verde is 0.8% in the general population, 7.9% amongst sex workers, 3.9% amongst drug users and 15% amongst homosexual men. The detection rate amongst women is greater than amongst men, due to the tests conducted during ante-natal care. This may also be related to socio-cultural barriers to homosexuals and sexual exchanges between men[14]. There is not much integration between prevention and care measures aimed at the population that is most affected and measures for the population as a whole. The HCs do not provide services to sex workers, drug users and homosexuals and there not sufficient resources to meet the demands for SRH guidance[6]. The PNSR just sets out general measures that aim to encourage the use of contraceptives.

Observational studies and face to face interviews have shown that there is a reluctance in the use of this input[10,13]. However studies conducted on populations have referred to its use by 65% of the people involved on an occasional basis, last year[14]. The perception that AIDs is a disease that affects "other people" namely: migrants, residents of poor boroughs and those who are "promiscuous", has also been noted in studies[5]. This type of mistake coupled with gender inequality, brings specific risks for women who correspond to 57.3% of new cases of the infection in the country[14].

Reach and limits of the PNSR

The reduction of maternal and infant mortality was estimated in 2011 as being 26 and 15 per 100,000 babies born alive respectively[15]. This is proclaimed as one of the main achievements of the PMI/PF/PAV. Thus, one of the PNSR`s commitments since it was developed, was to maintain these numbers and to achieve other objectives.

To this end, the PNSR strategy included the offer of SRH services being information and contraception methods as well as the provision of primary health care services to teenagers, young people and adult men in health units. The strategy also encompassed the carrying out of community outreach work on these themes and having activities done in schools. The change in the name signaled the widening of the program.

The success and the pioneering nature of the PMI/PF/PAV in the country, was such that professionals and users still use the name "PMI-PF" for services that provide SRH services. However the continuous use of the name also indicates the low number of regular and free HCs and RHCs in addition to contraception and primary health care in the puerperal pregnancy cycle which restricts the access of teenagers, young people and adult men. Principally pregnant women and children are the ones that go to CRs and RHCs on a regular basis[4-6].

The demand for health appointments reduces the availability of professionals to carry out educational activities that deal with SRH issues in an adequate way. There are accounts of permeating information that is distorted by value judgements that are made and are based on gender on the part of specialist workers at the HCs and the CRSs. There is mistrust regarding the confidentiality of information given particularly for minors where professionals and users come into contact with each other in their daily lives[4-6].

The Information, Education and Communication resources in the CRs and CRSs as well as in the schools and Youth Centers are insufficient. Therefore the access of the users to information is restricted to that which is given by the professionals. The families that only received access to SRH services after independence can rarely provide support to their children in these areas[10].

Also, sexual education in schools presented basis. Generally speaking, the approach taken in the SRH themes is done in the ambit of the discipline of Personal and Social Training (FPS) given by teachers who do not always have the required preparation and qualifications and it is not rare for them to convey their values and personal beliefs. This often leaves those who are being instructed, feeling constrained in revealing their doubts and queries on the themes[4-6].

The community activities aimed at providing guidance in the area of SRH have little structure as they depend on some of the professionals from the HCs and RHCs to present and discuss topics and to provide leadership to organize events.

When they do take place, the same problems arise in relation to the activities carried out in schools, the HCs and RHCs: a lack of dialogical methodologies that make the activities more interesting and participatory and is driven by the taking of valued judgements. Speeches in relation to the "irresponsibility" of young people or of the damaging effect of misoprostol which is widely used in illegal abortion, are frequent on these occasions. There is the denouncing and condemnation of practices involving sexuality and there is reinforcement of gender inequality[5,6].

Thus, although the PNSR recognizes the rights of people to practice their sexuality and it recognizes that SRH is not just a theme for women but also includes men, adolescents and young people, this recognition being recognized in practical terms, is limited. The potential brought by the coverage increase in activities related to the SRH and the structures that provide services on these theme, can be explored further.

Challenges of the PNSR

Given the objectives of the PNSR, the discussion of its effectiveness should also include a reduction in young people´s pregnancies and unplanned ones. It should also include: an increase in the use of contraceptives, a reduction in the number of abortions and new cases of infections brought about by HIV with greater usage of the services by men, teenagers and young people. As noted, the reaching of these objectives comes into conflict with the health system and professional postures in relation to SRH services. This means the challenges of the PNSR concerns the optimization of available resources and the creation of a consensus that permits the overcoming of identified cultural barriers. This means that the primary health care that is relevant and in force, needs rethinking.

It is necessary to have compatibility of costs and growing sector complexity coupled with an increase in demand and the incorporation of technology in health care. Communication channels need to be widened with the population with the aim of promoting health and which includes SRH services. As Cape Verde is a young country with a young population and it has a pressing need for economic growth, this theme is crucial. Unplanned pregnancies and HIV, for example, have negative impacts on development[16]. It opens up the challenge for proposing a primary health care model that focuses on: providing assistance with reference to health and the prevention of illnesses, covering SRH with the perspective of gender equality in the context of Cape Verdean culture and local sub-cultures[17]. This demands the building of inter-sectorial initiatives and changes in the ideas surrounding health being strictly to do with biomedical aspects.

