STATE AND CHALLENGES TO REPRODUCTIVE HEALTH IN ALGERIA

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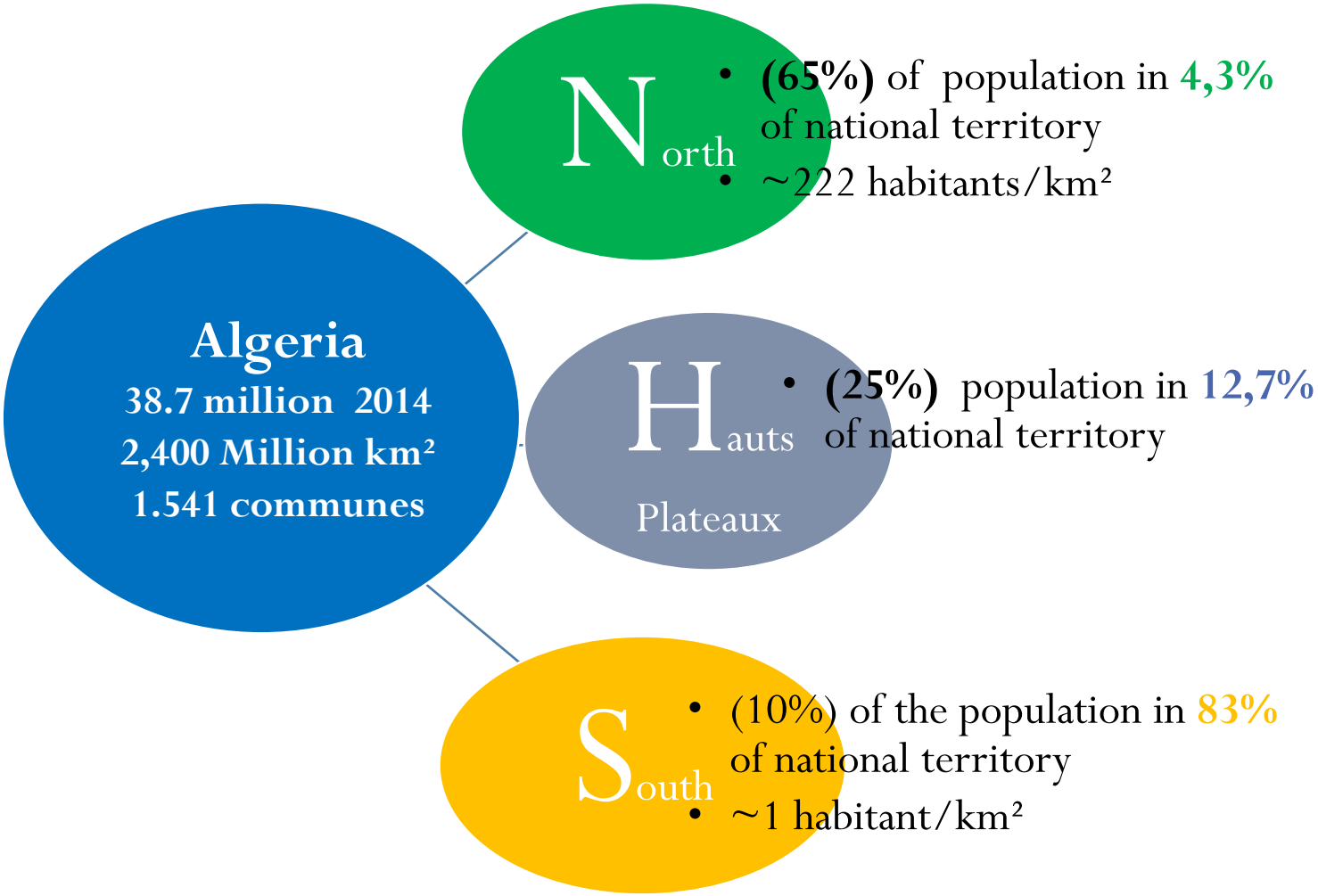
INTRODUCTION

- Algeria has made significant economic and social progress during the last decades by improving life expectancy at birth and reducing maternal mortality (0, 23 % to 0,078%) and infant mortality (4,6% in 1990 to 2,31 in 2011) and other measures of health status.
- However, considering its natural wealth and human resources, it has accomplished less than expected in terms of human development.
- Important social and health inequalities exist in and inter wilayas of the country and a large percentage of populations, particularly in rural areas, are disadvantaged from access to health facilities.

