VIETNAMESE FEMALE SEX WORKERS' PERCEPTION OF THE HEALTHCARE QUALITY IN CERVICAL CANCER SCREENING IN HO CHI MINH CITY

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ABSTRACT

The objectives of this paper are to explore issues relating to the quality of care received in reproductive health service, especially cervical cancer screening from perspective of Vietnamese female sex workers (FSWs) in Ho Chi Minh City (HCMC). From the findings, we make recommendations to improve the quality of reproductive health care service. This is a qualitative study using observation and in-depth interview with 15 female sex workers aged 18-44 years.

The research findings indicate that physician-client relationship, gender of doctor, information, privacy and technique competency are elements influencing their decision on cervical cancer screening.

Keywords: Cervical cancer; Female sex worker; Quality of health care.

1. Introduction

Health care quality is a broad concept. Institution of Medicine (1990, as cited in McQuestion, 2006) defined it as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". This definition is widely used in studies on health care quality because it emphasizes both individual and population levels of analysis, and it is also associated with health care service.

To assess and measure quality, Donabedian conceptualized three qualities of care dimensions: structure, process and outcome (Campbell, Roland & Buetow, 2000; Ndhlovu, 1995). Structure is the attributes of settings where care is delivered. Process refers to whether good medical practices are followed or not. Outcome is the impact of the care on health status and indicates the combined effects of structure and process. The context where care is delivered affects processes and outcomes. For instance, if the facility is unpleasant, people will not come. Donabedian (1988) also emphasized that to monitor outcomes is to monitor performances, which are conditional on structure and process. For example, low coverage rates in immunization program imply poor performance which might be because of without electricity, poor attitudes, other factors (McQuestion, 2006).

Based on Donabedian's framework, Judith Bruce also gave a definition and measurement of quality of care in family planning services. However, she focused on the process dimension of quality of care. Her framework was divided into three levels: the policy, service delivery and client provider interaction levels (Bruce, 1990; Ndhlovu, 1995). At the policy level, legal system and policies become enabling or limiting factors to quality services delivery. To service delivery or clinic level, the quality level is a function of the infrastructure that exists such as building, toilets, sitting facilities, equipment,

skills or what Donabedian referred as the structure. At the final level, quality measures the services received by the client. The six elements that were identified as part of the process of service delivery are: choice of methods, information given to clients, technical competence, interpersonal relationship, continuity and follow up, appropriate constellation of services (Bruce, 1990).

Therefore, the patient's perception on quality of health service which also affects health care practices (Chakrapani, Newman, Shunmugam, Kurian & Dubrow, 2009; Ghimire, Smith & Van Teijlingen, 2011). Quality refers to the increase of desired outcomes and it includes current professional knowledge. The perspective of practitioners, patients and community are addressed in quality assessment. Under the patients' perspective, the process of care and the physician-patient interaction have impacts on patient adherence, satisfaction and outcomes of care (Steinwachs & Hughes, 2008). According to Ghimire, Smith and Van Teijlingen (2011), the major barriers in seeking sexual health services among FSWs in Nepal are a lack of confidentiality, discrimination, healthcare providers' negative attitudes, poor physician-patient relationships. These barriers affect their utilization of sexual health services.

Based on statistics, the morbidity prevalence of cervical cancer among women in southern Viet Nam was 26/100,000 compared to 6.1/100,000 for women in northern Viet Nam (UNFPA, 2007; Van To, T., 2005). And Ho Chi Minh City is one of the areas in Southern Vietnam. The number of women who are diagnosed with cervical cancer is 5,000 and with 2,500 deaths from cervical cancer annually (Ferlay, et al., 2010). However, in reality, most of the patients go to hospitals when they are at the last stage of cervical cancer (Van To, T., 2005). The statistic figures from five centers for treatment of cervical cancer showed that 53.98% patients were only examined at the last stages of cervical cancer. Based on data from (Bruni et al., 2014), there is a limit of statistics on cervical cancer screening in the population as well as the high risk groups so that they set up appropriate preventive or intervention programs.

In recent years, the HCMC authority has constantly improved the control technique for detecting cervical cancer. In parallel, the health education programs are widespread in districts. In addition, the city has implemented many mobile programs that provide free-testing to poor women in isolated areas. However, these programs are not systematic and many different subjects have still not been approached. This implies that the cervical cancer screening rate is still quite low. Currently, limited published research on cervical cancer screening in Vietnam has focused on female sex workers (FSWs) and the physician-client relationships which result in low cervical cancer screening rate.

