

# New Approach to Women's Health Care Means to an End?

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*Does the new concept of reproductive health care being currently promoted enthusiastically by the health establishment and the population lobby really incorporate the deep concerns of the women's movement? Will it mean that women will get a better deal in health care?*

THE long postponed acknowledgement that reproductive causes—consequences of pregnancy, childbirth, abortions, diseases of the reproductive tract—comprise a significant and growing proportion of all causes leading to illnesses and deaths among women all over the world, has prompted a restructuring of health and family planning programmes. This more holistic approach to women's health appears to recognise the wide-ranging criticism of the health and women's movements and ostensibly puts the woman at the centre of health concerns.

What is the reproductive health approach? According to a widely circulated Ford Foundation document, the approach "will focus on the social, economic, and cultural factors that influence reproductive health". Reproductive health is dependent on whether "people have the ability to reproduce as well as to regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relationships free of the fear of unwanted pregnancy and of contracting disease." In other words the definition encompasses "safe motherhood, family planning, child survival and development and control of sexually transmitted diseases. It [the approach] recognises that individuals do not perceive their health needs in isolated categories, but rather as part of the circumstances of their 'whole lives.'" The new strategy will involve the building of institutional capacity for multidisciplinary research with a special focus on reproductive health and the testing of "affordable and replicable models for reproductive health care". It will promote three objectives: develop a comprehensive socio-economic, legal and biomedical framework for reproductive health; empower women to better understand their own reproductive health needs; and to promote public dialogue and advance public awareness about reproductive health and population issues. This translates into supporting community-based activities on the issue, developing and encouraging women-centred models for reproductive health care

and supporting education on these rights. It will also promote specifically dialogue and coalition building with women's groups. Given this, special emphasis is being paid to generating a new kind of social science interest in health which will "draw on theories about poverty, ethnicity and gender and will require the development of new methodologies".<sup>1</sup> Reproductive health is now a catchword being used in policy and programme documents, a recent example being the discussion draft of the population policy.<sup>2</sup>

Does this concept of reproductive health care indeed incorporate the deep concerns of the women's movement? Will it mean a more sensitive response from the health establishment to women's problems? Does it at long last acknowledge that a woman is not merely a child bearing unit, but an **individual with needs and responses quite different from a man's? And will it effectively result in an improvement of women's health status?**

## THE CONTEXT

In one sense women have been at the centre of health concerns for a long time. It is hardly surprising that in a situation of high maternal and infant mortality, pregnancy was seen as being an condition where intervention could have a positive impact on the picture of mortality. This focus on saving children and therefore women who gave birth to children translated into special programmes. It is as mothers that women made their entry into health programmes and policies at the dawn of independence.<sup>3</sup> The new concept of reproductive health apparently shifts the focus of concern from mothers to women.

If global socio-politics of the 1950s had been dominated by the atomic bomb, by the 1960s the perceived threat to the survival of humanity was the 'population bomb', sparked by the fact that the population of the world had doubled in the decade. Even as it gave rise to the new discipline of demography, pharmaceutical companies launched a massive search for modern contraceptives. The target was, of course,

women: research focused almost entirely on women and some of the successful products of this period were the 'pill' and the intra-uterine device (IUD), both of which have gone through several developments since then. Since the main contributions to the 'population bomb' came from developing countries, the means to control or defuse the bomb, that is, persuading or pressuring people to limit the size of their families to suit the population needs of a country through a state-sponsored family planning programmes came to the third world riding the many aid programmes.<sup>4</sup>

India was among the earliest proponents and advocates of this approach and was one of the first countries to enunciate a government programme on family planning. By the mid-60s, the earlier clinic approach had given rise to the motivational strategy, that is mass education and the use of incentives and disincentives. However the failure of the programme, partly due to the methods then available and partly to the state's approach to the issue, two components were added: terminal methods, especially female sterilisation and the integration of maternal and child health.<sup>5</sup> Integrating the family planning programmes with MCH was to 'catch' women when they were most 'vulnerable' and the carrot was safe delivery of a healthy child. The idea, prompted by a specific recommendation from international agencies and 'encouraged' by the USAID, was taken up enthusiastically.

