

Response to petition on gynaecological health issues

COMMUNITY AFFAIRS

REFERENCES COMMITTEE

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10 2 2006

Mr Elton Humphery
Committee Secretary

Thank you for the opportunity to submit a response to the petition "Gynaecological Health issues" tabled in the Senate in November 2005.

I am pleased to submit the following details that will assist the Community Affairs references Committee in its response to the Senate.

Please do not hesitate to contact me if you require further details.

Yours sincerely,

(By email)

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Author: "The Gynaecological Cancer Guide: Sex, Sanity and Survival" by Margaret Heffernan and Professor Michael Quinn, 2003, Michelle Anderson Publishing, Melbourne
AUD\$24.95 at all book stores
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The following report provides summary data for initial consideration for increased government support and funding for gynaecological cancers and female gynaecological disorders.

Gynaecological cancers comprise cancer of the vulva[C51],cancer of the vagina[C52];cancer of the cervix uteri [C53];cancer of the corpus uteri [C54]; cancer of the uterus[part unspecified] [C55] ;cancer of the ovary [C56] ;cancer of unspecified female genital organs [C57] ;cancer of the placenta [C58]

The report specifically asks you to give due consideration to the following urgent needs:

We seek the inclusion of other gynaecological cancers [especially ovarian] into the NHPA initiative to reduce the social and economic burdens these place on Australian society, the female and her extended family and networks.

We seek increased Government funding for treatment of gynaecological cancers to make it commensurate with the funding support for breast cancer and overturn the current inequity of funding between male and female cancer funding, and breast cancer funding.

We seek equitable cancer expenditure with male expenditure. Current average cancer expenditure in 2000 -01 for males at age 65-74 was \$641 and \$389 for females despite gynaecological cancer risk increasing for females from age 55. At 75 years and over males averaged \$984 whilst per female was \$480.

We seek increased training and education of all GPs in Australia (especially in remote locations where there is a decreasing rate of health employees) in the symptoms and early management of all gynaecological cancer disorder, not just ovarian cancer. Between 1998 and 2004, only 3.7 % of total referrals were made by GPs to a Gynaecologist (0.8 % rate per 100 cancer contacts).

We also seek funding for training of GPs in identifying psychosocial/sexual dysfunction in a patient,(especially in rural areas) where symptoms often present after treatment has finished [6 - 18 months later]. There is current confusion among GPs about when to make a referral.

We seek Government support and funding for the establishment of a National Gynaecological Cancer Centre [NGCC] dedicated to the management and development of all gynaecological cancer needs and resources. This centre would be separate to the National Breast Cancer Centre that is currently managing a small aspect of Ovarian Cancer guideline needs.

We seek Government support and funding for the development and regular review of ALL gynaecological cancer guidelines and a coordinated program of outreach, not just ovarian and cervix. We seek the establishment of a specialist gynaecological centre [NGCC] to manage this development as we feel it is inappropriate to be managed by breast cancer agents. We believe this will improve the efficiency and effectiveness of care and save millions of dollars. [NCCI (section 3:31) makes reference to Australian experiences in ovarian cancer is worse than could be achieved by best practice care.

We seek Government support and funding for women in remote and regional areas in all aspects of better gynaecological cancer diagnosis, management, and psychosocial/sexual support for the female and her family. For instance, females from remote locations experience a relatively higher cervical mortality rate in the target age range because of limited access to screening.

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We seek Government support and funding for integrated and unified promotion and communication of existing financial, organisational and communication support services after a gynaecological cancer diagnosis that is available for the patient and her family. This is currently managed State by State in an adhoc and inconsistent fashion (in 1986 -7 the Federal Budget was transferred to the states and territories) with women not aware of resources they may need in the future such as gynaecological cancer support services, financial support Cancer Helpline, sexual counselling, psychological support especially in rural and remote areas; patient escorts, social networks IPTAAS [The Isolated Patients Travel and Accommodation and Assistance Scheme] information and Financial assistance for Travel and Accommodation information needs improved dissemination and ALL remote patients should. receive this as a matter of course without the strain of having to concern themselves at a stressful time with formal documentation to meet current eligibility requirements. In some states patients have to make a claim in advance.

