CHAPTER – 3

REVIEW OF LITERATURE

Studies on reproductive and child health have assumed contemporary relevance after the International Conference on Population and Development (ICPD) in Cairo. An attempt has been made in this chapter to review the recent research focusing on reproductive health. The review has been presented as follows: first the international situation, then national scenario and last Kerala situation this is then described in three sections: studies on contraceptive ill-health, obstetric ill-health and gynecological ill-health. The objective is to identify the factors that contribute to the particular reproductive health behaviour and locate them in the framework of our study, viz., socio-cultural factors in reproductive health behaviour.

Studies on Contraceptive ill-Health

Edwards et al (2000) studied women’s knowledge and attitude towards contraceptive effectiveness and adverse health effects of women in Oxford. The result showed that women tended to overestimate the risks and underestimate the effectiveness of hormonal contraceptives. They were resistant to interference with their bleeding patterns and weight.

To assess the level of knowledge and use of family planning in Zimbabwe, Schwartz et al. (1999) conducted a study based on 6083 women from major cities in Zimbabwe. The results showed that as compared to the
1991 mother and child health survey, knowledge and coverage of family planning services have improved further, and in checking infection the introduction of contraceptives had proved a success.

Karel and Rasussen (1994) made an attempt to understand the knowledge and use of maternal and child health services by mothers in Papua New Guinea. The results indicated that use rate of a contraceptive method was very low among women who did not want to have another child within the subsequent two years. It was also observed that the most common method were injection and pills. Bolam et al (1998) evaluated the impact of post-natal health education for mothers on infants and on post-natal family planning practices. The study was based on 540 mothers from Kathmandu, Nepal. The study suggests that the recommended practice of individual health education for postnatal mothers in poor communities had no impact on infant feeding, care, or immunization, although uptake of family planning has slightly enhanced.

Islam et al. (1995) study based on data of 1941 ever married teenagers in rural Bangladesh showed that contraceptive use was 25 percent and was greater among women who talked with their husbands about family planning. Age and education also seemed to be predictors of contraceptive use.

Zhu (1998), tried to assess the status of reproductive Health and contraception and the future needs for family planning management in China. It was observed that contraceptive usage among women of child bearing ages
was 83.4 percent. 9.2 percent relied on male sterilization, 40 percent relied on female sterilization, 43.4 percent used IUDs and 4.1 percent used condoms. About 26 percent of women in married reproductive age had an unwanted pregnancy due to contraceptive failure. At the same time, the findings from the 1995-96 Puerto Rico Reproductive Health Survey among a sample of about 6000 women aged 15-44 years indicated that 29.1 percent used contraception at first intercourse. And 50 percent of women aged 15-24 years reported some sexual experience. Also, Contraceptive use was 77.5 percent and varied by age, educational level, and parity.

The focus of the paper, contraceptive knowledge and practice by women attending antenatal clinic in Ilea, Nigeria, by Ogunjuyige et al (1996), was to examine whether attendance at antenatal clinics does increase the knowledge and attitude of women who attend antenatal Health clinics and consequently increased their use of modern contraceptives.

Adolescence is a period when use of contraception is difficult because of lower compliance of the teenagers to these methods. Porozhanora et al. (1994) studied contraception among adolescents using 792 pregnant girls, 264 aborters and 528 teenage mothers. They found that only 12.88 percent of all patients had used birth control methods. Also, the condoms for men were the most popular and useful method in teenagers (4.23 percent) and natural family planning methods were practiced only by about 6.57 percent patients.
Adolescents form one of the largest groups with unmet needs for reproductive health services. One of the most important challenges facing reproductive health programmes in Asia is to address the needs of adolescents as they initiate sexual activity at an early age and are exposed to the risk of unwanted pregnancy and infection. Understanding the extent to which young people know about and use contraceptives is, therefore, a significant issue for research and policy. While knowledge of contraception is almost universal among married adolescents, understanding of specific methods and their sources is limited. Although rates vary among countries, there has been a significant increase in contraceptive use among unmarried adolescents but a large unmet need for contraceptives remains.

