



## **Women's Health Problems in Pakistan**

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### **A Brief Background**

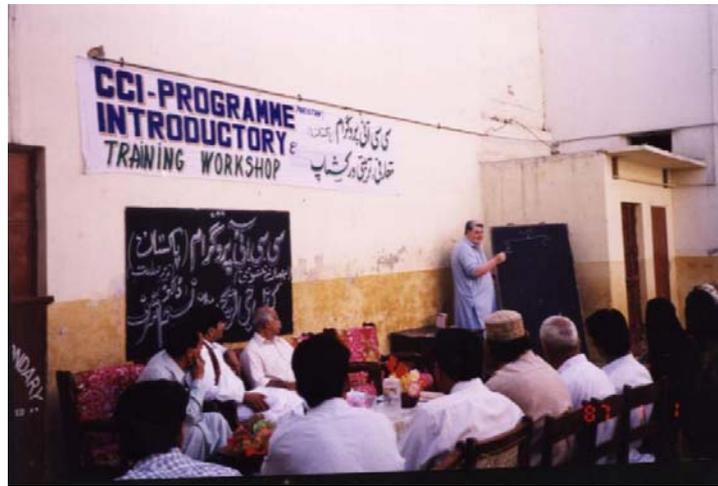
Ours is a male dominant society where only very few females enjoy full rights and have access to opportunities of even very basic human needs. This is even more true in the health sector, where unfortunately there is a great lack of female doctors combined with a large number of female 'quacks' in the country and the situation is at its worst in Shamsabad where there is only one or two qualified female doctors. The female doctors are neither easily available nor easily affordable and women do not prefer to be examined by male doctors.

There are a lot of government hospitals which provide free or low fee treatment to women but those are not preferred because of:

- The casual and offhand behaviour of doctors
- More than one male doctor examining the patient at one time
- The fear of crowds of medical students present at time of examination
- The fear that doctor may misuse this opportunity for some evil deed

Right from the beginning of my career, I have had very strong intentions to organize the primary health care system in my area and to make my clinic a model for others. Towards this end, I was very fortunate because I became involved with two very useful people, Dr Christopher Rose, PhD, Ex. Executive Director, Action in International Medicine (AIM),

London,UK and Dr Barry H. Smith, MD, PhD, Director of Dreyfus Health Foundation ( DHF ) , New York, USA. The two organizations were jointly operating a very famous Programme called CCI-Programme.



### *CCI Programme Training Workshop*

Dr Rose visited Pakistan twice, in 1998 and 1999, at my request. We had identified the Top Ten Health Problems of Shamsabad List during his last visit. Women's health problems were on the top of the list. (The term Women's Health Problems is strictly used to indicate only those health problems, which are specific to women).

Dr Christopher and I had decided to address these problems through the CCI-Approach, but this was not possible due to lack of funds because of the collapse of AIM. We did not receive any funds, from any organization.

I was left with three choices:

- a) Continue searching for the funds from other sources
- b) Quit the mission
- c) Continue the mission with my own personal resources at a very small scale through my clinic.

The first two were not possible for me due to many reasons, therefore, I decided to act on the third option and hence started to follow the PSBH1 - approach in my clinic.

Dr Barry H. Smith is an eminent neurosurgeon, development scientist and social work expert. Dr Christopher Rose is a renowned scientist, development & social work expert from Glangors, UK. Although the CCI-Programme does not exist anymore these two gentlemen are kind enough to consistently provide their moral support and guidance for our work.

Before starting the work, it was necessary to have some insight into the prevalence and magnitude of the most pressing health problems of women living in Shamsabad. Therefore, all the women attending my clinic for any reason were questioned about their (women's) health problems for one month and the following most pressing women's health problems were identified.

