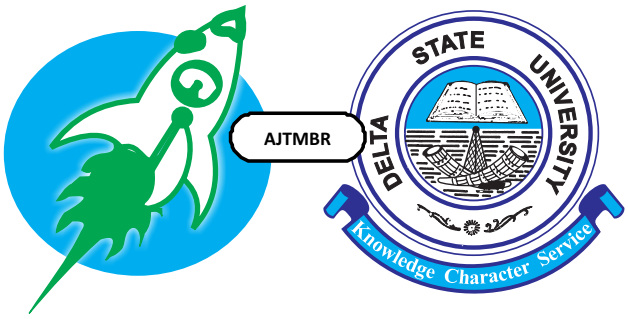
African Journal of Tropical Medicine and Biomedical Research (AJTMBR)



The Journal is the Official Publication of the College of Health Sciences, Delta State University, Abraka, Nigeria.

ISSN: 2141-6397

Focus and Scope

The African Journal of Tropical Medicine and Biomedical Research is a multidisciplinary and international journal published by the College of Health Sciences, Delta State University of Abraka, Nigeria. It provides a forum for Authors working in Africa to share their research findings on all aspects of Tropical Medicine and Biomedical Sciences and to disseminate innovative, relevant and useful information on tropical medicine and biomedical sciences throughout the continent. The journal will publish original research articles, reviews, editorials, commentaries, short reports, case reports and letters to the editor. Articles are welcome in all branches of medicine and dentistry including basic sciences (Anatomy, Biochemistry, Physiology, Pharmacology, Psychology, Nursing etc) and clinical sciences (Internal Medicine, Surgery, Obstetrics and Gynaecology, Dental surgery, Child Health, Laboratory Sciences, Radiology, Community Medicine, etc). Articles are also welcome from social science researchers that document the intermediating and background social factors influencing health in countries of Africa. Priority will be given to publication of articles that describe the application of the principles of primary health care in the prevention and treatment of diseases.

Editorial Notices

The journal will be published biannually in the months of March and September. Annual subscription fee in Nigeria is two thousand naira (N2,000) per volume (2issues); One-thousand-naira single copy (N1000). The annual subscription rate for other parts of the world is as follows: United Kingdom £60 (post free). West Africa $60 (post free). The rest of the World and the United States of America $120 (post free). A charge of $60 is made for reprints inclusive of postage. Cheques should made payable to the African Journal of Tropical Medicine and Biomedical Research and addressed to the Editor-in-Chief.

Journal Contact

All correspondence, including manuscripts for publication (in triplicate) should be addressed to:

Professor P.S. Igbigbi
The Editor-in-Chief,
Department of Anatomy,
Faculty of Basic Medical Sciences,
College of Health Sciences,
Delta State University, Abraka,
Delta State, Nigeria.

Or:
Professor Lawrence Omo-Aghoja
Editor
Department of Obstetrics and Gynecology,
Faculty of Clinical Medicine,
Delta State University, Abraka, Nigeria.
Email: journalajtmbr@yahoo.com
Cc: all email to
eguono_2000@yahoo.com
Tel: 08039377043

All authors are advised to submit an electronic copy in CD-ROM along with a hard copy of their manuscript, as this will spare remarkable time in the reviewing and typesetting processes.

In the alternative, authors can submit their articles and covering letter by email attachments. A covering letter (signed by all authors) accompanying the manuscript should certify that the article has not been previously published and is not being considered for publication elsewhere.

Information for Authors

All manuscript are peer-reviewed and accepted with the understanding that the work has not been published or being considered for publication elsewhere. Indeed, the authors would be requested

to sign a copyright form transferring the ownership of the paper to the African Journal of Tropical Medicine and Biomedical Research. All articles must include the correct names and addresses of author(s) including e-mail addresses and telephone numbers. Articles will be subjected to a thorough peer review process before any decision is made to publish or not. Authors should note that the African Journal of Tropical Medicine and Biomedical Research is not under any obligation to publish articles submitted, as decision to publish will be based on recommendations of reviewers and the editorial advisory board.

