

Health seeking behaviour about gynaecological morbidities among ever married women of reproductive age group in a city of Maharashtra, India

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Abstract

Context: Reproductive health, a crucial aspect of general health is of significant importance for human development. Lack of awareness, cultural barriers and economic factors prevent them from seeking timely care.

Aims and objectives: 1. To determine prevalence of gynecological morbidities among ever married women. 2. To assess the health seeking behavior for gynecological morbidities and 3. To explore factors associated with health seeking behavior

Methods and Material: It was community based cross sectional study conducted during January 2011 to June 2012 at Nanded city in Maharashtra including 750 ever married women. Probability proportionate sampling using 30 stage cluster sampling technique was used. Out of 65 wards in city 30 wards were identified and 25 study subjects from each ward were selected by rotating bottle at centre of the ward and continuing survey in the direction of mouth of the bottle.

Statistical analysis: Data analysis was carried out with the help of statistical measures, such as percentages, proportion, chi square test and chi square test for trend.

Results: Menstrual irregularity 351 (46.8%) was commonest gynecological morbidity. Treatment seeking behaviour was best among women suffering from infertility. There was statistically significant association between types of gynecological morbidities, no. of gynecological morbidities and treatment seeking behaviour. Most common reason of not taking treatment was feeling no need of treatment.

Conclusions: Treatment seeking behaviour differs in different type of gynecological morbidities. Commonly women prefer private health facility for taking treatment. Those women with a greater number of gynecological morbidities took treatment from health centre.

Key words: Health seeking behaviour, gynecological morbidity

Introduction

Women in India face constraints not only in obtaining health services, but also in expressing reproductive health needs^[1]. Usually many reproductive disorders go unnoticed, either because of being asymptomatic, or because of producing vague and non-specific symptoms^[2].

Women's health issues cannot be addressed in isolation. Various individual, household, and

community factors influence women's health as well as decisions about treatment seeking behaviour^[3]. Lack of awareness, cultural barriers and economic factors prevent them from seeking timely care^[1].

Aim and Objectives:

1. To determine prevalence of gynecological morbidities among ever married women of reproductive age group.
2. To assess the health seeking behavior for

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gynecological morbidities among women of reproductive age group.

3. To explore contributing factors for health seeking behavior among ever married women of reproductive age group.

Material & Methods:

It was a community based cross sectional descriptive study with health centre based clinical evaluation and laboratory investigations. The study was conducted during January 2011 to June 2012. A community-based survey was conducted at Nanded city in Maharashtra state. The total population of the city was 430733 distributed in 65 Municipal Corporation Wards^[4]. Reproductive ill health accounts for 36% of disease burden in Indian women^[5]. Thus, sample size^[6] was calculated as 750 taking 36% prevalence, 95% confidence interval and 10% allowable error.

Probability proportionate sampling^[7] using 30 stage cluster sampling technique was used for sampling the study population. Estimating 25 study subjects from each ward 30 wards were selected for entire sample of 750 study subjects.

The wards from which we had selected primary sampling unit, surveyed to detect centre of ward. Any temple, mosque, shop or hotel situated approximately at centre of ward was marked and a bottle rotated there to select the lane for the survey. Survey was started from the lane towards which mouth of the bottle directed. Each house on left side of that lane was visited and at the end of lane, survey was continued on left turn to the initial lane till primary sampling unit of 25 samples satisfying the inclusion criteria of study completed. If there were no women in the house satisfying the inclusion criteria then that house was skipped and next house visited. If there were more than one woman in house satisfying the inclusion criteria, then all were selected to participate in study. This method was adopted in all wards for selection of primary sampling units for study.

Ever married women of reproductive age group (15-49 years) and women who have given voluntary consent for participating in study were included in the study.

Pregnant women, women within puerperal period (< 42 days of delivery), seriously ill women (not related with gynaecological morbidities), non-resident women (those residing < 6 months in ward) and those fail to follow up for investigations were excluded from study/

Ethical Clearance was obtained from Institutional Ethical Committee of Dr. Shankarrao Chavan Government Medical College, Nanded Maharashtra. Participation in the study was purely on voluntary

basis. Before start of the study, they were assured of confidentiality about information obtained from them and privacy during examination and a written consent was obtained from them.

The investigator has undergone training under supervision of expertise in Gynaecology, Pathology and Microbiology department.