This strategy never took off—in the beginning because it was hospital-based and there were too few hospital deliveries. Later, because, the MCH component seen now only as a means to an end was given too little attention in terms of personnel and finance. But more importantly, even family planning services began to suffer since an element of coercion began to be associated with it. If one were to look more closely one would probably find that this integration was detrimental both to the MCH and to family planning programme. Thus the only component of the health programme specifically directed at women now became a component of a programme to limit family size. In other words, the notion that women needed special services only at and around pregnancy became more firmly entrenched in the state programmes.

By this time the threat of the population bomb had come to stay—the fear constantly promoted and projected was that third world countries, especially Asian nations, would by sheer weight of numbers begin to make their presence felt one way or the other. Also numbers were seen as a great detriment to development. This enabled funding agencies to widely promote family planning to the exclusion of other services, either in health or in other areas. For example, by

1979-80, the total external assistance to family planning comprised a quarter of the expenditure incurred on the programme. And by the end of the fifth plan expenditure on the programme had gone up from Rs 0.1 crore to a massive Rs 409 crore, an increase of 239 per cent.

What precisely did the family planning programme offer? Briefly, India had by now adopted the 'cafeteria' approach—with the choice of contraceptives ranging ostensibly from barrier methods such as cervical caps, etc, IUD and the pill to terminal methods. The only two methods available for men were condoms and vasectomies. Interestingly enough, the only successful method, going by number of acceptors, was tubectomies (except during the emergency period). As against 574,000 vasectomies performed in 1980-81, there were over 2,218,000 tubectomies and the proportion of women accepting other methods, such as the IUD and the pill was not only small but as a proportion of total acceptors either remained static or dipped.<sup>6</sup>

The MCH programme in the meanwhile had deteriorated to a service distributing pills and injections with occasional inputs of nutritional aids—for the child, and not for the mother. While the woman had long been replaced by the mother on the health scene, there was now a derecognition, in practice of even the maternal role, with an emphasis on the child. Maternal mortality rates continued to be high, with the programme making hardly an impact, and the two major causes of maternal deaths were anaemia which was rooted in the general low socio-economic and cultural status of women and sepsis reflecting the failure of the medical interventions in the programme.<sup>7</sup> Moreover, although the family planning programme with its huge inputs of resources was a vertical programme it had begun to eat into all other health programmes—resources allocated to other schemes were willy-nilly appropriated by the programme, personnel charged with multiple responsibility invariably neglected everything else and so on.

The pressures were beginning to tell and the breakdown of the programme had already begun. But there was scant recognition of this until the mid-80s. While certainly the rapidly multiplying population outstripped many developmental efforts, there was never a serious attempt to seek the roots of the problem—until almost too late. Moreover India's vast programme offered a good substratum for the testing of new contraceptive methods, the most important of these being the injectable contraceptive.<sup>8</sup>

Ironically enough it was this radically new method of birth control which initiated a coalescing of the various strands of the growing women's movement world-wide. And was perhaps the single crucial factor in the emergence of the new reproductive health strategy for the 1990s. To researchers, health planners and population control ad-

vocates, the injectable contraceptive, Depo Provera, was the logical progressive development after the pill. Here was a method which did not need to depend on the whims and fancies of women in order to be effective—once they had been persuaded to accept the injection, they could not have second thoughts about it and interfere with the process. And in the beginning, to thousands of women struggling to get out of the cycle of pregnancies, it must have seemed a boon. But the injectable also represented one more step towards taking away women's control over their bodies. Further, so eager were the researchers and drug companies to push this contraceptive that safety aspects were discovered to have been ignored. As problems surfaced, the women's movement which together with a progressive and vigorous health movement had gained strength as well as acumen to challenge the medical establishment began to question the testing and promotion of the contraceptives particularly on third world women. The cumulative effect of this was the public enquiry in the US on Depo Provera which shook the population 'pundits' who were confronted with a wealth of highly technical information put together by women's groups in association with sensitive health professionals. This in turn gave rise to a number of other movements elsewhere, for instance the movement in India for the banning of a harmful hormonal combination drug, which was routinely being misused for diagnosing pregnancy and the successful initiatives taken to stop the introduction of injectables into the programme.<sup>9</sup>