We seek Government support and funding for increased access to interpreters for women with gynaecological cancers where discussion of sensitive and intimate issues is often difficult in patriarchal and 'loss of face' cultures. Current interpreter services are not available on all working days. Although TIS [the Translating and interpreter Service] is available 24 hours /7 days a week it has to be booked in advance. It is not appropriate or realistic to expect the carer of family to fill the role of psychosocial support when often they are loss for appropriate action. The MCIS [Multicultural Cancer Information Service] is a telephone service available to ALL Australians for the cost of a local call it is only promoted within NSW and therefore remains unknown to most /all other cancer patients and their families.

We seek Government support and funding for better access to cancer services, especially radiotherapy and psychosocial/sexual support, for rural and remote areas. Priorities for Action in Cancer Control 2001 -2003 [CSG 2001]" identified the provision of psychologists in cancer centres and clinics as a cost –effective, much needed intervention. This is especially critical for gynaecological cancers where over 60% of women have psychosocial/psychosexual trauma as a result of diagnosis and treatment, and often have significant psychological morbidity requiring intervention by a skilled clinical psychologist – currently not readily available. Clinicians are not sufficiently aware of the psychosocial aspects of care.

We seek increased training and education of communication skills in all cancer care providers, from gynaecological oncologists, the whole care team and GPs, especially in response to psychosocial and psychosexual aspects of gynaecological cancer treatment. This training would also extend to training in communication skills with culturally and linguistically diverse backgrounds.

Cervical cancer is the only gynaecological cancer where a population –based screening test is available that can detect pre-cancerous lesions. Because regular screening can therefore help reduce the incidence of gynaecological disease we seek government funding and support for research and development of screening tests for all gynaecological cancers but most importantly ovarian cancer and vulva cancer. Early detection of the disease also offers opportunities for better management. Relative survival after the diagnosis of cancer of the cervix is generally high compared with all other gynaecological cancers except for gestational trophoblast disease [a relatively rare cancer of the uterus] therefore as early detection will increase survival rates of other gynaecological cancer we seek resources for early detection measures.

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This submission seeks Government support for [a] maintenance of the Pap screen program at its present levels

[b] Funding subsidy for the Human papillomavirus vaccine that will prevent dysplasia and cervical cancer [available 2008] for 'at risk' groups - Indigenous and ethnic minorities who will not participate in the Pap screen program

[c] Funding of the Human Papillomavirus vaccine that will make it economically viable for all Australians

We seek government funding and support for increased research into gynaecological cancers and their impact on psychosocial and psychosexual functioning so appropriate community based resources and interventions can be supplied especially in rural areas. This would include impact on relationships, body image, fertility, sexual and psychological functioning and stigma.

We seek government funding and support for increased culturally appropriate and sensitive gynaecological cancer resources and services for Aboriginal and Torres Strait islanders where these issues are strictly 'women's business' and cancer has an immediate connotation of 'death' and an impairment on the woman's social and spiritual responsibilities.

We seek government funding and support for increased research and development of preventative measures for sexually transmitted infections that lead to gynaecological disorders, especially Human Papillomavirus (a necessary cause of dysplasia and cervical cancer) and Chlamydia (that result in infertility and pelvic disorders).

The following information has been taken from Cancer Survival in Australia 2001; Cancer in Australia 1999; National Health Priority Areas Cancer Control Indicator [NHPA]s; Australian Institute of Health and Welfare [AIHW]; Clinical practice guidelines for the psychosocial care of adults with cancer, National Breast Cancer Centre [NBCC], Camperdown, NSW; National Cancer Control Initiative [NCCI]

In the past 5 years 7,395 Australian women have died from a gynaecological cancer - 55%, or 4,050 of those women, died from ovarian cancer.

