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Reproductive Health Problems of Women in Rural Uttar Pradesh: Observations from a Community Survey

Bella .C. Patel & M. E. Khan

A major challenge under the new RCH approach is operationalising the paradigm shift to a comprehensive and integrated program into reality. The new approach needs to be gender-sensitive, dealing with all aspects of human sexuality with a life-cycle approach to address reproductive health (RH) needs of men and women. The present paper attempts to understand reproductive health problems of women in Agra district as well as provider's difficulties in addressing to those issues. Two sets of data from the rural areas of Agra district have been used in this paper: (a) Community survey; and (b) In-depth interviews with providers. 77 per cent of the ever-married eligible women in their reproductive age reported at least one symptom indicating reproductive health problem. Only 28 per cent of them had taken treatment or consulted a health provider; mostly had relied upon private medical practitioners. Majority of the ANMs reported that women contact them with problems of white discharge, menstrual cycle, infertility, prolapse, abortion and PID. The paper reveals that majority of the ANMs are not in the position to provide any help to the women suffering from various reproductive health problems except referring them to higher level of clinics.

Introduction

Following the Cairo Conference, significant changes in the Indian family welfare program have been taken place. The focus of the program has shifted from method-specific target approach for achieving demographic goals to reproductive health and individual need based approach. The Government of India has moved from rhetoric to action by adopting a Reproductive and Child Health (RCH) approach to strengthen and broaden the scope of the family welfare program. The major areas of concern in reproductive health are: maternal mortality and morbidity, safe motherhood and contraception,

reproductive tract infections (RTI) and sexually transmitted diseases (STD), abortion, and HIV/AIDS.

A reproductive health approach means that: people have the ability to reproduce and to regulate their fertility; women are able to undergo pregnancy and child birth safely; obstetric and gynecological disorders are addressed; the outcome of pregnancy is successful in terms of maternal and child health and their well-being; and couples are able to enjoy sexual relations free from the fear of pregnancy and of contracting disease Fathalla, 1988.

From April 1996, Government of India has decided to withdraw method-specific family planning targets from all over the country. Studies have highlighted the consequences of method specific family planning target approach, e.g., sterilization of anemic mothers or insertion of an IUD to women already suffering from RTI by poorly trained worker Khan, Patel and Gupta, 1994. Therefore, there was a need to shift from target approach to voluntary use of family planning, which requires better access, information and motivation among various other factors. The program itself needs major modification and change in ideology to improve the quality of services.

Now it is increasingly realized that there is a need of comprehensive and integrated approach to these inter-related problems. Operationalising the paradigm shift to translate the intergrated program into reality is a major challenge. This calls for the designing and implementing of a comprehensive package of good quality services to address reproductive health needs of people Pachauri, 1996. The new approach needs to be gender-sensitive, dealing with all aspects of human sexuality with a life cycle approach to address reproductive health needs of men and women. The prevention of HIV/AIDS infection by the sexual and perinatal modes is directly related to the activities of welfare program.

Several community studies based on women's self, reporting of symptoms as well as clinical and laboratory examinations indicate that a high proportion of women suffer from gynecological morbidities Bang and Bang, 1989. According to Bang study, 92 per cent of the women were suffering from one or the other gynecological or sexual diseases and not average, each woman was from 3.6 diseases. Center for Operations Research and Training (CORT) in its baseline survey covering more than 7,000 households in Bhopal, Sagar and Vidisha districts of Madhya Pradesh revealed that at least 42 per cent of the women reported suffering form one or the gynecological problems. Similarly, results

from our community based studies show that 65 to 84 per cent of the women interviewed reported one or more reproductive diseases. The leading morbidities at each site were menstrual problems (33 to 58 per cent) and lower abdominal pain (9 to 22 per cent) BCC, CINI, SEWA-Rural, Streehitakarini, 1995.

Several studies shows that women suffer from reproductive morbidities for a long time because of their 'culture of silence'. Many women believe that reproductive health problems - discharge or pain - are simply 'women's fate' and therefore, not a condition for which they should seek medical help. Moreover, they are reluctant to discuss their morbidities with their husbands or health provider. A recent from rural Gujarat shows that due to the reluctance and lack of husband-wife communication on such subjects, many times the husbands remain totally ignorant about the health status, of their wives Khan, et al, 1997. According to the study, 52 percent were aware about the prenatal care received by their wives during the last pregnancy, 63 percent about postnatal complications, and 50 percent were aware about the reproductive health problems with which their wives were suffering. Accuracy of the husband's response was measured by comparing responses of their wives. Thus, few women were seeking reproductive health services - unless the disease became serious or it started affecting their normal work.

Recently, particularly after ICPD Cairo Conference and Government's declaration for introduction of RCH, approach, there is a growing demand for information on reproductive health problems of women, their health care seeking behavior and possible interventions to make the health services more accessible to women. The present paper based on different sets of data attempts to answer some of these questions.

Objective of the Study

The specific issues dealt with in this paper are:

- What are the levels of gynecological mobidities self -reported by women in the community? What is their treatment seeking behavior? Where do women suffering from gynecological morbidities go for treatment, public or private sector?

- What role ANMs and LHVs, the public health care providers in the rural areas, play in treating women with reproductive health problems?

Data

Two, sets of data from the rural areas of areas of Agra district have been used in this paper: (a) Community survey; (b) In-depth interviews with providers. These data set have been collected as part of various research activities which Population Council carried out in Agra and Sitapur districts under ANE OR/TA Project funded by USAID (for details of these Operations Research, see UPDATE 1, UPDATE 2, and UPDATE 9(Population Council, 1996, 1997). The following paragraphs briefly describe each of the data set used in writing this paper.

