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メタデータ	言語: English 出版者: 公開日: 2007-12-26 キーワード (Ja): キーワード (En): Cross Culture, Empowerment, Induced Abortion, Malawi, Reproductive Health, Unwanted Pregnancy 作成者: Nasoro, Ethel fortunate, Arimori, Naoko, Mori, Akiko, Horiuchi, Shigeko メールアドレス: 所属:
URL	http://hdl.handle.net/10285/422

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報 告

A Comparison of Reproductive Health Knowledge Between Malawi and Japanese Women

女性のリプロダクティブ・ヘルスに関する認識の比較
－マラウイと日本－

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〔Abstract〕

The purpose of this study was to compare the knowledge and understanding of reproductive health of women and adolescents in Malawi and Japan with the goal of promoting safe motherhood by preventing unwanted pregnancy and induced abortion. Documents and interviews provided data for this study.

Significant issues warranting interventions were observed in the two countries. These are lack of adequate reproductive health knowledge, social problems and gender imbalance. We found out that these three are the main contributors to unwanted pregnancy, hence induced abortion.

The results suggest that midwives in the two countries have a significant responsibility in promoting reproductive health education with adequate follow-up for the promotion of safe motherhood. High rates of unprotected sex are a threat to the promotion of safe motherhood.

During the study we also realized the importance of increasing the awareness of the different cultures and exchanging ideas from the two countries.

〔Key words〕 Malawi, unwanted pregnancy, induced abortion, empowerment, reproductive health, cross culture

〔キーワーズ〕 マラウイ，望まない妊娠，人工妊娠中絶，エンパワーメント，リプロダクテイブ・ヘルス，比較文化

Introduction

The World Health Organization has endorsed strategies for the promotion of safe motherhood to achieve Health for All. Every birth involves two people, a mother and a baby. All over the world

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2001年11月20日 受理

women are the ones who are directly involved in child bearing, an important role in the continuation of human existence. It is therefore important to educate women and adolescents about reproductive health so as to prevent unnecessary deaths and thereby achieve the goal of a healthy nation.

Background

I am a trainee of the Bishop Williams Memorial Fund currently studying at St. Luke's College of Nursing in Tokyo. My country is Malawi and my objective in Japan is to study maternal and child health with a plan to apply the gained knowledge to my own country upon return, I hope that this will help to reduce maternal and infant mortality rates.

Malawi is a small country located on the eastern part of Central Africa between 9 degrees and 17 degrees south of equator (see Figure 1). Tanzania borders it to the north, Mozambique to the east and south and Zambia to the west. It occupies an area of 118,482km². The population is about 11,000,000. It is a multicultural country with seven local languages. English is a national language and it is used in all educational institutions. 90% of the population is Christian; the others are Muslim or follow traditional religions. The literacy rate is 30% for females and 48% for males. (National Statistical Information, 1998). Table 1 presents a summary of this information and comparable information about Japan.

Table 1 Statistical Information about Malawi and Japan (1998)

	MALAWI	JAPAN
Area	118,482km²	372,723km²
Population	11,000,000	126,000,000
Culture	Multicultural	Mono cultural
Religion	Christian	Buddhism
Language	English	Japanese
Literacy rate	48%M 30%F	100%M/F
Midwives	4,000	24,000
Obstetricians	131	11,509