Pilot study was conducted at one municipal corporation ward of the city. Before starting the field survey, a good rapport was built with the community by taking help of health care workers (i.e., social worker, anganwadi workers, link workers) who work in close contact with community. The face-to-face interview was carried out in local language (*Marathi/Hindi*). Data was collected using pre-designed and pre-tested semi-structured questionnaire.

Socio-demographic characteristics of study subject were recorded. Information regarding age at menarche, age at first pregnancy, no. of pregnancies, no. of abortions, and reproductive problem in women, like details of vaginal discharge, menstrual irregularity, type of bleeding, age at menopause, fertility related problems, h/o anything coming out through vagina, continuous passage of urine or micturition during sneezing or coughing was also asked for.

H/o receiving treatment in relation to different gynaecological morbidity, place where treatment received, reasons behind not receiving treatment were asked. Gynaecological examination was performed under supervision of gynaecologist at Urban Health Training Centre.

The investigations performed for diagnosis of various gynaecological morbidities were vaginal swab examination for bacterial vaginosis, candidiasis, and trichomoniasis (vaginal pH examination, wet mount, KOH mount, Whiff test and Gram stain), endocervical swab examination for gonorrhoea (Gram stain), urine microscopy, RPR test for syphilis & Pap test for cervical malignancy. Data analysis was carried out with the help of statistical measures, such as percentages, proportion, chi square test and chi square test for trend using software Graph Pad Prism Version 5.01 and Open Epi Version 2.3.

Results

Women of age group 25-34 years were constituted major 321 (42.8%) part of study subjects. 330 (44%) of women belong to nuclear family followed by 284 (37.87%) from three generation family. 396 (52.8%) women were Buddha by religion. 198 (26.4%) of women had taken secondary education while 196 (26.13%) women were illiterate. 348 (46.4%) women belong to socioeconomic class V, followed by 192

(25.6%) in class IV while only 22 (2.93%) women were from class I. (Table 1)

Table 1: Socio-demographic profile of study subjects (n = 750)

Sl no.	Socio-demographic variable		Number of women (%)
1.	Age (yrs.)	15 - 19 yrs.	32 (4.67)
		20 - 24 yrs.	119 (15.87)
		25 - 29 yrs.	168 (22.4)
		30 - 34 yrs.	153 (20.4)
		35 - 39 yrs.	128 (17.07)
		40 - 44 yrs.	80 (10.6)
		45 - 49 yrs.	75 (10)
2.	Education of women	Illiterate	196 (26.13)
		Primary	75 (10)
		Middle	159 (21.2)
		Secondary	198 (26.4)
		Higher Secondary Certificate	86 (11.47)
		Graduate and Postgraduate	36 (4.80)
3.	Socioeconomic status (Modified BG Prasad Classification)	I	22 (2.93)
		II	65 (8.67)
		III	123 (16.4)
		IV	192 (25.6)
		V	348 (46.4)
4.	Marital status	Married	693 (92.4)
		Widow	20(2.67)
		Separated	37(4.93)

Among 750, 568 (75.73%) women were suffering from at least one gynaecological morbidity. Menstrual irregularity 351 (46.8%) was most common gynaecological morbidity among study subjects followed by reproductive tract infection in 189 (25.2%) and pelvic organ prolapse in 113 (15.07%). Uterine malformation (0.13%) was least common. No case of Carcinoma cervix (Ca. Cervix) was seen. (Table 2)

Table 2: Distribution of gynaecological morbidities among study subjects (n = 750)

Socio-demographic variable	Number of women (%)
Menstrual irregularities	351 (46.8)
Reproductive tract infection	189 (25.2)
Pelvic organ prolapsed	113 (15.07)
Infertility	86 (11.47)
Cervical dysplasia	60 (8)
Stress urinary incontinence	44 (5.87)

Urinary tract infection	29 (3.87)
Premature menopause	26 (3.47)
Pelvic inflammatory disease	08 (1.07)
Fistula	05 (0.67)
Uterine malformation	01 (0.13)
Cancer Cervix	00 (00)

Treatment seeking behaviour was best among women suffering from infertility while worst among women suffering from cervical dysplasia. Out of 86 women suffering from infertility, 48 (55.81%) received treatment and 38 (44.19%) did not received treatment while out of 60 women suffering from cervical dysplasia, only 16 (26.67%) received treatment and 44 (73.33%) did not received treatment. There was statistically significant association between types of gynaecological morbidities and treatment seeking behaviour among them. (Table 3)