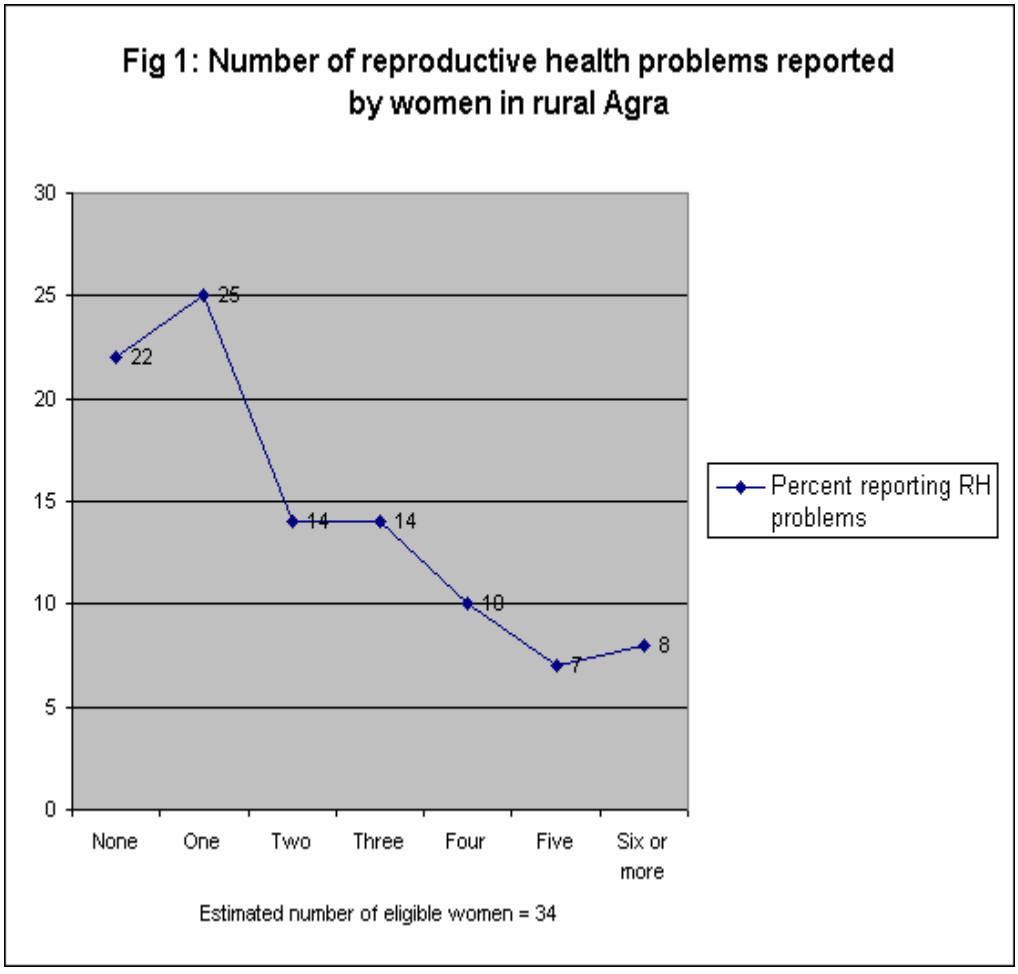
Community Survey: Before initiating the OR project, in both Agra Sitapur districts, a detailed survey was conducted. However, as information on reproductive health problem was collected in only Agra district, in the present paper from only Agra baseline survey has been used.

A total of 2,864 ever-married women between age 13 and 49 years from 2,474 households were interviewed for a baseline survey of family welfare program in the district of Agra. A multi-stage stratified systematic random sampling design was adopted to provide district level estimates of demographic parameters and contraceptive prevalence rate for the rural and urban areas. As the present paper is focussed on rural areas, data from only 1,790 eligible women interviewed in the rural areas has been used. Each of the ever-married women interviewed was asked a series of questions about symptoms associated with reproductive health morbidities and their treatment seeking behavior for the reported morbidity. A brief discussion on these findings is presented in the following paragraphs.

In-dept Interviews with Providers: A total of 62 ANMs from three block PHCs of Agra and five block PHCs of Sitapur were interviewed in detail for the various reproductive health services provided by them. These women represent about 26 percent of the total ANMs working in the study area. To interview the ANMs, a semi-structured interview schedule was used. Apart from this, most of them were also engaged in informal discussion during the various field visits and good volume of qualitative data was collected on the issues under investigation.