INTRODUCTION

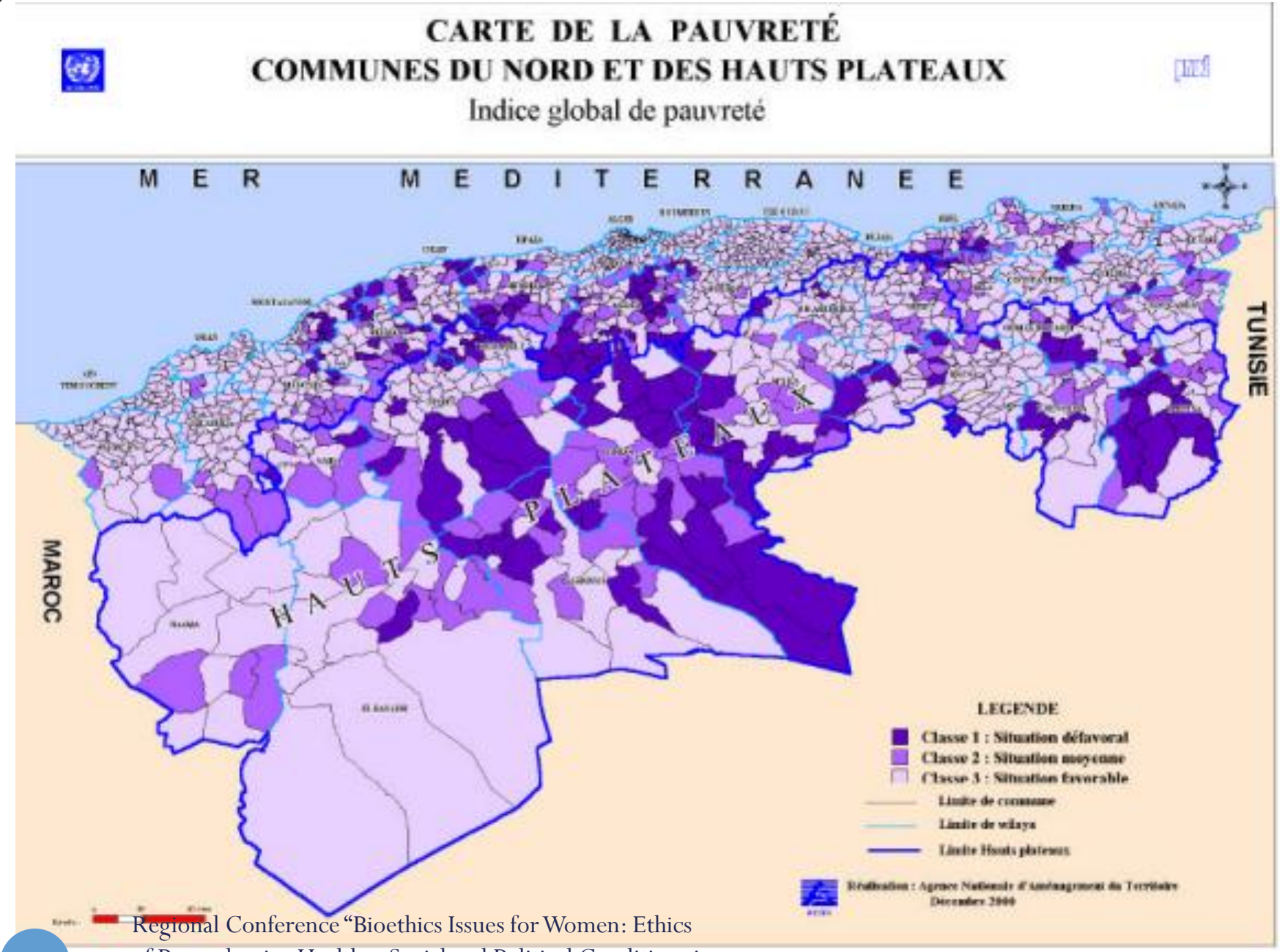
- Algeria count a population of 38.7 million since January 2014
- Annual population growth rate of 2.16 %
- Total fertility rate which decreased from 4.4 children per woman in 1998 to 2.27 in 2009, and an increase from 2.87 in 2011 to 3.02 children per woman in 2012;
- Average life expectancy is 76,4 years, and 8.4 % of the population is over 60 years old.