By the mid-80s it was also clear that the family planning strategy was going nowhere. Reviewing the programme in 1988-89, the Public Accounts Committee Report expressed concern about the fact that although couple protection rate had gone up from 22.5 per cent in 1977 to 34.9 per cent by March 1986, the birth rate had remained stationary at 33 per cent per thousand population since 1977. Moreover 77 per cent of the acceptors had used terminal methods with most of them having three or four children. This meant that the growing population of younger couples were unprotected and spacing methods currently available were not being accepted.<sup>10</sup> A study evaluating family planning and maternal and child health services in 398 PHCs in 199 districts in India in 1987-89 showed that not only were the quality of MCH services poor, but so were the family planning services. Only in the case of 12 per cent of the PHCs was the recommended pattern of one PHC: 30,000 population achieved.<sup>11</sup>

Yet another factor was that the maternal mortality rate had hardly registered a decrease and, worse, the largest proportion of maternal deaths was due to anaemia which cannot be tackled at the point of pregnancy and is a reflection of the social status of women. Nor had deaths associated with lack

of pre-, intra- and post-natal care shown a decrease to match the spread of infrastructural facilities. Further maternal mortality was only the tip of the huge iceberg of maternal morbidity which no one had any estimates about.<sup>12</sup> Among the desperate programmes of the late 80s was the Safe Motherhood Initiative, launched through the initiative of the World Bank and the WHO which continued to short-sightedly address the problem of motherhood and not of women.

Simultaneously, as a consequence of the women's movement's interests, a vast amount of data about female morbidity was being accumulated. For instance, the first ever epidemiological study of gynaecological illness of women undertaken a couple of years ago in Maharashtra revealed that 92 per cent of the women suffered from one or more gynaecological or sexual diseases and the average number of diseases per woman was 3.6. This was a first and shocking picture of morbidity which had never been acknowledged let alone tackled.<sup>13</sup> Similar studies elsewhere have brought to light the extent of undiagnosed and unattended reproductive tract infections, which have other implications.<sup>14</sup> A simultaneous motivating factor for determining the extent of RTIs, some of which were sexually transmitted was the new threat of AIDS. In the third world, with prostitutes being identified as the target group, there has been a tangentially an increasing interest in sexual mores and behaviour and the sexual needs of women.

Thus the three threads: the failure of the family planning programmes in the third world, the increasing awareness of women about their health needs, mobilisation of women's opinions and the articulation of their needs through the women's movement, its critique of sex biased policy and the demand that women be participants even at the programme planning stage and the apparent recognition of what is termed women's reproductive morbidity were woven together to evolve the reproductive health approach to women's health. It would appear then that the new approach is designed to suit the long-standing demands of the women's movement.

In the last couple of years all this has contributed to efforts by various agencies, including the WHO, the Ford Foundation and the World Bank to involve women in the designing of future programmes. While the WHO has systematically sought to organise meetings with women's groups especially in the third world, the Ford Foundation has facilitated the seminars, workshops and debates on the issue. Its mid-decade review in 1987 recommended that emphasis be placed on, among other things, enabling women to be more effective as health providers and advancing knowledge of the 'social and cultural context of health programmes'. It sought a women-centred, community-based approach to reproductive issues.

It is against this background that the possible impact of the new strategy must be assessed. The new approach is being promoted and strategies are being evolved with the specific goal of achieving population targets. Not only is this because of the specific global context in which the approach has evolved, but in the components of the programmes being promoted. To illustrate:

The basket of components being recommended by the World Bank are as follows: Services for girls aged 5 to 15 years—these will include sex education as well as monitoring of health and nutrition status; family planning—which will make available a wide choice of contraceptives and promote the idea that ‘family planning is essential for reproductive health’, maternity services and abortion services.<sup>15</sup> Pregnancy or rather ‘unwanted’ pregnancy is being posed as a major threat to women’s health.

In India this is being reflected in new policies and documents. In 1991, at a meeting sponsored by the International Women’s Health Coalition and the Rockefeller Foundation in Italy a team from the Indian Council of Medical Research proposed a comprehensive reproductive health policy and programme.<sup>16</sup> The proposal saw the need for a comprehensive approach for prevention and control of RTIs which included not only maternal health and family planning but services for gynaecological and sexual problems, safe abortion services and reproductive health education. The model of proposed services was aimed at ‘integrating prevention and management of RTIs within the MCH component’.

