SEXUAL & REPRODUCTIVE HEALTH AND THE MDGS IN THE AUSTRALIAN AID PROGRAM – THE WAY FORWARD
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"Reproductive health is 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 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 of their choice, as well as other methods of their choice for the 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 of reproductive health, reproductive health care is defined as a constellation of methods, techniques and services that contribute to reproductive health and well being 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 reproductive and sexually transmitted diseases"[1].

This paper will discuss the

1. epidemiology of reproductive health especially in developing country settings, demonstrating how reproductive health issues are a major health problem for the world;
2. provides a rights agenda perspective on the issue;
3. discuss the components of the reproductive health approach and briefly the present status of these services and interventions in development settings;
4. demonstrate the affordability of reproductive health services, ,
5. demonstrate throughout the paper the underlying developmental causes of these problems – many of which are targeted in the MDGs; namely MDG1 poverty and hunger; MDG2 lack of access to female education, MDG3 gender inequality, MDGs 4-6 maternal and child health and addressing endemic health problems such anaemic and HIV, and MDG7 environmental degradation; .
6. illustrate many of these points by using voices from Vietnam, based on my own ethnographic based research[2].

FACT ONE : SEXUAL AND REPRODUCTIVE ILL-HEALTH ARE A MAJOR BURDEN OF DISEASE FOR THE WORLD AND ESPECIALLY FOR THE DEVELOPING WORLD.

"Sexual and reproductive ill health … accounts for over 1/3rd of the global burden of disease for women of childbearing age and 1/5th of the burden for the whole world" all ages, male and female[3].

EVERY DAY: There are estimated to be over 100 million acts of sexual intercourse taking place every day in the world. These result in 356,000 sexually transmitted infections and 910,000 conceptions - of which 455,000 are unplanned and 227,500 unwanted. Every day more than 2,000 women will die from complications of pregnancy. 1/4 - 1/3 of these maternal deaths in the world are due to complications of unsafe abortion.

Approximately 300 million couples do NOT have access to family planning services. This equates to an unmet need for family planning estimated at 17% of currently married women. In numbers this means that 201 million women in developing countries would like to stop childbearing or space their next birth, but are not using a modern contraceptive method. Meeting this "unmet need" would avert 52 million unintended pregnancies annually, preventing 142,000 pregnancy-related deaths and 1.4 million infant deaths[4]. This lack of access is a symptom of inequity: in most developing countries the wealthiest 20% of women are twice as likely to use modern contraceptives as the poorest 20%. The lack of access is exacerbated because of

[1] UNFPA 1995
[2] People's identity has been protected.
[3] Family care international fact sheets. Downloaded 22/07/06
[4] Ibid

women lack access to information, education, and counselling on sexuality and family planning, cannot access contraceptives, or face other social, economic, or cultural barriers. Poverty, gender inequality and lack of education contribute to this problem.

It has been estimated that 800,000 women die annually from complications of pregnancy and childbirth, all but 4,000 of whom are in developing world. Sisters in Africa have a 1 in 19 to 1 in 29 lifetime risk of dying due to maternal cause, compared to Australian women's risks of 1 in 6,500. For every women who dies due to pregnancy and childbirth another 10 – 100 suffer from a significant morbidity. Maternal health related issues are the major cause of death and disability foe women aged 15-49 in most development settings.

"6 out of 10 women in many countries have a sexually transmitted disease. All face a higher risk of infertility, cervical cancer or other serious health problems"[5]. Globally, every year amongst men and women, it has been estimated that there is a minimum of 120 million new cases of trichomoniasis, 25 million new cases of gonorrhoea; 50 million new cases of chlamydia, 30 million new cases of genital warts; 20 million cases of genital herpes; 3.5 million new cases of syphilis and 2 million new cases of chancroid[6]. Amongst pregnant women in developing countries, gonorrhoea rates are 10 - 15 times higher, chlamydia 2 - 3 times higher and syphilis 10 - 100 times higher than developed world. In our nearest neighbour- Papua New Guinea field based studies conducted by the PNG Institute of Medical research found the prevalence of trichomoniasis amongst rural women of the Asaro Valley (not labelled high risk) of 42.6%, for chlamydia 26.5% and for gonorrhoea 18.2%. Overall almost 60% of the women studies had at least one sexually transmitted disease and 14% had clinical evidence of pelvic inflammatory disease[7]. High levels of STIs especially ulcerative STIs clearly linked to high transmission of HIV/AIDS. For a women it means:

> *"Sometimes I have an infection with itch and vaginal discharge like fish blood. This is very harmful. . . It is so itchy that I want to put a finger inside and hook it out. I scratch and scratch. Many women have the same and want to do the same". (Chi Binh, commune women, Vietnam)*[8]

Every minute of the day 11 people infected with HIV – of whom 6-7 are women. It as been estimated that nearly 40 million people in the world are living with HIV/AIDS – almost half of whom are women, and the majority of the transmission is sexual. Worldwide less than 1 in 5 people at risk of HIV have access to means of prevention and only in 8 have access to testing[9].

STIs are one of the major causes of infertility for men and women. WHO estimates that there are between 60-80 million infertile couples worldwide of whom 2-10% are unable to bear a first child and 10-25% a second or subsequent child. The causes may be male based (33%); female based (25%), both male and female related causes (20%) and undetectable (12-15%). Childlessness can be a factor that contributes towards gender violence and divorce for women, which in many settings leads to poverty and may lead to commercial sex work.

Gender violence is a major reproductive health problem for women, and also increases women's risks for other health problems. Gender violence includes violence from traditional practices : 100 - 132 million women in the world have undergone female genital mutilation and it is estimated that there are 2 million new procedures per year; violence in domestic arenas: among women 18 - 21 in 5 countries 8 - 18% have been raped[10] (WB 1994) and between 20-60% of all women have been beaten by their partners. Rape and domestic violence account for 5% of the total burden of disease in women and reproductive age.

Reproductive cancers are a major and increasing problem – and in the majority of cases preventable by existing cost-effective interventions. There are at least 460,000 new cases cervical cancer annually of which 75% in developing world and annually 183,000 women die in these countries. Breast cancer kills 158,000 annually in developing countries. Then there are the largely unenumerated problems of reproductive morbidities that cause poor quality of life, and can lead to social and economic isolation such as urinary tract infections and incontinence, fistulas, menstrual disturbances, uterine prolapse, and menopause.

[5] (UNFPA, 1997 :3).
[6] WHO estimate (1990)
[7] Passey, Mgone, Lupiwa et al 1998; Mgone, Passey Anang et al 2002
[8] Whittaker, M 2000.
[9] UNAIDS 2006
[10] World Bank 1994

FACT TWO: ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RELATED SERVICES IS A HUMAN RIGHT

Paying attention to addressing and maintaining these reproductive health rights for men and women, and adolescents around the world will be a major step towards meeting the MDGs as well as our international human rights obligations. The International Planned Parenthood Federation (IPPF) has, through an analysis of various UN Charters and other key documents, twelve sexual and reproductive health rights[11]. These are the right to:

1. life
2. liberty and security of person
3. equality and to be free from all forms of discrimination
4. privacy
5. freedom of thought
6. information and education
7. choose whether or not to marry and to found and plan a family
8. decide whether and when to have children
9. health care and health protection
10. the benefit of scientific progress
11. freedom of assembly and political participation
12. be free from torture and ill treatment.

FACT THREE: WE KNOW WHAT SERVICES AND INTERVENTIONS NEED TO BE PROVIDED, BUT THERE ARE ACCESS GAPS FOR THE MAJORITY OF MEN AND WOMEN IN DEVELOPMENT SETTINGS.

Under the reproductive rights mentioned above, specifically there are three that focus on sexual and reproductive health services and quality of and access to those services. These are[12]:
"9.1 All persons have the right to the highest possible quality in health care including all care related to their sexual and reproductive health.
9.2 All persons have the right to comprehensive health care services including access to all methods of fertility regulation including safe abortion and diagnosis and treatment for infertility and sexually transmitted diseases including HIV/AIDS.
9.5 All persons have the right to sexual and reproductive health care services as part of primary health care which are comprehensive, accessible, both financially and geographically, private and confidential and which pay due regard to the dignity and comfort of that person"

The components of a reproductive and sexual health services include:
- Family planning
- Education and services for prenatal care, safe delivery and postnatal care
- Prevention and appropriate treatment of infertility;
- Prevention of abortion and management of the consequences of abortion, and provision of safe abortion services
- Treatment of reproductive tract infections, STIs & other reproductive health conditions
- Prevention of HIV transmission, and access to voluntary counselling and testing and treatment services
- IEC on human sexuality, reproductive health and responsible parenthood,
- Active discouragement of harmful practices such as female genital mutilation and violence against women