There also needs to be a rethink on what should be the indicator of success for the PNSR. Pregnancy amongst young people, for example, just does not take place in Cape Verde[18] and it should not be thought of only in relation to access to information and methods. This is a frequent occurrence especially in poor, developing countries that involve cultural and symbolic aspects apart from sanitary ones[19]. The Strategic Plan for the Young People in Cape Verde, for example, considers the young as those between the ages of 15 to 29. This is in spite of the fact that many girls aged 18 feel ready to choose maternity and boys before reaching 29, are accepted socially as adults[20]. A group of people defined as *adolescents* and young people in the country represent about 25% of the population and it is very heterogeneous. For some people, experiences in relation to maternity, paternity and sexuality can represent possible affirmations of a person's femininity, masculinity and life projects[21]. In other words, not all cases of pregnancy amongst young people are deemed as a problem even though some are unplanned or undesired.

Unplanned pregnancies occur in various countries with the magnitude and the extent of occurrences differing amongst women of different ages and for different reasons. There is the perception that pregnancy is a natural phenomenon and planning only refers to the decision to not have children[18]. Thus unplanned pregnancies cannot be summed up as a problem concerning access to contraception, concepts around reproduction and maternity interfering in their (contraceptives) being used. In a similar vein, the reduction of unplanned pregnancies in Cape Verde would involve both the increase in the access to services that make methods and the gamut of contraceptives available (currently centered on the use of hormonal and oral methods as well as injections) and cultural changes in denaturalizing maternity. What should also be considered is the importance of the opportunities of self-realization for women which is fundamental for the consistent use of contraceptives[22].

Induced abortion is also a practice that has disseminated across the world. It is not just the preserve of single women or young people and its use is not due to a lack of access to contraception.

There is a recognition that even when there is access to methods that prevent pregnancies, women become pregnant and decide not to proceed with the pregnancy. There have been policies developed that permit termination in a safe way[23]. Although in Cape Verde this possibility exists, the difficulties of access reflect the controversies surrounding the theme and have become obstacles for the carrying out of safe abortions. The deepening of the debate on this theme and the production of data on the characteristics of this practice in the country is a challenge that needs to be faced with the debate on decriminalization of commerce in this area and the use of misoprostol as well as the dissemination of contraception in emergencies.

Educational activities done in the community based on gender equality can contribute to male responsibility being taken in SRH and a reduction in both pregnancies and abortions that are the result of forced sexual relations[24]. However the proposal to bring men to health services such as those being organized, might not be a strategy that is adequate for this purpose. The traditional design of the reproductive health services does not attract the male[21] population. When used, it is restricted to supporting partnerships without there being an appropriation of this space by men to cover the questions and issues raised in SRH that interests them.

It is also correct to question the strategy of concentrating on prevention of HIV for specific groups. Although these are global guidelines, the cultural transition that Cape Verdean society has lived through, has made sexual networks particularly complex. The focus on prevention in specific groups has ended up pushing away people that have high risk sexual practices that involves having sex without the use of protection with those of the same sex or those that use their bodies in sex industry. This has occurred without people necessarily identifying themselves with some of the groups considered most exposed to infections[25].

Final Consideration

One cannot deny the relevance and opportunity of the PNSR for Cape Verde. The reduction in maternal and infant mortality and the possibility of Cape Verdean women having control over decisions that relate to reproduction, are elements that are undeniably worthwhile.

The gaps and challenges of the PNSR ought to be considered, bearing in mind: the socio-cultural transitional process that the country is going through, the characteristics of the primary health services and the organization of health services and practices. Also, the difficulties faced for the SRH program in developing countries and those with a large population of young people, need to be considered.

The current health services that exists with medical doctors being at the center of the care process, shows fragilities and does not correspond to the reality of the country. There is a scarcity of doctors where they are essentially needed and there is a lack of measures in the area of prevention or the promotion of health care carried out by professionally trained individuals for this type of activity who have been trained to take a program-like perspective.

However, a change of the assistance model coupled with a greater emphasis on inter-sectoral working, the promotion of health and the strengthening of primary health care networks, will not in itself guarantee the effectiveness of the PNSR. The challenges of the different concepts on gender and sexuality that permeate the practices, need to be faced.

Sexuality, even though it is a human dimension that is a part of the body, its foundation is that of subjectivity and therefore it is both fluid and dynamic. Its approach in organized health services for medical assistance, in spite of being necessary, is insufficient and often reductionist. Therefore the complementary practice requirement and inter-sectoral working can have impacts on the culture and socially constructed meaning for sexuality. Health care models based on strong primary care and aimed at the promotion of health, can favor dialogue in this area and contribute to the creation of new meanings and values in relation to sexuality and sexual health.

The proposals of the PNSR in Cape Verde have the major potential of transforming local sexual cultures through either the services that are provided or through the vehicle of information, postures and values relative to the theme. It actions should consider the socio-cultural dynamics relative to sexuality and to the context of economic and demographic transition which the country is going through. This is so that there are guarantees of universal access to sexual and reproductive rights integrating the SRH to the strategies and national programs for development in accordance with what is set out in the CIPD and which is reiterated in the Sustainable Development Objectives.

Collaborations

WV Villela, RW Lima and CF Brito also participated in the survey of empirical and bibliographic data that gave origin to these reflections, their analysis and discussion and the writing of the manuscript.

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