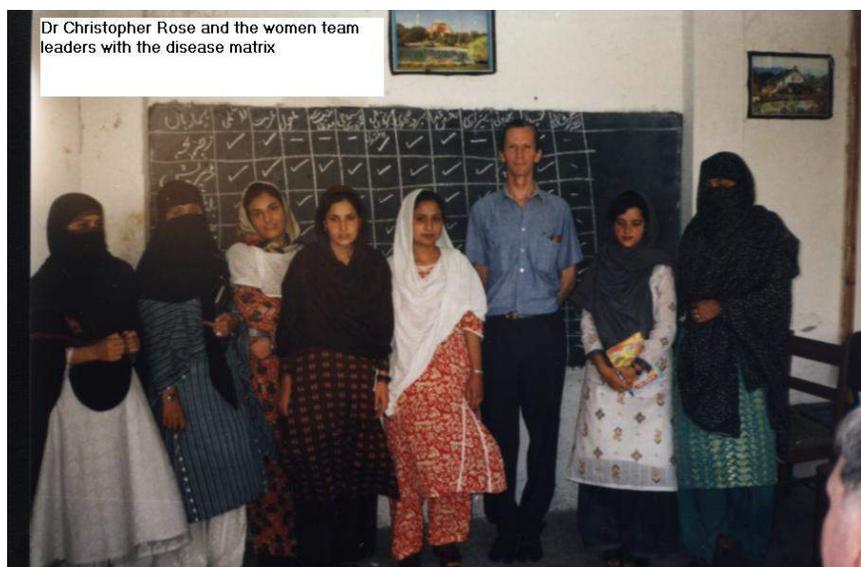
Later, some conclusions were drawn, from this data, in a very crowded free camp held in my clinic on the second Sunday of July, 2000.

The main problems were:

- 1) Vaginal discharge
- 2) Unwanted pregnancies in married women
- 3) Breast Problems
- 4) Malnutrition
- 5) Menstrual disorders

Strangely, only a few indicated the lack of facilities for Antenatal care and problems caused by childbirth by traditional birth attendants who are uneducated and lack training. To make the list more real and practical, the problems were re-numbered as follows:

- 1) Lack of facilities for antenatal care and childbirth
- 2) Vaginal discharge
- 3) Unwanted pregnancies in married women
- 4) Breast Problems
- 5) Malnutrition
- 6) Menstrual disorders



**Defining the Problem:** The women's health problems were discussed during different workshops in Shamsabad which were attended by cross section of the community and the following were identified as aggravating factors:

Lack of medical facilities,

Ignorance,

Lack of nutritional facilities,

Prevalent social environment,

Psychological factors,

Unemployment and Poverty

**How we are addressing the problems?**

### **The Logistics**

Maqbool clinic, a General Practice clinic, has been owned and operated by myself since 1986. It is situated in Shamsabad, Dhoke Kala Khan, Rawalpindi very close to Islamabad. The surrounding area is densely populated (approximately, some 100,000) where a number of Afghan and Pashtoon refugees of Afghanistan live among local mix urban, suburban and rural population.

Mrs. Rahila Manzoor (my wife) is a locally trained health technician who can perform vaginal examination and take HVS and Pap smears. She is playing a vital role in this work. The clinic always has at least one nurse capable of dealing with women. It was decided that Mrs. Rahila would first examine the patients and if she found something

requiring examination by a doctor, the patient would be given a choice to either have a pelvic examination by myself but if she refused, referral to hospital female doctor with a full personal reference from us. I had already trained and upgraded my skills in obstetrics and gynaecology via further training from friend Gynaecologists, and via the internet and audio-video aids. The necessary skills were then taught to Mrs. Rahila .It was decided that expenses for the women's health project would be met from income of our clinic's other routine activities and all income from this project would be utilized to add facilities for enhancement of our activities.

There was no pathology laboratory near my clinic. There was a great need for a laboratory that could provide quality results at low price for our "Women's Health Project", especially those essential during antenatal period. I was already doing blood sugar testing, urine sugar testing and pregnancy tests in my clinic from my own resources; but there was an immense need to initiate the following very important tests: Blood grouping, Haemoglobin Estimation, ESR, urine screening for sugar and albuminuria, urine routine examination, screenings for Hepatitis-B, Hepatitis-C and HIV/AIDS.

I had some savings from my clinic's income for this purpose. I used that money to buy the essentials. We have a part time laboratory technician. I had already refreshed my pathology knowledge and skills and undertook training in these tests. I have been performing these tests since 2002. I have kept the rates at a level which is affordable for all patients and I do these free for the very poor. I am using Standard Control Technique to prevent false results. Our patients have benefited not only via the affordable costs, but also get quality results without going very far. To keep it self sustainable, all income from the laboratory is being reinvested to buy the diagnostic reagents and material.

### **What was the main obstacle?**

The main obstacle was that no-one could imagine that women would have an examination by a GP who is operating a clinic right near their homes. The following were identified as restraining factors:

- \* The concern as to how they could face this person again
- \* What if my husband finds out?
- \* The fear that someone may peep in during examination
- \* The fear that the staff of clinic would disclose this information to my neighbours/relatives.