Manuscripts

Articles submitted for publication should be typed double-spaced with 2.5cm margins with accompanying CD-ROM in Microsoft Word format for easy and quick peer review and typesetting. Each of the following sections should begin in a new page: title page, abstract, introduction, materials and methods, results, discussion, acknowledgment (s), references, tables, legends to figures and illustrations. The manuscript should include:

Title Page

The title page should include the following information: 1. the title and sub-title; 2. the name(s) of the author(s); 3. the affiliation(s) of the author(s); 4. name and address of the corresponding author and 5. three to six key words for indexing and retrieval purposes.

Abstract

The abstract should be structured and not more than 250 words. It should carry the following headings: Introduction, Materials and Methods, Results and Conclusion.

Original Research- The journal welcomes articles reporting on original research, including both quantitative and qualitative studies. Full-length articles should generally not exceed 3000 words, excluding abstract, tables, figures, and references. The subject matter should be organised under appropriate headings and sub-headings as itemized above.

Review Articles- Comprehensive review articles on all aspects of tropical medicine and biomedical sciences will also be considered for publication in the journal. Reviews should provide a thorough overview of the topic and should incorporate the most current research. The length of review articles must not exceed 3,000 words and the organisational headings and sub-headings used are at the author's discretion.

Short Reports - Brief descriptions of preliminary research findings or interesting case studies will be considered for publication as short reports. The length of the abstract and article should be restricted to 150 and 2,000 words respectively and organisation of short reports are left to the author's discretion.

Commentaries or Editorials- Commentaries or editorials on any aspect of tropical medicine and biomedical sciences in Africa will be considered for publication in the journal. Opinion pieces need not reference previous research, but rather reflect the opinions of the author(s). The length should not exceed 2,000 words.

Tables and Figures

All tables and figures should be submitted on separate sheets of paper and should be clearly labelled. Coloured tables and figures may be reprinted in black and white. Authors should especially take care that all tables are clear and understandable by themselves, independent of

the text. A reader should be able to read only the tables and easily grasp all information without the text.

Acknowledgments

Acknowledgments should be included on a separate sheet of paper and should not exceed 100words. Funding sources should be noted here.

References

References should be in the Vancouver style and numbered consecutively in the order in which they are mentioned in the text. Titles of journals should be abbreviated according to the Index Medicus style. Authors must cross-check and make sure that all information provided in the reference list is complete and correctly written. Reference numbers should be inserted above the line on each occasion a reference is cited in the text, e.g., … as 1-3 reported in other studies. Numbered references should appear at the end of the article and should include the names and initials of all authors. The format of references should be as published by the International Committee of Medical Journal Editors in the British Medical Journal 1988, volume 296, pages 401-405. The following are sample references for an article published in a journal and for a book: Ahmed Y, Mwaba P, Chintu C, Grange JM, Ustianowski A, Zumla A. A study of maternal mortality at the University Teaching Hospital, Lusaka, Zambia: the emergence of tuberculosis as a major non-obstetric cause of maternal death. Int J Tuberc Lung Dis 1999; 3: 675-680. Whitby LG, Smith AF, Beckett GJ. Enzyme Tests in Diagnosis. In: Lecture Notes on Clinical Chemistry. Whitby LG, Smith AF & Beckett GJth (eds). 4 editions. Blackwell Scientific Publications. 1988. 103-127.

Units of Measurement

All measurements should be expressed in SI (Systeme International) Units.

Galley proofs

Corrections of galley proofs should be strictly restricted to Printer's error only. Orders for offprints should be made when the corrected proofs are being returned by the authors. Articles accepted for publication remain the property of the journal and can only be reproduced elsewhere in line with section 5 of the copyright agreement.

Table of Contents

Editorial

Sexual and Reproductive Health: A Bird's Eye View and The Nigerian Dimension

Omo-Aghoja LO

Department of Obstetrics and Gynecology, Faculty of Clinical Medicine, College of Health Sciences, Delta State University, Abraka, Nigeria.

