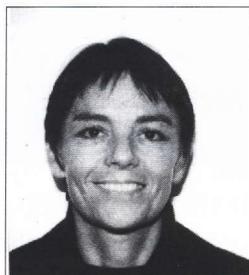


Health Priorities in the New South Africa – Women's Health

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Curriculum Vitae

Katrien Debaeck achieved her MBCbB in 1976 and FCOG (SA) in 1983. From 1983 - 86, she was appointed as a consultant in the Department of Gynaecology at Grootte Schuur Hospital with a special interest in Gynaecological Oncology. Since 1986, she has been a consultant in the Department of Gynaecological Oncology, and in April 1991, Katrien started a private practice but still keeping her sessional appointment in the Gynaecological Oncology firm at Grootte Schuur Hospital.

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Summary

In South Africa the priority lies in education, as the majority of our South African women are illiterate, not only uneducated. Women should be warned that they are being targeted in a clever way by the cigarette companies. Women who suffer violence against them, should have safe centres in the New SA to go to for help. Older women need to be cared for. In the field of reproductive health, contraception, abortion and pap screening are discussed in the light of new laws and limited funds. Every contact should be seen as an opportunity for education.

Introduction

Internationally it has been realised that women's health should be addressed as a separate entity, and it was encouraging to see that in the 9th Family Practitioner's Congress it was scheduled under "Health Priorities in the New South Africa". All over the world, but more often so in developing countries, women are expected to shoulder the responsibility for their families, the sick, the disabled and the old, as well as earn a daily wage, and the value of their work is not recognised. They have little say in family or political decisions. Men assume the right to speak for them, and all these factors influence the health of women of society.

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Health Priorities in the New SA

Time has come to look and see what impact all this has on the general health status of women. Women's health needs to be seen in all its parts, as part of a wider system as well as personal. It does not just refer to the reproductive health.

In her reproductive years a woman may encounter many other health problems, for instance: occupational hazards, nutritional problems, stress and fatigue. Past her reproductive years, the life expectancy of a woman can stretch up to the next two to three decades, and certainly health needs to be addressed during this time of her life as well.

What do people need to be healthy? For people to be healthy they must earn enough money for a decent life and work in safe and clean conditions. Also people need decent housing, clean water and efficient means to dispose of rubbish. General health is also improved when people have a reasonable standard of education and opportunities for rest and recreation.

In South Africa we have a wide spectrum of socio-economic classes, but in each class the woman has her own health problem to deal with. The biggest group, of course, is the low socio economic income group. As we all know, these are mainly black

women. In this group there is a lack of even the most basic facilities of housing, sanitation and water supply, which make it virtually impossible to strive towards personal health. Internationally, women's educational status is recognised as a key indicator of a society's health. If that is so, we have a very unhealthy society, as the majority of women are still illiterate, never mind educated. So the priority as far as women's health is concerned, lies certainly first and foremost, in improving living conditions and increasing the level of education. Once we have achieved that, half of the health problems will be solved already.

The other problem that needs to be addressed, however, is that of male domination. This is noticeable in all spheres of a woman's life. At home, at work, in religion, in culture, economically and politically. Even in research, health is male orientated. The patriarchal society has contributed a lot to leave women unassertive, with a low self esteem and without control over their own bodies.

To summarise, women provide fundamental contributions to the functioning of our society as mothers, home providers and bread winners, but they are the group in society that is mostly neglected.

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“EXCELLENT TOLERABILITY...”

We have a new government. With that comes a new constitution and with that comes a change from old policies, and certainly one of the priorities high on the agenda for change is that of a woman's health policy. This policy should ideally, and hopefully:-

- cover a woman's whole life, not just the years when she has children;
- recognise women as health care consumers, to be treated with dignity in an environment which provides for privacy, informed consent and confidentiality;
- aim to promote greater participation by women in decision making about health services and health policy as both consumers and providers, and
- acknowledge that informed decisions about health and health care require accessible information which is appropriately targeted for different socio-economic, educational and cultural groups.

Policies don't always become law, but certainly we, as health workers and doctors, can make a difference in providing a better deal for women in the health sector.

I would now like to look at a few more specific women's health issues: what the situation is now, and possibly what we would like to aim for. Before I specifically move to reproductive health, there are three issues I would like to highlight. The first one is smoking, the second one is violence and the third one is the ageing population.

Smoking

The general trend in the world has been firstly for men to take up smoking. The incidence increased rapidly at the beginning of the 20th

century and by the 1950s the prevalence of cigarette use among men approached about 70%. The onset of widespread use among women lagged behind that of men by about 25 - 30 years.

But as the incidence of emphysema and lung cancer increased among men, more and more men gave up smoking and women were targeted by the cigarette companies. Now in the first world, lung cancer is most probably overtaking the incidence of breast cancer. More and more women in the first world are giving up smoking, and starting to realise the negative effects of smoking. The cigarette companies are now putting their energy into targeting developing countries, and in particular, women in developing countries.