- Demographic transition is well advanced; however, there are large regional disparities, both on life/health quality that of territory area occupied.
- Actually, the population distribution pattern in country is marked by major imbalances where for a total area of the country of 2,400 Million km², we have the following situation;


Algeria
38.7 million 2014
2,400 Million km²
1.541 communes
North
(65%) of population in 4,3% of national territory
~222 habitants/km²
Hauts Plateaux
(25%) population in 12,7% of national territory
South
(10%) of the population in 83% of national territory
~1 habitant/km²

In terms of health/Poverty

- 47% of **1.541** communes in the country have a relatively favorable situation (Class III), those in the North represent nearly 72% of the 724 communes of these categories, while southern regions they only account for 2%.
- There are large regional differences at the expense of municipalities in the Highlands and South, in fact, the number of 168 disadvantaged communes (class I), 11% are found in the northern regions and 53% in Highlands regions and 36% in the South


CARTE DE LA PAUVRETÉ
COMMUNES DU NORD ET DES HAUTS PLATEAUX
Indice global de pauvreté
M E R M E D I T E R R A N E E
TUNISIE
MAROC
H A U T S P L A T E A U X
LEGENDE
Classe 1 : Situation défavoral
Classe 2 : Situation moyenne
Classe 3 : Situation favorable
Limite de commune
Limite de wilaya
Limite Hauts plateaux
Réalisation : Agence Nationale d'Aménagement du Territoire
Décembre 2000

- Over the last fifty years, Algeria has experienced profound political, socio-economic and especially demographic changes. In terms of population, the current situation and its problems are the opposite of the conditions of the sixties.
- Economic perspective, the country has recorded growth situated to an average 2.7% in 2011-2012, thanks to an expansion of 5.8% in the non-hydrocarbon sectors in which infrastructure development and agriculture have contributed.
- All sectors grew during this period, with the exception of the oil sector, where production has been declining since 2006. GDP per capita reached 5,559 dollars in 2012, surpassing its 2008 peak ($ 4 967) [5].

- Thus in the field of health, operating budget and equipment of the sector almost quadrupled between 2000 and 2009.
- The share allocated to preventive programs and activities of reproductive health, including activities such as obstetrics, purchase antiretroviral drugs and oral contraceptives, represents 15% of operating budget [6].
- In fact, the request of the population evolved and looks for a better health coverage, which is not the case actually because it requires a good management of all services and at every level, and this is the big challenge for the country.

Organization of Health System to meet the challenges of the millennium

Major challenge to health systems worldwide : Maternal mortality:

Global initiatives to intensify policy intervention for maternal mortality began with the 'Safe Motherhood Initiative' in 1987

The ICPD (1994) strengthened international commitment to reproductive health

Focus on maternal mortality improved when **reduction in maternal mortality** became **one of 8 goals** for development in the Millennium Declaration

The objective for MDG 5 **is to reduce the maternal mortality ratio (MMR) by three-quarters from 1990 to 2015.**

INSTITUTIONAL PERSPECTIVE

- To implement the recommendations of International Conference on Population and Development (ICPD - Cairo in 1994), Algeria established in 1994 **the Department of Population**, in charge of carrying out the population programmes, creating and making functioning the **National Committee of population (CNP)** and the **National Committee of Reproductive Health and Family Planning (RH/FP- SR/PF).**
- In terms of benefits and after the ICPD there has been, **introduction and reinforcement of the concept of "Reproductive Health" and "Reproductive Rights" with the creation of organs of support as:**

Development of contraceptive practice

- Over the ninety's, family planning made a notable advance in Algerian society. The increase in family planning is also one of the factors that led to the evolution of demographic indicators, marked by reduction in the fertility rate and thus a slowdown in the pace of population growth. The utilization of contraception was estimated at 40.6% of married women of reproductive age in 1990, reached in 1995, 56.9% represents more than one in two women.
- However, access to contraception remains uneven: the southern region has the lowest contraceptive prevalence rate of 48,2% and the western region with the highest rate 63%, the eastern region and the central region are substantially at the same level of use with 56.2% and 56.3%.[8].