Data on contraceptive use by unmarried adolescent are rare but suggest even lower rates of use than among their married counterparts. Asian adolescents need accurate information about sexuality reproduction and contraception as well as user friendly reproductive health services, intervention research is needed to identify appropriate strategies to address these needs.

The number of studies on contraceptive ill–health is limited as compared to obstetric and gynecological ill–health. Most of the studies on contraceptive ill-health were carried out in developed countries. A few studies have been conducted in India during the last two decades (MOHFW, 1991; Bhatia and Cleland, 1995; CORT, 1995; SIFPSA, 1996). These studies have
found that a significant number of women experienced many ill-health problems related to the use of Intra-uterine device (IUD) and female sterilization. But these studies were based on clinical or community surveys having small sample size.

The reasons for not carrying out large community based contraceptive ill-health surveys in India are unknown. But, it is a fact that majority of people in the country are not using any contraceptive method. Most often the eligible couples have to compromise on the use of contraception to any one of the permanent terminating methods. The theoretical availability and unmet needs of contraceptive methods are well known. The majority of the couples use female sterilization as the only contraceptive method in their life time.

The experience of contraceptive morbidity has significant impact on the future continuation of the contraceptive methods particularly for the temporary method like IUD among couples. Bhatia and Cleland (1995) noticed that the prevalence of self reported symptoms of reproductive tract infections is relatively high among contraceptive users compared to non–users. They calculate the prevalence of various contraceptive ill-health symptoms among the users of IUD and tubectomy. Table 3.1 provides the percentage of current users of IUD and female sterilization and the various health problems arising out of them in the states of Karnataka, Madhya Pradesh and Uttar Pradesh from the Bhatia and Cleland’s study. Their study was based on sample surveys at the community level. It was noticed that most
of the women had backache and feel weakness and inability to work. Since prevalence of ill-health in these studies is derived from self-reports of the respondents, it is very useful to understand the future continuation of this contraceptive method.

Table: 3.1. Percentage of current users of IUD and female sterilization by problems in selected states of India

<table>
<thead>
<tr>
<th>Problem</th>
<th>Menstrual</th>
<th>Pain/Backache</th>
<th>Weakness/inability to work</th>
<th>Others</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karnataka</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>7.9</td>
<td>13.9</td>
<td>16.2</td>
<td>2.3</td>
<td>258</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>0</td>
<td>20.3</td>
<td>28.3</td>
<td>0</td>
<td>1263</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>7.1</td>
<td>32.0</td>
<td>19.3</td>
<td>13.4</td>
<td>-</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>6.2</td>
<td>4.2</td>
<td>-</td>
<td>1.0</td>
<td>187</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>-</td>
<td>14.6</td>
<td>5.0</td>
<td>8.0</td>
<td>151</td>
</tr>
</tbody>
</table>


To examine the relationship between MCH services and acceptance of terminal contraceptive method, Ramanujan (1997) studied the problem with a coverage of 405 adopters of terminal contraceptive methods and 480 non-
adopters in the rural area and 145 adopters of terminal contraceptive methods and 123 non adopters in the urban area in Tamil Nadu. The results of the study indicated that, though the average score of MCH services used was higher among adopters than non-adopters in both the urban and rural areas, difference was significant at 1 percent level in the rural area only. The findings implied that there is a strong evidence for the positive impact of utilization of MCH services on adoption of contraceptive method in the rural area but with less evidence in the urban area. The findings of the present investigation established the positive relationship between the use of MCH services and adoption of contraceptive method in the rural area. The findings suggested the need for improving the quality and reach of MCH services in all sections of population to the desired level and strengthening of the health information and education system in order to minimize the effect of factors which are negatively influencing the adoption of contraceptive method.