There is a synergism between each of these components – seen as a constellation of services. For example: "*There is also overwhelming evidence that STI interventions are one of the most critical HIV for dealing of STIs with the massive burden strategies available for HIV prevention – as well as an essential public health strategy … in their own right*[13]*".*

The international benchmark for the quality of these services defines quality of care as[14]: choice of method/ services; Information given to clients; Technical competence; Interpersonal relationships; Follow-up and

[11] International Planned Parenthood Federation, 1996.
[12] International Planned Parenthood Federation, 1996).
[13] Ballard in UN/USAID 2002
[14] Bruce J 1987

continuity mechanisms ; Appropriate constellation of services. The reality is that there are serious shortfalls in all of these variables of quality in the majority of health services in development settings. Under financing of health services, and in particular reproductive health services, health human resource shortages (exacerbated now by the impact of HIV/AIDS on the health workforce), poor post-basic education services, limited health promotion skills ands services and access to media, impact negatively upon quality of care.

Accessibility is also a vital factor in ensuring needs are met. Access includes physical access, culturally and gender acceptability, women's autonomy to make decisions to access; ability of these services to provide a competent service; acceptability and non-judgemental attitudes of staff and access to information about types and locations of services; affordability) in actual costs and the opportunity costs). The reality of the many women's lives s that the services are not accessible:

> *"If your husband doesn't agree - you don't go for treatment. Only when your husband agrees. Otherwise he will scold and intimidate you. If your husband doesn't let you go and you try to go, he will say, "If when you return you are weak or have some trouble, I will not pay you any attention, I will not care for you or your condition".* (Chi Dung, Vietnam Indepth 16)[15]. And
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> "*When the rich and the poor have disease they go to hospital. In the situation where the poor arrive at the same time as people who have money - the health worker will speak 10 sentences with the rich. They will only speak with the poor for 1 or 2 sentences. They let us sit, like, we joke, a "dog with the flu" sitting in the corner"* (Ba Phung, FGD 12)[16]*.*

FACT FOUR
WE NOW WHAT IS NEEDED, WHAT IS COSTS, IT IS COST EFFECTIVE AND AFFORDABLE BUT…

It has been estimated that the costs per head of providing family planning services is US$0.90; of antenatal and delivery care US$3.00 and basic STI care using the syndromic approach US$0.20 – all less than the cost of a cup of coffee or tea or a Coke. The ICPD requested for the governments of the world a minimum financial commitment of US$18.5 billion in 2005 – which has not been met. UNAIDS in 2005 estimated the resource needs for a global AIDS prevention programme for the triennium 2006-88 was US$ 29.8 billion; for treatment and care US$ 12.3 billion. For comparison Australia's health expenditure in 2002/3 was $Aus 72 billion ($US 2874/person/year) and the gglobal military expenditure and arms trade was valued at over $950 billion in annual expenditure in 2003[17]. Scaling up available prevention strategies in the low and middle income nations of the women was avert new infections - for HIV is estimated doing so would save US$24 billion in treatment costs over the next 10 years[18].

CONCLUSION

The transformation of reproductive and sexual rights and health into realities for many women and men remains a big step requiring political will, national and international financing, monitoring and evaluation and equal participation for citizens. It needs concerted efforts by all - nationally and internationally to advocate for reproductive rights, funding of reproductive health care services and maintaining/increasing allocations of developed countries to development assistance especially in the interlinked social sectors of health, education, poverty alleviation and human rights. Women and men want their rights to be recognised, and we need to be part of the effort to ensure that their voices are heard and their needs and desires are met.

In a focus group discussion held in Vietnam one woman summed it up by saying:

> *We only hope that the government gives priority to women, provides medicine to treat women's diseases and protects us against these diseases. Rural women have little information or documents about these things. … So help rural women have the information and education to study about and protect themselves against these diseases. (Chi Ghi[19]).*

[15] Whittaker M 2000
[16] Whittaker M 2000
[17] (Stockholm International Peace Research Institute (SPIRI)
[18] UNAIDS 2006
[19] Whittaker, m 2000