In 2001 there were 1,537 *NEW* cases of Cancer of the Uterus (299 deaths and 4,300 person-years of life lost [PYLL]), and 1,295 *NEW* cases of cancer of the Ovary (857 deaths and 6,598 PYLL lost (Cancer in Australia 2001). Cancer of the uterus has increased by .3% per year between 1991 and 2001. Although cancer of the ovary has declined by 0.4% in the same period it remains a lethal killer with 75% of diagnosis resulting in death. This is due to the advanced stage of the disease at diagnosis.

Furthermore cervical cancer and cancer of the uterus as a proportion of cancer deaths in the population all *increase with remoteness*. These cancers currently have no early detection test or adequate Government support. Both are listed by AIHW as most frequently occurring female cancers.

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Ovarian cancer: 1,151 new cases of ovarian cancer were diagnosed in 1997. **Survival from these cancers is appreciably less than world benchmark figures – in fact 20% lower than USA because the Australian Government admits the National Health programs fail to give the best care**, despite the outcome for ovarian cancer survival being recognized as ‘poor’ [61/133] – 40% survive five years from diagnosis, because diagnosis is most common in advanced stages where survival is 20% or less.

In February 2002, as part of the National Ovarian Cancer Week activities, the Ovarian Cancer Program published a new report Ovarian Cancer in Australian Women. This **report highlights the need to take immediate action on ovarian cancer**, the leading cause of death from gynaecological cancers in women in Australia. This marks the first time that data have been compiled Australia-wide and gives a basis for developing priorities in ovarian cancer control.

In 2001 the Government allocated \$500,000 for ovarian research yet this is not sufficient support to reduce the incidence or survival of these cancers, nor an equitable proportion of the total expenditure on health research [\$215million or 18.2% of all health research in 2000-01]. Gynaecological cancers other than cervix are not listed in major initiatives or documents relating to female cancers [the emphasis being on breast and cervix]. No gynaecological cancer is listed in the ‘Cancer Trials Australia’ program group.

Gynaecological cancer is a significant cause of female deaths from cancer yet the Government agrees:

“No known effective method for early diagnosis of ovarian cancer”

“No Australian guidelines; no referral policies”

Australian Government Priorities for Action in Cancer Control 2001-2003 indicates:

Although Cancer consumes 6% of overall direct Government expenditure on health (\$1,905 million: AIHW and AACR 2000), gynaecological cancer needs were grossly under-represented as a priority. Of 350,000 Australians diagnosed every year with a cancer, 34,000 will die from it. – This represents an Annual loss of nearly 480,000 disability adjusted years of life!! [p21]

- Priority actions have addressed 7 of 8 National Health priority areas but did not sufficiently recognize gynaecological cancer needs.

Gynaecological Cancer priorities emphasized cervical cancer but rather than introduce new initiatives to allay women’s risk, it was recommended that there be a reduction in Pap screening from 2 – 3 years]

Prevention – There was NO mention of gynaecological cancer

Screening and Early detection: cervical cancer – improving efficiency of national cervical screening program by increasing the screening interval from 2 – 3 years. Pg 15 states ‘yield substantiated cost savings, but might entail a small increase in the burden of cervical cancer’.

(1 extra death is too much, yet alone the psychosocial cost of fear!)

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Treatment: Improving outcomes from ovarian cancer by ensuring that all people with these cancers are assessed at a multi-disciplinary specialist centre as soon as possible after diagnosis.

(Regrettably with the geographical dislocation of Australia this is not possible for many women. Furthermore, ovarian cancer is often misdiagnosed until is at an advanced stage. Therefore there is an urgent need to fund increased education of the community, GPs and surgeons so that women do get access to multi-disciplinary specialist centres.)

Support for Cancer patients: **Improving psychosocial care of people with cancer through provision of psychologists in cancer centres and clinics.** The availability and scope of education and community awareness and prevention programs is inadequate.