The majority of women in South Africa do not smoke and it is important that this positive health behaviour is reinforced. The tobacco industries are aware that women are a potential new target and aim advertising especially at women; for instance the Vogue Slims advertises – tall, thin women, tall, thin cigarettes, and women need to be made aware of this advertising onslaught, and to be able to resist it. I think it is very important for us to inform women about the negative effects that smoking has on health. Not only on their own health, but also on the health of their offspring. I recently attended a talk by a Swedish member of parliament, who addressed us about women's health. In Sweden they are not using the health issues as such to try and put women off smoking, because they have found that it has no impact, certainly not on the adolescent and teenager. They have started using that of the smoker's face – the thick, leathery

Women provide fundamental contributions to the functioning of society, but are still badly neglected.

skin which heavy smokers develop around the ages of 50 and 60. This method apparently has had some success, and impact on the younger women. Another way of trying to decrease the smoking habit in the general population of course, and I believe some economic policies have been developed around this, is heavy taxation of cigarettes.

Violence Against Women

When we talk about violence against women, this includes all forms of violence, be it sexual, mental or physical abuse. We as health care workers and doctors, should be aware of the existence, but in particular, the magnitude of this problem, and be very sensitive to the issue. Special provision should be made available for the physical and mental care of the women who have been subjected to any form of abuse. It may not be a bad idea to have special centres, preferably staffed by female health care workers, to look after victims of violence. It is my opinion that we are not properly trained during our medical education to deal with issues like battery, sexual assault, including rape cases, and therefore it is often seen that doctors shy away from dealing with women who have been the victims of these violent acts.

The Ageing Population

Life expectancy of women is on the increase, especially with the event of modern medicine and technology.

The life expectancy of women in general, is on average, between the ages of 75 and 80 years. However, in South Africa, the life expectancy of the various population groups differ. The life expectancy of African and Coloured women is below average and only ranges between the ages of 55 and 60. That is due to the poorer living conditions, nutrition and the uneven distribution of health services. Despite this, women are living longer, and therefore it is becoming more and more important to address problems like the menopause, cardiovascular disease, osteoporosis, as well as the care of the aged.

This is a very neglected area. Very few facilities are available for the older women. There are few lessons to be learnt, maybe cross-culturally on this matter. Due to westernisation and modernisation the family unit is not what it used to be. But if one looks at the African rural family unit, there is a very good caring and support system for the ageing woman. She becomes a very important part of the family, and is looked after until she dies. When we look at the more westernised

Cigarette companies are now targeting women in developing countries.

“AN EXCEPTIONALLY UNIQUE ANTI-DEPRESSANT...”

families, older women become a burden, especially, if there are medical problems, (like incontinence, possibly fractures that happen due to osteoporosis, etc). The younger family does not want to be burdened with this problem, so they often end up very impoverished and neglected at the end of their life. This attitude certainly should change, and we should also make sure that in future care of the older women is incorporated in our health system.

Women's Reproductive Health

On the subject of reproductive health, I would like to single out a few issues, not because of their importance, rather because they are controversial. Firstly, contraception, secondly abortion, and thirdly pap screening. There are many more issues that need attention, for instance that of the high figure of maternal mortality in our low socio-economic group of women, the lack of proper antenatal care and on the other side of the coin, the over-servicing of women in pregnancy and during labour.

Contraception

Contraceptive use is influenced by moral and religious factors as well as by societal norms and a basic principal must be recognised from the onset. While socio-economic status remains low, contraceptive use remains low. The ultimate success of a contraceptive service depends on the participation of a more empowered community, particularly women in this instance. I am saying particularly women in this instance, but male responsibility for contraception should be emphasised. In this day and age of sexually transmitted diseases, the use of the

condoms cannot be over-emphasised and over-stressed.

This remains a problem area, however, because men remain very reluctant to use the condom, and leave the women with no other choice than to possibly expose themselves to sexually transmitted diseases. The refusal by women to have sex unless a condom is used, often ends in battery.

The relative safety and health benefits and especially the overwhelming evidence of the health benefits of contraceptive use need to be emphasised. As a long term goal, one needs to aim to achieve credibility as a contraceptive service providing advice and choices after providing adequate information.

Information and education remain the key issues for a successful end point, and education needs to start from a young age, so that we can prevent the high incidence of teenage pregnancies and the need for abortion in the teenager.

While talking about contraception, I would like to say a few words about the injectable contraceptive – Depo Provera. This form of contraception is by far the most reliable and successful with the lowest failure rate. However, as we all know it has been abused in the past, particularly politically. (“If you don't get your injection, you cannot get a job”.) Even though this attitude has slightly improved, at present the injectable contraceptive is given to patients without proper information of the possible side effects. The ideal subject for the injectable Depo Provera is the woman who has had a few children, and possibly is not planning any further pregnancy, but the two-month injection. Nuristerate can be used in the younger woman, as

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Abortion is an unresolved issue throughout the world.

the prolonged infertility following the use of this injection is not a major problem. Used for the right woman, with correct information, it is most probably closest to the ideal form of contraception.