Table 3: Association between different types of gynaecological morbidities and treatment seeking behaviour

Types of gynaecological morbidity	Treatment received (%)	Treatment not received (%)	Total number of women (%)
Reproductive tract infection	68 (35.98)	121 (64.02)	189 (100)
Menstrual irregularities	128 (36.47)	223 (63.53)	351 (100)
Pelvic organ prolapsed	31 (27.43)	82 (72.57)	113 (100)
Infertility	48 (55.81)	38 (44.19)	86 (100)
Stress urinary incontinence	16 (36.36)	28 (63.64)	44 (100)
Cervical dysplasia	16 (26.67)	44 (73.33)	60 (100)
Urinary tract infection	10 (34.48)	19 (65.52)	29 (100)
Premature menopause	10 (38.46)	16 (61.54)	26 (100)
Other	06 (42.86)	08 (57.14)	14 (100)

($\chi^2 = 20.71$, $df = 8$, $p = 0.008$)

(Other - PID, Uterine malformation, Fistula)

Women preferred treatment from private practitioner for all types of gynaecological morbidities except in women with premature menopause. 41 (60.29%) of women with reproductive tract infection received treatment from government institutions while only 6 (37.5%) women with stress urinary incontinence consulted government institutions. 42 (87.5%) women with infertility received treatment from private practitioner while only 2(20%) women with premature menopause consulted private practitioner. (Table 4)

Table 4: Distribution of place of treatment received for gynaecological morbidities:

Types of gynaecological morbidities	Treatment received	Place of treatment received		
		Government	Private	Other
Reproductive tract infection	68(100)	41(60.29)	48(70.59)	05(7.35)
Menstrual irregularities	128(100)	67(52.34)	91(71.09)	11(8.59)
Pelvic organ prolapsed	31(100)	16(51.61)	16(51.61)	02(6.45)
Infertility	48(100)	21(43.75)	42(87.5)	03(6.25)
Stress urinary incontinence	16(100)	06(37.5)	13(81.25)	02(12.5)
Cervical dysplasia	16(100)	07(43.75)	11(68.75)	01(6.25)
Urinary tract infection	10(100)	06(60)	07(70)	01(10)
Premature menopause	10(100)	08(80)	02(20)	01(10)
Other	06(100)	03(50)	04(66.67)	01(16.6)

(Other place of treatment means - Quacks, Unqualified practitioners, Self-treatment)

As no. of gynaecological morbidities among women increased, percentage of women receiving treatment also increased. Only 72 (25.62%) women suffering from one gynaecological morbidity received treatment while, 87 (37.99%) and 29 (50%) women suffering from two and more than three gynaecological morbidities received treatment. There was statistically significant association between no. of gynaecological morbidities and treatment seeking among study subjects. (Table 5)

Table 5: Association between no. of gynaecological morbidities and treatment seeking behaviour among study subjects (n - 568)

No. of gynaecological morbidities	Treatment received	Treatment not received	Total number of women (%)
One	72 (25.62)	209 (74.38)	281(100)
Two	87 (37.99)	142 (62.01)	229(100)
Three and more	29 (50.00)	29 (50.00)	58 (100)
Total	188 (33.1)	380 (66.9)	568 (100)

($\chi^2 = 17.05$, $df = 2$, p value = 0.0002)

(χ^2 test for trend = 17.05, $df = 1$, p value < 0.0001)

Most common reason for not receiving treatment was felt no need to take treatment for symptoms seen among 216 (56.84%) women with gynaecological morbidities, they had followed by 72 (18.95%) women who felt themselves apparently healthy and 64 (16.84%) women who were shy or scared to take treatment. (Table 6)

Table 6: Distribution of reasons for not receiving treatment for gynaecological morbidities:

Reasons for not receiving treatment	Number of women (%) (n = 380)
Felt no need to take treatment	216(56.84)
Apparently healthy	72(18.95)
Shyness/ scared to tell	64(16.84)
Expenses	26(6.84)
Not allowed by family members	10(2.63)
Long distance	09 (2.37)
Lack of time	08(2.11)
Non availability of lady doctor	06 (1.58)
Lack of faith	04 (0.01)
Non availability of proper health services	03 (0.007)

Discussion

This was a community-based study aiming to demonstrate the prevalence of gynaecological morbidities and the health seeking behaviour among reproductive age group women. The result revealed high frequency of these morbidities and the culture of silence in health seeking behaviour.

