

Self Reported Gynaecological Morbidity Among Currently Married Women In Urban Slums Of Kakinada City, Andhra Pradesh

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Abstract: Background: Women's health has always remained neglected because of the traditional reductionist approach to women's health issues. This article presents an analysis of self-reported symptoms of gynaecological problems among currently married women of reproductive age group (15 to 49 years). **Method:** 800 currently married women of reproductive age group were selected by systematic random sampling from 10 of the urban slums of Kakinada city of Andhra Pradesh between January to December 2012. Information was gathered from these women on their socio-demographic variables, gynaecological problems as perceived by them and their treatment seeking behaviour. **Results:** Gynaecological morbidity was found to be significantly influenced by women's age, educational status, age at marriage, duration of marital life and age at first child birth. 44.5% women reported at least one current gynaecological symptom. Major complaints were menstrual problems (66.3%), low backache (27.2), and abnormal vaginal discharge (15.4%). Of these, 53.7% did not seek any treatment.

Key words: reproductive age group women, gynaecological problems, treatment seeking behavior.

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I. Introduction

Gynaecological morbidity includes maladies of the reproductive system of women. It excludes any condition related to pregnancy, abortion or childbirth. However it may be related to sexual behaviour¹. It has a considerable impact on a woman's quality of life and includes a wide array of disease conditions some of which are lethal and many chronic².

The WHO reports that reproductive ill health accounts for 36.6 % of the total disease burden among women aged 15 to 45 years at a global level³. Among currently married women in India, 39% report at least one reproductive health problem related to vaginal discharge, urination or intercourse⁴. The few studies done in this field are hospital based and therefore do not reflect the magnitude of the disease burden. Large proportions of women do not visit health facilities unless the disease becomes serious. Further, the statistics provided by hospitals are based on biomedical causes only with scant information on social, economic and demographic factors⁵.

Another cause of concern is women's' indifferent attitude towards their own health and their poor health seeking behavior⁶. In most cultures, women accept reproductive morbidity as an inevitable part of their life and do not seek health care till it becomes an emergency. Studying the prevalence of gynaecological morbidity not only helps in identifying its magnitude but also recognizes special at-risk groups at whom interventions should be directed. A community-based appraisal of the problem also helps to discover the underlying social perspectives⁷. In view of the above considerations, the present study is carried out to look at aspects related to gynaecological morbidity.

II. Objectives

To estimate the prevalence of gynaecological morbidity and to identify socio-demographic factors which influence it in currently married women of 15 – 49 years age group and also to describe their treatment seeking behaviour.

III. Materials And Methods

This descriptive study, conducted between January to December 2012 involved 800 currently married women aged 15 – 49 years residing in the urban slums of Kakinada city of Andhra Pradesh. 10 of the existing slums in the city (total of 101) were selected by simple random sampling and 80 women from each of these

slums were selected by systematic random sampling of households. A pre-designed and pretested questionnaire was used for collecting data on socio-demographic variables, gynaecological morbidity and treatment seeking behavior of the study subjects. Variables studied under socio-demographic characteristics include quantitative variables like age, per capita monthly income of the family, age at marriage, duration of marital life, age at first child birth and qualitative variables like education, occupation, religion, caste, and children ever born. Pregnant women were excluded from the study. All the participants were asked whether they are suffering from any of the following gynaecological problems: menstrual problems, abnormal vaginal discharge associated with itching and / or odour, itching in genital region, burning micturition, lower abdominal pain, dyspareunia, post coital bleeding, mass per vagina, genital ulcers/ warts, low back pain, prolapse, fistulae, mass per abdomen and also infertility. The health seeking behaviour for above said conditions was inquired about.

The collected data was entered and analysed using Microsoft Excel and SPSS version 17. Descriptive statistics and chi square test as a test of association were applied for the analysis and interpretation of the result at 5% Level of Significance.

