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Commentary on a Community-Based Approach to Reproductive Health Care.

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Introduction

Communities in the developing world face a number of obstacles to receiving Reproductive Health and Family Planning (RH/FP) services and HIV/AIDS information and care. People living in remote areas may have to travel long distances to reach health facilities. Transportation can be difficult to find and prohibitively expensive. Many have heard little or nothing about family planning, and women do not know that there are safe, effective ways of preventing and spacing pregnancies [1]. In many areas of the world a family's prestige is tied to the number of children they produce. Traditional values hold large families in high esteem and are seen as a source of prestige. Consequently, women are expected to marry early and have many children. Traditional methods of child spacing are often ineffective and may be dangerous for both mothers and their children. [2]

Life for women rural is exceedingly difficult. Most women work in fields and for the remaining 8 months, they survive by doing miscellaneous work for daily wages. A woman's average daily income is very low, which she spends on family survival needs. Communication and transportation are extremely poor. The social status of women is low. Dowry must be given for marriage and husbands commonly beat their wives. Superstitions and taboos about normal bodily functions abound. From menarche to menopause and even thereafter, a woman's reproductive health is of hale concern to the society [3]. The isolation and poverty of the district, along with the low status of women, contribute to a variety of reproductive health problems. The few health care services that exist focus on maternity care and family planning. Women in the district desperately need safe abortion services care for gynecological and sexually transmitted diseases, and sex and reproductive health education [4]. Unwanted pregnancies and clandestine abortion are major threats to women's health. A common reason for unwanted pregnancy is contraceptive failure. The government family planning program is implemented by health workers under tremendous pressure to meet "targets" of "acceptors." The result is that the quality of contraceptive care is inadequate. 'Failure of tubectomy or vasectomy operations, for example, is not uncommon [5]. Literature has reported that the husband of a woman had y vasectomy 4 years ago, but she conceived 1 year later and delivered a child. To avoid further pregnancies, she had a laparoscopic tubectomy, but again she conceived [6]. What are the consequences of such an unwanted pregnancy? Moreover, if the poor woman cannot face another birth, she must beg for an abortion at the door of

the same incompetent providers. Usually she receives a very unsympathetic response from the official health care personnel because no special payment is made for medical termination of pregnancy (MTP) and she is no longer eligible for sterilization incentive payments [7]. Women are often forced to seek an "illegal" abortion from unqualified persons, because safe services, though legal, are not available. The district headquarters town is the only place where diagnosis and treatment of unwanted pregnancy, gynecological diseases or obstructed labor can be provided. No female doctors are available outside of district headquarters and women simply do not want to consult male doctors for their gynecological or sexual problems. But women cannot easily travel to district headquarters as the district is 250 km long [8]. As a result, approximately 95% of births are attended by traditional birth attendants, if anyone, with severe consequences for the woman and the infant. The SEA approach to women's reproductive health care. How can one provide the necessary reproductive care to women in such a situation [9]. As the name implies, the aim of this study is to find the health problems of the people in rural areas and develop appropriate ways to cope with them. Our work on women's health includes four components: (i) Participatory research on women's reproductive health; (2) Participatory mass education on sexual, reproductive, and social issues; (3) Village-based women's health care services; (4) Referral services.

Participatory Research

The study involved a half-hour, in-depth interview about the woman's sexual and reproductive life, physical and pelvic examinations (a first experience for most of them), and various pathology investigations and minor operations like dilatation and curettage (D&C), cervical biopsy, or cauterization. Among 650 rural women in two villages aged 13 years and above, with or without gynecological symptoms, who were interviewed and examined, the mean age was 32.1 years and mean gravidity was 3.99. About 55% of women had one or more gynecological symptoms; 45% were asymptomatic. Ninety-two percent of the women suffered from one or more gynecological or sexual diseases and the average number of these diseases per woman was 3.6. Infections of the genital tract contributed to half of this morbidity. Forty-nine types of disease were observed, including menstrual disorders (dysmenorrhea, 58%; menorrhagia, 15%); psycho-sexual problems (frigidity, 12%; dyspareunia, 9%); infection (bacteriel vaginitis, 62%; candida vaginitis, 34%; pelvic inflammatory disease, 24%; trichomonas vaginitis, 14%; syphilis, 11%; cervical erosion, 46%; cervical dysplasia and metaplasia, 2%). Ninety-nine percent of the symptomatic women and 84% of the asymptomatic women had gynecological diseases. Unfortunately, diseases that do not kill, such as non-neoplastic gynecological diseases, are neglected. Their consequences include: difficulty in occupational and domestic work because of chronic backache caused by PID and cervical erosion (present in 30% of women): fetal wastage due to abortions, or stillbirths caused by syphilis or chronic PID (38% of women had bad obstetrical histories); neonatal infections from birth canal infections; anemia due to menorrhagia; marital disharmony due to sterility or sexual problems (9-12%); anxiety and stress. Only 7.8% of the women had ever had a gynecological examination m the past, even though 55% were aware or gynecological problems and 92% had disease. Obviously there is a large gap between need and care. Women blame contraceptives for preexisting gynecological disease (such as PID, cervicitis, vaginitis or menstrual disorders). Tubectomy or insertion of a Copper T can, of course, exacerbate pre-existing disease. In our study, 66% of the women who had undergone tubectomy blamed the operation for gynecological problems.

A very low prevalence of Copper T use (only 7 women had them) suggests its unpopularity, in spite of intense promotional efforts by the state government. Adolescent sex education and health care are clearly critical needs not yet met by government programs.

Implications for reproductive health education and services.

This demand resulted in a series of 3-day camps for village women and youth, and the formation of women's and youth groups in many village for further action on women's health and social problems. Such groups in 10 villages are practicing to stage their own plays. Men in many villages said that they realized that sexually transmitted diseases (STDs) were a major health problem for them, as well as their wives. They have demanded a studv of STDs in males organized like the earlier gynecological study. Mass signatures were collected in three villages in support of this demand. These demands suggest that even in a society where sexual and related matters are usually taboo, people can participate in research and action to improve their own reproductive health. High technology cannot solve such problems: awareness and community activity must be there, along with simplified and appropriate technology. Village-based women's reproductive health care A question repeatedly arose in women's meetings. "Where should we go for our gynecological problems? There are no female doctors and we cannot go to the district town for treatment of these problems." We have trained 30 village-based nurses in diagnosis and treatment of common gynecological problems, which together constitute 70% of the gynecological diseases in women, including bacterial, candida, and trichomonas vaginitis; PID, cervicitis; and dysmenorrhea. We are now also training traditional birth attendants to educate women on sexuality and reproduction; they are also learning simple treatments for vaginal discharge.

These female workers, though medically less qualified than male doctors, are closer to the women in the villages and hence are more acceptable. A baseline knowedge, attitude and practice (KAP) survey and symptom prevalence survey has been done; an evaluation will be done after 2 years to assess the impact. These village-based female workers also refer women to our clinic in the district town for problems of complicated pregnancy and delivery, abortion of unwanted pregnancy, gynecological diseases such a; sterility and tumors.

Reproductive care needs to be broadened beyond maternity care and family planning to include care for gynecological and sexual problems, safe abortion services, and sex and reproductive health education. Our epidemiologic study of rural women has shown a very high prevalence of gynecological diseases. We tried to develop a community based approach to comprehensive reproductive care by undertaking participatory research, fostering mass education with the people's involvement and by making care available through village-based female workers and improved referral services. We end with two appeals "MCH" needs to be replaced by WCH: not merely Maternal and child Health but Woman and Child Health. Care should be provided through a community-based participatory approach, not through narrow vertical programs.

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