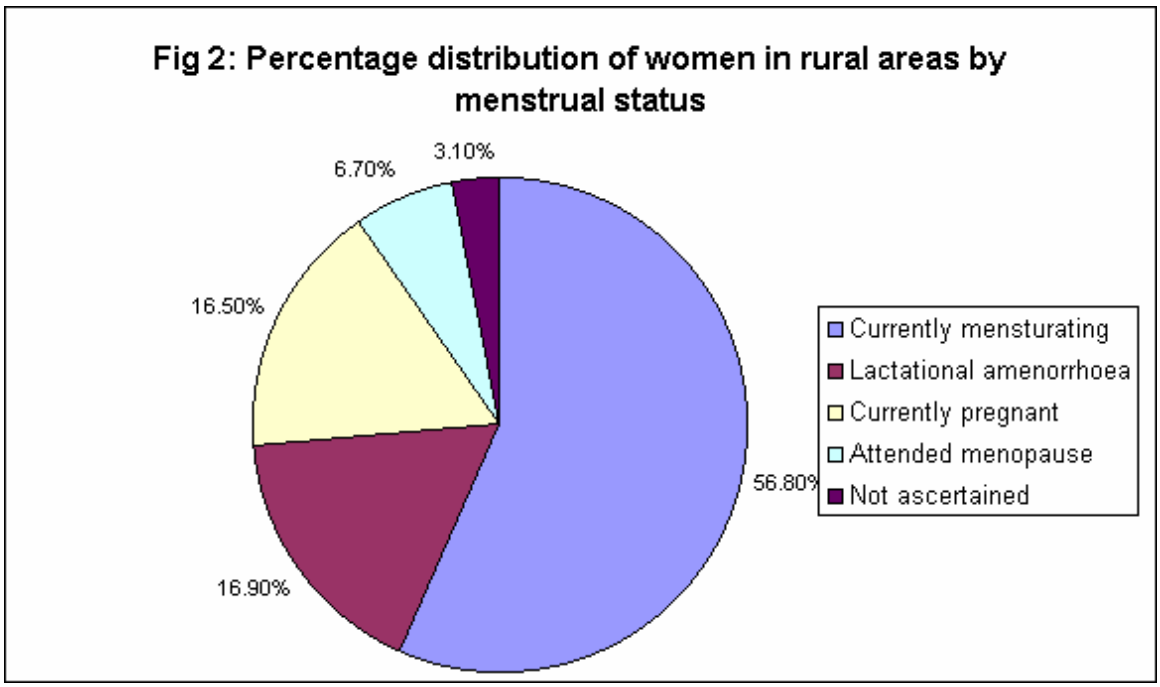
Findings from Community Survey

As high as three-fourth (78 per cent) of the ever married women aged 13 to 49 years, reported at least one symptom indicating reproductive health problem. Around 39 percent of them reported one or two symptoms while 24 per cent were suffering from three or four problems and another 15 per cent reported five or more symptoms indicating gynecological morbidities (Figure 1). Thought all reported symptoms do not necessarily indicate a disease yet the fact that so many women reported reproductive problems and several of them had multiple symptoms perhaps indicate a very high prevalence of reproductive health morbilities among women in rural areas of Agra district. Similar high prevalence of reproductive health problems was reported from other parts of Uttar Pradesh (CORT, 1997).



Menstrual problems: Of the total women interviewed, 57 per cent were currently menstruating, 17 per cent reported lactational amenorrhea, 16 per cent were

currently pregnant and 7 per cent had attended menopause (Figure 2). The menstrual status for the remaining 3 per cent was not ascertained.



Of the women currently menstruating 6.1 per cent reported having menstrual problems (3.5 per cent of the total eligible woman). Of those women reporting menstrual problems (estimated number, 11750), 33 per cent had excessive bleeding, 27 per cent had occasional (off and on) bleeding, and 20 per cent had continuous bleeding for 10 days or more. If we recalculate the percentages, considering all currently menstruating women as the base, the corresponding figures would be 2.0, 1.7 and 1.2 per cent respectively (Table 1).

Table 1: Types of menstrual reported by women in Rural Agra District

Menstrual problem	Of those women who reported		Percentage of those reporting morbidity			Total N
	Currently menstruating	Menstrual problem	Taken treatment	Source		
				Govt.	Pvt.	
Any types	6.1	100.0	48.9	3.7	45.2	11750

Excessive bleeding	2.0	33.4	54.1	5.3	48.8	3922
Occasional (off and on) bleeding	1.7	27.5	41.6	6.4	35.2	3233
Prolonged bleeding (> 10 days)	1.2	19.6	50.3	9.0	41.3	2307
Non-Specified bleeding problem	1.2	19.5	NA	NA	NA	2288
Estimated number of women	193601	11750				

Estimated number of eligible women in rural Agra = 340779

Specific reproductive health problems as reported by the women are discussed below.

On about half of the women, reporting menstrual problems had taken treatment. Treatment seeking behavior by types of menstrual problems revealed that a somewhat higher proportion (54 per cent) of women with excessive bleeding than those with occasional bleeding (42 percent) had sought treatment. The treatment was mostly sought from the private sources. Only around 4 percent of those who had menstrual problems sought treatment the public sector.

Further probing revealed that two-thirds of the women currently menstruating considered their blood flow during menstruation as moderate, while a third of them through it to be scanty. A typical reaction of the women reporting scanty bleeding during menstrual period was:

> "We hardly have blood in our body, so how do we bleed. If there is blood in our body, then there could be question of bleeding moderately or excessively."

Only 2 per cent reported their menstrual bleeding to be excessive. On an average, the mean duration between the menstrual cycle was 27 to 28 days ("2.66 days). The mean age at menopause was reported to be around 41 years.

Vaginal discharge: Table 2 presents responses of women suffer from vaginal discharge and their treatment seeking behavior. Out of the total women interviewed, 57 per cent reported suffering from excessive vaginal discharge. Probing on the specific nature of vaginal discharge revealed that the same woman was suffering from wore than one type of discharges. For instance, while more than half of the total estimated women (53 per cent) reported thin white water discharge, 34 per cent also reported thick curdy discharge on other occasions.

Table 2: Problems of vaginal discharge faced by women in their reproductive age (Rural Agra)

Nature of vaginal discharge	Percentage reporting suffering	Percentage of those suffering				Estimated number reporting suffering
		Undergone treatment	Source			
			Home	Govt.	Pvt.	
Excessive vaginal discharge	**57.0**	**37.8**	**1.4**	**4.1**	**32.3**	**194183**
Thin water discharge	53.0	37.2	1.6	4.3	31.3	180771
Thick curdy discharge	34.2	39.1	1.6	3.5	34.0	116535
Discharge with blood stain	4.8	40.6	1.1	3.5	36.0	16190
Foul smelling (those reported)	42.2	41.1	1.5	5.2	34.4	81881

* Based on the estimated number of eligible women in rural Agra = 340779.

Base is those who reported any vaginal discharge (N = 194183).

The survey also revealed that around 4.8 per cent had vaginal discharge with bloodstains. Further questioning revealed that 42 per cent of the women, who reported vaginal discharge, also reported that their discharge had foul smell.

The proportions who had sought any treatment ranged between 37 and 41 per cent. The study thus reveals that though a high proportion of the women were suffering from various kinds of vaginal discharges, only a small proportion

sought treatment. Again most of the women who sought any treatment depended on private sources.

Pre-vaginal itching: The analysis shows that one-fourth of the women had complained about itching around genitals and 43 per cent of them and sought treatment, mainly from private medical source (Table 3).

Table 3: Gynecological problems faced by women in their reproductive age Rural Agra

Women reporting gynecological problem	Percentage suffering *	Percentage of those suffering				Estimated number reporting suffering
		Undergone treatment	Source			
			Home	Govt.	Pvt.	
Itching around genitals	25.1	43.4	1.7	5.5	36.2	85474
Uterus prolapse	4.2	32.9	1.4	8.1	24.8	14157

* Based on the estimated number of eligible women in rural Agra = 340779.