More recently, the discussion draft of the population policy which is currently under debate also incorporates the reproductive health component. Drawing attention to the poor quality of MCH services and the fact that the lack of requisite rapport between the health worker and the people which in turn has been detrimental to achieving low fertility, it suggests that programme activities need to be oriented and organised around the needs of people. It is in this context that reproductive health care for women ‘from menarche to menopause’ is recommended. Components listed are antenatal care, safe delivery, post-natal care, immunisation, use of ORT and treatment for acute respiratory infections, monitoring of nutritional status, ‘use of contraception and other required services for reproductive health’.<sup>17</sup>

Reproductive health is achievable only when reproductive illnesses or problems can be eliminated. So far as we have seen, this has included only pregnancy-related problems. Today it encompasses a range of gynaecological problems. Reproductive morbidity has been conceptualised and defined variously. Zurayk et al definition of reproductive morbidity in these terms for

their study in west Asia encompassed: ‘obstetric morbidity including conditions during pregnancy, delivery and the post-partum period; and gynaecological morbidity including conditions of the reproductive tract not associated with a pregnancy such as reproductive tract infections, cervical cell changes, prolapse and infertility. It also includes such conditions as urinary tract infections, anaemia, high blood pressure, obesity and syphilis.’<sup>18</sup>

Undoubtedly, these are important conditions which have received scant attention so far. RTIs are caused by a variety of bacteria, viruses and protozoa and usually originate in the lower tract as vaginitis and cervicitis and may result in abnormal white discharge, a burning feeling with urination, abnormal vaginal bleeding or genital pain or itching. Without treatment they may spread past the cervix to the upper tract and affect the uterus, fallopian tubes and ovaries. This affects the reproductive outcome: it may cause infertility, higher risk of tubal pregnancy, cervical cancer, chronic pelvic pain, and childbirth complications. Many sexually transmitted diseases manifest as RTIs, although not all RTIs are STDs. Chlamydia, a bacteria infection which can lead to infertility and the human papillomavirus which is the leading cause of cervical cancer account for 50 million and 30 million new cases per year respectively. In the Bang study infections constituted 50 per cent of the burden of gynaecological diseases.

RTIs are not a newly discovered group, although more work has gone into them over the past decade. Not surprisingly, the current focus on RTIs is not fortuitous. Among the major reasons for a revival of interest in these infections is the fact that some of these are reported to be linked to increased risk of HIV transmission. Interestingly, RTIs have been linked to IUDs and to hormonal contraceptives: early studies showed that IUDs increase women’s risk of RTIs by three to five times and oral contraceptives although they are marginally protective against PID predispose the user to candidiasis and increase the risk of chlamydia cervicitis.<sup>19</sup> However, a more recent international perspective suggests that the risk is substantially higher only in the first 20 days after insertion but does not in general increase risk with long-term usage *as long as* users have been selected for low risk of sexually transmissible disease.<sup>20</sup>

Certainly, female RTIs so long neglected need to be a focus on health interventions. And this is precisely why we need to critically evaluate programmes where the prevention and care of RTIs is being integrated into the MCH-FP programmes. The utter neglect of MCH in the context of FP targets is a lesson which cannot be forgotten. While the new agenda spells MCH differently, it comprises the same elements as the integrated MCH-FP package, which was also pushed through the safe motherhood initia-

tive. Motherhood is not a biological event—its psycho-social and physical context has never been acknowledged by the medical establishment and even less by the health planners. While there has been much talk about nutritional programmes for women, they have hardly made an impact because they comprise end-point interventions. A 1986 study on anaemias shows that India has probably the highest prevalence of nutritional anaemia. In that year 17 per cent of all deaths due to maternal causes were due to anaemia, the same as in 1981. In one study in Rajasthan, where the maternal mortality rate was 592 per 1,00,000 live births, there were some 60 episodes of illness associated with every death, and about 17.5 per cent were directly related to pregnancy and childbirth.<sup>21</sup> This is hardly the kind of record one would expect in a successful programme. And it is not surprising that maternal mortality figures are nowhere mentioned in the section on health in the Eighth Plan document.

The problem has always been that the MCH programmes are not taken seriously, but are simply taken as entry points for the family planning programme. And the very fact that the new strategy being promoted so self-consciously as a reproductive health strategy for women, once again views safe motherhood as a one-point programme, is indication enough of the real contents.