(An ideal need but resources still not allocated across all centers. Therefore we ask Government fund this earlier promise as a matter of urgency)

Current levels of research funding:

Cancer Incidence Projections for Australia 2002-2011 [AIHW]

Female cancers are projected to increase by 29% from 40,518 cases in 2001 to 52,356 in 2011. By 2011 AIHW has predicted that there will be 198 new cases of ovarian cancer for women aged between 15 and 44 years.

“With the expected ageing of the population, the overall number of new cases of gynaecological cancers is projected to increase by 15% from 3,886 [2001] to 4,488 in 2011

FINANCIAL REALITY: [AIHW report]

- In 2001 Government expenditure on cancer management totalled \$2.7 billion....however of that 71.3% was spent on Hospital care
- \$215 million was spent on cancer research – whilst this seems a lot it represents only 18.2% of the total health research budget
- There are differences between males and females in expenditure:

CANCER EXPENDITURE PER MALE / FEMALE 2001 DATA [AIHW]		
AGE	MALE [per head]	FEMALE[per head]
Average age:	\$146	\$135
65 -74	\$641	\$389
75+	\$984	\$480

AIHW data shows cancer prevalent at older age, and this includes gynaecological cancers, yet Males are allocated at least double Female cancer expenditure [refer Table].

Of all GP referrals between 2002 -2004 only 0.5 -1.0% were referrals to a gynaecological specialist despite the number of women across Australia diagnosed with a gynaecological cancer per year.

PROMISES: [26/133]: Ensure cancer control services are responsive to needs and wishes of consumers”

[26/133]: Ensure that equity is considered across ALL levels of cancer control.

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ACTION: [In September 2001, the Australian Commonwealth Government announced the establishment of a new program in ovarian cancer. Funds of \$500,000 over two years were provided to support the program and the National Breast Cancer Centre was asked to implement the program.

(\$250,000 PER ANNUM IS NOT GOING TO FUND RESEARCH INTO AN EARLY SCREENING TEST FOR OVARIAN CANCER)

The provision and adequacy of current services and treatment options

1. The incidence of gynaecological cancers

INCIDENCE OF GYNAECOLOGICAL CANCERS 1983 – 2001 [AIHW DATA]															
CANCER	YEAR		DIAGNOSIS IN 2001 BY AGE												
	2001	1983 -2001	15-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
VULVA /VAGINA	314	4,519	2	5	9	23	15	23	18	22	29	36	41	38	52
CERV UTERI	735	18,479	50	59	88	67	101	78	53	47	43	42	181	40	28
CORPUS UTERI	1,537	23,253	3	12	18	50	93	179	237	217	181	187	39	102	77
OVARY /OTHER	1,295	20,861	52	28	38	59	96	122	132	141	123	128	153	108	111
NEW CASES	3,881	67,112													

GYNAECOLOGICAL CANCER DEATH INCIDENCE 1998 – 2003:	
[C51] vulva	320
[C52] vagina	167
[C53] cervix uteri	1,279
[C54] corpus uteri	1,186
[C55] uterus[part unspecified]	271
[C56] ovary	4,050
[C57] unspecified female genital organs	119
[C58] placenta	3

SUPPORTING DATA

NHPA

The National Health Priority Areas (NHPA) is an initiative of the Australian Health Ministers Conference (AHMC), involving collaboration between the Commonwealth, state and territory governments seeks to focus public attention and health policy on those areas that contribute significantly to the burden of disease and injury, but offer scope for improvement (NHPAC 2002).

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The NHPA initiative acknowledges that in order to relieve the burden of disease, a holistic approach to health care must be taken, encompassing prevention of disease and injury through to treatment and ongoing management. Currently seven different health areas have been marked for priority attention as NHPAs, namely cardiovascular health, cancer control, (Lung cancer; melanoma; non-melanocytic skin cancers; **cancer of the cervix**; breast cancer; colorectal cancer; prostate cancer; and non-Hodgkin's lymphoma (NHL) injury prevention and control, mental health, diabetes mellitus, asthma, and arthritis and other musculoskeletal conditions.