Sources: see text

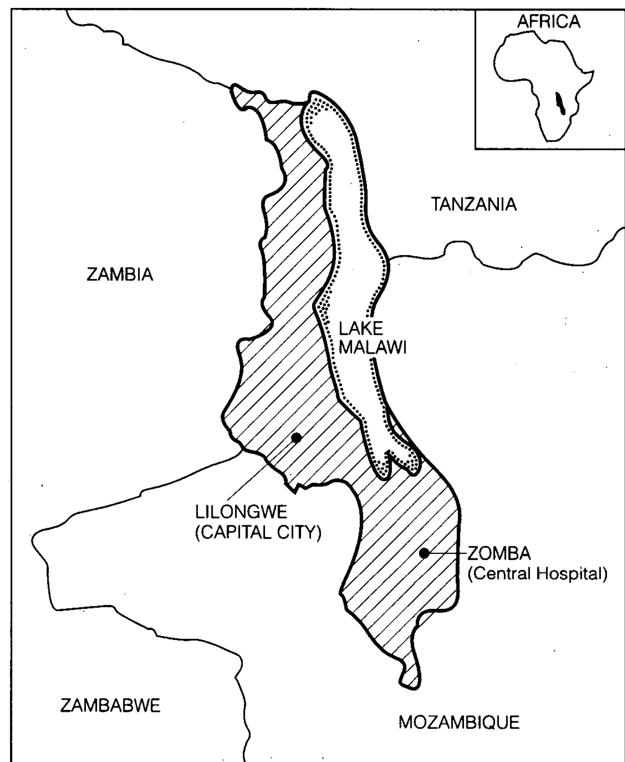

Fig 1 Map of Malawi

Malawi and Japan

Malawi is a developing country, and has a lot of problems in achieving the goal of having a healthy nation through the safe motherhood initiatives. Seventy percent of the Malawi population is mothers aged 15 to 40 and children aged 0 to 5. Maternal and child death rates are high and nutritional status is poor. There is a shortage of qualified midwives and obstetricians in health institutions in Malawi. Adolescents are engaged in early sexual activities and marriages due to poverty. This leads to high rates of teenage and unwanted pregnancy, which can also lead to high rates of induced abortion. HIV/AIDS infection among the adolescents is on the increase.

Japan is a developed country, and has no problems to achieve the safe motherhood strategies. One hundred percent of the women in Japan are literate. Maternal and child death rates are low and nutritional status is good. There are enough qualified midwives and obstetricians in all health institutions. Even though there is basic knowledge and enough resources in Japan, induced abortion rates are very high (Mothers and Children's Health Organization, 1999, p109).

In 1998 the birth rate in Malawi was 47 per 1,000 population and in Japan it was 9.5 per 1,000 population (International Nursing around the World, 1998, p47 and p288 respectively). Fertility rate was 6.7 children per woman in Malawi while in Japan it was 1.4 per woman; one woman has many children in Malawi while in Japan one woman has few children. The maternal mortality rate was 620 per 100,000 live births for Malawi and 8 per 100,000 live births in Japan. The infant mortality rate was 134 per 1,000 births and 4 per 1,000 births in Japan (Mothers' and Children's Health Organization, 1999, pp112−113). The Induced abortion rate was 1 per 1,000 women in Malawi and 11 per 1,000 women in Japan. The total number of abortion was 1,520 in Malawi (Reproductive Health Unit Statistics, 1998) and 333,220 in Japan (Mothers' and Children's Health Organization, 1999 p109). Induced abortion is illegal in Malawi while in Japan it is legal. Twenty two percent of women use contraception in Malawi and 59 percent in Japan. Life expectancy was 50 years for males and 55 years for females in Malawi (National Statistical Information, 1998) while in Japan it was 77.9 for males and 83.8 for females (Mothers' and Children's Health Organization, 1999 pp112−113). Table 2 summarizes this information.

Table 2 Vital Statistics of Malawi and Japan (1998)

	MALAWI	JAPAN
Birth rate	47/1,000population	9.5/1,000population
Fertility rate	6.7/woman	1.4/woman
Maternal mortality rate	620/100,000L births	8/100,000L births
Infant mortality rate	134/1,000L births	4/1,000L births
Induced abortion rate	1/1,000women	11/1,000women
Total induced abortion rate	1,520	333,220
Contraception prevalence	22/100women	59/100women
Life expectancy	50yrs/M 55/F	77.9yrs/M 88.9F

Source: see text.

Purpose

The purpose of this study was to compare the knowledge and understanding of reproductive health of adolescents and women of the two countries in order to plan appropriate action for the promotion of safe motherhood. This will help adolescents and women to make an informed choice regarding their reproductive health issues.

Method

We gathered statistical data about maternal and child health in Malawi and Japan. The clinical information on Malawi was based on my 8 years working experience in two of Malawi's biggest hospitals. In Japan we interviewed 25 adolescents after obtaining their consent. The tone of the interviews was friendly and relaxed and questions were open-ended. The interviews were documented both written and taped. The content of the interview focused on knowledge about sex, pregnancy, abortion, contraception as well as the role of reproductive health education classes. This was complemented by a visit to a company that publishes books and magazines on reproductive health education for junior as well as high school and teaches students on the subject. Data was collected from May through August, 2001.