**Mrs Rahila Manzoor, the lady health technician, who is playing a vital role in project**



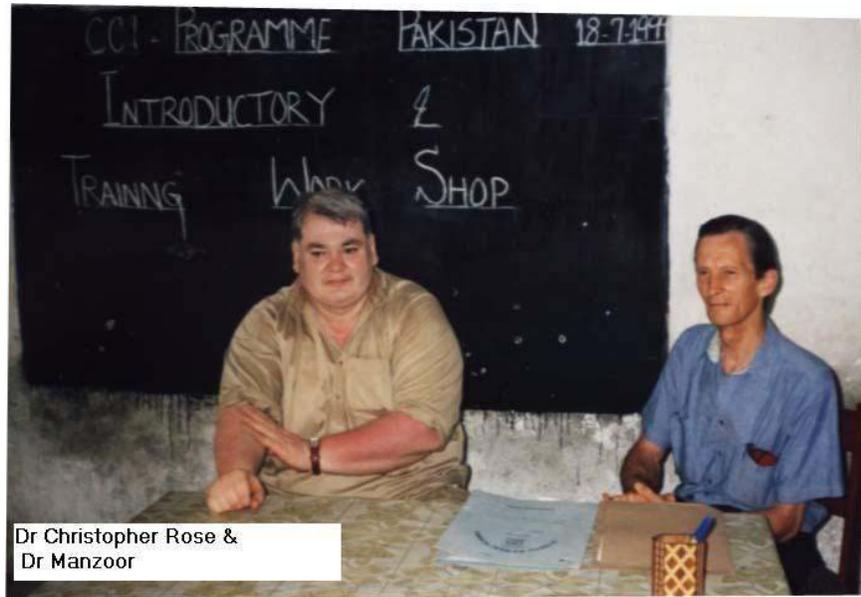
### **How we overcame these problems**

First of all, I established an all day help line (from 06am to 01 am) which provided free advice and guidance for medical and social problems of patients. I am proud to inform you that I have saved lives of many innocent girls who were at the point of committing suicide because of their social circumstances. My clinic is more of a social welfare office and we are available for everyone regardless of faith and religion.

I respect every patient, especially women. I always reassure our reluctant patients that having a physical examination is not a sin on their part nor any opportunity for me to do some evil. I inform them that a doctor is fully aware of the human body and when he examines private parts of a female, it is for benefit of women and not for satisfying his evil feelings. Right from the start, I referred to patients as relatives, such as sister, daughter, and aunt so that they should understand I do not have any evil feeling for them. To overcome other difficulties, we took the following steps:

- 1) The examination room of my clinic permits complete privacy

- 2) During examination, my wife or a female nurse is always present
- 3) Patient is allowed to bring in one of her relative or friend into examination room during check up, if she likes.
- 4) All information regarding a patient's examination and disease is kept fully confidential, even from the husband if the woman demands. If she is suffering from some serious problem, we always encourage her to take the husband into confidence.



To address the problem of lack of awareness among women about the importance of Antenatal care and complications of childbirth by non-qualified, non-trained midwives, the following question was formulated:

***Question***

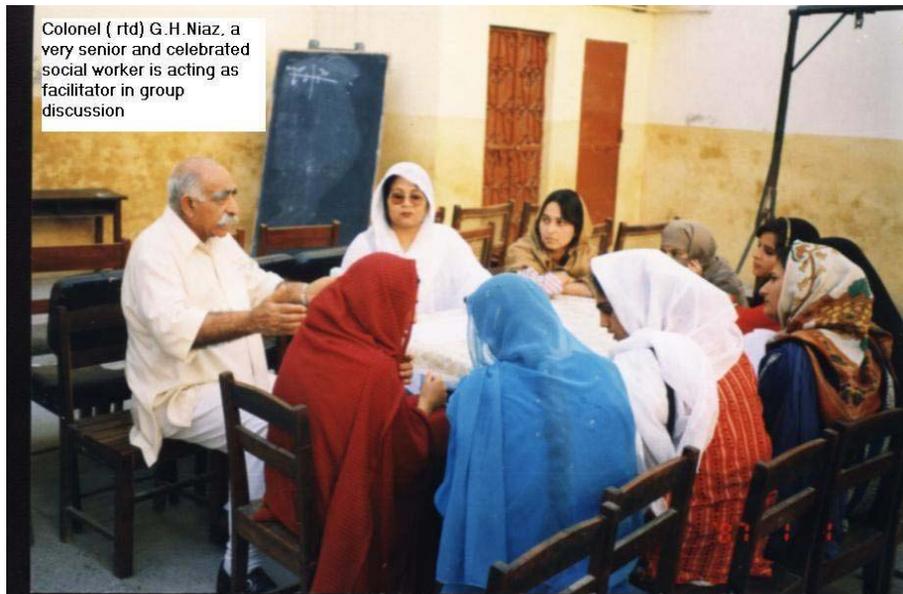
*Will a Programme of motivation and awareness about the importance of antenatal care and childbirth by a trained and qualified midwife/hospital staff whether at home or in hospital, organized at Maqbool Clinic, Dhoke Kala Khan by Dr Manzoor, Mrs. Raheela Manzoor, Miss Sobia , Miss Shabana & Miss Sajida (local volunteers) for one year, for pregnant women of Dhoke Kala Khan, create awareness at least in 30% of those attending the clinic?*

The activity was initiated formally on 01-05-2000. All pregnant women attending our clinic were informed about the presence of Antenatal centers in the city and they were encouraged to visit such free government centers for antenatal booking and delivery. They were informed about the importance of:

- (a) Diet during Pregnancy
- (b) Regular Blood pressure checkups

- (c) Regular weight measurements
- (d) Regular fundal height checkups
- (e) Hb % determination
- (f) Blood /Urine Sugar determination
- (g) Blood group determination
- (h) Determination of foetal well being through ultrasound examination
- (i) Immunisation against Tetanus and Hepatitis

During 2001, this activity was performed with about 700 women . The outcome was greater than expected. Many women now come to us for antenatal checkups. Their number is at least five times more than those who were coming to us previously.



It was realized that the following activities are urgently needed to augment this effort:

- a) More organised Antenatal checkup facilities including basic relevant tests at our clinic
- b) More advocacies for ultrasound examinations and hospital delivery
- c) The most important of all is the availability of resources for training of local midwives who are already popular among women.



We are already performing pregnancy tests, blood sugar measurements, and urine sugar /albumin measurements and immunization against tetanus.

To address the problem of vaginal discharge in married women, the following question was formulated:

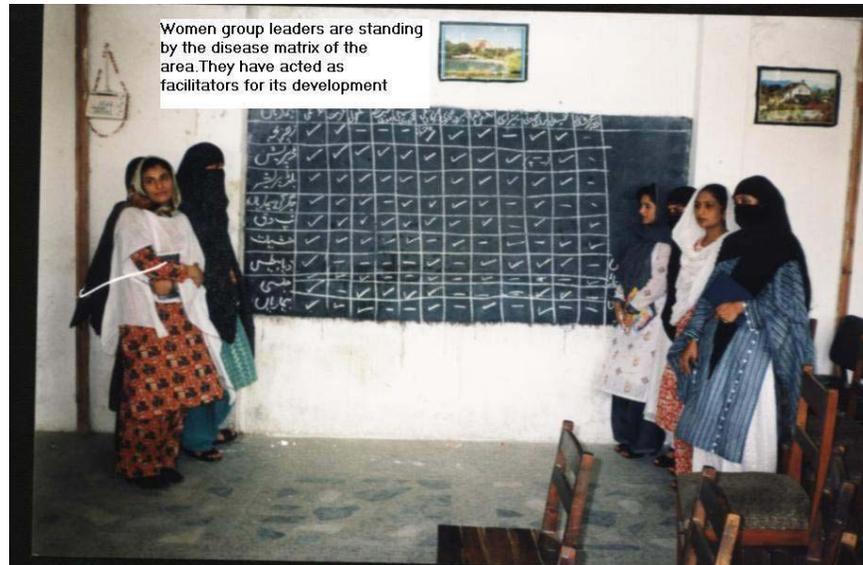
***Question***

*Will a Programme of "health education and affordable facilities of pelvic examination, HVS study, Pap Smear test, specific treatment of infections and, referral of difficult-to-treat cases to a gynaecologist" at Maqbool Clinic, Dhoke Kala Khan organized by Dr Manzoor, Mrs. Raheela Manzoor, Miss Sobia (clinic nurse), Miss Shabana & Miss Sajida (local volunteers) and other supporting persons/organizations for one year for women of Dhoke Kala Khan reduce the incidence of vaginal discharge by 25% in those coming for guidance and treatment?*