The specific contraceptive issue, that of post coital contraception, should be included amongst contraceptive choices. Not on a long term base, but at present, very few women are aware that this is available. It is the responsibility of the health workers, when they speak to women about protecting themselves with condoms and from pregnancy – at the same time they should give them information about this form of contraception.

Abortion

Because contraceptive methods have failure rates, we now come to the issue of abortion. Even though it is a very sensitive issue, it needs to be addressed. Unplanned pregnancies often end with unwanted children. Unwanted children lead to child abuse, street children, neglect. Neglected children become inadequate adults and there starts the vicious circle.

We have the very high incidence of unsafe backstreet abortions, ending up with sepsis, infertility, possible

hysterectomy and sometimes, at the end of the line, death. Figures are not available, but it is thought that in South Africa, over half a million women per year seek back street abortions, as I mentioned, sometimes with disastrous results.

Women throughout history have resorted to abortion in the face of unwanted pregnancy, regardless of prevailing religious or legal constraints, and what we need to ask ourselves is: do we have the right to make the decision whether a woman should have a child or not? The question on the other side is: has the women the right, once she is pregnant, to decide to abort this child? Certainly a very unresolved issue right through the world. But in the face of the problems in this country, it would be my opinion that our abortion law should be changed to accommodate more women with unwanted pregnancies.

However, abortion should be seen as the last resort, and not as in some countries used as a primary method of pregnancy prevention. With our changing government, and new constitution and laws, hopefully, we will achieve that aim. The ideal situation should be abortion clinics attached to State Hospitals, and clinics offered as a back up service for

The emphasis lies on education.



“AN EXCITING NEW CHEMICAL ENTITY...”

failed contraception, associated with pre and post abortion counselling. It should be forbidden by the law for any party to force a woman to undergo an abortion against her will and no member of the health team should be forced to perform an abortion against his or her conscience. We would then end up with a pro choice abortion law, which in this country would save a great deal of pain and suffering. This of course is a very debatable matter. Once again, the emphasis lies on education. An abortion service should be part of a much wider fertility regulation service, which should include sex education at school levels and the provision of accessible contraception.

Pap Screening

As we all know invasive cancer of the cervix is the most common cancer of women in South Africa. However, it is also a preventable cancer. We have seen in countries where they have successful cytology screening of the cervix, the incidence of cancer of the cervix has vastly decreased. In South Africa, at present, there is no pap screening service. And to institute a service, would cost billions. So we need to look a bit more in depth on who needs the screening? How can we decrease the incidence of cancer of the cervix? Is it cost effective to do screening?

We can look, firstly, at who needs to be screened and secondly, who needs to be treated.

If we look at the peak incidence of pre-invasive cancer of the cervix, we see that this falls into the age group of between 30 - 35. The incidence of invasive cancer falls in the group 40 - 45. The aim is to prevent the cancer from becoming invasive. So therefore

we should aim our screening at that population group. An age group where there is the highest incidence of pre-invasive lesion, but not a very high incidence of invasive lesion yet.

That would fall in the age group of 30 years. After considerable research, taking into account these factors, the suggestion is that there should be a free screening service for women and that they should be allowed three free pap smears in their life.

The most cost beneficial programme would be starting the screening at the age of 30. In this age group, one would pick up the highest number of pre-invasive lesions, without compromising the women. The other two smears should be offered ten years from this. To do this on a nationwide basis, would still be an enormously costly exercise, but comparing it to the amount of invasive cancers that one would prevent by treating these pre-invasive lesions, it becomes a cost effective exercise.

Cytologists and technologists would have to be trained and new laboratories opened and the system needs to be accompanied once again by an extensive education programme. And an adequate treatment and follow-up programme for those who have an abnormal smear.

That brings me to the question of who needs the treatment. In Cervical Intraepithelial Neoplasia (CIN 1, 2 & 3), we know that the early lesions often regress back to normal. Certainly pure Human Papilloma virus does not warrant immediate treatment as the body's own host immune response often takes care of this virus. We could follow up patients with low grade CIN 1 and 2,

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as well as HPV on a three monthly to six monthly basis. If the lesion regresses there is no need to worry, if the lesion persists or progresses, then this is the patient who needs the treatment, as well as the patient who, for the first time, has a CIN 3.

Treatment can then be offered in secondary hospitals. Pap smears should be taken at any clinic, hospital or private hospital. Should the woman want additional pap smears inbetween, she will have to pay for them. This is an ideal screening system for a developing country. The implementation of it however, is very complex, and will need a lot of dedication to become successful.

So, in summary, what should we say about women's health?

1. Women's rights should be recognised.
2. Health and sex education should be given from an early age. Information and education centres should be available and should give special preference to matters such as contraception, sexually transmitted diseases, pregnancy and child care, preventative medicine and the ill effects of smoking.

Finally, it remains the responsibility of the health care workers, the general practitioner and the nurse, (or with whomever the patient comes in contact), to use that contact point as an opportunity for education.

YOUR GREATEST EXPECTATIONS WILL SOON BE MET!