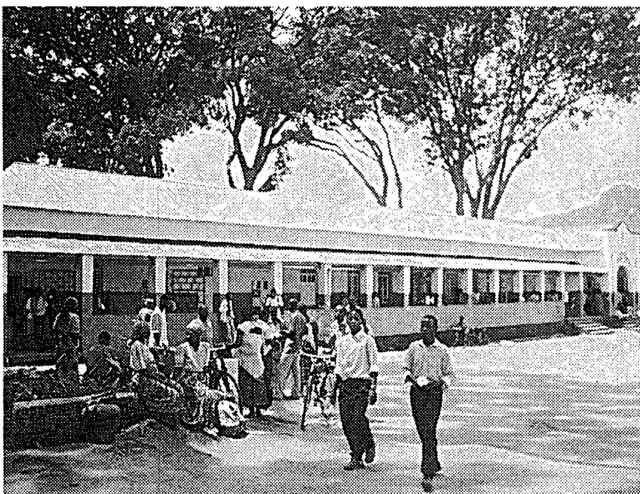

Photo 1 A block at Zomba Central Hospital, Malawi

Results

Our findings about reproductive health are categorized in the following problem areas, (a) lack of adequate information, (b) social problems,

Table 3 Comparison of Factors Related to Reproductive Health in Malawi and Japan.

Factors	Malawi	Japan
Lack of adequate information	No open discussion	Basic information
	Women illiterate	All women literate
	Unwanted pregnancy	Unwanted pregnancy
	Increasing STD and HIV	Increasing STD and HIV
Social Problems	Poverty-poor nutrition	Enough money-good nutrition
	Sex for financial help	Sex a sign of true love
	Abortion a crime	Abortion one's freedom
	Fetus a special gift	Fetus not valuable
	Child care for all	Child care for individuals
Gender imbalance	Male dominance	Male dominance
	Contraception for women	Contraception for women
	Sexual abuse	Sexual abuse/Domestic violence

(c) gender imbalance (**Table 3**).

Lack of Adequate Information

In Malawi adolescents are not taught about reproduction. They are not supposed to know about human sexuality until they reach marriage age. That is the only time they can get counseling from elders. Society believes that teaching the adolescents about reproduction will activate them into sexual activities.

The adolescents have no understanding of the physiology of reproduction; therefore they indulge in unprotected sex in ignorance. They do not believe that having sex once can make them pregnant. Adolescents go out to seek information from their peers. In most cases they get wrong information, which induce them into sexual activities. This leads to unwanted pregnancy and sometimes sexually transmitted diseases including HIV infection from unprotected sex.

The high illiteracy rate among women makes it impossible for them to read some important health information.

In Japan adolescents have basic information about reproductive health through reading books/magazines and watching films. A publications company in Tokyo publishes books for the teaching of reproductive health in schools. However the entire society is not very open for discussion about reproductive health. Despite having basic knowledge about reproductive physiology, adolescents and women are engaged in unprotected sex. Most women and adolescents lack negotiation skills, they fail to persuade their male partners to use condoms. They get unwanted pregnancy and sexually transmitted diseases including HIV.

Social Problems

In Malawi there is intense poverty among many families and nutritional status is poor because people have no money to buy food. Poverty forces adolescents and women to be engaged in sexual activities in order to get financial assistance from their sexual partners. Most adolescents get into early marriages instead of continuing with their studies because their parents do not afford to give them enough financial assistance (Bachrach,Clogg & Entwisle, 1993 and Balwid, 1993).

Induced abortion is a crime in Malawi because it is a Christian country. A fetus is regarded to be same as a human being. Despite all these social problems, the society helps in childcare because children are thought to be a special gift from God to society.

In Japan most women are able to find employment because of their education therefore they get enough money for their needs including food. This makes their nutritional status good.

The adolescents interviewed stated that they are engaged in sexual relationships just for fun, not for financial gain. They feel that this is one way of showing genuine love for each other. They also stated that a fetus in not valuable and it is their right and freedom to have an induced abortion when they get unwanted pregnancy. Induced abortion is legal in Japan and the adolescents feel that they

Photo 2 A pregnant adolescent aged 18 years, formerly a college student

Photo 3 Adolescent mother aged 18 years with first baby

have nothing to worry about as regard to induced abortion because qualified medical personnel can perform it at any hospital of their choice.