Another dimension of the new approach is that it ignores the fact that women suffer from diseases other than of the reproductive tract. In the Bang study women were found to have TB, suffer from malaria, iron deficiency anaemia and leprosy until then undiagnosed.<sup>22</sup> A women-oriented health care strategy would acknowledge the fact that women seek help for many of these diseases much later than men do and are less likely to continue treatment. Also infections like malaria impact on their nutritional status in a manner which adds to their debilitation especially when they bear children. Moreover there is very little data on the morbidity load women bear, because morbidity surveys, it is being pointed out now, may not have been designed to capture women’s morbidity.<sup>23</sup>

What is perhaps most disturbing is that this new approach to women’s health is being sought to be implemented through the involvement of women. The population policy discussion document, for instance, recommends that women and child development committees be set up at the panchayat level to prepare and monitor village level plans for integrated services. However, the articulation of demands at any level is not a non-confrontational process. It necessarily implies political action. Such a recommendation depoliticise the very process of mobilisation of women around issues about which the state or its agencies may be sensitive. The experience of the ‘sathin’ programme in Rajasthan which attempted

to sensitise and mobilise women with the help of state support has been none too encouraging. How do women's movements respond to all this?

Carmen Barroso, a Brazilian feminist in a paper presented at a seminar on maternal morbidity and mortality sought a way out of this coming dilemma. She suggests that among the criteria one must use to judge a programme the most important should be whether the redefinition of issues contributes to an increased decision-making power for women and secondly, whether this will help women move towards a transformation of all social relations.<sup>24</sup> Even so it is not going to be easy to evolve an alternative strategy, or even to understand how to cope with the establishment's new awareness of women's on reproductive health.

#### TOWARDS ALTERNATIVES

It is my contention that the only way to cope with this new bent is for progressive movements to understand the complexities of women's lives and to integrate this understanding into all aspects of critique and practice. For so long the health and women's movements have dealt with these issues piecemeal: when it is family planning, they have focused on the issue of available contraceptives or in critiquing particular new products; with MCH, they have noted the fact of the missing 'M' and gone on to discuss the inadequacies of the child care practices; in pharmaceuticals, it is only lately that women have made an appearance and that too in relation to contraceptive testing. We have talked about the burden women bear and yet have never integrated into the health care perspective how this burden translates into ill-health load when women suffer from TB, malaria or leprosy.

Second, we need to explore whether the biomedical model of the female is a limiting factor in understanding women's health and welfare concerns. As we pointed out before, the current concern about reproductive tract infections, for instance, stems from an increasing awareness, prompted by the women's health movement, that medical perceptions of women's bodies and their illnesses had prevented even the accumulation of information. This medical bias, so integrated into medicine through centuries of practice, has come in for increasing questioning.<sup>25</sup> And an alternative model which incorporates socio-cultural dimensions needs to be evolved, if women's health needs are to be met. This would, for instance, make a difference to say, how the medical establishment treats a woman with TB or malaria—while the technology for diagnosis or treatment may be the same, its application needs to be sex-sensitive.

Such an alternative model programme should take into account all our concerns and set it up against the reproductive health approach to women's health. Some of its components would be: (1) A radical restructuring

of the medicare structure putting women at the centre and sensitising health care workers including doctors to women's needs and critically evaluating current medical education practices and teaching. (2) Special services are indeed necessary for preventing and controlling RTIs. But these need not be either separate from health services delivered at the primary level.<sup>26</sup> A more sensitive response to gynaecological problems would go a long way in locating and diagnosing RTIs and also ensure that problems of women beyond the reproductive age are also diagnosed and treated. (3) Pregnancy and maternity services have to be revamped and strengthened putting the care of women at the centre of concerns. While child health is a major component and is inarguably critical, the 'M' has to be brought back into the scheme of things. (4) It is not enough to monitor nutritional and health status of children. There must be concomitant programmes which ensure that children can be taken care of when mothers (and fathers) are at work. (4) While a family planning programme, in terms of targets set, methods pushed, etc, may or may not be necessary, the availability of safe and effective contraceptives which women can handle must be ensured. Supportive and advisory services must also be available to those who want to plan families and also deal with problems such as infertility. Every support must be given to women to decide whether they want to bear children or how many and when. While this is the subject for a larger debate, it is unethical for the state to decide on how many children a couple must bear. (5) Women must certainly become the planners as well as the deliverers and receivers of care. But such participation is not possible with a top-down approach and enough room must be allowed to women to select their priorities and implement their plan.

