Reproductive Health, Gender and Human Rights: A Dialogue

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4. Women’s Reproductive Health: The Public Health Perspective

Our objective in public health is, of course, to make the world a better place, and it is not an easy task. For starters, there are some huge global reproductive health problems:

♦ Unwanted/mistimed pregnancies—75 million per year
♦ Unsafe abortions—20 million per year
♦ “Unmet need” for family planning—100 million per year
♦ Pregnancy-related deaths—585,000 women per year
♦ Pregnancy-related morbidity—15 million per year
♦ Anemia and other nutritional deficiencies—500 million cases per year.

One must also include huge HIV/STI problems in the list:

♦ Deaths from HIV/AIDS—2.6 million thus far
♦ New HIV infections—5.6 million per year
♦ Total HIV-infected—36.1 million
♦ New gonorrhea, chlamydia and syphilis infections—50 million per year.

There are also huge global child survival problems:

♦ 11.6 million child deaths per year, of which
  ♦ Acute respiratory infections kill 4.4 million;
  ♦ Diarrhea claims 2 million; and
  ♦ Immunizable diseases claim 1.6 million.

Disability-Adjusted Life Years (DALYs) take into account the age at which events occur in estimating the human potential that is lost due to the major causes of death and disabilities. The ten leading causes of DALYs lost for 1998 are listed in Figure 4-1.

This list illustrates the impact of infant and childhood diseases and conditions, as well as the tremendous toll that HIV/AIDS is taking among adolescents and young adults. Attention must also be given to the large numbers affected by chronic diseases. The amount of health-related human misery is large, but the resources available to fight them are puny. The public health community has always had a scarcity mentality. Because resources are so scarce relative to the problems to be addressed, we are necessarily very frugal. Public health is obsessed with how to accomplish the most with the least amount of funds.

There are three standard ethical principles that public health adheres to:

♦ **Beneficence**: the obligation to maximize benefits and minimize harms;
♦ **Equity**: distributing the benefits and burdens of actions fairly; and
♦ Autonomy: defending the right of persons to self-determination and protecting those with impaired autonomy.

To a great extent, these three principles explain what we in public health are trying to do. We advocate for the common good, for fairness and justice and for the rights of all persons. The constituency of public health is everybody, including those who do not come for services. An illustrative motto comes from North Carolina: “Public Health is Everywhere, Everyday, Everybody.” There is a tendency in public health to think in terms of numbers; however, we need to remember, as former director of the CDC William Foege put it, “In everything we do, behind everything we say, as the basis of every program decision, we are willing to see faces.” Priority should depend on the magnitude of the problem and how good the intervention is. Not all problems have good solutions. An example is aging. We can age “well,” but we have no good solutions to stop the aging process.

The public health approach looks for the following in determining which problems to address and what interventions to address them with:

- It is an **important** problem.
- There is an **effective** intervention.
- There will be a **broad benefit** from the intervention.
- The approach considers **selectivity** and **priority**.
- The approach uses **leverage or synergy** to maximize effectiveness and efficiency.
- The approach is **strategic**—it has well-thought-out objectives and achievable results.
- A key priority is **prevention**.
- The intervention is **feasible** (in terms of resources, politically, and other factors).
- The intervention is **sustainable**.

An example of selectivity and priority is the case of smallpox immunizations in Bangladesh, as shown in Figure 4-2. In order to be feasible and sustainable, the strategy was to immunize people who lived near known cases of smallpox. In public health we try to adopt an opportunistic approach—in the case of Bangladesh, to immunize during the season when incidence is lowest.

It is important to recognize that women play a pivotal role for health and well-being in the family and community, for the child and for themselves. There is a multiplier effect in dealing with women, since women are the brokers for their children’s health, both before and after birth.
These are some examples of public health interventions:

- Various types of health services and outreach
- Curative (oral rehydration therapy)
- Diagnostic (blood pressure checks)
- Preventive (immunization)
- Non-clinical (social marketing of condoms)
- Environmental (clean water, guard rails)
- Behavior change (smoking cessation)
- Regulatory (restrictions to protect against second-hand tobacco smoke)
- Legal (laws against drunk driving)
- Financial (tax on tobacco and alcohol)
- Information (labeling of food and drugs)
- Nutritional (vitamin A-fortification)
- Economic development (education, more nutritious food)
- Political/normative/social/human rights (eradication of female genital cutting)

Notice that there is really a very broad range of approaches, and clinical services delivery is not necessarily the most important. To paraphrase a political slogan: “It’s the intervention, smarty!” Intervention is the key in public health. The public health community must do whatever works within ethical boundaries. Let us consider the best public health approach to dealing with sexually transmitted infections (STIs).

