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DIARRHEAL DISEASE CONTROL AND FAMILY PLANNING: THE STATUS OF WOMEN AND COMMUNITY PARTICIPATION

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Turkey has had a successful immunization campaign and will now have campaigns for diarrheal disease control and family planning. As there has been considerable attention given to the providers of health services in these campaigns, I would like to discuss these services from the point of view of the users, especially the women and mothers.

How does the mother see immunization? We must convince her before we can do anything for her child. This means she must have information and she must trust us. How does the mother see diarrheal disease control? She has a sick baby and she must do something herself. How does the mother see family planning? Nobody is sick and she must do something that concerns the future. So in diarrheal disease control and family planning, unlike in immunization, the mother is the primary care giver, not the health worker.

How are the mothers doing? In Turkey, as in all countries, there are more infant deaths where the mothers are living in more deprived conditions. This is, at least in part, because the way the mother deals with her baby depends on her education, her social support, and so on the status of women in general. In Turkey there are wide variations in the status of women, in literacy rates, in levels of education, in socio-economic status.

Since infant mortality is highest in areas where women are most deprived, let us take a look at the conditions of mothers in that part of Turkey where more babies die: Eastern Anatolia. The low status of women in this region has been documented elsewhere and is perhaps best illustrated by the illiteracy rate of 70% for all women in Eastern Anatolia. A survey of over 2000 women of child bearing age from representative areas of Eastern Anatolia was carried out in 1985[1]. The survey found that in those areas where the oral rehydration packets had been recently distributed, 43% of the women had heard of this form of treatment for diarrhea in their infants while 57% had not heard of oral rehydration. Furthermore, of those who had heard of the treatment and had received oral rehydration packets, 55% had actually used the packets when their infant had diarrhea while 45% had not included oral rehydration in their management of their sick baby.

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How are the women of Eastern Anatolia doing concerning family planning? The survey showed that the literate group, 30% of the women, wanted, on the average, 3.5 children, half of them boys and half girls. The illiterate 70% of the women wanted, on the average, 4.6 children and there was a strong preference for boys. On the other hand the literate women in fact had 4 children while the illiterate women had 6 children. So both groups of women want fewer children than they actually have. Among the literate women, knowledge of the various family planning methods ranged from 40% to 66%. Among illiterate women the range was from 2% to 59%. How do the women of Eastern Anatolia accept family planning? 21% of the literate women are non-acceptors while 76% of the illiterate women do not accept family planning. The survey thus found insufficient levels of knowledge of family planning and high levels of non-acceptors of family planning, especially among the illiterate women.

The women of Eastern Anatolia are not doing very well with either diarrheal disease control or with family planning. But we must be careful not to blame the victims – the women. These women are not uncaring. They are burdened down with the enormous tasks of daily living with inadequate opportunities and inadequate support. In other words, the way women cope with diarrheal disease control and family planning is directly related to their status.

What can be done? If both diarrheal disease control and family planning involve mothers' doing something, then mothers need education in what to do and support in doing it. With education there are two possibilities: we can tell them or they can tell each other. The first possibility is sometimes called social marketing and can involve all levels from nation-wide media to the local school teacher. Regardless of level it always has in common two characteristics, *we* are telling *them* and the "*we*" is always the official sector of society (whether a TV program, a doctor, a midwife, a teacher). This first possibility is important and much discussed and used widely, for example, in the recent Turkish immunization campaign. The second possibility is sometimes called self-help or mutual aid and is more and more recognized as being equally important, especially if the women themselves provide the care. This second method relies heavily on the unofficial or traditional sector of society, especially the indigenous female lay care network. This network exists in every village and only recently is its great importance in the functioning of the village being recognized. The tradional birth attendant is often a key person in this indigenous female lay care network and experience shows that service programs which recognize, honor and cooperate with this network are much more accepted and used.

The effectiveness of this self-help approach can be illustrated by an example from Turkey. A pilot project was recently conducted in Turkey[2] in which trained midwives were instructed in how to work with village women. The midwives went to representative villages where they carefully selected one or two village

women who were in key positions in the indigenous female village network. These women might be the wife of the village leader, or one of the women occasionally assisting at birth (sometimes called tradional birth attendant) and they were often illiterate. Using techniques suitable for the illiterate, the midwives taught the selected women the basic principles of diarrheal disease control and family planning. The selected women then became the "village health workers" and, in turn, "educated" the other women of the village through the usual means of communication of the female network. The project found marked improvement in knowledge and practice in diarrheal disease control and family planning. The project, however, made no attempt to measure the effect of the program on the status of women. It is clear that this project provided not only "education" to the village women but also the social support of the village female network so that the women could do what had been suggested. The village women are empowered; they can see that they can better control their own lives and their infants' lives. This kind of program provides enabling help rather than the disabling help which makes women feel helpless and dependent on others such as doctors, teachers, etc. The European experience shows that the self-help method is also highly effective in urban areas where mothers are often isolated and in need of education and social support in doing the best job as the primary care givers for their infants.

It is to be hoped that as Turkey mounts its campaigns for diarrheal disease control and family planning, they will use both social marketing methods and self-help methods in reaching and supporting the women of Turkey.

Summary

In a lecture presented during the XXXth Congress of the Turkish National Pediatric Society in March 1986 in Ankara, the author points out how the social and educational status of women in Turkey and their participation in the community have an effect on the control of diarrheal diseases and the practice of family planning.

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