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Submission on the priorities for Primary Health Care Research, Evaluation and Development

**To the
National Information Service
Department of General Practice
Flinders University.**



1. Introduction.

The Australian Reproductive Health Alliance (ARHA) is a non-government not for profit agency that was established as a direct result of the Cairo Program of Action (CPA), which was agreed upon at the UN International Conference on Population and Development (ICPD), held in Cairo in September 1994. The program was again ratified at the United Nations General Assembly Special Session (UNGASS) on population and development held in New York in 1999. The Australian Government endorsed the CPA without reservation at both meetings.

While ARHA concentrates most of its endeavours ensuring that Australia meets its CPA obligations in the area of our overseas development assistance program administered by AusAID, it does from time to time, comment on domestic issues where these can be clearly seen to have relevance to CPA.

The detailed aims and objectives of ARHA can be found at appendix A.

ARHA believes that the most glaring example of Australia failing to meet its international obligations as set out in CPA is in the area of indigenous health and because of its area of interest, ARHA has concentrated on the areas of reproductive health.

Also, as the submission must be confined to no more than four A4 pages, and there is a large body of research already into indigenous health issues, including reproductive health, ARHA is briefly outlining the urgent issues that remain to be addressed assuming that the National Information Service, Department of General Practice, Flinders University has access to and is knowledgeable about, prior work in this area.

2. Primary Health Care Research On Indigenous Reproductive Health Matters.

It is acknowledged that a number of problems have already been identified in this area. These problems include:

- a) Lack of adequate birth spacing resulting in unacceptably high infant mortality rates and maternal morbidity rates.
- b) Lack of uptake and/or of or access to adequate post and ante natal services.
- c) A high prevalence of STDs/RTI amongst the indigenous community often resulting in infertility.
- d) A lack of uptake of screening services even when such services are accessible, which often they are not.

Research therefore needs to be continued in all these areas if better outcomes are to be achieved. It is acknowledged that conducting research in such a sensitive area as reproductive health behaviour is extremely sensitive and ARHA is of the opinion that such research needs to be action orientated and must include the participants in every step of the process, from design through to implementation. Where possible the leaders of reteam teams should be indigenous people with adequate qualifications (not necessarily academics). Where this is not possible, researchers should have a proven track record of conducting sensitive, results orientated work with Indigenous People.

A starting point may be to consider that despite obvious goodwill, existing data, and a high injection of resources, the outcomes have not met the required targets. It may be a lack of suitable, accessible services that are easily accessible to the people concerned. Another possibility is that enough use is still not being made of Aboriginal Health Workers and there may not be enough of them adequately trained to deal with these sensitive matters.

A further point to consider is that where there are other grave needs, such as lack of adequate sanitation, housing and transport infrastructure, and multiple serious health problems, reproductive health is not seen as a high priority. ARHA would argue that many of these problems are interlinked and to ignore, or relegate reproductive health to a lower priority is extremely counter

productive as it impacts on both the general well being of the people concerned and has vast social implications.

3. Social Implications of Inadequate Reproductive Health For Indigenous People.

ARHA acknowledges the high suspicion in the indigenous community to programs that are in any way seen as “family planning” or birth limitations. Indigenous people have good reasons to be wary of any attempts to limit their population growth. However, there is massive international research that links high infant mortality to births not spaced far enough apart and mothers either being too old or too young to successfully deliver a healthy baby without great harm to their own health and that of the child’s. (See various UNFPA State of the World Population Reports for just one example).

Ways must be found to encourage indigenous women and men to see the wisdom of birth spacing. This suggests massive education programs (there are good examples of these types of programs being undertaken by Family Planning Northern Territory, Family Planning Queensland and Family Planning Western Australia). However, the lack of significant improvement in the area would suggest that much more needs to be done.

Accessibility to and acceptance of methods of family planning that suit the individuals concerned must be improved. The use of longer acting contraceptives such as injectables and the new implants would seem a useful addition to the range of contraceptives on offer in very remote areas, but it must be accepted that some indigenous people have had their human rights violated in the past by the indiscriminate use of Depo Provera, without informed consent. Thus acceptance of these methods would need careful handling.

Also, given the high rate of STDs, these types of contraceptives may not be the most suitable if not used with a condom. Given the above stated reluctance to use birth control methods of any kind, it is perhaps unrealistic to expect users to actually accept the need for double protection as is now being advocated in both some developed and developing countries.

However, given the remoteness of some communities and the contentious issues around termination of pregnancy, to suggest only the use of condoms would seem irresponsible. Research could be considered into whether this might be an ideal opportunity to test the efficacy of advocating the use of condoms, with prepacked emergency contraceptives (and pregnancy testing kits) being freely available from health workers and other suitable outlets in remote and rural areas.