We seek the inclusion of other gynaecological cancers [especially ovarian] cervical cancer into the NHPA initiative to reduce the social and economic burdens these place.

Cancer is a notifiable disease in all states and territories and is the only major disease category for which an almost complete coverage of incidence data is available. Cancer is also a major cause of death in Australia.

Excluding non-melanoma skin cancers, there were 88,398 new cancer cases and 36,319 deaths due to cancer in Australia in 2001. With this incidence of cancer rate prevailing in 2001, it would be expected that 1 in 4 women (1 in 3 men) will be diagnosed with a cancer in the first 75 years of life. Cancer is currently 26% of female deaths. Further, an estimated 257,458 potential years of life would be lost to the community each year as a result of people dying of cancer before the age of 75.

Onset of cancer

In 2001 the average age of first diagnosis of a cancer for females was 64 years and the median age was 65 years. For the overall population, the average age of first diagnosis was 65 years and the median age was 68 years.

The population in the age groups from 50–59 years and above is increasing rapidly as the generation born during the baby boom (1946 to 1961) reaches these ages. This is leading to an increase in new cases of cancer much greater than overall population growth, despite a small decline in age-standardised incidence in recent years.

Age and sex differences

Cancer 393.3 per 100,000 for females, resulting in an age-adjusted sex ratio of 1.4. Of people diagnosed with cancer, 0.7% of all cancers (excluding non-melanoma skin cancers) occur in those aged less than 15 years, 9.4% in the 15–44 year age group, 32.6% in the 45–64 year age group, and 57.2% in those aged 65 years and over. While the pattern of deaths across age groups is similar to that of incidence, a larger proportion (72.5%) of cancer deaths occurs in those aged 65 years and over. The risk of cancer increases with age.

The age-specific incidence rate in 2001 for all cancers combined (excluding non-melanoma skin cancers) was 15.2 per 100,000 population for people aged less than 15 years; 95.6 per 100,000 population for 15–44 year olds; 700.5 per 100,000 population for 45–64 year olds; and 2,190.2 per 100,000 population for people aged 65 years and over.

GP visits

In Australia, a visit to a general practice is usually the first point of healthcare contact. Consulting a doctor is the most common action related to health care taken by Australians. About 24% of Australians visited a GP in the two weeks prior to the 2001 National Health Survey (ABS 2002).

Of the problems managed by GPs in 2002.03 (AIHW: Britt et al. 2003),

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INCIDENCE OF SEXUALLY TRANSMITTED INFECTIONS

Estimated Prevalence and annual incidence of curable STD's by region

(Source: Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections, WHO, 1999' <http://www.who.int/docstore/hiv/GRSTI/002.htm>)

STDs are still a major public health concern around the world and can be linked to acute illness, infertility, long term disability and death leading to severe medical and psychological consequences for millions of people. In women of childbearing age, STDs (excluding HIV) are second only to maternal factors as causes of disease, death and healthy life lost'. The presence of an untreated STD can also 'increase the risk of both acquisition and transmission of HIV by a factor of up to 10'. It is thought that countries tend to substantially underestimate the total number of new cases because many people are thought to avoid health care systems due to the social stigma that can surround infection. Infections rates can vary enormously between countries in the same region and between urban and rural populations. However In general, the prevalence of STDs tends to be higher in urban residents, in unmarried individuals, and in young adults.