IV. Results

A majority of the 800 women studied, belong to the age group 20 to 29 years (51.3%); 76.8 % were from the Hindus religion and 38% were illiterate. A majority (80%) belonged to socioeconomic class III and below and only 4.9% of them were working women. Age at marriage for the study subjects ranged from 10 years to 28.5 years (Median age 17.1 years). 68.1% of them were married below 18 years of age. 8.1% of the study subjects had never given birth, 10.6 % had a birth order of 4 and above. Mean no. of children born is 2.14. 14.4 % of the women had their first child birth at below 16 years, 53% between 16 – 19 years. Median age at first child birth for the study subjects is 18.2 years. Age at first child birth ranged from 12 to 31 years.

356 (44.5%) women reported to have at least one current gynaecological symptom. Out of 800 women 29.5 % were suffering from menstrual problems, 12.1 % by low backache, 6.9 % abnormal vaginal discharge and 3.5 % lower abdominal pain. 2.4% of the women had infertility. (Table 1). Among 356 women who reported gynaecological morbidity, 65.5 % reported single problem, 23.3 % reported 2 problems and 3.9 % women reported more than 3 problems. No. of gynaecological problems ranged from 1 to 6 in number (mean 1.51 ± 0.861) among women who reported at least one gynaecological morbidity. Out of 236 women who reported menstrual problems, 70.8% reported dysmenorrhea, 19.9% oligomenorrhoea and 17.8 % menorrhagia.

Table 1: Distribution of different gynaecological problems among study subjects (n = 800)

| S. No | Gynaecological Morbidity (n=800) | No. | % |
|-------|----------------------------------|-----|------|
| 1 | Menstrual problems | 236 | 29.5 |
| 2 | Low back ache | 97 | 12.1 |
| 3 | Abnormal vaginal discharge | 55 | 6.9 |
| 4 | Lower abdominal pain | 28 | 3.5 |
| 5 | Infertility | 19 | 2.4 |
| 6 | Frequent burning micturition | 19 | 2.4 |
| 7 | Pain during intercourse | 11 | 1.4 |
| 8 | Fever | 9 | 1.1 |
| 9 | Itching in genital region | 7 | 0.9 |
| 10 | Post coital bleeding | 1 | 0.1 |
| 11 | Nil Gynaecological problems | 444 | 55.5 |

Women in the 20 to 29 years age group reported least gynaecological morbidity (38.8%). 55.6 % of the women in 15 to 19 years age group and 54.3% of those in the 30 to 39 years age group reported gynaecological morbidity. This difference was found to be statistically significant ($p < 0.05$). Similarly gynaecological morbidity was found to be associated significantly with women's educational status, their age at marriage, duration of marital life, children ever born and age at first child birth. (Table no. 2)

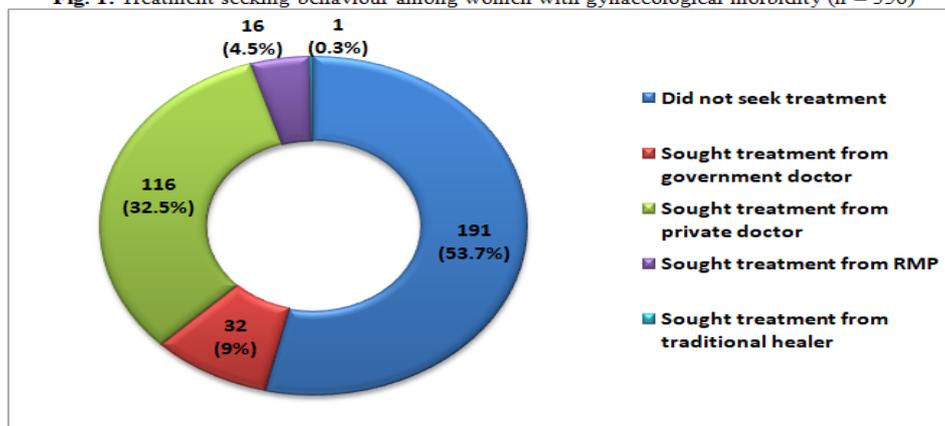
Table 2: Association between socio-demographic (SD) variables and gynaecological morbidity

