

Commentary on a community-based approach to reproductive health care

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A sketch of life in the Gadchiroli District

Gadchiroli district (population 700,000) is situated in the central part of India and covered by dense forest. Life for women here is exceedingly difficult. For 4 months, most women work in rice fields and for the remaining 8 months, they survive by doing miscellaneous work for daily wages or by selling forest products. A woman's average daily income is US\$0.50, which she spends on family survival needs. Most of her husband's income, about US\$0.60—0.70 per day, is often spent primarily on alcohol. Only 11% of women are literate, compared to 27% of men. Communication and transportation are extremely poor and many areas are cut off for 4—6 months during the rainy season.

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. For example, women must stay in a separate hut in the village during their

menstrual periods. From menarche to menopause and even thereafter, a woman's reproductive health is of little concern to the society.

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.

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. The husband of a woman named Mirabai had a vasectomy 4 years ago, but Mirabai conceived 1 year later and delivered a child. To avoid further pregnancies, she had a laparoscopic tubectomy, but again she conceived.

What are the consequences of such an

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unwanted pregnancy? If it is a vasectomy failure, the efficacy of surgeon's knife is never questioned. Rather, the woman's fidelity is suspected and she, not the surgeon, is subjected to her husband's anger. 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.

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. 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 SEARCH approach to women's reproductive health care

How can one provide the necessary reproductive care to women in such a situation? To answer this and other questions, we created a voluntary institution called SEARCH. As the name implies, the aim of SEARCH is to study 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:

(1) 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 [1]

Women and men in two villages, Wasa and Amirza, showed great interest and initiative in organizing the study of gynecological diseases. A village teacher vacated his own house and made changes in it, including a small operating theatre, for the study. An inauguration festival was organized for which the whole village observed a holiday, and a community dinner was served. The village people, who include some graduates, understood the requirements of the study and that the findings would be used to design a plan of action to reduce women's diseases. Village leaders and volunteers mobilized all the women to participate. 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 Indian 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 (bacterial 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 (7%) or sexual problems (9–12%); anxiety and stress.

Only 7.8% of the women had ever had a gynecological examination in the past, even though 55% were aware of gynecological problems, and 92% had disease. Obviously there is a large gap between need and care.

Women blame contraceptives for pre-existing 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.

Forty-seven percent of the unmarried girls had experienced sexual intercourse, an unexpected finding in this traditional Hindu society. Adolescent sex education and health care are clearly critical needs not yet met by government programs.

What should one do with such stunning findings? Can they possibly benefit the women and men on whose lives this study was based? We decided to report the findings to

the people of the villages first, and to journals later on.

Participatory mass education

Based on discussions with women's groups in about 20 villages, a women's awakening and health "Jatra" (cultural fair or carnival) was organized. An intensive, 12-hour educational and cultural program, developed by local artists and the SEARCH team, moved from village to village, starting on 8 March, International Women's Day. It included:

- A picture exhibition describing the findings of the gynecological study and other issues of women's lives and social life. A team of women drawn from each village helped us explain it to the viewers.

- Slide shows for males on STDs and for females on the sexual and reproductive organs and functions, and various health and social issues in relation to these.

- Prizes for the three houses with beautiful and clean surroundings to focus attention on the importance of women's housekeeping work.

- Songs on women's lives.

- A play entitled "When the Husband Gets Pregnant" staged by the SEARCH team. In the play, the husband finds himself accidentally pregnant and goes through all the physical and social strains that women normally undergo. The play attracted huge crowds with continuous giggles, and women dragged their husbands to see the play. As the Jatra moved from one village to another, it became so popular that a member of the provincial parliament and political leader of the area approached us and said that he would like to play the role of the pregnant husband in the play. He calculated that he would attract women's votes in the coming election.

- Demonstration of the scientific principles behind many so-called "miracles" performed by village magicians who cheat and exploit women.

- A Keertan (a traditional musical form of religious discourse) on rural poverty.

The Jatra was staged in 11 villages and was attended by a total of 30,000 people. All the arrangements were made by the village groups. The youth group organized the stage for the show while the women's groups prepared food, helped explain the exhibitions, and even sang and danced in the cultural programs.

Implications for reproductive health education and services. Women and youth in various villages said they enjoyed the Jatra but they would like to know more about women's health issues. 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 villages for further action on women's health and social problems. Such groups in 10 villages are practicing to stage their own plays. A movement against men's alcoholism is emerging.

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 study 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. These nurses, for the first time in India, are providing gynecological care to women in 50 villages. 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 knowledge, attitude and practice (KAP) survey and symptom prevalence survey has been done; an evaluation will be done after 2 years to assess the impact.

Referral services

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 as sterility, and tumors.

Summary

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 technocratic vertical programs. Let people shape their own lives!

References

- 1 Complete details of this research and its results are reported in Bang RA et al: High prevalence of gynecological diseases in rural Indian women. *Lancet* *i*: 85, 1989.

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