Uterus prolapse: On asking women if they had experienced or noticed any mass coming through the vagina (prolapse), around 4.0 per cent answered in creative. One woman said,

> "I cannot carry heavy load on my head; otherwise, something comes out of my body. I have to put the part of the body again inside the uterus; otherwise, it pains while waking. Sometimes an ulcer (chandi) also appears on it."

However, it was surprising that only one-third of these women had sought treatment.

Micturition problems: Table 4 presents the various types of micturition problems faced by the women.

Table 4: Problems of micturition faced by women in their reproductive age (Rural Agra)

Type of urinary problem	Percentage suffering *	Percentage of those suffering				Estimated number reporting suffering
		Undergone treatment	Source			
			Home	Govt.	Pvt.	
Any urinary problem	**31.4**	**40.7**	**1.7**	**4.0**	**35.0**	**106978**
Burning sensation urine	26.1	42.0	1.4	4.5	36.1	88841
Increased frequency of urine	14.5	39.8	2.9	3.2	33.7	49426
Continuous leakage of urine	6.7	40.9	0.8	2.4	37.8	22921
Difficulty in controlling urine e.g. while coughing	8.4	45.2	1.9	4.6	38.7	28540

* Based on the estimated number of eligible women in rural Agra = 340779.

One out of three (31 percent) eligible women reported urinary problem(s). The various types of urinary problems included burning sensation while passing urine (26 per cent) indicating urinary infection, increased, frequency of urine (15 per cent), continuous leakage of urine (6.7 per cent) and difficulty in controlling urine for example, while coughing; laughing and sneezing, urinary incontinence (8.4 per cent).

Treatment seeking behavior by number of symptoms reported: Only around 28 per cent of those women who reported any gynecological morbilities and sought medical treatment (Table 5).

Table 5: Number of reproductive health problem reported and treatment taken in rural areas

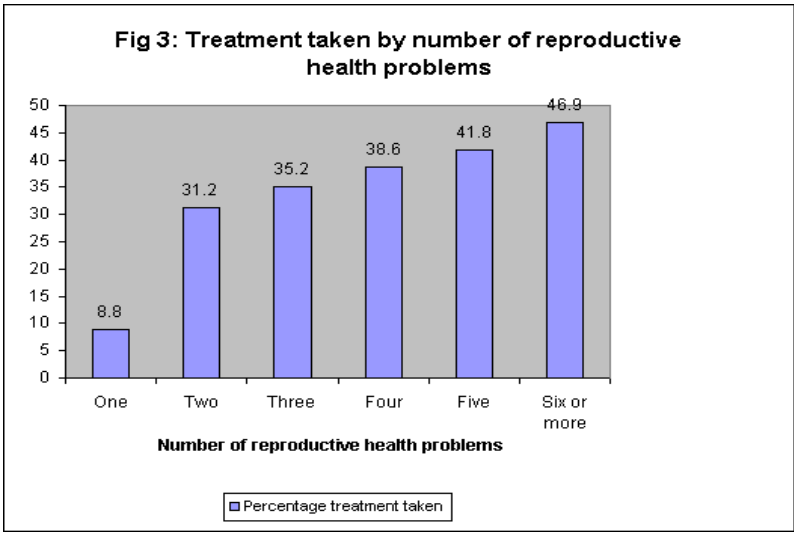
No. of RH problems reported	Percentage reporting problems	No. of those suffering	Percentage received treatment

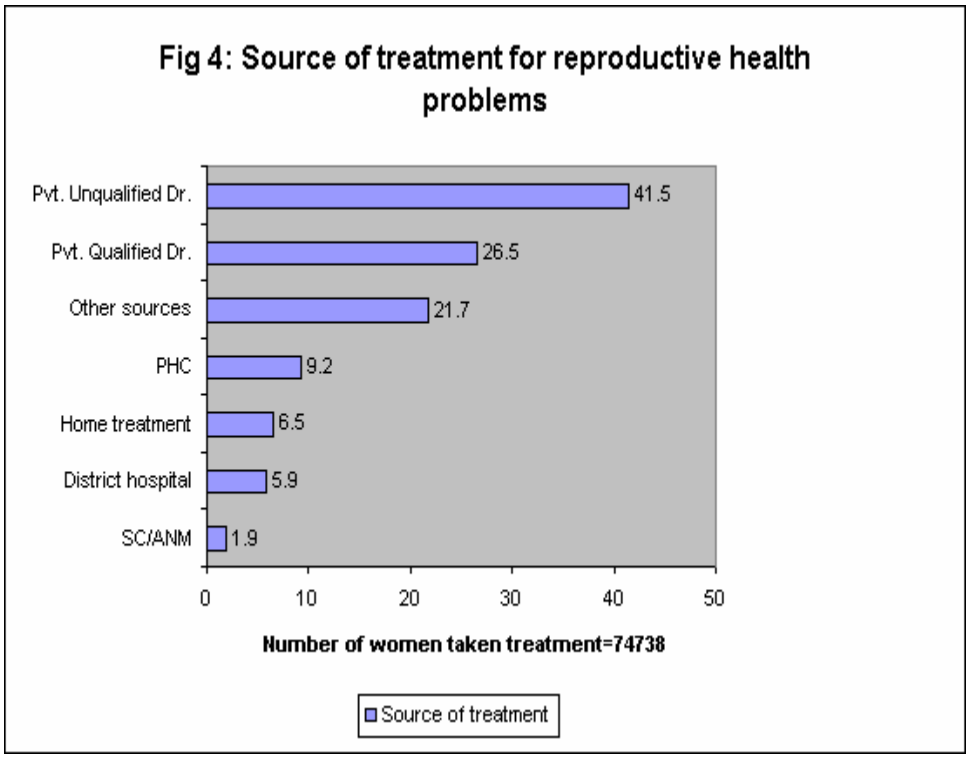
Any	**77.5**	**263970**	**28.3**
None	**22.5**	**76809**	**-**
One	24.6	83858	8.8
Two	13.8	46949	31.2
Three	14.4	49109	35.2
Four	10.0	33968	38.6
Five	7.0	23810	41.8
Six or more	7.7	26276	46.9
Total eligible women	340779		

Further analysis by number of reproductive health problems reported and treatment received shows that proportion of women receiving treatment was directly related with the number of reproductive health problems they were facing (Table 5). For instance, only around nine per cent of those reporting one problem had received medical treatment. The figure goes up to 31 per cent for those reporting two problems and then with increase in number of problems, the proportion of women receiving medical care also slowly increases (Figure 3). However, even with multiple symptoms (three or more) of reproductive health problems only between 35 and 47 per cent of the women received treatment. The remaining continued to suffer silently without receiving any treatment. The analysis thus reveals that only when women suffer seriously (measured by number of problems they suffer from), they tend to receive some medical care. Even in such cases, 50 percent or more do not get any treatment.