(Culled largely from a previous publication - Omo-Aghoja LO (2013). Sexual and Reproductive Health: Concepts and Current Status amongst Nigerians. Afr J Med Health Sci 2013;12: 101-11)

Correspondence: eguono_2000@yahoo.com; +2348039377043

Sexual and reproductive health (SRH) is a relatively new concept in the context of the dynamics of contemporary global issues.[1] It came to the fore against the background of the worldwide increasing trend in the rates of liberal sexual behavior and activity, with its attendant reproductive health implications and sequelae.[1] SRH is closely intertwined with the trio of Health, Population and environment, the three foremost challenging issues currently requiring global attention. It is greatly and significantly influenced by sociocultural, political, and religious considerations.[1,2] "It is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." [3] The Practitioners of SRH are usually drawn from across disciplines, which may include Obstetricians and Gynecologists as head of the team, Sociologist and Social workers, Counsellors, and trained nurse/midwives. Other practitioners are Teachers, Community stakeholders and heads of family, religious leaders and, indeed, just anybody.

Awareness about women's health issues that lead to the crystallization of this subject matter was

raised by the passionate works of earlier leading advocates and champions of maternal wellness.[2,4] The first major attention was following the seminal publication in the mid-80s of Rosenfield and Maine,[4] who were working in Colombia University. They raised a very critical question in their Lancet publication captioned: Maternal mortality — a neglected tragedy: Where is the M in MCH? About the same time, Harrison,[5] working at Zaria in northern Nigeria, in his publication in the famous British Journal of Obstetrics and Gynecology titled: Childbearing, health and social priorities: A survey of 22,774 consecutive hospital births in Northern Nigeria noted social, cultural and educational factors as crucial underlying factors in maternal morbidity and mortality and the association of early marriages (6% of mothers under 15 years accounting for 30% of maternal deaths). Before then, the overall global attention was on child survival without recourse to the "goose that lays the golden egg." However, following these triggers, the scope was broadened to include maternal health issues in the context of reproduction and family planning. Before these, some earlier international conferences such as the World Population Congress (WPC) that was held in Bucharest (1974), Convention on the elimination of discrimination against women (CEDAW, 1979) and international conference on population in Mexico in 1984 had attempted to look at issues and modifiable factors that could be addressed to optimize WOMEN and maternal health. These efforts were hardly translated into concrete and palpable realities as a number of largely sociocultural gender impediments and religious considerations militating against the[6] women folk acted as obstacles. Advocates of women's health issues matched these obstacles with sustained advocacy activities that led to successive global initiatives and international conferences relevant to women's SRH, including the 1987 Safe Motherhood Conference in Nairobi and the 1986 through 1987 Carnegie Corporation Prevention of Maternal Mortality Network in West Africa.[7,8] Others were the World Conference on Human Rights (WCHR, 1993), International Conference on Population and Development (ICPD, 1994), World Conference on Women (WCOW, 1995), ICPD+5 (1999) and the WCOW+5 (2000). These initiatives argued strongly that issues that border on reproduction and maternal health are of fundamental human rights and that indeed they should be justiciable.

The hallmark and turning point was the 1994 ICPD in Cairo that resulted in a radical departure in the scope of SRH to include adolescent SRH, and the issues of sexual and reproductive rights was adopted.[1,9] It was also observed that men needed SRH and that their involvement was pivotal if the obstacles to SRH were to be dismantled.[1] At the ICPD, the consensus of evidence was that ensuring access to SRH services for all and protecting reproductive rights were essential strategies for improving the lives of all people. Participating countries in this conference adopted "sexual and reproductive rights as human rights, and affirmed them as an inalienable integral and indivisible part of universal human rights."[3] To further buttress this, Kofi Annan – a past Secretary General of UN (*now of blessed memory*), aptly summed it up this way: "The Millennium Development Goals, (MDGs) particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed." And that means stronger efforts to promote women's rights and the greater investment in education and health, including reproductive health and family planning. No doubt his predictions came out correct as global targets of the MDGs were scarcely realized.