The matter of infertility amongst indigenous communities also needs to be urgently addressed. This is mainly caused by undetected and thus untreated STDs, especially (but not confined to) Chlamydia. In a society where motherhood is a vital key to women’s status, infertility is a major tragedy.

However, where testing is simply not done because of logistical reasons or its lack of acceptance by the people themselves, there obviously needs to be a major push on exploring ways to test efficiently and to make such testing acceptable and routine.

One of the problems in discussing reproductive health needs is that research in this area and even follow up programs tend to ignore the role of men and focus on the women. There is great (if understandable) reluctance to discuss the widespread existence of domestic violence (including rape) with the indigenous community. There is also even greater reluctance to discuss the high incidence of incest in indigenous communities.

ARHA considers it idealistic to talk about “empowering women” in this context until there has been a great deal of work done on male responsibility regarding all aspects of reproductive health. While

indigenous men continue to see it as “macho” or even culturally very acceptable to father many children and abuse their partners, little progress will be made.

While ARHA would see it as very important to work on empowering women, it would also see work with indigenous men of equal (if not of higher priority) at this point.

While ARHA has talked of the disastrous consequences of infertility caused by STDs, the spectre of an African type spread of HIV/AIDS cannot be underestimated. It is now admitted by the international aid community that such a disaster is now looming in Papua New Guinea, which has very real implications for the spread of the epidemic (which has now been accepted by WHO as a Global Emergency) into the Torres Strait Islander community and beyond. This makes our plea for a high priority to be placed on reproductive health even more urgent. If the HIV/AIDS epidemic begins to make inroads into the indigenous community, the implications are horrifying.

4. Research Requirements For Reproductive Health In Primary Health Care In Indigenous Communities.

Implicit in some of the discussion under 3 above are some research requirements. These include:

- a. The need to research contraceptive methods that will assist in both birth spacing and barrier protection against STDS, which would be accessible and acceptable to indigenous communities.
- b. The need to work on male responsibility in the reproductive health area.
- c. The need to address the issue of domestic violence, rape and incest within the indigenous community. Obviously this will involve in depth consultations with both women and men in separate groups within each community.
- d. The need to continue and expand urgently all efforts at educating the communities regarding the importance to the health and well being of both mother and child for birth spacing.
- e. The need to consult communities which have a low uptake of both post and ante natal care. ARHA realises that much research has been done on this issue but there are obviously some major impediments to adequately access such services which suggests they are either not seen as important or they are seen as culturally unacceptable. Work with the grandmothers might be a useful approach in this area.
- f. The need to ensure that wherever possible, Aboriginal Health Workers are adequately trained to offer the broadest possible range of reproductive health care directly to communities.
- g. The need to continue and build on the excellent HIV/AIDS prevention education programs with an even greater sense of urgency.

Other areas of research which could be explored include examining the wider use of locally based volunteers in the delivery of contraceptive supplies including oral contraceptives, emergency contraception, condoms, etc. Precedents already exist in many developing countries for this approach (Indonesia, Vietnam, Laos and many African countries).

Similar approaches in using well trained male volunteers from the local communities in talking with men about reproductive health and reproductive responsibilities to their partners.

Where appropriate, much success has been achieved in developing countries to enlisting the support of religious leaders, chiefs, accepted women's groups and leaders in this whole educational process. The possibility of replicating this model in indigenous communities in Australia should be more widely explored and if considered feasible, implemented quickly. Of course, adequate training is essential.

In many developing countries, there are now many well-trained female and male doctors who have worked extensively in this field. It may be worth researching whether or not such people would be viewed with less suspicion if they undertook short-term contracts working with Australian indigenous communities. Great care would have to be taken in such an enterprise as many of these doctors would come from countries where population reduction was a prime aim of programs in which they are involved. There may also need to be some special registration process for such professionals if it were felt that they did not meet Australian registration requirements.

5. Conclusions.

It is ARHA's contention that the primary health care needs of indigenous Australians are still not being adequately addressed. Further, ARHA strongly contends that reproductive health should be of equal priority with other pressing health needs. Unhealthy children, perhaps with some intellectual impairment due to inadequate post and ante natal care will mean that the indigenous community will not be able to address the many pressing issues facing them.

ARHA urges that a more lateral-thinking approach to both research and service delivery be considered. Australian authorities should not be afraid to look to models being implemented successfully in developing countries for possible answers – the wheel may have already been invented!

**Dianne Proctor
Chief Executive Officer
ARHA
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