

## Women Healthcare in the Developing World: A Global Disparity

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**Received:** March 30, 2018; **Published:** June 27, 2018

Women in the developing world face the constant dilemma of inequality in the availability of health care.

Since the advent of the Millennium Development Goals in 2002 effort have been made to work towards maternal health and women's reproductive health. Since 1990, the maternal mortality ratio has been cut nearly in half, and most of the reduction occurred since 2000. However this proportion was lower than the agreed three-fourth reduction originally targeted for 2015.

After years of slow progress, the goal to provide antenatal care to women around the world was not achieved. At best only half of pregnant women receive the recommended amount of antenatal care [1].

Lack of national health care programs and ineffective health care systems in the developing world may still account for failure to achieve these goals. The scarcity of financial resources and the lack of governmental commitment to address health problems are two of the crucial factors that result in inadequate facilities and the lack of trained professionals in health services.

Maternal mortality, female genital mutilation, reproductive and sexual health and cervical cancer are a few of the issues that plague developing nations.

### Maternal Mortality

Pregnant women in developing nations specifically those in rural areas have the least opportunity for health care access, this coupled with lack of trained birth attendants and skilled professionals translates to increased antenatal morbidity and mortality. Obstetric complications such as post-partum hemorrhage, obstructed labour, hypertensive disorders of pregnancy, puerperal sepsis and unsafe abortion practices are the main causes of maternal deaths in these areas [2].

In 2015 the world mortality rate was 217 deaths per 100,000. Just two regions of the world account for 88% of the maternal deaths worldwide namely: sub-Saharan Africa and South East Asia [3]. Post-partum hemorrhage accounts for the leading cause of maternal mortality accounting for almost 25% of maternal deaths [4].

Multiple Cochrane reviews have revealed that active management of the third stage of labour significantly reduces the risk of hemorrhage [5-8]. As defined by RCOG guidelines, it involves use of uterotonics (using oxytocin is most economical), early clamping of the cord along with control traction for complete delivery of the placenta.

Training health personnel in the use of magnesium sulphate in the management of hypertensive disease of pregnancy can be an effective mean to reduce morbidity and mortality. This along with easy access to antenatal care with support from government funding and mass health education may increase detection rates.

Delay in detection of obstruction of labour is in part due to lack of health education of traditional birth attendants who are the forerunners in most home deliveries. This coupled with the scattered distribution of equipped health facilities, where emergency obstetric care

is available, adds to the delay when professional help may be sought. This has to be dealt with, by public health care leaders as policy makers if these countries are to reduce incidences of maternal deaths.

Comprehensive family planning programs need to be established and advocated to prevent unplanned pregnancies and thus unsafe abortion practices.

On average, in developing countries women become pregnant more often than their counterparts in developed economics, so is their susceptibility to death as a result of childbearing related complication [9]. Mass providence of effective contraceptive methods not only prevents unplanned pregnancies and sexually transmitted diseases, such programs provide women, control over their lives and thus improve the quality of life of families.

### Female Genital Mutilation

Female genital mutilation (FGM) is defined by WHO as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other nontherapeutic reasons” This practice has no medical benefits, on the contrary are associated with severe complications. More than 200 million girls and women have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated [11]. Immediate complications include severe pain, excessive bleeding, infections, improper healing and shock. Long-term complications include urinary tract infection, difficulty menstruating, and complications during childbirth and psychological trauma.

It is also ingrained into certain cultures and geographical areas, however is a human's right violation in accordance with WHO and has now become part of the 5<sup>th</sup> sustainable development goal “eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation” [12].

This however needs to be dealt with at ground level with effective means of health educations and placing government led sanctions on areas where it has become common practice.

### Reproductive and Sexual Health

Family Planning plays a pivotal role in the health and well-being of women. It not only reduces rates of unwanted pregnancies and subsequently unsafe abortions, it decreases both maternal mortality and transmission of sexually transmitted diseases i.e. HIV. Currently 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method [13].

All women in the developing world can benefit from birth spacing and ill-timed pregnancies thus reducing infant mortality rates and improving the quality of life of other children in the family. Health education regarding contraceptive use can be delivered effectively and at low cost using local cellular services and via text messages. This method has shown some promise and is an ideal way to deal with both unwanted pregnancies, increased rate of teenage pregnancies and sexually transmitted diseases according to one Cochrane review [14].

### Cervical Cancer

Currently cervical cancer accounts for 0.8% of all new cancer cases worldwide. It is the fourth most frequently occurring cancer in women. Approximately 90% of the 270,000 deaths from cervical cancer in 2015 occurred in low- and middle-income countries [15].

The high mortality associated with cervical cancer in developing countries is due to lack of screening programs available, which means that women present much later in the course of the disease than acceptable. Screening should be offered to women in the target age group of 30 - 49 years of age according to WHO. This should be coupled with HPV testing, cytology and colposcopic inspection of all suspicious lesions.

The goal is to detect pre-cancerous lesions and provide treatment. Such an effective and widespread screening programme requires a liaison of the government with community leaders and health care experts to fund a national screening programme and to maintain national tumor registries.

As of now 7 United Nation agencies under the United Nations Task Force have established a Joint Programme to prevent and control cervical cancer and to provide individual governments the technical support needed to build such screening programs.

### Conclusion

Women in developing economies face much more than the health care related issues mentioned above. Dramatic changes are required in all areas of health care if women's health is to become a priority in these countries. Certain cultural aspects and social roles played by women often impact their access to health care in society. Almost all developing nations still operate an out-of-pocket health care system, this coupled with the fact that these areas of the world are engrained in the workings of a deeply patriarchal society, leaves the women at the hands of their male counterpart to financially support health care cost.

Much effort is needed, by local governments, third party funding sources and non-for profit organizations, if we are to correct these challenging health problems and empower women to improve their quality of life.

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**Volume 7 Issue 7 July 2018**

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