Mishra et al. (1995) presented a report based on the findings of the baseline survey of family planning programme in Agra district in UP. Family planning knowledge was universal, but knowledge of specific methods was limited, 66 percent in urban and 47 percent in rural areas had ever used contraception. Current use was higher among the better-educated women and higher caste Hindus. Major reasons for unmet need are identified as future plans for contraceptive use, dislike of existing methods, lack of services,
opposition by husbands or family members and menopause. Many reported a belief that family planning methods would result in complications.

These studies could establish the fact that a significant proportion of women who used a contraceptive method, particularly female sterilization and IUD suffer from various illnesses (Bhatia and Cleland, 1995). The recent study by Sowmini and Sharma, tried to find out the association between IUD use and female sterilization with reproductive morbidity among women in Kerala. The high prevalence rate of contraceptive use in the state in comparison with other states of the country was one of the reasons for selecting Kerala for their study area (Sowmini and Sarma, 2004). They noticed that the morbidity conditions such as reproductive tract infections, dysmenorrheal and menorrheal are more among the users of IUD. Again, women who have undergone sterilization are more prime to report menstrual problems especially dysmenorrhoeal. The chances of morbidity increase with the duration of contraceptive use for IUD and female sterilization (Ibid).

In another study on socio cultural determinants of contraceptive method choice in Goa and Kerala, India (1998) by Rajaretnam indicated that though Goa and Kerala are almost equally forward in respect of many socio cultural aspects as compared with most other states of India, contraceptive use was relatively low in Goa (48 percent) and high in Kerala (63 percent) but the proportion of users depending on reversible and traditional methods was high in Goa (36 percent) and low in Kerala (24 percent). In both states, socio-
cultural factors like education of women and Christianity play a major role and economic factors play no significant role in the choice of traditional and reversible methods. On the other hand, the choice of sterilization methods depended largely on the number and sex composition of living children of the couples and not on their socio cultural and economic conditions.

A study by Gulati (1996) highlighted specific important socio-economic, cultural and demographic determinants of the choice and use of contraceptive methods in different socio-economic and cultural settings of two states in India, Kerala and Uttar Pradesh. The study clearly highlighted that contraceptive use rates were significantly lower amongst the Muslims compared to the Hindus and other religious groups despite controlling all the important predictors of contraceptive use behavior. Also, the improvement in general health conditions and thus reduction in infant and child mortality helped in higher use of contraceptive methods.

A study based on 525 adolescents at Sree Avittam Thirunal Hospital, Medical College, Thiruvananthapuram from 1991 to 1996 revealed that non-use of contraceptives may be the reason for most of the unwanted pregnancy among currently married girls. Almost 76 percent of the sample who came for abortion is unmarried girls and 19 percent were currently married girls and the remaining ones were previously married but currently not residing with their husband.
Studies on Obstetric ill-health

The number of studies on obstetric ill-health is much higher as compared to contraceptive ill-health. Most of the studies on obstetric ill-health were based on clinical samples. It is difficult to consider many of these studies purely as obstetric ill-health studies because many of them were conducted as a part of the gynecological studies.

Previous studies acclaimed that maternal morbidity is high in less developed countries particularly in the Asian continent. Because of this, the International Conference held in Nairobi in 1987, gave much attention to maternal health through the safe motherhood initiative. This conference emphasized the need to reduce maternal mortality because even at that time half a million women die each year because of the pregnancy-related complication and a high significant number of deaths were from the less developed countries (WHO, 1986, Rochat, 1981; Tinker et al., 1993). Maternal mortality is just the tip of the iceberg of the obstetric problems of women and many women suffer severe disability due to pregnancy even though they survived (Bhatia, 1996).

Obermeyer and Potter analysed the patterns and determinants of maternal health care utilization using data from the Jordan Fertility and Family Health survey of 1983. The study focused on the utilization of prenatal care and on where and under whose care Jordanian women deliver their children. The author’s inclination was to suspect that the underutilization
of public preventive services in Jordan is a rational response to the deficiencies of the available services.