Year	Population aged 15-49 years (million)	Prevalence (million)	Prevalence Per/1000	Annual Incidence (million)
North America	156	3	19	14
Western Europe	203	4	20	17
North Africa & Middle East	165	3.5	21	10
Eastern Europe & Central Europe	205	6	29	22
Sub Saharan Africa	269	32	119	69
South & South East Asia	955	48	50	151
East Asia & Pacific	815	6	7	18
Australia & New Zealand	11	0.3	27	1
Latin America & Caribbean	260	18.5	71	38
Total	3040	116.5		340

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HUMAN PAPILLOMAVIRUS AND CERVICAL CANCER

It is now widely accepted that cervical cancer is the second most common cancer affecting women. Caused by oncogenic high-risk types of human papillomavirus (HPV) the link between HPV and cancer, and HPV as a sexually transmitted infection (STI) is not well understood by most in many communities, which may influence the uptake of HPV vaccination as a preventive measure against the virus.

HPV AND CERVICAL CANCER PREVALENCE

Infection with HPV usually occurs in the early years of sexual activity, but it takes up to twenty years for it to develop into a full-blown malignant tumour. Because of its contagious nature, approximately two thirds of all people who have ever had sexual contact with an HPV - infected partner will develop an HPV infection, within an incubation period of three months. It is now accepted that oncogenic (high-risk) types of HPV are the causative agent of cervical cancer. (99% of cervical cancers contain oncogenic HPV DNA). Oncogenic (high-risk) types include HPV 16, 18, 45, 52 and other less common types (16 & 18) contribute to 70% of cervical cancers worldwide), whilst types 6 & 11 are the cause in ~90% of cases of genital warts. As the incidence of HPV infection increases the number of cervical cancer cases can be expected to increase. It is predicted that by the year 2050 there will be one million new cases per annum.

CERVICAL CANCER IN AUSTRALIA

Cervical cancer

Cancer of the cervix is a declining problem but still a significant health issue in Australia. It is the 18th most common cause of cancer mortality in Australian females. It has higher survival rates in comparison to other cancers. There were 267 deaths from cervical cancer in 2000; 72% of these were females aged 20–74. Cervical cancer deaths represented 2% of all cancer deaths among females that year.

The risk of cervical cancer increases with age. Females who are, or have been, sexually active and who have not had a hysterectomy are at a higher risk of developing this cancer. Mortality rates for the states and territories, with the exception of the Northern Territory, ranged from 2.0–3.2 deaths per 100,000 population. The Northern Territory reported the highest incidence rates for cervical cancer (14.6 per 100,000 population). A major contributor to this incidence rate is the high rate of cervical cancer among the Indigenous population, which d'Espaignet et al. (1996) indicated was up to three times the rate of the non-Indigenous population. This situation is also

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reflected in a high mortality rate (6.7 deaths per 100,000 population) which may be an indicator of late-stage detection of these cancers.

Cervical screening in Australia is provided as part of the mainstream health services.

Approximately 80 per cent of the Pap smear tests are performed by general practitioners.

LENGTH OF SURVIVAL:

Length of survival constitutes an important measure in assessing the impact of early detection and treatment in reducing mortality.

The five-year relative survival rate after diagnosis for cervical cancer was estimated to be 75% in the period 1992–1997. Relative survival rates decrease with age at diagnosis. Females aged in their 20s (diagnosed with cancer of the cervix) have the best relative survival rates, whereas those aged in their 80s and 90s has the lowest survival rates.

IMMIGRANTS AND CERVICAL CANCER

In Australia, some populations have lower rates of participation in cancer screening programmes. For non-European immigrants in Australia with cervical cancer the SMR [standard mortality rate] ranges between 1.19-1.23, indicating that immigrants from these regions experience a relatively greater mortality for cervical cancer than the Australian-born population. In terms of reproductive health, studies incorporating the experiences of minority groups generally focus on immigrants' access to screening programmes. Some immigrants have lower rates of participation in cancer screening programmes in Australia due to socio-cultural factors relating to beliefs, attitudes and knowledge differences in religious and philosophical beliefs.