Interestingly, Nigeria continues to take the lead in

the sub-region with regard to signing on to global initiatives as enunciated above, while at the same time adopting, adapting and/or making policy pronouncements as to the readiness of the government to implement the tenets of the respective initiatives. Despite these, there are hardly palpable indices to suggest that the government pronouncements translate to a better state of health for its citizenry. The Nigerian Demographic and Health Survey (NDHS, 2008)[10] and indeed other reports[11] clearly attest to this fact that there is continuing high rates of maternal and perinatal morbidity and mortality, poor contraceptive prevalence rate, high incidences of unsafe abortions and its sequelae, high rates of vesicovaginal fistula and female genital tract malignancies among other reproductive health challenges. Therefore, like was rightly echoed by Kofi Annan, the MGDs and indeed the set targets of other initiatives have been scarcely and poorly realizable in Nigeria, particularly in the face of ravaging poverty and hunger across the country. Also, considering the fact that SRH and associated issues are greatly and significantly influenced by sociocultural, political and religious considerations and colorations, the true concepts may not be correctly presented to a larger proportion of the populace.

It is therefore imperative that there must be deliberate and concerted efforts at sustained advocacy activities to educate all relevant stakeholders as to the tenets and scope of SRH as well as enunciation of public health policies that would guarantee the right of every citizen, particularly women, to lead the highest standard of health must be secured, as good health, in particular SRH, is a *sine qua non* for productive and fulfilling life. The right of all citizens, especially women, to control all aspects of their heath, in particular their own fertility, is basic to their empowerment. Therefore, a society where individuals have knowledge, skills and resources to enjoy their sexuality is one we must all aspire to be part of and bequeath to future generations.

References

1. UN Population Information Network (POPIN). Report of the international conference on population and development, Cairo, Sept 5-13, 1994, Oct 18, 1994. New York: United Nations, 1995: Sales No. 95. XIII.18 Available from: http://www.un.org/popin/icpd/conference/o ff eng/poa.html [Las accessed on 2006 Aug 14].
2. Horton R. Reviving reproductive health. Lancet 2006; 368:1549.1595-1607.
3. Glasier A, Gülmezoglu AM, Schmid G, Garcia Moreno C, Van Look PF. Sexual and reproductive health: A matter of life and death. Lancet 2006; 368:1595-607.
4. Rosenfield A, Maine D. Maternal mortality — a neglected tragedy: Where is the M in MCH? Lancet 1985; 2:83-5.
5. Harrison K. Childbearing, health and social priorities: A survey of 22,774 consecutive hospital births in Northern Nigeria. Br J Obstet Gynecol 1985;92 (suppl 5):1-119.
6. Barbara S. Family Planning Saves Lives. 3rd Ed. In: Shane B, editor. Washington, D.C.: Population Reference Bureau; 1997. p. 1-24.
7. World Health Organization (WHO). In: Tompson A, editor. Safe motherhood. A newsletter of Worldwide Activity. Vol. 25, Issue 1. Geneva: World Health Organization (WHO); 1998. p. 6.
8. World Health Organization (WHO). Safe motherhood newsletter 3, no. 19. Geneva: World Health Organization; 1995. p. 1.
9. Langer A. Cairo after 12 years: Successes, setbacks, and challenges. Lancet 2006; 368:1552-4.
10. National Population Commission (NPC) [Nigeria] and ICF Macro. Nigeria Demographic and Health Survey. Abuja,

Nigeria: National Population Commission and ICF Macro; 2009.
11. Omo-Aghoja LO, Omo-Aghoja VW, Aghoja CO, Okonofua FE, Aghedo VO, Umueri C, et al. Factors associated with the knowledge, practice and perceptions of contraception in rural southern Nigeria. Ghana Med J 2009; 43:115-21.