Therefore, this paper explores issues relating to the quality of care received in cervical cancer screening from perspective of Vietnamese FSWs, which influences their decision on cervical cancer screening. From then, we recommend several solutions to improve the quality of health service, especially in women-centered services.

2. Literature review

Whittaker (1996) explored the meanings of quality of care for rural village women in Northeast Thailand receiving a range of reproductive health services. The findings showed that inequalities of power fundamental to gender, class and ethnic relations are factors affecting the service-giving process.

A research on barriers to utilization of sexual health services by FSWs in Nepal by Ghimire, Smith, and Van Teijlingen (2011) showed that the major barriers in seeking sexual health services among FSWs were a lack of confidentiality, discrimination and healthcare providers' negative attitudes, poor

communication between service providers and clients, and fear of exposure to the public. Most FSWs in this research reported that asking personal questions, especially about their job and sexual history by health service providers in private clinics as well as doctors in the government hospital made them de-motivated in seeking care. They also reported the doctor's and other health service provider's indifference as a reason for the non-attendance to governmental health services. They did not feel comfortable during examination and felt a lack of proper care by health service providers. Sexual harassment by service providers was also a barrier to access to health service among FSWs in Nepal.

Also the research on barriers to free ART treatment access for FSWs in Chennai, India by Chakrapani, Newman, Shunmugam, Kurian and Dubrow (2009) showed the lack of comprehensive and adequate counseling service at government centers as a barrier to attend ART program. FSWs reported that their rights to privacy during counseling were not protected in some government hospitals. They also believed that getting adequate information about ART and its benefits during post-test HIV counseling kept them motivated to go to an ART center for their check-up and treatment.

Although many barriers to cervical cancer screening including lack of knowledge, lack of facilities, cultural beliefs, economic burden, poor physician-patient relationship and stigma have been studied extensively among general women (Abdullahi, Copping, Kessel, Luck & Bonell, 2009; Agurto, Bishop, Sanchez, Betancourt, & Robles, 2004; Anorlu, 2008; Boonmongkon, Nichter & Pylypa, 2001; Ghimire, Smith and Van Teijlingen, 2011; Lee, Tripp-Reimer, Miller, Sadler & Lee, 2007; Markovic, Kesic, Topic & Matejic, 2005), limited published research on cervical screening has focused on FSWs. Especially, in Vietnam, most previous research focused on knowledge of cervical cancer, clinical signs of cervical cancer or preventative way to human papillomavirus (HPV). There are limited research studies that explain cervical cancer screening practices among FSWs in particular. Therefore, there is the need to explore the social determinants of quality of care.

3. Research methodology

To gain detailed explanation, we employed a qualitative design using in-depth interviews. At one level, this paper is descriptive account of some FSWs' experiences and assessment of quality of service they receive, and examines the elements which underlie these assessments. In this paper, we draw on data from my research on cervical cancer screening among FSWs in Ho Chi Minh city, Vietnam from July to November 2014. Ho Chi Minh City was selected as the site of this research because it was the city which had the highest number of sex workers and also high rate of cervical cancer in the country. We conducted observation in health center and interviewed 15 FSWs working on the street, beer pubs, barber shops and coffee shops through local non-government organization's introduction. The interview guideline was used to give the participants the opportunities to express individual opinion and experiences. As FSWs-centered analysis, it also sought to expand the quality of care perspective. Before entering fieldwork, we gave several selection criteria: (a) FSWs with at least three years of work in Ho Chi Minh City; (b) over the age of 18; (c) FSWs who have cervical cancer screening; FSWs who have not ever had cervical cancer screening. Most of the interviews were audio-recorded under the participants' consent. Each interview lasted for approximately an hour in a comfortable and privacy place. All data being tape-recorded were transcribed and translated into English. After interviews, field notes were taken. NVivo version 7 was used in data analysis. In term of privacy and confidentiality, I used the participants'

nicknames at their consents for the purpose of the research.

I used data related to perceived quality of health service in gynecological examination from observations and interviews because there are common reasons of attendance and non-attendance to gynecological examination and cervical cancer screening. I focused on two groups to gain comprehensive understanding of cervical cancer screening practice. One group has FSWs undergoing cervical cancer screening. Another group includes FSWs who have not ever done cervical cancer screening. The issues of quality of health service consist of the physician-client relationship, gender of doctor, information adequacy, technical competency and privacy according to Judith Bruce's framework.