These are of course only the broad elements of a new structure of health care. Much needs to be done before we can even begin to evolve an alternative strategy for women's health. A first step would be to undo the damage which has been caused with decades of neglect.

#### Notes

[This is a revised version of a discussion paper prepared for a meeting of the Medico Friend Circle at Sevagram in 1992.]

- 1 *Reproductive Health: A Strategy for the 1990s*, Ford Foundation, New York, June 1991.
- 2 'A Population Policy of India: A Draft for Facilitating Discussion', Department of Family Welfare, New Delhi, August 1993.
- 3 See Padma Prakash, 'Blind Spot in Health Policy' in *In Search of Our Bodies: A Feminist Look at Women, Health and Reproduction*, Shakti, 1987.
- 4 See for example, Margret Wolfson quoted in Manisha Gupte 'Population Control: For or Against People?', *Socialist Health Review* (SHR) 1:4, 1985.
- 5 There is today a large body of critical studies on the family planning programme in India.

Here I only want to trace how women have figured in the health and family welfare policies and programmes.

- 6 Padma Prakash, 'FP Programme: Women as 'Targets', Background paper for the Medico Friend Circle Meet on Family Planning, Jaipur.
- 7 *Maternal Mortality: A Global Handbook*, WHO, Geneva, 1991.
- 8 See Ramala Buxamusa, 'The Price of Assistance' and Kusha 'Contraceptive Research in India', *SHR*, 1:4, 1985.
- 9 Padma Prakash, 'Women and Health: Emerging Challenges', *Lokayan Bulletin*, 4:6, 1986.
- 10 *139th Report of the Public Accounts Committee (1988-89)*, Family Welfare Programme, Lok Sabha Secretariat, New Delhi, 1988.
- 11 *Evaluation of Quality of Family Welfare Services at Primary Health Centre Level*, ICMR Task Force Study, ICMR, 1991.
- 12 *Maternal Mortality: A Global Handbook*, op cit.
- 13 R A Bang et al, 'High Prevalence of Gynaecological Diseases in Rural Indian Women', *The Lancet*, January 14, 1989. The methodology which has been developed to capture women's reproductive morbidity may be termed a radical new approach. Some discussion of what this involves is available in Huda Zurayk et al, 'Concepts and Measures of Reproductive Morbidity', *Health Transition Review*, 3:1, 1993.
- 14 Jodi L Jacobson, *Women's Reproductive Health: The Silent Emergency*, Worldwatch Paper 102, June 1991.
- 15 F T Sai and J Nissim, 'The Need for a Reproductive Health Approach', *Journal of International Gynaecology and Obstetrics (Int J Gynecol Obstet)*, Supplement 3 (1989).
- 16 Usha K Luthra et al, 'Reproductive Tract Infections in India: The Need for Comprehensive Reproductive Health Policy and Programmes' in *Reproductive Tract Infections: Global Impact and Priorities for Women's Reproductive Health* edited by Adrienne Germain and others, Plenum Press, New York, 1992.
- 17 Population policy discussion paper, op cit.
- 18 Zurayk et al, op cit.
- 19 Ruth Dixon-Mueller and Judith Wasserheit, *The Culture of Silence: Reproductive Tract Infections among Women in the Third World*, International Women's Health Coalition, 1991.
- 20 T M M Farley et al, 'Intrauterine Devices and Pelvic Inflammatory Diseases: An International Perspective', *The Lancet*, March 28, 1992.
- 21 *Maternal Mortality: A Global Handbook*, op cit.
- 22 R A Bang, et al 1989, op cit.
- 23 At a recent meeting of women health activists and others organised by the WHO Regional Office in New Delhi, this gap in data and the possible reasons were touched upon.
- 24 *Women's Health Journal*, ISIS 1991.
- 25 An annual meet of the MFC in 1982 focused on this theme. Since then several contributions have been made towards a growing understanding of the sexist bias of medical science and practice.
- 26 Luthra et al recommend the strengthening of laboratory services at the PHC for better diagnosis of RTIs. R A Bang et al have reported a successful programme of training community level nurses to diagnose and treat gynaecological problems. See R Bang and A Bang, 'Commentary on a Community-Based Approach to Reproductive Health Care' *Int J Gynecol Obstet*, Supplement 3, 1989.