If we look at the global incidence of curable STIs, half of the people infected do not have symptoms. We also need to look at public health limitations—i.e., the
systems we have for helping the people affected.

Trichomoniasis is the most common STI, but while clearly a problem, it is not of the same gravity as other STIs. Notice in Figure 4-3 that gonorrhea and chlamydia together equal about 150 million new cases per year. This is a daunting reality. How do we deal with a problem of this magnitude?

Figure 4-4 demonstrates how difficult it is to have a public health impact by using a treatment approach. Each bar represents a critical step in dealing with a case of STI. The proportions are illustrative but instructive. All of the things listed on the bottom—symptoms present, treatment sought, correct diagnosis, correct treatment, treatment completed—are necessary to achieve a cure, but the probability of success is very low. Many people have STIs with no symptoms and many with symptoms do not seek treatment. The last step, partner referral, is especially weak. Thus, it is very difficult to see how a treatment approach to STIs in the broad population can have much of a public health impact.

Figure 4-5 demonstrates the major weakness of using the presence of vaginal discharge to diagnose the presence of an STI for presumptive treatment with an antibiotic. Many women with gonorrhea and chlamydia have no discharge (upper right). The large majority of women with discharge have no gonorrhea or chlamydia. This makes partner referral for a presumed STI very problematic since most do not have an STI. Also, this diagnostic approach leads to a large waste of and over-treatment with multiple antibiotics.
Presence of Vaginal Discharge Not Helpful in Identifying Gonorrhea and Chlamydia

Women with no discharge

Women with discharge

No Gonorrhea and Chlamydia

Gonorrhea and Chlamydia

Source: Adapted from Piot and Fransen in WHO, 1997

Figure 4.4

Figure 4.5
We need better strategies, such as targeting the high transmitters. Figure 4-6 demonstrates how important high transmitters are for STI transmission. Based on this modeling of data from Kenya, 500 commercial sex workers (CSWs) with 80 percent HIV prevalence would be expected to infect over 10,000 people. Five hundred of their “clients,” however, would be expected to infect 88 others. Most importantly, the female partners of the male clients would be expected to infect far fewer still. We need to promote prevention. We need to promote humane ways to prevent transmitters from transmitting.

USAID’s programmatic technical guidance document *Integration of Family Planning/MCH with HIV/STD Prevention* (December 1998) supports a three-pronged approach stressing prevention. Much of the strategy is to get outside of the “clinic box” with interventions that synergize with family planning programmatic strengths.

Thailand adopted a three-pronged strategy to prevent STIs. They targeted men, high transmitters and the general population. The broad-based strategies were—

♦ Aggressive condom promotion
♦ Social marketing (condoms and antibiotics)
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- Awareness-raising and education
- Behavior-change communication
- Policy and advocacy
- Research

The “100% Condom Program” was targeted to CSWs in Thailand, and to some extent, their clients (Figure 4-7). This illustrates the power of the prevention approach. It is a classic example that should be in every introductory textbook of public health. There was an 80 percent decline in all five reportable STIs in men, nationally. Thus, the prevention approach prevented many thousands of STIs. HIV has since stabilized in Thailand. The 100% condom policy started a major decline in male STIs. It was a successful attempt at making condoms a social norm.

![Thailand 100% Condom Policy: Major Decline in Male STIs](image)

Source: Hanenberg et al., 1994

**What Does the Rights Approach Mean?**

There are questions that come to mind about a “rights approach” as it applies to public health:

- What does it mean for something to be a right?
♦ Whose obligation is it?
♦ What is the remedy when it does not happen?
♦ Which social goods are included as rights and which are not?
♦ Who decides what is a right and on what basis? Are there any priorities?
♦ What about the changing role of nation-states vis-a-vis rights? For example, some countries that formerly assumed responsibility for “rights” to jobs, have backed away.
♦ How can the rights community and public health community mutually support public health efforts?

There are “rights conflicts” in public health, when the liberties or rights of individuals conflict with the common good. Some examples include:

♦ Laws against drunk driving
♦ Prescription drugs (vs. over-the counter remedies)
♦ Gun control
♦ Mandatory seat belts
♦ Compulsory immunizations
♦ Quarantines
♦ Fluoridation of water

The question of what is a right sometimes devolves to practicalities. What is defined as a right is what can be enforced. Many different kinds of rights are spoken of—civil, political, social, cultural and economic rights. What is the relative weight of each of these rights when compared to the health interests of the public at large? Whose side do we take if there is a conflict between an individual’s right and the right of the public to be protected?

In trying to make the world a better place, there are merits to using both the public health approach and the rights-based approach. Although we all look at the world through different lenses, we must look for ways to harmonize our efforts.

References