4. Findings

4.1. The physician-client relationship

The majority of FSWs reported that doctors seldom ask them private questions related to their work. Doctors often ask the reason why FSWs go to the hospital, what symptoms they suffer, how many children they have, daily practices of washing vagina and menstrual cycle. FSWs thought that these questions are normal and they do not feel stigmatized. They only express dissatisfaction with health staff or doctors. From institutionalized discourses on sex work as an illegal status, a source of the diseases and a promiscuous woman, FSWs often carry social stigma and they also felt stigmatized by themselves. Some participants said that when they went to the hospital, they were afraid to be blamed as immoral women by people surrounding them. Sometimes they caught inquisitive eyes and impolite words by other patients and health staff. This made them feel sad. They were also afraid to be scolded by doctors. Thus they did not dare to ask the doctors more information related to their symptoms.

Thuy, a female sex worker working at a coffee-shop, said that *"When we go there, we are scared to be considered. We worry that most people will keep inquisitive eyes and consider us as a call girl or a prostitute. They think that maybe we get STDs or HIV, so we must go there for a check."*

Another participant told her story when she went to the hospital. Binh said,

"Doctors did not have enough time to talk with me. I saw a lot of patients waiting in front of the doctor's room. Maybe I made the doctor angry and scold me. The doctor said shortly. They gave me a prescription and asked me to follow it. If I hadn't got better, I would have visited again. They often talk without subject, sometime they wound my pride. Instead of giving more explanations and talking gently, they just give and request to visit if I do not get better. I wish that the doctor could give me more explanations and talking softly. This makes me be at ease."

Binh also recognized that most doctors say by snatches. If they like, they talk softly with subject. If they don't like, they talk tersely with squeaky voice, it means that they browbeat her. They wore masks while they were talking, so she could not hear clearly. When she asked again, they changed their voice. Since then, she did not want to ask more.

In this study, FSWs compared doctor's attitude with other health staff's attitude. They often make more complaints with health staff than doctors. Doctors often treat them equally as other people. They seldom speak authoritatively or impolitely with FSWs. For health staff and nurse, they expressed bad attitude with FSWs. This made FSWs feel so sad and self-pity. As Van's story, she changed her voice when she talked about nurse's attitude. For doctors, she thought that they are well trained, so they treat her equally. She was not stigmatized by doctors. However, for nurses, she sometimes feels extremely angry due to their attitudes and behaviors. She said that nurses talked loudly as if she heard but not do. In her opinion, the way they talked was hard to please everybody. Many sick

people go there to check, and she spent much time to go there, so they should respect her.

She said that "*They are very odd, they impolitely talk, and they always scream at everybody."* One day, she quarreled with them. She was angry and said *"why you learn much, you go to school much more time than me, but you badly talk. If you talk like this, I think you should be at the market. You don't learn from your school how to communicate with people. I think you are not a nurse; you are rude as a seller at the market. I go here to have a check-up; it's too crowded for me and everybody to hear your voice. You should repeat again. Why do you scream at them? If you don't know how to talk to everybody, I will teach you. I learn less than you but I can teach you about this."* She thought that she should not quarrel with them. If she had done like this, she would have been condemned. People say that she was obscure, not proper.

4.2. Gender of doctors

Together with interaction of physician-client, gender of doctors is sometimes mentioned as barriers by few FSWs. Some FSWs do not hesitate to expose their body and ask doctor during examination. They thought that they get sick and need to be treated. They considered that *"I do not feel shy or hesitated because male doctors like my clients. Showing the body in front of strangers is very normal. If they are hesitated, how will they earn money by exposing their body? Another thing is that we are patients, we are getting sick. Thus we need to ask doctors more information to protect our health. I never feel shy or hesitated due to this." (Linh, who has not done cervical cancer screening)*

On the other hands, other FSWs are afraid to expose their body, especially male doctor. Despite that they cannot choose doctors, they like female doctors much than male doctors.

Binh had just cervical cancer screening during last year and said that: *"Of course, if female doctor examines, I am not shy because she is female like me. But male doctor is different. They are of different gender, so I am shy a little. However, I accept this because I cannot choose another doctor. This is public health center, not private center. Hence, I cannot ask for female or male doctor."*

Quyen also thought that she felt safer when she talked with female doctors because they could understand her situation and symptoms.