Public health System and social security

- The health system is structured around public sector and private sector.
- The Ministry of Health, Population and Hospital Reform (MSPRH) manages the hospital care and public health and controls the conditions of the private sector.
- The public hospital facilities consist of hospitals, Specialized Hospital Establishments (EHS), and university hospital (CHU) totaling approximately **54,000 beds**.
- Infrastructure consultations, care and prevention include polyclinics, health centers and treatment rooms, the medico-social centers, the unit testing and monitoring school health, preventive medicine units in academia, centers blood transfusion and pharmacies.[8]

Public health System and social security

- Currently, coverage of hospital beds is at 1.88 per 1000 inhabitants. It should be noted also the opening of the health sector to private clinics since 1988 (Decree 88-204). We are witnessing a multiplication of private clinics, surgeries and radiological centers throughout Algeria.
- In terms of organization, until 2007, the national public health system was based on the sanitary sector, which included extra hospitals (clinics, health centers and treatment rooms) which gravitated around structure of hospitalization covering a given geographical area.

Public health System and social security

- Since the organization was changed. In fact, the principle of hierarchy, that prevailed outside hospital care was maintained but reduced to two levels, under the generic "structures of proximity health" and including the polyclinic with consultation missions in general and specialized medicine, dental surgery and activities of maternal and child health.
- This set is supported by a technical platform for radiology and biology and the treatment room with the missions of general practice and general care. The expected result is the proximity of health care for citizens [9].

Public health System and social security

- The social security system in Algeria is based over a single scheme, which covers substantially all of the people against social risks, grouped into five branches.
- Medicare is part of the branch of social insurance. It is based on insurance system professional basis, financed by contributions of employees and employers.

Public health System and social security

- Are recipients of Medicare: the employed, self-employed, older workers whose social security benefits, specific groups (students, disabled, poor receiving welfare state, apprentices, etc.) and their beneficiaries.
- System management is handled by two organizations: the National Social Insurance Fund for Employees (**CNAS)** and the National Social Security Fund unsalaried **(CASNOS).** Both organizations have boards of directors and are under supervision of the Ministry of Social Security. Medicare covers about 9/10th of the population (insured and beneficiaries).

Public health System and social security

- The network of health infrastructures that offer services reproductive health and family planning is estimated to be 1 965 units, spread across the whole wilayas. Composed of medical units from the polyclinic to the treatment room, the benefits provided often remain of uneven quality level ranging from the true family planning consultation to simple "distribution" of oral contraceptives.[8]
- It should be noted that all maternal and child welfare programs are delivered free of charge in over 5000 public medical centres distributed throughout the country.

Situation and demographic evolution

- The studies carried out [8] showed the following deficiencies and some progress as:
- An insufficient quality service, since the majority of structures does not have a personal reception, this function is assumed by the service staff in 67% of cases;
- The staff is in charge of several activities including in the context of follow up of children, which made family planning a part-time activity in 77% of cases;
- Less than 10% of structures organize activities of teaching and information/communication and have consulting service: the initiative of information is left to personnel during the consultation.

Situation and demographic evolution

- The offer of reproductive health services and family planning is widely available across the country with a network of nearly 2,000 units, human resources illustrated by a ratio of sage-femme/900 women of childbearing age and one gynecologist for 7,000 women of childbearing age.
- Population issues have been brought to public debate in the eighties, which contributed to changing attitudes towards family planning, thanks also to the associations involved in awareness about family planning.
- Significant advance in planning for Algerian society from start of the program is illustrated by a rate of contraceptive use of 57% for 1995[8]. However, despite progress in practice contraception, nearly 20% of couples are not yet vested at the family planning. .

Situation and demographic evolution

- The inter- sectoriality that characterized the launch of the control population growth has faded in the Nineties.
- According to the report of the National Economic and Social Council for 2003, 57.4% of maternity lack gynecologists, 34.3% do not have nurses and 25% have only one table of delivery.
- The importance of the level of maternal mortality, despite a high rate of assisted childbirth is related to these gaps. Indeed, the poor quality of diagnosis of complications and the lack of logistics do not allow the transfer in timely complicated cases to specialized structures.

Situation and demographic evolution

- Important social and health inequalities exist in and inter wilayas of the country and a large percentage of populations, particularly in rural areas, are disadvantaged from access to health facilities.
- The reproductive health and the maternal and child protection are national priority issues, and are among Algeria's public health policy objectives. The focus is on family planning, maternal health, childbirth under professional supervision, and the elimination of sexually transmitted diseases and waterborne diseases such as typhoid fever, cholera, diarrhoea and hepatitis.