The determinants of the use of family planning, pre-natal care, child immunization and ORS were studied by Backer et al. (1993) using the survey data of 8000 women in Mebro Cebco, the Philippines. The results showed that maternal education was the most consistent and important determinant of use of the health services in both urban and rural areas. Also, economic status and access to service variables had less consistent patterns.

In a study based on 5304 births in the hospital of Pelotas, Brazil, Balpern et al. (1998) examined neonates and their mothers regarding socio demographic conditions, family income, reproductive health, and medical care during pregnancy. The study showed that 95 percent of women received per-natal care. It was also noted that women who did not receive prenatal care were from the lowest socio-economic stratum and were mostly adolescents or over 50 years of age. Prenatal mortality rate was 50.6/1000 on the group without prenatal care and 15.8/1000 in the group with more than 5 visits. With regard to utilization of health care, the study showed that 25 percent of women with high gestational risk received inadequate prenatal care. The study suggested the need for improvement in the quality of prenatal care with special attention to mothers with high gestational risk.

The estimates for maternal morbidity and mortality during the period of 1980s and 90s in various parts of the world suggest that the problem is
severe in the world. World Bank (1993) calculated the number of morbidities in each year using various estimates of small studies across various places of the world and found that around 8.25 million morbidities are happening each year worldwide. However, Koblinsky et al. (1993) calculated that there are over 100 acute morbidity episodes for every maternal death, giving a global total of 62 million morbidities annually.

There are a few studies on obstetric ill-health conducted in India during the last decades. Most of them are clinical based studies and a few are combined level of community and clinical surveys.

A retrospective hospital study done in Pondicherry by Rathore et al. during August 1984 to July 1994 found that incidence of genital prolapse was found to be 28 in 373 deliveries. Around 6.1 percent were below 20 years of age 77.5 percent were in the age group of 21-30 years and 16.3 were among 31-40 of age. About a third of the women had no previous pregnancies or only one pregnancy. In case of 40 percent women, the duration of prolapse was less than a year. For 306 percent women it was between 1-3 years and in 29.5 percent cases it was more than 3 years. Retention of urine was the most common urinary complication. Abortion and premature birth were the most common obstetric complications observed (Rathore et al., 1996).

A study in urban slums of Delhi by Batnagar et al. (1998) on maternal and child health status and pattern of health care, covers 1085 currently married women in 4 slums of Delhi Eleven percent of the sample women
were pregnant at the time of survey with less than 1/4 of them registers for ANC, 16 percent of them were receiving iron and folic acid tablets and 12 percent were protected against tetanus.

The maternal morbidity due to massive obstetric haemorrhage in Pune, Maharashtra has been studied by Pawas et al., in 1996. This prospective hospital based study noticed that in 66 percent of cases, massive obstetric haemorrhage occurred in late pregnancy, in 18 percent of cases in early pregnancy and in 16 percent of the cases it was after delivery. There were major complications in 43 percent of the cases. Hyperemic shock occurred in 53.5 percent of the cases. The study also found that massive obstetric haemorrhage was associated with surgical interventions like accidental injury to the bladder during caesarian-sections, bower injury during suction of vesicular mole and during medical termination of pregnancy (MTP) and perforation of the uterus. Ten women died following the massive haemorrhage.

A prospective study was conducted by Ramakrishna et al. (2000) in rural Karnataka to establish the type and extent of obstetric morbidity, explore health seeking behaviour and factors affecting service uptake during the study period. The study started in August 1996 and the sample consisted of 388 women out of the total 535 women registered at the ages of 18-24 years. The information was collected through questionnaires during pregnancy, immediately after pregnancy and three months post partum. The socio-
economic characteristic and symptoms of post delivery illness were also collected. Qualitative data containing perceptions of morbidities and process of care seeking were taken from a subset of women. The study found that antenatal care is very high. Around 97 percent of women reported that they have routine antenatal care check up and the most common person consulted was the Auxiliary Nurse Midwife (ANM). More than half of the women had their first contact in the first trimester. The delayed contact was more common among women who were poorly educated and had fewer possessions.