They feel that they have to be very well prepared before becoming mothers because childcare is for individuals only. The society is not friendly and does not help in childcare. It is very difficult for a young mother to take care of her baby because most adolescents don't have experience in childcare.

Gender Imbalance

In Malawi there is male dominance with regard to reproductive health issues. Most men feel that they are superior and therefore they are decision-makers in reproductive health issues. In Malawi all contraceptives are free of charge including condoms but most men refuse to use condoms because they feel contraceptive use is for women. Most women and adolescents are willing to use contraceptives but in most cases they have to get consent from their male partners who in most cases refuse to let their female partners use contraceptives. Adolescents and women are in a dilemma because their male partners refuse condoms and do not want the women and adolescents to use contraceptives. The adolescents and women always compromise to their male partner's sexual needs and therefore engage in unprotected sex.

Adolescents and women are sometimes sexually abused by men who sometimes threaten to kill them if they refuse to have sex with them or if they tell anyone that they have been sexually abused.

In Japan there is also gender imbalance as regards to reproductive health issues. Despite the knowledge of the physiology of reproduction and the general acceptance of condoms, most men refuse to

use condoms. The adolescents stated that if they insist that their male partners should use condoms, men are very angry and in most cases they threaten to end the relationship. To keep the relationship going, the adolescents and women give in to unprotected sexual activities. Some adolescents lack good decision making on the choice of contraceptives.

Adolescents and women are willing to use contraceptives but it is difficult for them to get contraceptives such as pills because they have to get a prescription from a doctor ("We are shy to go to the Obstetrician to ask for contraceptives because they ask us many questions"). They are shy to go and ask for a contraceptive prescription from a doctor.

Some irresponsible men sexually abuse adolescents and women and there is also a general concern about domestic violence in Japan.

Discussion

Contrast about Reproduction

We found out that there are reproductive health problems and needs to be addressed in Malawi and Japan. Malawi is poor in resources but the society has a very positive attitude towards reproduction and childcare whereas Japan is very rich in resources but the society lacks good attitude towards reproduction and childcare. In Malawi adolescent mothers are supported in child-care by parents and relatives and some go back to school. (Table 4).

Common Need: Promoting Reproductive Health Education

In both countries creating health education programs might have positive outcomes for reproductive health of women and adolescents. We feel that the most important thing to do is to create an environment for free discussion about reproductive health in both Malawi and Japan. With the support from the governments of the two countries, midwives should engage in promoting reproductive health education among women and adolescents. Adolescents and women should be made to understand that unprotected sex always leads to unwanted pregnancy. Moreover, now with HIV infection around the world and the increase of sexually transmitted diseases, women and adolescents need to protect themselves against these infections. Reproductive health education will empower women and adolescents to be decision-makers in reproductive health issues; this will help to reduce unwanted pregnancy and therefore reduce induced abortion rates and the risk of HIV infection.

Table 4 Contrast Factors Related to Reproduction and Child Care in Malawi and Japan

Malawi	Japan
	Basic information
Lack	Enough money
	Good nutrition
Fetus is human	
Child special gift	Lack

Program Plan

Our target groups are adolescents and women. Results of research with adolescents provide evidence for effectiveness of AIDS risk interventions in improving knowledge, attitudes and behaviors (Kim, N., Li, X., Dickersin, K., & Galbraith, K., 1997), and we hope to include these interventions in our programs.

We would like to form peer groups of adolescent volunteers who can teach each other about reproductive health. We feel that adolescents will be very comfortable to discuss topics related to sexual behavior and reproductive health with people of the same age; but we will also include adult facilitators. This plan respects local cultures and also reflects the findings of Jemmott, (Jemmott Fong, 1998). While there was no statistically significant differences among adolescents in their responses to groups led by either peers or adults; participants who had peer co-facilitators liked their interventions more than did those who had adult facilitators.

Developmentally and culturally designed interventions delivered to naturally formed peer groups recruited from community settings should help behavior changes among the targeted groups. Our reproductive health education will not be restricted to a particular place like schools only, but we would like to go into the community. We can meet the adolescents and women in places of their own choice and convenience. Some games will be included in our reproductive health education (such as netball and basketball) so as to attract adolescents. Drama and video shows will also be included.