Van has not done cervical cancer screening yet, but she felt embarrassed when she was examined by male doctor. She just felt uncomfortable a little bit. Later, she felt fine. She thought that vagina is private body. For clients, she does not feel shy because they do not know her disease. However, for doctors, when they exposed her vagina and looked it at; she did not like. She believed that "anyhow it is my private body." However, she still accepted this issue because she got sick. *"How can I choose? Actually, I cannot. It depends on the day when I visit to the hospital. In the same examination room, today female doctor may be there, but tomorrow it changes".* Despite that she felt shy a little bit; she likes male doctors better than female doctors because male doctors are very skillful and careful.

4.3. Adequate information

In this study, some FSWs thought that they got enough information from doctors. Doctors often gave them good advice. In contrast, other FSWs said that sometimes doctors did not talk so much. They just give FSWs prescription and ask FSWs to follow their guide. In fact, doctors do not have much time to talk with all patients. The process of examination lasts about five minutes for one patient. Therefore, they rarely say many things.

"I only want to finish soon, I do not like waiting for a long time" and *"I do not know questions which I should ask doctors"* are used by two-third of FSWs. In daily life, FSWs in this study said that they often got up so late. It was about 10 o'clock. They stay at home until they work. They were tired of waiting for doctors. Thus, they would like to

finish examination soon.

I made observations at a health center and big hospital. At the health center, I only saw some posters related to cervical cancer and HIV. Especially, there were more posters about HIV than cervical cancer and screening. During observation, I took notes of questions which doctors often asked patients.

"Q: What is your name?
Q: How old are you?
Q: Why do you go here today?
Q: How long have you suffered this symptom?
Q: How many children do you have?
Q: Which contraceptive method do you choose?
Q: When did you get menstruation?
Q: Have you engaged in sex during past two days?
Q: Do you hang your knickers in the sun?
Q: Do you often wash your vagina after intercourse?
Q: What kinds of hygienic water do you choose?
Q: How do you wash your vagina?
Q: Do you know how to put medicine inside your vagina?"

Also, two key informants said that they have few chances to interact with their clients. Tuyet said that, *"We must obtain regulations of hospital. We do not have much time to talk with patients. Each patient just has some minutes. We still consult or suggest them to do cervical cancer screening in some cases. However, they have the right to do or not to do."*

4.4. Privacy and convenience

I observed a doctor room when I voluntarily took two FSWs to a health center. It is the Preventive Health Center in district 4. It is a three-floor building. The first floor is clinic and ultrasound. It is a place that FSWs get gynecological exam. In front of the clinic, there are row-seats. Although the door was closed, outside-people could still hear the conversation between the doctor and the client. In fact, there is only one room. The room consists of one long-table for the patient to lie down on for examination and one desk for the doctor to consult and write prescription. Another place is Da Lieu hospital. I had an opportunity to follow a FSW into the doctor room. I just stayed with the nurses and introduced myself as a researcher as well as a volunteer of peer-educator group while FSW was being examined by the doctor. Again, I heard the conservation between the doctor and the client.

After FSW had finished examination, I interviewed her at another place. She said that *"I must accept it because the examination room is quite small while many patients come there. They wait and hear. I think nobody wants to hear my conservation. In big hospitals, you also find similar situations like here. You must wait outside the examination room. There are 3-4 patients to come to test at the same time. It is normal. However shy you feel, you will not get anything at all. Thus I don't feel shy. I just think I get disease and I should visit the doctor. It is everything I thought." (Binh, who did cervical cancer screening)*

However, when I interviewed other FSWs who have not ever done cervical cancer screening, they said that they felt uncomfortable while other patients stayed with them in the examination room. They did not know if people pay attention to their conservation or not. But they were afraid a little bit. One FSW said that *"Sometimes, I gave doctor inaccurate information. I do not want doctor and other people know about me. Once time, I said that I was a poor woman; I worked as a street vendor. I also said that I did not have sex in recent days. However, actually the doctor knew that it was right or wrong. For other people, they did not know about my frequency of sexual intercourse. It was such a sensitive topic that most people did not like to talk more."* (Ngoan)

In terms of privacy, most FSWs felt inconvenient due to complex administrative

documents and waiting for a long time. Thuy, whom I followed to Da Lieu hospital to test white blood discharge, said that *"The first thing is it takes me much time to go there and wait for a long time. I went with you from 1 p.m. to 3.30 p.m. The second thing is complex administrative documentary. For example, a moment ago, I spent much time to move around to ask where the examination room was."*

4.5. Technical competence

In terms of technical competence, FSWs agreed that some doctors were very skillful, especially the senior doctors. Doctors penetrated speculum into vagina very softly. Actually, FSWs felt painful a bit when speculum was used to open their vagina. To reduce pain, doctors often asked FSWs some questions. When FSWs concentrated to answer the doctor's questions, they would feel less painful. In some cases, the doctor encouraged FSWs not to fear. They tried to perform their task carefully.