DEMOGRAPHIC EVOLUTION

- Accordingly, the health and population sector and hospital reform are part of the effort to improve the situation of mothers and children [MSPRH).
- Indeed, the annual average of population growth was over 2.6%, and at this rate, the population doubles in less than 30 years [10].
- Some studies such that published showed that this growth was still expected to accelerate and could reach 4% to 1985 and the country would see its population doubling in less than 20 years. For this, in 1983, there has been implementation of first program of controlling population growth (PNMCD) and currently, contraceptive prevalence among women aged 15 to 49, for all used methods is 61.4% from which 52% for modern methods.

DEMOGRAPHIC EVOLUTION

- The total fertility rate fell from 4.4 children per woman in 1992 to 2.4 in 2002, a reduction of two children during the period. However, the total fertility rate in 1970 peaked at 7.8 children per woman, a reduction of 5.4 children per woman in the space of 22 years[5].
- In terms of the birth, it was found an increase in births during the period 2000-2009. In fact, it goes from 589,000 in 2000 to 849,000 in 2009 following a decline from 1985 to 2000. This recent and continuing increase in the number of births seems most likely due to the unprecedented increase in the number of marriages between 2000 and 2009, from 163 126 à 341 321[9]

DEMOGRAPHIC EVOLUTION

- **a) Natality and fertility**
- Compared to the year 2011 when the increase in births between 2010 and 2011, 2012 was a strong rebound in birth rates, resulting in a relative increase passing from 2.4% during the period 2010 -2011 to 7.5% between 2011 and 2012. This led to a significant rise in the level of gross birth rate rose from 24.78 ‰ to 26.08 ‰ between 2011 and 2012 [1] (see Figure 1).
- Similarly, the total fertility rate was affected by the increase from 2.87 to 3.02 children per woman during this period. In contrast, the average age at childbirth continues to decrease with the same rate observed in previous years, a decrease of point 0.1 per year, reaching 31.5 years.

DEMOGRAPHIC EVOLUTION

- **b) Overall mortality**
- The volume of deaths in 2012 reached a rate of 4.9% compared to 2011, which has led to a rise in the gross mortality rate, which went from 4.41 ‰ to 4.53 ‰ between 2011 and 2012.
- Moreover, the effect of increasing the volume of deaths has led to a slight decline in the level of life expectancy at the estimated one tenth of a point (0.1) with respect to the level recorded in 2011 birth from 76.5 to 76.4 years[1]. (Figure 1)

DEMOGRAPHIC EVOLUTION

- **c) Maternal mortality**
- The general maternal mortality ratio declined from 117.4 maternal deaths per 100,000 live births in 1999 to 81.4 in 2009 and 73,9 in 2011 (500/100 000 in 1962). The contraceptive prevalence rate for modern methods is 52 per cent. [1] [2]
- Maternal and perinatal mortality in the south continues to be a major public health problem in Algeria. Despite efforts since the seventies on health of the mother and child, the reduction of maternal and neonatal mortality remain too low [3].

DEMOGRAPHIC EVOLUTION

- The maternal and perinatal mortality in the South continues to constitute a major problem of public health in Algeria. In spite of the efforts granted since the seventies regarding health of the mother and the child, the decrease of the rates of maternal and neonatal mortality remains too low. On a national scale, it is observed in 2004, 99,5 deaths for 100 000 living births and 92,6 for 100 000 living births in 2006, while 95,3 % of the deliveries take place in assisted environment[3].

DEMOGRAPHIC EVOLUTION

- Maternal mortality alone constitutes 10% of all morality of women aged between 15-49 years. Mortality rates are also characterized by large regional disparities. For example, in southern Algeria, the maternal mortality rate is significantly higher than in the North and is 230 per 100,000 in Adrar and in Tamanrasset 117.4 cases per 100 000 live births. Recall that this rate does not exceed 31 per 100 000 births in developed countries[3] (according to UN data).

DEMOGRAPHIC EVOLUTION

- **d) Stillbirth and Early childhood mortality**

For 2012 it has been observed the registration of 15,795 stillbirths, a slight increase in volume compared to 2011 where the number of this population was 15 480. In contrast, the stillbirth rate fell by 0.8 percentage points, from 16.7 ‰ to 15.9 ‰ during the same period.