| S.No | SD factor | Gynaecological morbidity Present (356) Absent (444) | Chi Sq | P value | OR | 95% CI |
|------|--|---|--------|----------|-----|-----------|
| 1 | Current age >30years | 182 (50.1 %) | 8.6 | 0.003** | 1.5 | 1.1 – 2.0 |
| 2 | Literacy – High School below | 340 (47.9 %) | 10.02 | 0.002** | 2.5 | 1.4 – 4.8 |
| 3 | Age at marriage <18 years | 263 (48.3 %) | 9.8 | 0.002** | 1.6 | 1.2 – 2.2 |
| 4 | Age at 1 st child birth <19 years | 148 (52.5 %) (n=735) | 17.3 | 0.00003* | 1.9 | 1.4 – 2.6 |
| 5 | Duration of marriage >10 years | 213 (50.7 %) | 13.8 | 0.0002** | 1.7 | 1.3 – 2.3 |
| 6 | Nulliparous | 41 (63.1 %) | 9.9 | 0.002** | 2.3 | 1.3 – 4.0 |

**p < 0.01 statistically highly significant

In the present study, of those suffering with gynaecological morbidity, 165 (46.3 %) women had sought some form of treatment. 32.5 % had taken treatment from a qualified private practitioner, 9% from a government doctor, 4.5 % from quacks and 0.3 % from traditional healers). The remaining 191 (53.7%) women did not seek any treatment (Fig.1). Reasons for not taking treatment included affordability, lack of time, shyness in expressing problem and fear of surgery. A popular belief is that treatment is not necessary for gynaecological problems and they will subside spontaneously as age increases.

Fig. 1: Treatment seeking behaviour among women with gynaecological morbidity (n = 356)



V. Discussion

Prevalence of gynaecological morbidity of 44.5% in the current study is on par with the findings of another similar study by Sogarwal R et al⁸ (46%) in India. In many studies it was much higher ranging from 70 to 88%^{9, 10, 11, and 12}. Reshmi RS et al¹³ and Stephenson R et al¹⁴ reported lesser prevalence (36% and 34% respectively).

Menstrual problems (29.5%) were the major complaints reported by study subjects in the present study followed by low backache (12.1%) as seen in a study by Inamdar IF et al⁹. In a study by Garg S. et al¹⁰ the common gynaecological morbidities reported were low backache (64%), vaginal discharge (57%), low abdominal pain (42%) and menstrual problems (26%). Majority of women with menstrual disorders remain undiagnosed in the community as they did not perceive it as a health problem. Women generally do not consult to health personnel for menstrual problems thus it persists in the community in large proportion.

Infertility was reported by 2.4% of women in the current study which is similar to other studies^{15, 16}. Inamdar I.F. et al⁹ (11.6%) and Dangal G et al¹⁷ report a higher prevalence (11.6 and 9.3 % respectively).

Women exposed to sexual activity at an earlier age are more vulnerable to gynaecological morbidities. Long marital duration is associated with higher parity and in turn higher gynaecological morbidities in developing countries. Illiterate and less educated women suffer from high gynaecological morbidity burden due to lack of awareness. Socio-demographic factors like women's age, educational status, their age at marriage, duration of marital life, children ever born and age at first child birth significantly influenced gynaecological morbidity as seen in other similar studies^{8, 9, 12, 18}.

In the present study, 46.3% of women with gynaecological morbidity had sought some form of treatment which is relatively better than seen in a study by Rangaiyan G et al¹¹ in which only 15 % had sought treatment. Women's lack of awareness may not be the main or the only reason for failure to seek treatment. Reasons can range from lack of time, insufficient money, physical inaccessibility, and refusal of husband's permission⁶. Even if some women do perceive it as a problem, they may fear ridicule to seek medical attention as other women do not consider it as an illness¹⁹.

VI. Conclusion

The high prevalence of gynaecological morbidity in the current study emphasise the need for health care systems to work with women at the community level. There is a dire need to educate women to identify important symptoms of gynaecological illness and to seek prompt treatment from the right source. All health personnel in the community and Anganwadi workers must be involved in discussions with adolescent girls and women in the reproductive age about their gynaecological problems. The message must be made clear that women need not suffer unnecessarily with such health problems. The health system must also be empowered at all levels with the essential diagnostic and management facilities to deal effectively with gynaecological morbidities seen in the community.

VII. Limitations of the study

Morbidity has been assessed based solely on self reported symptoms by the study subjects. Clinical examination and laboratory investigations have not been done because of logistic constraints.

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