However, FSWs also compared young doctor's competency with senior doctor's competency. They thought that young doctors were not skillful and well experienced. Thus, sometime they put the speculum very hard. It made FSWs scared and painful.

5. Conclusion and Recommendation

This study reported that the relationship between health professional and FSWs was limited. Although the doctors do not ask personal things, they give a little information. It is not enough for clients, especially FSWs. This is seen as a direct cause of the inaccessibility to the cervical cancer preventive screening program. This result is similar with previous studies on utilization of health service (Ghimire, Smith, and Van Teijlingen (2011). Most participants are always afraid to ask more because they fear for being scolded. Therefore, sympathy and good interaction are necessary to improve the physician-client relationship. Although there is the positive change of discrimination, most participants face this problem. They are still vulnerable. They are less likely to access to health service due to their illegal status. This is similar to previous studies which considered as an obstacle to health care utilization. The previous studies reported that FSWs have negative experiences with healthcare providers. Some FSWs pointed out the staff's unfriendly attitude in the government hospitals such as viewing FSWs as "promiscuous" and using insensitive language (Ghimire, Smith and Van Teijlingen, 2011; ICRW, 2004; Ngo MD MIPH Mphil, Ratliff, McCurdy, Ross, Markham & Pham; 2007). Others reported that doctors in the government hospital make them de-motivated in seeking care (Braun & Gavey, 1999; Chakrapani, Newman, Shunmugam, Kurian & Dubrow, 2009; Ghimire, Smith and Van Teijlingen, 2011; Lazarus, Deering, Nabess, Gibson, Tyndall & Shannon, 2012). In addition, doctor gender also plays an important role in good interactions. Some FSWs who had cervical cancer screening or gynecological examination during the past two years revealed that having female doctors examine the test was critical because it helped to reduce their uneasiness. Although some FSWs like male doctors because they are very skillful, FSWs still would like to be examined by female doctors. They thought that they easily talked and found sympathy from female doctors. Most FSWs in this study have also felt stigmatized. They said that they feel sad when most people keep inquisitive eyes with them or talk about them. In healthcare setting, they sometimes catch inquisitive eyes and impolite words. Therefore, unless they could not manage it, they did not come to meet doctors. Therefore, how doctors and health providers interact with clients affects the rate of regular Pap-smear or gynecological examination among Vietnamese FSWs.

According to Kleinman, the physician-client relationship has been seen as an important component in health care service (Helman, 1990). Therefore the way Vietnamese FSWs do cervical cancer screening is influenced by the way they

look at physician - client relationship. For Vietnamese FSWs, health providers possess great authority because they have a high social status. Therefore, the physician-client relationship is hierarchical and the doctors hold enormous power. Vietnamese people often say *"lương y như từ mẫu"*, it literately means *"doctors like gentle mothers".* This implies that the care of a physician is like a mother's care. Xinh said that "*Doctors should be a gentle mother. To young doctors, they need to be friendly and respect to patients. It is important to make patients feel comfortable to come and talk to doctors."* However, in fact, some FSWs are quite uncomfortable to ask doctors, especially when doctors are busy.

In conclusion, the quality of health care has sometimes been counted as synonymous with the availability and/or accessibility of reproductive health methods. Both the quality of care and availability of services are vital determinants of reproductive health methods.

