Women's health

Range of services needed

Most women know about the contraceptive pill but little else. **Marion Stevens** shows how a range of reproductive health choices needs to be provided in the public and private health sectors in order to promote women's full well-being, especially in a time of HIV.

Mothers' Day (9 May) this year heralded the 50th birthday of the oral contraceptive that prevents pregnancy. Commonly known as 'the pill', it was approved by the Food and Drug Administration in the United States. It enabled women to decide when they would become pregnant... if at all, thus providing them with a measure of choice and control.

The pill now is part of our culture, having transcended in South Africa, the times when access was only for married women. Women are nevertheless often still embarrassed about asking for contraception, as it means they are planning to have sex.

The idea of a woman addressing her personal sexual and reproductive health and rights – whether for sexual pleasure or to prevent pregnancy is still often unmentionable in 2010. This means that sexual and reproductive health services that provide for women's health and well-being is not well understood, or provided for by the public or private sector.

CONTRACEPTIVE CHOICE NEEDED

Within South Africa, about 60% of women use contraception. The majority of women use the injectable contraceptive, which works on the same principles as the pill but lasts longer. While the pill is a best friend to some who find that it helps their acne, increases their sex hormone by binding globulin to aid fertility, and helps them lose weight, to others it results in possible weight gain, withdrawal headaches and uneven libido.

The reality is that women react to the pill differently.

Contraception has played an important role in addressing unwanted pregnancy for women. Men however have mainly been let off the hook, which has made negotiating safer sex extremely difficult for women who want to use condoms – female or male.

Being sexually active these days is not a simple roll around in the park. While teaching at the University of Cape Town second-year students took as given that women would use hormonal contraception, but we had complex discussions about condom use. Male condoms are mainly used, and female condoms very little. The idea that a woman might insert a condom hours before to prepare for sex was seen as a bit forward of women! UCT still mirrors patriarchal societal values.

Access to contraceptives and choice is not that easy and, given the context of HIV, is often not viewed by health providers as part of health care that urgently needs to be provided.

Our history of limited access to women's health services is complex. Under apartheid we had a military operation, including mobile clinics of population control, which provided injectable contraceptives to black women. But today even many middle class women cannot access contraception through their medical aid as it is not a prescribed minimum benefit. There are severe inequalities in health provision in our country but women who use the private sector are not receiving good reproductive health care either.

Hormonal contraception, including the pill, does not protect against sexually transmitted infections including HIV/AIDS. Researchers suggest that in our context an unwanted pregnancy is seen as more of a problem than HIV. The reality is that many women in South Africa are ill or die in pregnancy – we have high rates of maternal mortality and morbidity.

At the Federation of International Obstetricians and Gynaecology Conference in Cape Town last year, a range of research presentations dealt with the contraception that HIV-positive women should take. Research with sex workers in Zambia suggests that hormonal

contraception promotes the progression of womens' HIV disease, particularly amongst younger women aged 19-25. However, scientists were not sure of this and more studies need to be done. Some tout the inter-uterine device (IUD) as a good option for HIV-positive women but these questions demand urgent inquiry.

WOMEN'S SERVICES LACKING

Women's health has many facets and does not only belong in the health services. Young girls at school have the right to reproductive education. Principals and communities are still uninformed and act against the law, barring pregnant young girls from schools.

Education is known to increase women's health by decreasing the risk of HIV transmission and unwanted pregnancy. Currently women's health services are lacking in a number of ways.

To give an example. We need to improve screening and treatment of reproductive cancers including cervical cancer. HIV-positive women are more likely to be infected with the Human Papilloma Virus (HPV), the main virus that causes cervical cancer. Cervical cancer is usually a slow growing cancer, yet in HIV-positive women, it is fast growing.

Current cervical cancer screening policy suggests that we screen with three pap smears starting at age 30, then at 40, and finally at 50. This was a good policy in 1996, but today it must be updated so that upon HIV diagnosis women have access to screening. We have low rates of cervical cancer screening, possibly only 20% of the target of 70% so this needs to be fast tracked.

There is also a need to vaccinate young girls (and boys) with the HPV vaccination now that costs have decreased. HIV-positive women should also have access to anti-retroviral treatment (ART) as this may also delay the progression of cervical cancer.

There are two safe ways of having an abortion: surgical abortion which involves a procedure, and medical abortion which involves taking medication. Abortion services are poorly provided and medical abortion is only available in the private sector up to 56 days after the women's last menstrual cycle. The public sector does not provide medical abortions.

Within the National Strategic AIDS plan, under the provisions of prevention of mother-to-child transmission, one of the key activities under the prevention of unintended pregnancies is to finalise the medical abortion guidelines within the public sector. These guidelines have been dancing across desks within the Department of Health for a number of years and by now probably need new dancing shoes!

It is an injustice that some services are available only in the private sector, and that class is a barrier to getting medical abortion.

There are few providers of surgical abortion, particularly in the second trimester (six months) and this is also of concern. Currently abortion within the first trimester (three months), of which 70% are provided by nurses in the public sector, is not recognised under the Occupational Specific Dispensation, so nurses are not adequately paid for this service.

The provision of surgical abortions has also decreased from the 60% of facilities which were operational. Given that our maternal morbidly and mortality rate has not decreased, and that we are seeing deaths from unsafe abortions for the first time since it was made legal, the lack of accessible, safe abortion services needs urgent attention.

PLANNING BROADER SERVICES

Contraception funding ended following the former US Republican administration's cutting off American funding for the United Nations Population Fund which was the main international agency supporting sexual and reproductive health. The Obama administration has restored the financing, and we are slowly planning a broader continuum of services under the banner of sexual and reproductive health and rights including HIV/AIDS.

The reality is that women's lives cannot be compartmentalised. In 2010, women should be able to express their sexuality, control their fertility and their bodies and access care that supports their well-being. A full sexual and reproductive health rights package should be provided that includes:

- maternity care (ante- and post-natal care, skilled birth attendants and emergency obstetric care);
- access to safe abortion.
- comprehensive prevention and treatment for HIV and all other sexually transmitted infections (including human papilloma virus and associated cervical cancer).
- access to contraception.
- programmes that address violence against women; and
- comprehensive sex education from an early age that provides children with appropriate ways of dealing with their feelings and explaining how their body works, and helping them to claim their human rights in order to promote gender equality.

On their own, these individual services are not sufficient, and as women in 2010, we deserve better. LB

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