An attempt had been made by Niranjan and Rao (1996) in their paper to examine to what extent the socio-economic characteristics affect the use of MCH services in Andhra Pradesh. The findings of the study clearly indicated that among the background characteristic of the respondent’s education level is positively associated with the use of MCH services. Religion is found to be significant in the utilization of health care services. The utilization services were also found to be poor in low caste rural and agricultural respondents.

The adolescent pregnancy in Manipal, Karnataka was examined by Shobana et al. in 1997. This study was based on a retrospective hospital survey. The study was conducted during 1989-93. Around 347 pregnancies including all gravidae less than 20 years of age at the time of delivery were included in the study. The study population constituted around 5.5 percent of all admission for delivery in the hospital. Around 82.2 percent were
primigravidae and the remaining was second grvidae. Unwed mothers were around 3.1 percent of the pregnant women. Around 57 percent of the women had spontaneous vaginal delivery. The caesarean section was 31 percent. Antenatal complications were found in 64 percent of the women under study. The most common complications are abortion with 25 percent, followed by pre-eclampsia with 20 percent. Around 16.5 percent of the cases have anaemia. One maternal death has also occurred due to post partum haemorrhage. The still birth and neonatal deaths are 24 and 7 respectively. More than one third of the adolescents (37.3 percent) delivered low birth weight babies and the pre-term deliveries were about 13 percent (Shobhana et al. 1997).

Begum, 1998, conducted a hospital based prospective study at the Sree Avittom Thirunal Hospital in Trivandrum, Kerala. She noticed that 90.5 percent of the pregnant women were from rural areas and two –third belonged to lower socio-economic group; primigravide were 45 percent and around 93 percent of them had regular antenatal check-up. Among the study population, 53.3 percent were high risk and 5.3 percent were of severe risk group rating. There were two maternal deaths among the high risk pregnancy group and were related to caesarian section. Caesarian section was greater in the high risk group compared to the low-risk group. This was statistically found significant. This study noticed that there was an increase in the rate of c-sections with the increase in maternal age and parity. It was also found that
prenatal mortality and low birth weight were associated with high risk pregnancies. Manual labour and reduced food take during pregnancy have adversely affected the pregnancy outcomes.

Asari and Sathyan’s (1997) study based on married women in Kerala described that most pregnant women in the sample area attend the antenatal clinics, which had indirect effect on the lowering pregnancy wastage in term of miscarriages and still births. They also held the view that the increase in the rate of immunization of women and children and the improvement in food habits, personal hygiene and safe drinking water had influenced the reproductive health of women.

In an unpublished report “How effective is the policy in Kerala”, Vijayakumar et al. tried to assess whether the distribution of iron and folic acid tablets through Primary Health Centres (PHC) has had a positive impact on the haemoglobin status of women using antenatal services at these centers. Factors such as age, socio-economic status, parity and presence of complications had little influence on prevalence of anaemia. The prevalence of anaemia among women going for rural institutions is higher compared to that of urban institutions. This means that rural women had more anaemia compared to urban women. The urban women went for antenatal check up in earlier trimester of pregnancy and this may have reduced the prevalence of anaemia among them. The study recommended that in Kerala, in spite of the universality of antenatal services, promotion of early registration during
pregnancy may help in bringing the prevalence of anaemia among pregnant women further down.

**Studies on Gynecological ill-health**

Plenty of studies are available on Gynecological ill-health in international level. The risk of acquiring HIV infection during pregnancy is more than double that at other times. A Ugandan study of 2,188 HIV – negative sexually active pregnant women and 8,473 control women clearly showed that this increase is unlikely to be due to sexual risk behaviours of the pregnant woman and their male partners than the other group. Though condom use was lowest in the pregnant women group, so were symptoms of genital ulcers; a known pre-disposing factor for the acquisition of HIV.