Source of Treatment for Gynecological Morbilities

As mentioned earlier, only around 28 per cent women suffering from gynecological morbidities had taken treatment or consulted a health provider. Majority (68 per cent) of those who sought treatment relied upon private medical practitioners in the village: 42 per cent unqualified and 26 per cent qualified. It, was followed by non-specified group (22 per cent) in others' category. Only around 11 per cent taken treatment from PHC or sub-center and 6 per cent form the district hospitals (Figure 4).





Further probing on location of sources revealed that 46 per cent had sought medical assistance from sources located in the same village while 59 per cent had traveled to nearby village, town or city for such assistance. They study also shows that only 55 per cent of those who had received medical services reported complete recovery or some improvement in the health status.

Poverty and high cost of treatment taken together constitute the most important reason for not seeking medical care. It was followed by the perception of the women that the problem is not serious. Many of those women had multiple problems. How far such perception is conditioned by the low self-esteem of women is not clear and hence need further investigation. However, some of the recent studies show that often women neglect their health and treatment because they believe these reproductive health problems as their fate (Patel, et al., 1992, Kapadia, 1997. In many cases, when and where women should get treatment is dependent on their family members and not on the women suffering from problems. This is particularly true in the case of young and old dependent women. In the present study also about 16 percent reported this reason.

The study clearly calls for more in-depth investigation on access and quality of reproductive health services. How many actions they take, and how frequently they visit the health providers to be cured and at what cost? What is the quality of services offered by the providers?

Table 6: Reasons for not taking any treatment for RH problems

Reasons *	**Percentage**
Have no money/poverty	30.4
Treatment is costly	10.4
Problem is not so serious	28.4
My own laziness/will take now	13.1
Family members do not feel it necessary	16.3
Do not get time	7.7
Lady doctor not available	2.4
Place of treatment is far off	1.9
Other reasons	35.9
Number of suffering women not taken treatment	**189232**

* Percentage adds to more than 100 due to multiple responses.

Provider's Role In Providing Reproductive Health Services

Each of the ANMs, with whom the discussions were held, said that women do come to them for help or guidance for treating a reproductive health problem. For each of the diseases mentioned by the ANMs for which women seek assistance from them, further probing was made to understand the terminology used to express the problem, frequency of such cases, symptoms and etiology and profile of the patients who come with the specified problem. Attempt was also made to understand the type of treatment or medicine provided by the ANMs, place of referral, follow-up and maintenance of records in the cases of reproductive health problems. The following paragraphs briefly describe the reproductive health services offered by the public sector health workers.

Majority of the ANMs reported that the common reproductive health problems with which women contact them are 'white discharge' (1 00 per cent), menstrual problems (98 per cent), infertility (95 per cent), irregular bleeding (89 per cent) and prolapse (79 per cent). Around two-thirds of the A.NMs also reported that women visit them to seek advice on foul smelling discharge and abortion (Table 7). While half of the ANMs said that they encounter with women who seek assistance for STDs.

White discharge: This is the most common problem reported among the rural women. Most of the women come to the ANM with 'safed pani ki shikayat' (complaints of 'white water discharge'). All the ANMs associated white water discharge with the medical term leucorrhoea. Usually, the ANMs get around 5 cases of white discharge each month. Around 70 per cent of the ANMs had 6 to 10 or more cases of white discharge during the three months period prior to the date of survey, while around 13 per cent had 1 or 2 and 18 per cent reported upto 5 cases during the same period.

ANM Saroj Sharma says

> "Women complain of weakness and say that in the beginning the vaginal discharge was 'patla aur safed' (thin and white/light) but later as the condition becomes worse the discharge becomes 'ghada aur kala' (thick and dark).

Amina Syed says,

> "Some patients complain of suffering from white water discharge as thick and white as choona (lime)."
>
> "I have white water discharge like rice water."
>
> "I have Dahi Jaisa (curd like) and sometimes badboodar mawad (foul smelling discharge)."

Some cases of leucorrhoea also had problems of foul smell and blood stained discharge or reddish discharge. Ratidevi of Rampur says,

> "Four to six of my cases have slightly red discharge once or twice a month."

Most of the women who come for treatment of the disease are young or middle aged married women of different parity. According to 60 per cent of the ANMs, fungal infection and unhygienic ways of life of the women were associated with leucorrhoea. An ANM, Anita Sharma explains,

> "Leucorrhoea mainly occurs because of fungal-infection. This fungus is usually found in the elementary tract but due to various-habitual practices and improper hygiene finds its way into the vagina resulting in leucorrhoea. I advise Metronidazole for its treatment."

Some (n=8) of the ANMs reported that they give calcium sandoz tablets and refer the case to the district hospital if the women complain of discharge with red (blood) stain.

Most commonly understood etiology of leucorrhoea among ANMs (except three) is infection in vagina because of use of dirty clothes during, menstrual cycle. The women are thus advised to use clean cloth during menses.

A couple of ANMs informed the researchers,

"Earlier leucocap capsules were provided by the government. These were very effective. Now we are no longer supplied with these capsules. Village women are also asking for these capsules, what can I do? All I do is prescribe them leucocap to be purchased from the market. Those who can afford may buy it."

Another around ten ANMs were giving Terramycin injection for the treatment of leucorrhoea and they found it very useful.

Equally good number of ANMs (around 40 per cent) felt that leucorrhoea is caused due to general nutritional deficiency. Therefore, they advised calcium and iron folic acid tablets to women suffering from white water discharge. According to Sushila Dwivedi,

"Causes of this problem 'safed pani/dhat' is deficiency of calcium and iron in the body. So I prescribe them calcium and IFA tablets and ask them to avoid taking oily and spicy food."