HPV VACCINE

There are currently two HPV vaccines in development – one targeted at HPV types that are a factor of cervical cancer only; the other for HPV types that are a factor of both cervical cancer and genital warts. The aim of the HPV prophylactic vaccination programme is to reduce the incidence of persistent HPV infection and subsequent risk of mortality from cervical cancer in women by at least 80%. This will however be based on their being widespread community understanding, acceptance and agreement to HPV vaccination being mandated. In Australia, the first regulatory dossier for GARDASIL has just been submitted to the TGA for approval, with licensing anticipated in late 2006. A structured HPV vaccination programme has limitations due to the considerable lack of public understanding and awareness of HPV both as a sexually transmitted infection (STI) and a primary cause of cervical cancer in all global communities.

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Chlamydia

Chlamydia is the most common treatable bacterial sexually transmitted infection. It can cause serious health problems such as ectopic pregnancy, if it is not treated.

Estimated new cases of Chlamydia infections (in million) among adults, 1995 and 1999

Region	1995			1999		
	Male	Female	Total	Male	Female	Total
North America	1.64	2.34	3.99	1.77	2.16	3.93
Western Europe	2.3	3.2	5.5	2.28	2.94	5.22
North Africa & Middle Europe	1.67	1.28	2.95	1.71	1.44	3.15
Eastern Europe & Central Asia	2.15	2.92	5.07	2.72	3.25	5.97
Sub-Saharan Africa	20.2	20.28	40.48	18.93	23.96	42.89
South and South East Asia	20.2	20.28	40.48	18.93	23.96	42.89
East Asia & Pacific	2.7	2.63	5.33	2.56	2.74	5.3
Australia & New Zealand	0.12	0.17	0.3	0.14	0.17	0.3
Latin America & Caribbean	5.01	5.12	10.13	4.19	5.12	9.31
Total	42.77	46.38	89.15	41.95	50.03	91.98

Gonorrhoea

Gonorrhoea is a bacterial infection. It is sexually transmitted and can infect the cervix, urethra, rectum, anus and throat. It is a curable STD, however if left untreated can cause serious health problems such as pelvic inflammatory disease (PID).

Estimated new cases of gonorrhoea infections (in million) in adults, 1995 and 1999

Region	1995			1999		
	Female	Male	Total	Female	Male	Total
North America	0.92	0.83	1.75	0.84	0.72	1.56
Western Europe	0.63	0.6	1.23	0.63	0.49	1.11
North America & Middle East	0.77	0.77	1.54	0.68	0.79	1.47
Eastern Europe & Central Asia	1.16	1.317	2.32	1.81	1.5	3.31
Sub-Saharan Africa	8.38	7.38	15.67	8.84	8.19	17.03
South & South East Asia	14.55	14.56	29.11	15.09	12.12	27.2
East Asia & Pacific	1.47	1.8	3.27	1.68	1.59	3.27
Australia & New Zealand	0.07	0.06	0.13	0.06	0.06	0.12
Latin America & Caribbean	3.67	3.045	7.12	4.01	3.26	7.27
Total	31.61	30.54	62.15	33.65	28.7	62.35

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Syphilis

Syphilis is a bacterial infection that is usually sexually transmitted, but may also be passed from an infected mother to her unborn child. Syphilis is a treatable STD.

Estimated new cases of syphilis (in million) among adults, 1995 and 1999

Region	1995			1999		
	Male	Female	Total	Male	Female	Total
North America	0.07	0.07	0.14	0.054	0.053	0.107
Western	0.10	0.10	0.20	0.0696	0.066	0.136
North America & Middle East	0.28	0.33	0.62	0.167	0.197	0.364
Eastern Europe & Central Asia	0.05	0.05	0.10	0.0530	0.052	0.105
Sub-Saharan Africa	1.56	1.97	3.53	1.683	2.144	3.828
South & South East Asia	2.66	3.13	5.79	1.851	2.187	4.038
East Asia & Pacific	0.26	0.30	0.56	0.112	0.132	0.244
Australia & New Zealand	0.01	0.01	0.01	0.0004	0.0004	0.0008
Latin America & Caribbean	0.56	0.70	1.26	1.294	1.634	2.928
Total	5.55	6.68	12.22	5.29	6.47	11.76