Official data on the prevalence and nature of STIs in Bangladesh is very limited, due in large part to the lack of information systems to record the incidence of such infections and the inability of health–care workers at the grass roots level to diagnose STIs. Some studies indicate that there are 2.3 million individuals infected with STIs. Surveillance systems for HIV/AIDS are similarly weak.

Sexually transmitted diseases (STDs) are a major cause of reproductive tract infections. More than 300 million causes of curable STDs – trichomeniasis, chlamydia, gonorrhea and syphilis – are estimated to occur world-wide each year. Current estimates from North America and Western Europe indicate that eight or nine of every 100 persons aged 15-49 are
infected with a curable STD each year, further rates of infection in some regions of the developing world are as much as three times as high. Worldwide STDs (including AIDS) accounts for 16% of the time that women of reproductive age lose because of this disability – about the same as time lost as a result of maternal conditions.

Plenty of studies are available on gynecological ill-health in India. Most of these studies are based on clinic or small sample surveys. The method usually called symptomatic approach was mainly used for understanding the level of gynecological ill-health in most of these studies. Thus the method solely depends on the symptoms of gynecological diseases. The policy makers and researchers utilise this information to calculate the prevalence of gynecological ill-health in the community.

Almost all previous studies have documented a high prevalence of self-reported gynecological ill-health among women in various parts of the country (Bang et al. 1989, Pachuri et al. 1994; Bhatia et al. 1995, Singh et al. 19995, Rano et al. 2003). The common self-reported gynecological ill-health symptoms by women in many parts of the country were abnormal vaginal discharge, irregular vaginal bleeding, lower abdominal pain, infertility menstrual problems and genital prolapse.

Majority of the studies conducted at the community level of the country were based on small samples and the methodology used by them was symptomatic approach. This raises many criticisms about the accuracy of the
present level of gynecological morbidity. Some researchers argue that it only provides a rough estimate of the prevalence of ill-health among women in the country. For instance, Michael Koenig et al, view that the estimates computed through small samples were either under- as over- estimates (Koenig et al. 1996). However the clinical based studies that were performed followed by the community based studies in many places of the country established the fact that estimates from the community-based studies using symptomatic approach are more or less accurate to assess the prevalence of various diseases in the community.

Table 3.2 provides the prevalence of self–reported and clinically diagnosed gynecological ill–health among women in six studies across various parts of the country.

Table: 3.2. Prevalence of self reported and clinically diagnosed gynecological morbidity among women

<table>
<thead>
<tr>
<th>Location</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample size</td>
<td>654</td>
<td>500</td>
<td>756</td>
<td>840</td>
<td>440</td>
<td>110</td>
</tr>
<tr>
<td>Menstrual problems</td>
<td>60</td>
<td>33</td>
<td>41</td>
<td>58</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td>Excessive discharge</td>
<td>13</td>
<td>50</td>
<td>31</td>
<td>22</td>
<td>22</td>
<td>57</td>
</tr>
<tr>
<td>Lower abdominal pain</td>
<td>13</td>
<td>17</td>
<td>21</td>
<td>9</td>
<td>16</td>
<td>NA</td>
</tr>
<tr>
<td>Lower back pain</td>
<td>37</td>
<td>5</td>
<td>39</td>
<td>24</td>
<td>NA</td>
<td>30</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>7</td>
<td>2</td>
<td>NR</td>
<td>NR</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>One or more conditions</td>
<td>55*</td>
<td>65</td>
<td>74</td>
<td>65</td>
<td>NA</td>
<td>84</td>
</tr>
</tbody>
</table>
Clinically Diagnosed