ANM Jasbir Kaur of SC Almora says,

"In the initial stage I give Iron and Osteo-calcium to women suffering from white water discharge, but if the problem continues, I refer them to the lady doctor at CHC."

ANM Madhu Sharma says,

"Safed Pani ki shikayat khoon ki kami se hoti hai" (complaint of white water discharge is due to lack of 'blood in the body). It can also be caused due to too much consumption of rice. Rice is starchy and white in color and too much of its consumption can really harm and lead to leucorrhoea (rice water discharge). So I tell my patients that it is better to avoid eating too much of the rice. I also advise them to take lots of green vegetables.

At least four ANMs associated leucorrhoca with breast feeding of older children (more than one year) by malnourished mother. In their words,

"There are many women who continue breast-feeding their children, but they themselves do not take milk adequately. This results in mobilization of calcium from the bones resulting in weakness and then leucorrhoea."

Menstrual Problems: Majority of the ANMs are approached for services related to menstrual problems ranging from heavy menses, scanty menses, prolonged menses period and absence of menses. Over a period of three months, about two-thirds (65 per cent) of the ANMs get upto 1 0 cases of menstrual problems. On an average, they get 10 to 11 cases of menstrual disorders in three months.

Some of the ANMs conduct pelvic examination to check for pelvic inflammatory disease. Most of the ANMs assume that the women are suffering from anemia and give them iron folic acid tablets or prescribe Ayurvedic preparations, like Ashokarisht. An ANM, Lila Mishra, says,

"Out of ten cases of irregular menses, eight suffer from anaemia which could be the cause of menstrual irregularities. These problems are all inter-related. I give them iron folic and vitamin A tablets and refer them to PPC."

She further adds,

"When women complain of experiencing excessive pain during menses, I advise them to take Ayurvedic tonic Ashokarisht and for hot water compress during cycles.

Some (5 per cent) ANMs did not know what caused menstrual irregularities while others associated it with use of dirty clothes during menses which causes infection.

For instance, ANM Ramvati explains,

"Women in the villages do not understand how important cleanliness is. They use dirty clothes during menses. Moreover, there are no toilets so they go to open fields for defecation and catch infection. I do not give any treatment. I simply advise them for maintaining cleanliness and refer them to LHV."

Another ANM Sitadevi explains,

"In all such cases, I prescribe Ashokarisht (Ayurvedic medicine) and tell them that if they do not get relieved they should consult a female doctor at CHC, district hospital or a private clinic, whenever convenient to them."

If women complain of absence of menses, nearly all the ANMs reported that they conduct PV examination to check for pregnancy and advise accordingly. During the field visits, however, it was observed that PV examination was not done for any such cases. In a new PHC, a young woman with one-year old daughter, her third child, came to the ANM and explained.

> "I had not menstruated for last two months (Do machine se mahwari nahi hai). Kindly check me and if I am pregnant, my husband wants me to get it aborted (safai kara lo)."

The ANM Malti Gupta, made her lie down on a thin bench for check-up, pressed her abdomen with palm of her hands, then she gently pressed with her fingers. She did not do PV check up (she has complained earlier about no room and privacy issue) nor pregnancy test was recommended. She said,

> "There is no sign of pregnancy. However, you come after 15 days for another check-up so that I can better make out if you are pregnant and decide if abortion is necessary.

In another case of a lactating mother of one-year old son, who had not menstruated for last three months, the ANM said,

> "You are suffering from anaemia. There is no blood in the body, how can you have menses? Moreover, Saal bhar ka bachha hai, aur abhi bhi doodh peeta hai (one year child is still breast-feeding) so there is less chances of getting pregnant.

ANM looked irritated while doing abdominal check up. No PV examination was done when she said

"Not having period does not always lead to pregnancy. Do you have blood at all?"

Turning to the researcher, she said,

"Can you make out anything, I can't feel ante lump."

We also observed that some ANMs associated menstrual irregularities with the use of oral pills and IUD. If an acceptor of oral pills or IUD complained of irregular menses, she was immediately asked to stop the use of FP method.

Sunita came with her husband Sushil Kumar from a village 5 kms away from the PHC. She said,

"I had my menses cycle over just 10 days back and today I am bleeding again."

ANM probed: Are you taking oral pills?"

Sunita: "Yes."

ANM: "Did you purchase the pills front the market or did you take them from me?"

Sunita: "Market se aadmi ne kharida thaa (At, husband had purchased them from the market)."

ANM: "Did you check the date of expiry, before consuming the pills?"

Sunita: "No."

ANM: "Are you still bleeding?"

Sunita: "Yes."

The ANM then talked with the male doctor and doctor gave her antibiotics to be consumed three times a day, ANM then said,

> "Stop taking oral pills and come for IUD insertion once the bleeding stops."

Prolapse of the uterus: Being approached by the women with prolapse of the uterus was reported by 79 per cent of the ANMs (49 out of 62). However, frequency of women with such problems approaching the ANM was very less: around 2-3 cases in 3 months (Table 7). It generally occurs to women who have had many (5 or more) deliveries assisted by untrained personnel.

Table 7: Common reproductive health problems with which women contact the ANMs (N=62)

	Percent of ANMs approached	**Frequency during past 3 months**							**Average frequency in 3 months**
		0	**1-2**	**3-5**	**6-10**	**11-20**	**21-30**	**31+**	
White discharge	100.0	--	12.9	17.7	12.9	35.5	6.5	14.5	14.4
Menstrual problem	98.4	4.8	17.7	25.8	22.6	12.9	8.1	8.1	10.8
Infertility	95.2	6.5	30.6	32.3	19.3	6.5	4.8	5.4	5.4
Irregular bleeding	88.7	12.9	17.7	21.0	24.2	11.3	4.8	8.1	8.9
Prolapse	79.0	25.8	38.7	24.2	11.3	--	--	--	2.4
Abortion	69.4	43.5	14.5	22.6	11.3	6.5	--	1.6	3.8
Foul smelling									
Discharge	62.9	41.9	22.6	25.8	6.5	--	1.6	1.6	3.2
STD	48.4	53.3	17.7	12.9	6.5	--	4.8	4.8	4.0
PID	22.6	79.0	14.5	6.5	--	--	--	--	2.1
Others	14.5	85.5	8.1	4.8	1.6	--	--	--	0.5

ANM Surjit Kaur of Jaspur SC says,

> "Very few women come with this problem. There will be one such case in 3 to 4 months. The women complain 'Bachchedani neeche khisak aayee hai' (uterus has come out of the body)."