The activity formally started on 01-05-00. Although the clinic had been operating since 1986 the following had to be arranged from the clinic's own financial resources;

A gynae-examination table, examination lights, examination instruments especially vaginal speculums, sterilisation equipment, disposable plastic gloves, sterilised disposable gloves, sterilisable gloves, accessories for pap-test and HVS and regular supply of relevant medicines

During 2001, about 390 females came for examination. Out of these, 85 were virgins and 305 were married.



a) The virgins were only examined by naked eye and 35 out of these 85 were only having a watery discharge. These women were reassured and provided with advice for better personal hygiene; the other 50 were having monilia infection, confirmed by discharge. They were given advice and treatment.

b) Out of 305 married women, one patient complained of foul smelling discharge after birth. She came to the clinic on the 25th day postpartum. On examination, there was a hole in her posterior fornix and there was lot of pus and bloody discharge coming out of it. She was sent to hospital for admission but they sent her back. The next day, I used personal resources to get her admitted to the Gynaecology ward. She died there on the third day after admission.

- One patient was having VVF, she was referred to hospital for an operation.

- Thirteen patients were having third degree utero-vaginal prolapse with ulceration of the cervix. They were referred to hospital for care.

- Fifty seven patients had second degree utero-vaginal prolapse. They were also referred to hospital for care.

- Twenty patients were actually having stress incontinence, they were also guided to hospital.

- Ninety were only having uncomplicated monilial infection. They were given treatment and advice re better personal hygiene

c) The rest of the 123 women out of 305 had moderate to severe infections. They were advised for HVS. Only 25 agreed and were later treated according to the laboratory report. The rest of the 98 women were given treatment for two weeks; 70 responded very well to treatment and were followed up successfully.

d) Our real problem was the remaining 28 women who were having very severe pelvic infection and cervical ulcers. They were asked to have a Pap test. 15 did not come back, 2 went to hospital for this test with our reference, and 11 agreed to have a test at the clinic. The laboratory report indicated that two were having borderline dyskaryotic changes. They are being closely watched.

It was realized that there is a great need for health education regarding personal hygiene and sexually transmitted diseases (STDs). The following very important observations were recorded;

- Almost no women take a bath during menses (5 to 7 days)
- Almost no women take a bath before intercourse; they only bathe after intercourse and at least 4 to 6 hours after the act
- Most women use pieces of old bed sheets during menses as a sanitary pad; only a few use cotton and none were using sanitary pads.
- The majority of women do not wear suitable under clothes

To address the problem of unwanted pregnancies in married women, the following question was formulated:

***Question***

*Will a programme of "health education and affordable facilities for family planning for married women of Dhoke Kala Khan at Maqbool Clinic, organized by Dr Manzoor, Mrs. Raheela Manzoor, Miss Sobia, Miss Shabana & Miss Sajida and other supporting persons/organizations for one year reduce the incidence of unwanted pregnancies by 10% in married women?*

This activity was started at random in October of 1999 but we started to keep records formally from 01-05-00. It is actually a joint venture with the Government of our province, Punjab, and a very resourceful NGO called Green Star. The Government and the NGO provide us with very cheap supplies of family planning medicines and accessories and we in turn provide our non-profit service to the women of area. The NGO has also organised training workshop for us.

During 2001, about 275 women came to us for advice regarding family planning. All of these were briefed about available facilities and especially about "Emergency Family planning". About 55 never came back for advice or services. 25 preferred an IUD and were guided to nearby centres for insertion of the device as we do not yet have this facility. Out of the remaining, 30 selected condoms, 117 started injections with us and 48 preferred pills.

Unfortunately, only 15 out of 117 took regular injections at an interval of two months for one year. Only 10 out of 48 on pills came for a second month's dose because they were reluctant to take the pill daily.

This activity was more of a failure because;

- a) Women do not understand the importance of timing in the menstrual cycle
- b) They have a lot of misbeliefs regarding medicines
- c) Women do not have sex education knowledge
- d) There are a lot of 'quack' medicines available in the market, which claim effectiveness for one year if taken once a year.