<table>
<thead>
<tr>
<th></th>
<th>650</th>
<th>500</th>
<th>756</th>
<th>548</th>
<th>385</th>
<th>324</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual problems</td>
<td>62</td>
<td>4</td>
<td>15</td>
<td>11</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Excessive discharge</td>
<td>48</td>
<td>14</td>
<td>40</td>
<td>13</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Lower abdominal pain</td>
<td>46</td>
<td>2</td>
<td>21</td>
<td>5</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Lower back pain</td>
<td>24</td>
<td>1</td>
<td>16</td>
<td>8</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>0.5</td>
<td>17</td>
<td>18</td>
<td>5</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>One or more conditions</td>
<td>NA</td>
<td>43</td>
<td>74</td>
<td>26</td>
<td>70</td>
<td>43</td>
</tr>
</tbody>
</table>

NR = not recorded; NA = could not be ascertained from available data

* Does not include lower back pain and lower abdominal pain.


2. CINI’s (Child is Need institute) study in Rural West Bengal, 1990-91 (BCC et al, 1995, Bhattacharya, 1994)


4. BCC’s (Baroda Citizen Council) study in Baroda, 1990-91 (BCC et al, 1995; Latha et al, 1994)


Using the six studies mentioned above, Koenig et al., 1996 analysed the major issues related with the reproductive health among women in India. These studies demonstrate the central importance of close engagement with the community for the successful completion of such studies. These studies illustrate the importance of giving appropriate medical care to the respondents. Many women utilized these surveys as an opportunity to address their reproductive health problems. The importance of ascertaining and using local terminology and language when querying about gynecological conditions were well illustrated in these studies. The biggest methodological problems in self– reported response on gynecological morbidity may be the underreporting of gynecological problems by women (Koenig, et al. 1996).

It is a well accepted fact that reproductive tract infection (RTI) is a major threat for women’s health. Globally, the morbidity and mortality among women are significantly caused by three different types of RTI (Lien et al. 2002). They are sexually transmitted diseases, endogenous infections and iatrogenic infections. The common sexually transmitted diseases among women are gonorrhea, clamydia, syphilis, trichomenas and recently HIV infections. The endogenous infection is resulting from the overgrowth of organisms normally present in the reproductive tract. For example candidacies
and bacterial vaginosis. The iatrogenic infections are mostly related to medical procedures such as menstrual regulations, abortion and insertions. So, the prevalence of iatrogenic infections gives an ideal of the general quality of health service provision available for women in a community.

Oomman (2000) studied the determinants of morbidity as perceived by women in relation to their socio-economic context. The study was carried out in three phases. First, an ethnographic study, second a cross section community based survey and third, a clinical study. In addition to key informant’s interviews, focus groups discussion, body mapping, participant observation, and direct observation, free listing, past illness narratives and semi-structured interviews were conducted. The study found that 47.9 percent of women had menstrual problems. The causes described by the women were weakness, worry, abortions, problems in delivery, eating hot foods, drinking too much tea, wearing a copper–T and men sleeping with other women. Around 20 percent of the women who claimed that they had prolapse could not distinguish between vaginal and uterine prolapse. Economic constraints are considered the significant underlying cause of all women’s illness because women’s perception of it can lead to physiological weakness. Majority of women did not seek any treatment for their illness like discharge, menstrual problems etc. In the case of severe illness, the most frequent first informed person was husband.
Bhatia JC and John Cleland (Ibid.) studied the self-reported symptoms of gynecological morbidity and their treatment in South India. This cross-sectional community survey consisted of 3600 women aged below 35 years and having at least one child younger than 5 years. They noticed that anaemia, and lower reproductive tract infections, menstrual problems and acute pelvic inflammation were the reported problems by women. The women who reported that their symptoms lasted for more than one year were around 20-25 percent. The mean duration for symptoms associated with prolapsed, and vaginal/coloured vaginal discharge were 12 months and 26 months respectively. The proportion of women who sought treatment for various conditions except for infertility ranged from 43 to 55 percent. Women who had lower economic status, less education (fewer than 6 years of schooling), and lower class background were more likely to report symptoms of illness compared to other women.