ANM, with a gesture showing four fingers of the hand, says, women explain, 'this much part of the body comes out of the uterus.'

Another ANM says,

> "People complain that when she sits or lifts heavy weight she can feel something coming out of her vagina and touching her petti-coat."

The ANMs associated it with no rest and poor nutrition during pregnancy. Says another ANM,

> "She does all her duties and domestic chores throughout her period of pregnancy. They fetch water from the well, wash clothes, etc. This results in prolapse of the uterus in later life. Besides, wrong massaging practices during delivery by untrained dai also causes this problem."

Pelvic Inflammatory Disease

Usually pelvic inflammatory disease (PID) is presented as pain in the lower back or abdomen, fever and swelling in the uterus. Of all the 62 ANMs interviewed, only 14 reported this problem and said that they get 1 or 2 cases of PID in three months. The ANM says,

"As the name PID suggests, this problem is caused by infection due to formation of pus in the body. This is due to bad hygienic practices like use of dirty clothes during menses. Women suffering from such problems complain of pus, fever and foul smelling discharge. 'Bukhar hai aur mahine ke raaste se badboodar mawad aa raha hai' (I have fever and am having foul smelling pus discharge from vagina).

The ANMs usually do not give any treatment to the women complaining of fever and infection. They refer them to CHC, PPC or district hospitals. ANM, Shila Kumari, says,

> "I wear gloves and do internal check-up. If the PV is painful there may be swelling in the uterus. I give the patient a course of Brufen or Tetracycline, whatever is available at the center. If it is not available, I prescribe it from the market. Sometimes, I also prescribe injection 'Placentrex' for treatment and refer the patient to a lady doctor. This is allopathic medicine made from extracts of different placenta and should be given in case of PID. It has no side-effects."

Another ANM of Deoria PHC says,

> "Some of the women came with the problem of severe vaginal itching. I give them iodine injection. It causes fever but relieves the women from vaginal itching and pain."

However, most of the ANMs replied like Kamla Trivedi,

> "I do not know what causes it and I do not do PV examination. I only refer all my cases to the lady doctor or PHC doctor."

Laxmidevi of Tikamgarh says,

> "I refer them to lady doctor at the PPC. I do not give any medicine to such women, in case the medicine does not suit the patient or led to any complications, I would be blamed for it."

At times the ANMs at the PHC discuss the medical history of the patient with the PHC doctor and he gives/prescribes her the required medicine but more often refer them to CHC or DH. Thus, nearly all the PID cases are referred to the attached PHC. CHC or district hospital and at times to private lady doctors also. At PHCs the patients are only advised and referred, not examined by the PHC doctor. No female patient is examined by the male doctor.

Infertility

Majority (59 out of 62; 95.2 per cent) of the ANMs reported encountering with women facing problem of infertility but they could not specify the number they receive in a month. However, over a period of three months, they roughly get 5-6 cases of infertility. It is difficult for them to say how many would be old or new cases.

ANM from Sirsa SC says,

> "Not many cases of infertility are received. One or two cases come in 2-3 months. If they are weak and anaemic, I give them vitamin A and Vitamin D. Often women do conceive after taking vitamin tablets regularly. If they still do not conceive and come again, I refer them to the district hospital."

ANM Rati Devi of SC Siwam says,

> "If women do not become pregnant within two years of marriage, they come to us saying 'humko bachcha nahi ho raha' (I am not able to bear children). For such cases of infertility, I suggest both husband and wife to go to district hospital and consult with the doctor."

In one of the PHCs, the lab. technician does the semen analysis to check for the semen count in males. In case the count is within normal limits, the ANM/doctor infers that the female partner needs check up and refers the wife to the, district hospital. However, at no other PHC such pathological tests were carried out for infertility.

Abortion

Women come to ANMs (43 out of 62; 69 per cent) when they have delay of two or more months for their menstrual cycle. Most of the women though do not exactly remember their date of last menstrual period, they start getting worried when the delay is unusual and then they start recollecting their date of last menstrual period by the local events/festivals or calendar. They then rush to the ANMs who hardly have any inclination to do a thorough check-up. The ANMs just do abdominal examination and mostly ask the women to wait for a couple of weeks before deciding to undergo abortion. Therefore, some of the delays in

getting unwanted pregnancy aborted are due to ANMs themselves. The ANMs put forth two arguments for this: first, this type of menstrual irregularity is due to the women being anaemic, and second, that these women are mostly lactating and/or malnourished and hence 'do not have anything in the body to menstruate'.

ANM, Shailaja, complains,

> "These women neither want a child nor do they want to adopt a contraceptive method. The only thing they want is safai (abortion) when they get pregnant."

All the cases of suspected pregnancy, if they want to undergo abortion are referred to CHC or district hospital. In a way, these cases are of special interest to the ANMs because according to government norm they have to adopt a family planning method after undergoing abortion, more specifically sterilization or IUD. This helps them in getting a 'FP (target) case'.

Reproductive Health Problems Related to the Use of FP Methods

ANM Shantadevi of Manarwa PHC complains,

> "45 women out of 88 IUD users in my area got it removed in the first one or two months after insertion. They complained of irregular bleeding, leucorrhoea and backache."