There is a great need for health education, counseling and group discussions regarding this problem

To address the problems of Breast disorders, the following question was formulated:

***Question***

*Will a Programme of "health education and facilities for free training for Breast Self Examination (BSE)" and affordable Breast examination, by Dr Manzoor and Mrs. Raheela Manzoor at Maqbool Clinic, Dhoke Kala Khan for one year for women of Dhoke Kala Khan reduce the incidence of breast problems by 20%?*

The activities were formally started on 01-05-00 and till now only consist of examination by me or my wife as well as referral of problem cases to hospital. I trained my wife with the help of the Internet and via patient examinations.

During 2001, about 142 patients attended our clinic.

- a) Fifty five were lactating women with acute infection; 29 were referred to hospital for I & D, the rest were successfully treated with antibiotics and other supportive measures.
- b) Thirty were young girls who complained of strange things palpable in breast. Examination revealed no abnormality but normal glands. They were advised, reassured, and given supportive treatment
- c) 1 girl presented with sinus in the left breast following acute infection. She was also successfully treated and is now receiving follow-up treatment by us as well as a surgeon in hospital.
- d) 1 woman was eighty years old with a hard mass in breast. She was referred to hospital where carcinoma was diagnosed and the breast was removed. She comes to us for regular follow-up.

e) 4 were discovered to have a lump in the breast and were referred to hospital where biopsy had revealed benign tumor. These have been reassured and given supportive treatment and advice for frequent follow-ups.

f) One unmarried woman of 33 years C/O discharge from nipple. She was referred to hospital for biopsy which revealed nothing. We are following her up by taking a smear from the discharge and we get it examined by a Pathologist every six months.

g) The rest of the women did not have any abnormality. They are advised to do "Breast Self Examination" every month and come here for a check up after every six months.

The major problem in this sector is that women present very late because of their shyness and the only answer to it is training of Breast Self Examination. We have purchased a Pentium-111 multimedia computer from the clinic's own resources and we have begun this training in groups.

To address the problem of Malnutrition, the following question was formulated:

***Question***

*Will a Programme of " health education and facilities of affordable health supplement" at Maqbool Clinic, Dhoke Kala Khan organized Dr Manzoor, Mrs. Raheela Manzoor, Miss Sobia, Mr. Mumtaz (male nurse in the clinic), Miss Shabana & Miss Sajida (local volunteers) and other supporting persons/organizations for one year for child-bearing women of Dhoke Kala Khan reduce the incidence of anaemia and malnutrition by 20%?*

To address the very common problem of anaemia and malnutrition in women of childbearing age of Shamsabad, we joined the Vitalet Project for Better Health. The activity formally started on 28-11-00. I took training about nutrition supplements on 03-10-00 from a very resourceful NGO named Social Marketing Pakistan.

It mainly consists of health education and facilities of affordable health supplements, which comprise multi-vitamins, and essential micro and macro minerals product whose market price is an 80-Pakistani rupee for one-month course. We get the supply of this supplement from the NGO on a regular basis at the rate of eight rupee per pack and provide our every registered malnourished patient at rate of ten rupees for one month for the maximum of four months.

To generate more awareness about the importance of a balanced diet, we arranged a general meeting of 35 women with a nutrition expert from an NGO in our clinic on 24-03-01 and thereafter-another special meeting of 30 pregnant/lactating women with the same expert on 21-05-01 in our clinic.

During these meetings, the women showed a lot of interest in the topic and we intend to keep up these activities in future. During the year 2001, a total of 360 women and 5 men were provided this supplement. Out of 360, some more than two dozen women were identified as grossly malnourished. These needed more attention and extra effort. We

planned an initial three week diet programme for each of these which generally consisted of:

- Half a litre of milk daily at the clinic for 21-days
- Ten multi-vitamin injections/or infusions at the clinic on alternate days
- High energy candies daily at the clinic for 21-days
- High energy biscuits daily at the clinic for 21-days

Every patient attended our clinic very regularly and at the end of the three week course, each was provided with this health supplement free of charge for four subsequent months. All costs of milk, injections, infusions, disposable syringes, candies, biscuits and the health tablets was borne by the clinic. In addition, we provided about three hundred and fifty rupees each to two patients for laboratory investigations. One of our patients was a tailor and was unable to operate her hand driven machine. We provided her with a motor and all accessories to convert her machine to a motorised sewing machine.

### **Menstrual disorders**

A number of patients attend our clinic with menstrual problems. They can be divided into two main groups.