Parvez et al made a community-based longitudinal study of discharge cases among women in Chandigarh during the period 1992-93. They observed that 30 percent of women had vaginal discharge for more than one year. These women were referred to a postgraduate institute located 5 kilometers away for further check-up and treatment. More than half of these women refused to go to the institute for treatment for various reasons such as lack of time, difficulty to go, unsuitable dates, and fear of multiple follow-up visits, nobody to take after children, expensive treatment and difficulty in locating
outpatient department in the institute. All the women who came for check-up had chronic gynecological morbidity like cervical erosion, chronic cervicites, non specific vaginitis and cervical polyp.

A qualitative study was done in Mumbai by Ramasubhan and Bhanwas (1997). The study tried to delineate the experiences of slum dwelling women regarding weakness and explore its linkages with reproductive health problems. Causes of weakness perceived by women were neglect of diet, pregnancy and childbirth, experience of sterilization, white discharge, tuberculosis, excessive housework, menstruation and mental stress. Health seeking for weakness takes place only when distress is so acute that housework is not possible.

The reported and clinically manifest gynecological morbidity were studied by Shenoy et al., in Thiruvananthapuram during 1995-96. This study also assessed the sensitivity and specificity of reported symptoms as against clinical and cytological examination. This cross sectional survey covered 1,383 women aged 13-48 years selected from five Panchayats of Thiruvananthapuram by cluster sampling. The study found that 30 percent of women had a prior gynecological consultation. The predominantly reported morbidities were vaginal itching, discharge per vaginum, lower abdominal pain and back pain. The percentage of women reporting these symptoms were 10.8, 26.8, 27.5 and 50.4 respectively. Women aged 20-39 years had higher level of problems like vaginal discharge, dysparencia, menstrual problems,
lower abdominal pain and back pain. This was also found statistically significant.

The sensitivity and specificity of clinically diagnosed vaginistis with reported vaginal discharge were 75 percent and 76 percent respectively. But in case of reported vaginal discharge with abnormal cytology, the sensitivity and specificity were 69 and 68 percent respectively. The study noticed that genital prolapse and parity higher than 2 were highly associated. The study also found that women who had postpartum sterilization had 26 times higher risk for gynecological morbidity. Similarly women who had parity 3 or more had 2.1 times higher risk of illness (Shenoy et al, 1996).

In brief, although a lot of research has been done in this field, several dimensions of gynecological morbidity particularly socio-demographic, behaviour, biomedical process and health seeking pattern are remaining relatively unexplored.

However, from the foregoing studies, one could easily cull out some of the sociological and cultural factors that characterise the health seeking behaviour of women in reproductive age and factors that stand as obstacles to making use of the treatment even when available. It is not absence of knowledge _per se_ that prevents a woman from approaching health service personnel, it is also culturally rooted factors - beliefs about certain food being taboo, certain behaviours being socially forbidden, shyness etc., which are rooted in culture - that are responsible for abstaining from seeking medical
assistance. Even negligence has a cultural basis as this would come out of an attitude that reproductive health matters are part of a woman’s normal reproductive process and do not need to be medically treated or even cared for.

At the same time, we should point out that these studies have certain limitations. They were done at different times and in different countries which are spatially, culturally and socially different from one another. Moreover, they are all micro studies whose findings may not have validity beyond their culture and the level of knowledge on reproductive health matters prevailing in these cultures at the point of time in which the studies were conducted (space and time limitations). For example, studies have shown that in the same countries, findings have varied because reproductive knowledge had changed. Even so there are certain basic findings that have validity beyond their cultural boundaries because they are based on human biology and basic human behaviour. On the basis of these findings we have formulated our hypotheses for the present study. These hypotheses are given in the next chapter, methodology.