This raises a serious question about use of IUD and reproductive health problems. For most of the ANMs, it was difficult to understand the vicious relationship whether the use of IUD caused reproductive health problem or whether the existing reproductive health problems caused IUD complications. They could not appreciate the fact that if IUD is not inserted with care it could cause pelvic infection. Investigating on readiness of the SC to provide RH service, it was noticed that 7 per cent of the ANMs in Agra and 40 per cent in Sitapur did not have IUD kits or very few had it in working condition (76 per cent in Agra and 44 per cent in Sitapur) Update 7. The ANMs seldom do PV examination to check for any existing RH problem. Even if the ANMs do PV examination, they do it without wearing gloves - adding another source of infection. The main reason was non-availability of gloves. Majority of the ANMs

confessed that even if they do PV examination, they are not trained to precisely detect the problem or treat the detected problem. For instance, ANM Urmila of Umargoan SC says,

"Even if I do PV examination, I can identify only pregnancy, wound or swelling. Further, in case I find some problems, I only refer the patient to PPC. I do not know what treatment or medicine should be given to them."

Another ANM says,

> "Some women who get IUD inserted complain of excessive bleeding, pain and waters, discharge."

AN M Rama Sharma at Malda SC says,

> "Some women come within a day or two of IUD insertion and complain of bodyache and watery discharge. Some of these women start crying and I have to remove the IUD for them. Sometimes, women themselves remove it."

Another ANM Leeladevi says,

> "Some patients experience bleeding 2-3 times a month, pain in the stomach and white water discharge after IUD insertion. Some complain of swelling and nausea."

LHV Sudha Sharma says,

> "Such cases of major complications after insertion of IUD have been demotivating and causes resistance both among the providers and beneficiaries. For instance, a woman had to be operated upon at the district hospital for IUD **'lost in her fallopian tube'**. This case spread a lot of fear even among the ANMs, which in turn severely affected their FP counseling regarding IUD insertion."

Problems Related to the Use of Oral Pills

Users of oral pills also complain of bleeding, dizziness, pain and vomiting. The ANMs neither perform any physical check up nor ask any questions before giving oral pills to women. The common response is,

> "Kya poochenge (what shall I ask)? I only ask if the woman is breast-feeding her child."

> "I do not do any check up before providing oral contraceptive pills. I do not even know if any check up is required."

During field visits, it was observed that the ANMs were either totally ignorant or lacked interest in FP counseling. Such ignorance leads to avoidable complications and discontinuation in most of the FP users.

Services Provided by the ANMs

Whenever approached for reproductive health services, 85 per cent of the ANMs reported that they advise the women to contact PHC, 32 per cent refer them to CHC or government hospital and 55 per cent to private doctors as well, depending on the type of problem and availability of doctor. The interviews with ANMs also revealed that 30 per cent of them would give or prescribe some medicines to the women seeking their help for reproductive health problems.

One of the ANMs while discussing the issue of treatment said.

> "I refer complicated cases of RH problems to the LHVs/doctors at PHC/CHC or district hospital depending on the availability of doctor."

Another ANM says,

> "During our training of one and half years, more stress is given only on FP, MCH and identification and management of high risk ante natal and natal cases. We are not taught about RH problems. So, I refer most of the women with gynecological problems to the PHC, CHC or private doctor."

LHVs also are not fully competent to handle RH morbidities. According to LHV Ram Devi.

> "We can guide and help them, look into their problems and even accompany them to the field in case they face problems in dealing with a family planning case, but otherwise we also have to refer cases to CHC or district hospital. We cannot give any medicine or treatment."

Further probing brought out that 13 ANMs out of 62 (21 per cent) had medicine with them to give to the women. The medicines which were mentioned include IFA tablets followed by osteocalcium, oral contraceptive pills, Paracetamol, Lariago, Septran, Metronidazole, Placentrex injection, Iodine injection, Brufen, Tetracycline, Ampetone, Regestron, Primolute-N, Contramexidol and Vitamin A (Table 8).

Table 8: Services provided by ANMs to women reporting gynaecological problems

Services provided	**Percentage**
Action taken by the ANMs	
Advise to contact PHC	85.5
Refer to CHC/GH	32.2
Refer to private doctor	54.8
Give/prescribe some medicines	30.6
Others	1.6
Percent of ANMs who have some medicine with them	21.0
Type of medicine prescribed/given	
IFA tablets	14.5
Osteocalcium/Calcium Sandoz	12.9
Tetramycine injection	16.1
Oral pills	4.8
Paracetamol	4.8
Lariago	4.8
Septran	4.8
Metronidazole	4.8
Placentrex injection	4.8
Iodine injection	4.8
Brufen	1.6

Tetracycline	1.6
Ampetone	1.6
Regestron	1.6
Primolute-N	1.6
Cotra Mexidol	1.6
Vitamin A	1.6

Thus, it is evident that a very high proportion of women seek services from ANMs for various reproductive health problems. However, ANMs are not trained to provide the RH services - be it check-up, diagnosis, prescribing medicine or referral. There seems to be a complete stage of confusion on how to handle such cases.

Discussions

The community study among eligible women, thus, reveals a very high incidence of self reported symptomatic problems indicating reproductive health morbidity. 77 per cent women reported at least one symptom indicating reproductive health morbidity. Only a few had the opportunity to seek treatment and use of government sectors for reproductive health service was very low. Unless the public sector is strengthened to provide such services, many reproductive health morbidities will remain untreated, leaving a large proportion of women (around 82 per cent) suffering from it as their 'fate'.

The treatment seeking behavior thus highlights serious bottlenecks in the existing reproductive health delivery system. Majority do not seek any medical assistance, even with multiple symptoms indicating reproductive health morbidity. Those who take treatment largely depend on unqualified village practitioners or non-specified group of health practitioners, and even after travelling long distance (at least once) only half of the cases are cured.

The ANMs and LHVs are not competent to provide reproductive health services to most of the women who contact them. In majority of the cases they refer the women to higher levels of clinic. However, as the results of community survey show, very few of them actually go to these referred clinics either because of poverty, distance or other social barriers. Half of them never get any treatment.

Ministry of Health and Family Welfare under its RCH program is committed to provide a package of reproductive health services through the existing health facility. However, given the organizational, managerial and resource limitations of the existing public health services, integration and actual delivery of the reproductive health services will be a major challenge. This points to an urgent need of operations research to develop and test different alternative strategies for strengthening reproductive health services in the existing system at all the levels (SC/PHC/CHC) in the most appropriate, culturally sensitive and cost effective way.

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