**Group-1** consists of girls aged between 12 to 25 and,

**Group-2** consists of women above 25.

In Group-1, most girls presented with dysmenorrhoea, amenorrhoea, oligomenorrhoea, and polymenorrhoea. These are provided reassurance, guidance and supportive treatment.

There is an increasing number of cases of young unmarried girls who present with generalized hirsutism accompanied with either amenorrhoea or oligomenorrhoea. Unfortunately, we are not capable of handling such cases because these require hormonal investigations and need an expert in hirsutism. Hirsutism is not only destroying their social lives but also inducing suicidal trends in these girls because they cannot afford very expensive laser therapy.

In Group-2, most of the women presented with dysmenorrhoea, amenorrhoea, oligomenorrhoea, and polymenorrhoea. These were provided reassurance, guidance and supportive treatment. There are certain patients who require hormonal assays, diagnostic D & C and other measures beyond the scope of this clinic. Therefore, at present we are only providing guidance to such patients.

## **Our results generally**

In the beginning only 5 % women consented for a pelvic examination by me.

Our efforts have seen gradual improvement. Most patients now prefer me to examine them and this includes the very rich women who can afford expensive treatment by women doctors, elsewhere. An important result is that now many husbands bring their wives to us and they convince their wives to get a check up. Most women have permission from their husbands or mothers in law.

Women have also seen that my attitude has not changed after examining them and now they bring their mothers, grandmothers and relatives and tell them that they have been examined by me. I always remember that I am a GP and not a gynaecologist, therefore, I do not hesitate to refer patients to hospitals or gynaecologists if I feel it necessary.

I am pleased to report that our women's health project is continuing quite successfully. I have performed more than seven hundred pelvic examinations on record since it began. Now I perform 2 to 3 pelvic examinations daily under strict hygienic conditions and about 1 to 2 breast examinations.

We have been able to generate awareness about many issues including health education and feminine personal hygiene (especially during menses and personal relationship with husband); general health issues; vaginal discharge and pelvic diseases; family planning both regular and emergency); sexually transmitted diseases; Breast examination; (especially the importance of early diagnosis of lumps) and antenatal, intranatal and postnatal care. A lot of work is still to be done but our pace is satisfactory, if not good.

We are also committed to help increase women's income.

I have introduced the concept of breast self examination in this community and there is increasing awareness about the importance of early detection and management of breast lumps. Towards this end, I have diagnosed five cases of carcinoma of breast during this year. I referred a real sister with one of these cases for prophylactic mammography which turned out to be another case of carcinoma at so small a size it could not be palpated. We always refer the suspected or high-risk patients to relevant government centres for further check ups and mammography or scinti-mammography.

Winners of embroidery competition held on 17/05/02 during women's week celebration



My greatest wish for the program is to provide organised training of female health workers, female health visitors, nurses, and other women health care providers who are licensed (e.g., homeopathic female doctors, traditional or eastern medicine health providers) to work, but lack adequate training and skills. It has always been my dream to initiate and establish an institution that could provide basic and recent training to health professionals, especially paramedics.

I have reduced my expenses, forgone all leisure pastimes and have not traveled overseas for the last eight years. I now have most of the required training materials. I have gradually purchased a computer, printer, scanner, and digital web camera entirely from my personal income. Towards this end, I have devised short courses for training and ways of examining candidates who complete training.

#### **What further help is needed?**

We are looking for collaboration with individuals and organizations that could be of help. We are trying our best to address women's health problems and some of its contributing factors. We intend to train a lot of female school teachers and married women in personal hygiene, safe motherhood, hazards of STDS and their prevention, and emergency family planning. The most important of all is the training of traditional birth attendants as most women here still prefer them.

Unfortunately, we are unable to do much to address the most aggravating factors, unemployment and poverty. We intend to help transform women's lives with all possible support including provision of small items of help in the form of paying off their bills for repairing of sewing machines, small accessories and motors for sewing machines and

small financial aid to start work. We also want to arrange healthy competition among female artisans to improve the level of their skills and to help them find suitable work.

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1 PSBH is a registered Programme of Dreyfus Health Foundation, New York, USA. To know more, visit: <http://www.dhfglobal.org>

**Editor's note:**

*Dr Manzoor Butt was awarded "Global Doctor of the Month" for August 2003, by Global Family Doctor - Wonca Online*