Most researchers, health advocates, women's groups and program managers observed that clients often received inadequate care. Therefore, it is important to promote the development of health care quality because we have human basic rights including the rights of choice and being treated with dignity. Especially, it is recommended to focus on women-centered services because they are more vulnerable than men; they face with a lot of reproductive health issues. Besides, understanding women's experiences and analyzing different impacts that women and men have of the public health structure will provide different services with both women and men. Moreover, many studies on quality of care revealed that many constraints that inhibited delivery of quality of care, so it also affects clients. For example, poor economy causes lack of facilities in the rural and mountain so health care system cannot meet clients' need. In addition, we can see that what clients or women-centered groups want as they reach the service including respect, privacy and confidentiality; understanding and sympathy; complete and accurate information; technical competence; access and fairness; results; cultural sensitive and convenient schedules and waiting times. Therefore, quality of care plays a more important role in dealing with different types of clients. In the case when this quality of care is low; it can lead to prevent clients to access when they are sick. Especially women, they have many reproductive health problems such as reproductive cancer, STDs, RITs and so on. The obvious result is that when women do not access to good quality of care, they will refuse to go to the hospital for treatment. If this issue prolongs, their health will be worse. In short, people have human rights on accessing to health care system in general and good quality of care in particular. The quality of care is good when it can meet the demands, supply good services, full of facilities, and good attitude to clients and so on. Although quality of care is influenced on social determinants such as socio - cultural barriers (autonomy, norms on sexual reproductive health, fear of discrimination) or client's perception of services; this quality plays more important role on promoting and increasing opportunities for treatment to vulnerable groups as well as clients.

To set up high-quality services is not easy when technology is low; therefore we should solve this problem based on human rights, gender equality and quality of care because costs for improving technology and facilities are high. According to Bruce – Jain framework, we have six elements focusing on clients' perspective which supports providers in setting up and managing quality of care. These elements reflect six aspects of services that clients experience as critical. In other words, this framework is meant to provide an ordered point departure from which to develop description of the service unit and define its quality. Following this framework, the first thing is we should place the client at the center of the service because high quality of care

cannot be sustainable without the assessment of the contact with clients. In addition to clients, we also mention on changing providers' attitudes. In practice, clients are hesitate to access to health care system because they fear discrimination from health professionals. From this, providers should "… put themselves in the place of the client and give the kind and care we would like for ourselves". Health professionals and health care should spend much time communicating with clients through asking questions, giving directions. Especially, doctors and nurses should respect clients' knowledge of their own situation, encourage clients to talk, ask about needs and wishes and advise them well because if clients are usually happy, providers feel satisfied with their job. They have positive motivation to continue job.

Together with focusing on clients, we should set up a set of management principles including information – based, participatory, collaborative decision – making and focus on systems and processes to support and enable personnel. Moreover, technology also needs to be improved but the costs for improvement is high. So we should invest money in documentation because it is strong indirect evidence of impact of insufficiently which trained providers can be detected in accounts of program or nationwide experience with specific methods. When clients or patients have enough information, they are confident to make decision as well as support them when necessary. In the case clients lack information, it will leads to discontinuing using health care services and belief in rumors may be a deterrent to use altogether. So the more information health professionals provide to clients, the more clients go to the hospitals. However, providers note the development of culture-specific standards of "full and balanced information" in addition to health information. Many data from the Program for Appropriate Technology in Health indicated that most people remember messages better if the spoken word is reinforced by written or pictorial messages. Such visual materials support program staff in remembering and systematizing all they are to transmit, and they help the clients as well.

Besides health professionals should address gender equality and sexual rights. We can see that most women are more vulnerable than men, so their demands are also higher than men's ones. Most studies revealed that women usually get sexual and reproductive health problems while health care systems cannot meet their demands effectively. Therefore, we should pay attention to women groups in order to set up appropriate programs and constellation of services, which refers to situating family planning services so that they are convent and acceptable to clients, responding to their natural health concepts, and meeting pressing pre-existing health needs. These services can be appropriately delivered through vertical infrastructure, postpartum services, comprehensive reproductive health services, employee health programs or others. In parallel, male involvement is also mentioned because it contributes to ensuring equality between men and women, advancing women's empowerment and increasing inter spousal communication, partnership based on shared roles and responsibilities.

With aimed to low technology, sustainable and consistent good quality of care in sexual and reproductive health services, we again note that community-based distribution systems have largely been devised to increase the accessibility of services. Community-based programs may have to approach the issues of continuity and follow-up. Where the health infrastructure is very low, and services and workers scare, follow-up visits for family planning might be integrated with those for other purposes. According to Stephens, he suggested the use of an integrated some-based record-keeping system wherein the health status both adults and children is recorded. Such a procedure would reinforce the clients' rights to information about their own health

and may be a practical solution. Therefore, it is necessary to build up network in order to serve women living remote rural situations with their permission, in some way so that new users could be given names of other women in their area using the same methods■

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