



Title: Value adding in sexual and reproductive health in the Asia- Pacific region: Enhancing Australia's role in evidence informed policy, research and advocacy

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Australia has had a long history of progressive support for sexual and reproductive health (SRH) within our region. Australian expertise in evidence informed policy and in building the capacity for human resources in health could be further utilized to improve sexual and reproductive health in the region.

Within the Asia-Pacific region, sexual and reproductive health services are provided by health workers in government agencies and both local and international non-government agencies as well as the private sector. Policies on and implementation of sexual and reproductive health at both government and non-government levels vary in appropriateness and effectiveness. It is useful to analyse for example the countries within which HIV prevention policies have been based on evidence, which countries have effectively implemented these policies and how they have been effective in managing the epidemic. (See proposal to AusAID on PLWHA).

One of the major impediments to sustainable implementation of policies is inadequate investment in human resources in SRH, with many countries having insufficient numbers of skilled staff, inappropriate location or skill mix of staff, limited training of human resources, poor coordination between various levels of care as well as scarcity of transport, equipment and supplies. (See proposal *Human Resources in Reproductive Health*).

An ongoing issue is the isolation of researchers, practitioners and policy makers from one another, leading to little opportunity for researchers to share their findings and little opportunity for practitioners and policy makers to be involved and informed about relevant research. Because SRH is often a sensitive issue there is also a reluctance to invest in advocacy which can provide opportunities for co-ordination, recognition and policy dialogue about the issues. Advocacy can also assist by providing a vehicle for agreement around priorities and drawing support from a greater range of stakeholders.

Response

Responding to the emerging gaps in Australia's response to SRH in the Asia-Pacific, a number of initiatives have begun to address some of these important issues. Firstly, in 2005 Genderhealth@UNSW¹ and the Australian Reproductive Health Alliance (ARHA) initiated a **network** and newsletter aimed at increasing information sharing and discussion in the area of sexual and reproductive health in both Australia and the broader Asia Pacific region – ***Asia Pacific Sexual and Reproductive Health Matters***.

Secondly, we are collaborating on capacity building through training health workers and researchers in SRH, bringing together local and international participants in a **Gender and Health workshop** in September (sponsored by AusAID ISSS and ARC Asia Pacific Futures Network).

Thirdly, the issue of reproductive health in refugee and conflict settings will also be tackled in the first meeting in Australia, of the **Interagency Working Group** (a well established and influential network comprising UN agencies and major international NGOs). We are holding discussions with UNFPA to become part of an academic partnership to provide training for reproductive health in emergencies. This is a key initiative for AusAID to engage with.

Fourth, we are also highlighting gender and population health issues in medical education at UNSW, including through an international health perspective. Developing a national curriculum in this area would be important.

Finally, an Australian collaboration has been formed that incorporates advocacy (ARHA), service provision (MSIA) and research/evidence (UNSW). We believe this is an effective grouping through which to improve SRH and the MDGs in the region.

¹ Genderhealth@UNSW has a commitment to promoting evidence-informed policy on reproductive health and gender issues throughout the Asia-Pacific. Genderhealth@UNSW works with governments, academics, practitioners, civil society organisations and communities: it is only through ongoing knowledge generation and exchange that any dent on the MDG indicators, and on inequity, poor health outcomes and on promoting better health for women, their children and communities more generally, can be achieved.



Human resources in reproductive health: Analyzing the role for traditional birth attendants

Obstetric complications are the leading cause of death for women of reproductive age in developing countries today, and constitute one of the world's most urgent and intractable health problems. Reducing maternal death and illness is recognized as a moral and human rights imperative as well as a crucial international development priority, including by the ICPD Programme of Action and the Millennium Development Goals.

Despite progress in some countries, the global number of deaths per year - estimated at 529,000 - has not changed significantly since the ICPD². Millions more women survive but suffer from illness and disability related to pregnancy and childbirth. Although data are hard to come by, the Safe Motherhood Initiative, a coalition of UN agencies and NGOs, estimates that 30 to 50 morbidities - temporary as well as chronic conditions - occur for each maternal death.

The World Health Report 2005 says that in 2005 more than 4 million babies would not survive the first month of life and more than half a million women will die in pregnancy, childbirth or soon after. The report says that reducing these numbers in line with the MDGs depends largely on every mother and every child having the right to access healthcare through pregnancy, childbirth, the neonatal period and childhood.

The existence and quality of services to promote health, prevent illness or to cure and rehabilitate depend on the knowledge, skills and motivation of **human resources for health**. However around the world, the health workforce is in crisis and most severely in the least developed countries. In such circumstances the role for **all** human resources for health, including family members, practitioners of traditional medicine such as traditional birth attendants (TBAs), must be carefully analysed.

There is lack of consensus on the role played by TBAs in assisting in childbirth. According to the World Health Organization (WHO), more than half the births in developing nations are attended by TBAs and relatives. Although most of these women intend to assist their patients, mortality rates are higher in the rural areas where they operate. In addition, in many countries, the definition of a TBA varies enormously from women who have received no training at all and are illiterate, through to women who have undergone training with NGOs and therefore gained some skills. Traditional birth attendants are often the main health providers in isolated and insecure areas and are an important resource who should be considered in relation to future health workforce planning.

Traditional Birth Attendants have been shown to provide essential and sometimes the only delivery service to rural women. Evidence on effectiveness of training TBAs has been mixed. Training has been shown to heighten knowledge and to an extent practice but does not result in observable reduction in maternal or infant morbidity or mortality. However some suggest that the fault lies not in the strategy but in the lack of supervision and support for TBAs.³ Much more needs to be documented about the part TBAs can and do play and their safety in different areas. According to World Health Report 2005 "It is not technically valid to frame a general training strategy without taking into account variations (in knowledge and experience and cultural traditions from one region to another)".

The question is how TBAs are currently, and could be linked in the future, to the formal health workforce? Methods are needed to identify the contribution they can make, so they can be incorporated into national plans for maternal and neonatal health. Genderhealth@UNSW has developed a proposal to explore this topic in four countries in the region, over the next 18 months. The intention is to gain global support for a multi-country study to provide policy and human resource development on this issue.

Achieving MDG5 more equitably will require political, social, legal, and economic strategies as well as scaling up technical strategies.

² Maternal mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA, Geneva, World Health Organization 2004

³ Sai FT, Measham DM. Safe motherhood initiative: getting our priorities straight. *Lancet*, 1992, 339:478-480.