Since we have identified male dominance as a contributing factor to unwanted pregnancy, there is need to promote gender equality among women and men in our reproductive health education. A particular concern in Malawi is that adolescent-abstinence rather than condom use is supported by most churches because sex before marriage is considered a sin whether with condom use or not. Midwives are in a dilemma because they would like to promote condom use, but the churches condemn them. There is also a general and great concern that encouraging condom use will encourage adolescents to be involved in sexual activities.

We hope to adopt interventions that will increase knowledge of HIV and STDs, support abstinence, increase self-efficacy and negotiation skills regarding the ability to resist pressure to have sex. Condom use will be taught and promoted.

Follow-up and evaluation

Our programs for reproductive health education should be on-going. Evaluation of program effects will be at intervals based on the enrollment of the participants, for example every three months, six months, nine months and twelve months. Evaluation will be important to check behavior change among adolescents and women. Adolescents and women should be able to say whether they are able to use the taught negotiation skills, contraceptives or abstinence. Studies (Kim, et al., 1997 and Jemmott, et al., 1998) have shown that follow up and evaluation are important because if there is no follow up the adolescents start to relax and there is a relapse toward irresponsible sexual behavior.

Photo 4 Midwife conducting a mother class at Zomba Central Hospital

Conclusion

During our study we found out three major contributing factors to reproductive health problems: (a) lack of adequate information, (b) social problems, (c) gender imbalance between men and women. Some of the reproductive health problems are similar for both countries while others are a contrast. Malawi is poor in resources but the society has a very positive attitude towards reproduction whereas Japan is rich in resources but the society lack good attitude towards reproduction and childcare.

We also realized the importance of increasing the awareness of different cultures and exchanging ideas from the two countries.

Midwives have a significant responsibility in promoting maternal and child health in the two countries thereby reach the goal of Health for All. There is a saying in Malawi that "Once you educate a woman, you have educated the whole nation".

Acknowledgements

My heartfelt thanks to all the faculty members of the Maternal Infant and Midwifery department of St. Luke's College of Nursing, their guidance and participation in many discussions made this paper possible.

We are grateful to the adolescents who participated in the interviews. We also acknowledge the support and contribution to this study by the staff of the Publications Company we visited in Tokyo, Japan.

We thank Professor C. White for checking the manuscript and the recommendations she made. We sincerely thank Hiromi Eto of Ishimura Maternity home for the technical support and advice.

My sincere thanks to the executive committee of the Bishop Williams Fund of Rikkyo University (St. Paul's) for sponsorship and this rare chance offered to me to come to Japan and study at St. Luke's College of Nursing.

References

Bachrach, C.A., Clogg, C.C., & Entwisle, D.R. (1993). Outcomes of early childbearing. *Journal of Research on Adolescence*, 3, 337−348.

Baldwin, W. (1993). The consequences of early childbearing. *Journal of Research on Adolescence*, 3, 149−252.

International Nursing Foundation of Japan. (1998). *Nursing around the world*, (4th ed.). Tokyo: Author.

Jemmott, J.B.III, Jemmott, L.S., & Fong, G.T.(1998) Abstinence and safer sex: HIV risk-reduction

interventions for African-American adolescents. *Journal of American Medical Association*, 279(19), 1529−1536.

Kim, N., Stanton, B., Li, X., Dickersin, K., & Galbraith, K. (1997). Effectiveness of 40 adolescent AIDS risk-reduction interventions: A quantitative review. *Journal of Adolescent Health*, 20, 204−215.

Mothers' and Children's Health Organization. (1999). *Maternal and child health statistics of Japan*. Tokyo: Author.

National Statistical Information. Republic of Malawi, 1998.

Reproductive health Unit Statistics. Malawi ministry of Health, 1998.

World Health Organization. (1993). *Maternal and Safe Motherhood program Progress Report, 1991−1992*. (Division of Family health, WHO-FHE/MSM/93.6).

World Health Organization. (1996). *Maternal Health and Safe Motherhood Program Progress Report, 1993−1995*. (1996). (Division of Reproductive Health, WHO-FRH/MSM/96.4)