Highly correlated with infant mortality, the probability of dying between birth and exact age 5 expressed by the quotient, experienced a slow decline from 26.8 ‰ to 26. ‰, from 2011 to 2012. Examination of this indicator evolution between 1990 and 2012, shows that the level of child mortality is reduced by a little more than half, from 55.7 ‰ in 26,1 ‰. [1](Figure 1)

DEMOGRAPHIC EVOLUTION

- **e) Marriage**

Unlike what has been observed in 2011, which saw a significant increase in the volume of weddings, civil status offices experienced in 2012, recording 371,280 unions, there is a moderate increase of 0.6% compared to 2011 The gross marriage rate has experienced a slight decline and from 10.05 ‰ to 9.9 ‰ between 2011 and 2012[1] [2] (see Figure 2).

Figure 1: Evolution of main Indicators (ONS 2013)

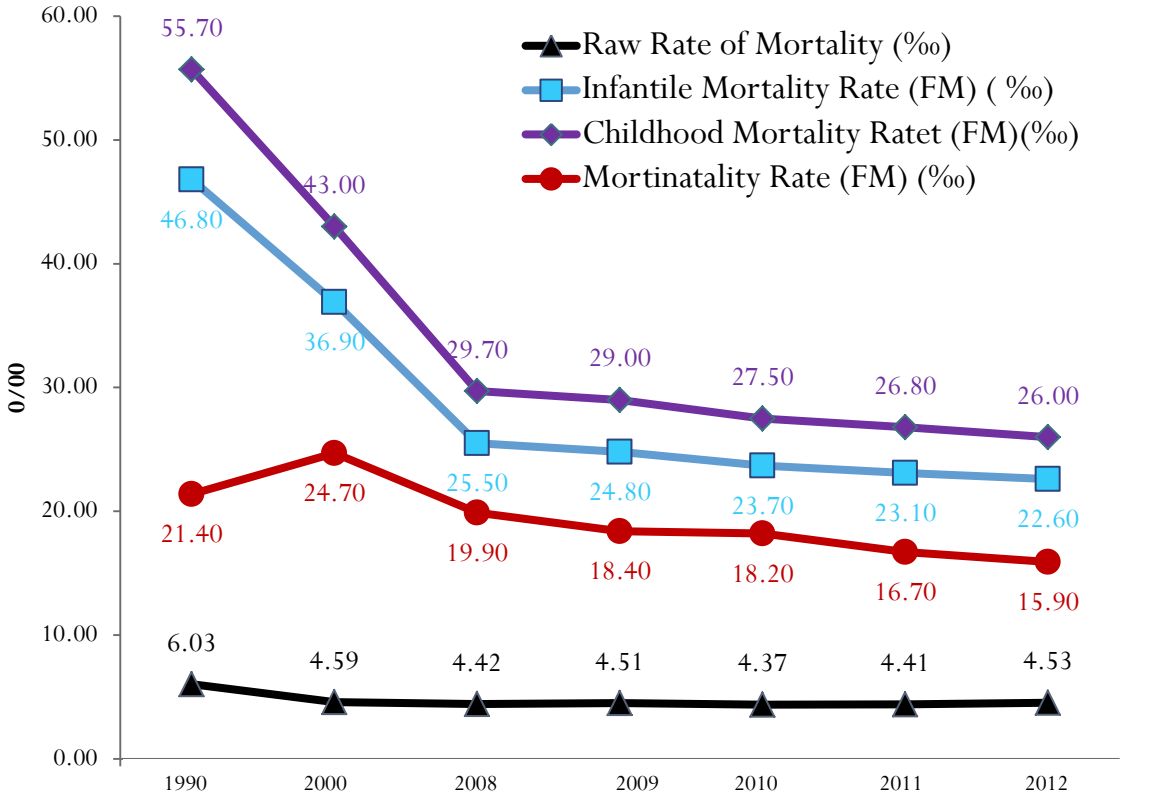
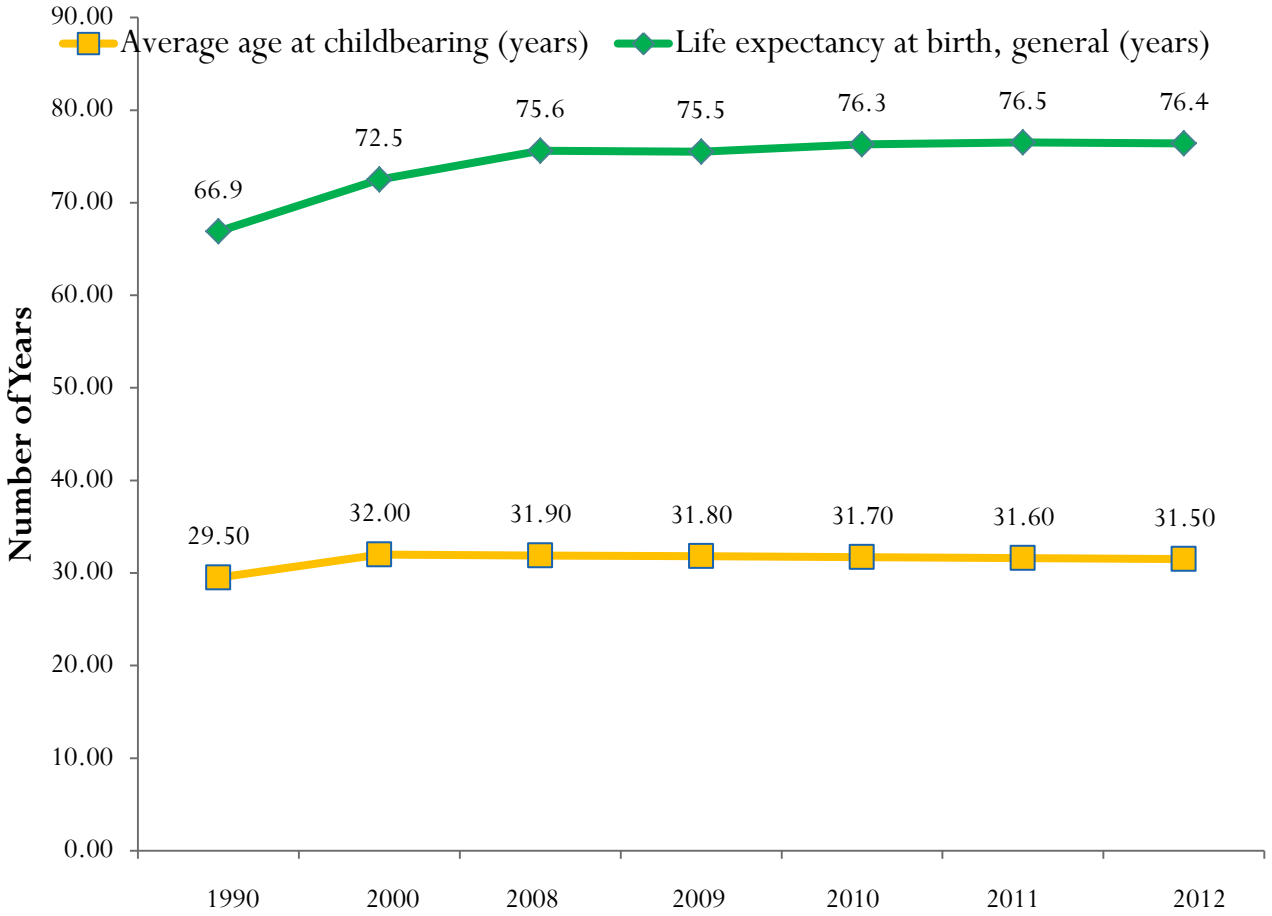


Figure 2: Evolution of Childbearing and life expectancy(ONS 2013)



CONCLUSION

The Algerian health system is subjected to four forms of pressure, namely:

a) Demographic pressure, that puts more people in situation of seeking care;

b) The epidemiological transition in Algeria, that becomes evident since nineties and where, communicable diseases and chronic diseases cohabit;

c) The opening to private, which means to have an organization able to ensure accessibility to care and finally;

d) Extent of certain diseases as cancer and diabetes, respectively second and fourth causes of death. These diseases considered as serious diseases not only for the cost of their care, but also to their difficult prevention related to certain factors including behavioral risk (food consumption patterns, smoking / alcohol, physical inactivity …).

CONCLUSION

- In addition, the persistent regional disparities require a steady attention from the authorities towards regions not having begun their demographic transition, in particular the southern ones. Improved egalitarian territorial distribution includes specialized care, a satisfactory availability of drugs, training for nursing staff, access to housing for the most disadvantaged, increasing the supply of housing and eradicating the precarious housing, are all factors that promote the good life.