In present study, menstrual irregularity followed by reproductive tract infection were most common gynaecological morbidities among reproductive age women which was similar to study conducted by Zafer S.^[8], Sehgal Alka^[9] & Bonetti T.R.^[10] Comparable prevalence of reproductive tract infection 20 - 30%^[11-14] was observed in study conducted at Rajasthan, Nepal and Oman. Worldwide variation was seen in the prevalence of pelvic inflammatory disease ranging from 1.5% to 19%.^[12,15-17] High prevalence of stress urinary incontinence as compared to present study was seen in study of Ozel Begum^[18], Merville L.

Jennifer^[19] and Singh Abha^[20]. No case of carcinoma cervix was seen similar to study in Lebanon^[21], Oman^[14], and Maharashtra, India^[22]. Worldwide variation in the prevalence of gynaecological morbidities can be explained in relation to difference in culture, taboos and health practices in different countries that influence prevalence.

In present study, most of the women with gynecological morbidities need not sought appropriate treatment. However, health care seeking was best among women with infertility, which may be because of being infertile can socially stigmatize the women and may cause marital problems. Treatment sought for infertility was 79.9% in Lebanon^[21], 62% in Aberdeen^[23] and 14.3% in Delhi^[24] India. Only 25% women with cervical dysplasia sought treatment for the morbidity. This shows poor knowledge and awareness among reproductive age group women regarding progression of cervical dysplasia to carcinoma cervix and further consequences.

Private practitioners were most consulted health personnel for seeking treatment for gynaecological morbidities. 70.21% women sought treatment from private practitioners followed by 52.13% from government institutions while 6.9% from quacks and unqualified medical practitioners. Treatment sought from private practitioners was 68% in Uttar Pradesh^[25], 38% in Madhya Pradesh^[26]. In contrast, majority sought treatment from unqualified village practitioners 22% and auxiliary nurse midwives 42.8% in Haryana^[9].

92% women sought treatment from local dais in South India^[17]. This shows lack of trust shown by women on government institutions for taking treatment on gynaecological morbidities. They may prefer private practitioners and unqualified persons as they want to hide these problems due to stigma attached to it.

25.62% women with one gynaecological morbidity received treatment. The figure went up to 37.99% for women with two problems and 50% for women with three and more problem. Similar rising trend was seen in study conducted by Bella C. Patel^[25] among women with single gynaecological morbidity 9% to 35.2% in women with two morbidities and further increase to (46.9%) among women with six and more morbidities. Women deny to take treatment for gynaecological morbidities till the severity of disease increases thus there is need of periodic check-ups and follow ups for women with increasing age for early detection of morbidities.

Most common reason for not receiving treatment for gynaecological morbidity was felt no need to take treatment for symptoms. In study conducted

by Bella C. Patel^[25] most common reasons for not receiving treatment were not having money followed by perception of women that problem is not serious, while in Alka Sehgal^[9] study non availability of female doctor was the most common reason followed by non-availability of proper health services. In Indra P. Kambo^[15] study major reasons, as mentioned by women for not seeking any health care for gynaecological problems were lack of time followed by inability to go alone. In study conducted by Jasmin Helen Prasadet^[16], 58% women reported that they felt the symptom was not alarming and so there was no need for treatment. Other less common reasons were absence of a female provider in the nearby health care centre, lack of privacy and distance from home.

Conclusion

Menstrual irregularities followed by Reproductive tract infection were most common gynaecological morbidities. There was significant difference between treatment seeking behaviour among women with different gynaecological morbidities. Women preferred consulting private practitioners for this. Treatment received by women for gynaecological morbidities increased significantly as no. of morbidities among women increased. Perception among women of no need to take treatment for their symptoms was most common reason for not receiving treatment, while no relief after partial treatment was common reason for incomplete treatment.

Limitations:

Some investigations and examinations like ultrasonography, Antigen testing, Urine culture, Pad test etc. which are important for diagnosing gynecological morbidities were not performed in our study due to feasibility and recourse constrain. Inadequate information was obtained regarding quality and training status of doctors from women with poor educational qualification. Resource constrain is also one of the problems.

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