Chapter IV

RESULTS AND DISCUSSION

(Socio-economic and dem...
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SOCIO ECONOMIC AND DEMOGRAPHIC FACTORS

4.1 Socio-Economic and Demographic Factors

Socio-economic demographic variables play a vital role in shaping the state of health. The health status of women is influenced by several socio-demographic variables such as educational status, marital pattern, occupation and so on. Socio-demographic factors are as important as physical health variables in affecting a person's ability to function normally in their everyday life. Research indicates that socio demographic variables are the key factors in determining the quality of life of women. Inequities in wealth and quality of life, low socio economic conditions among women and its correlates, such as poverty, lower education, and poor health ultimately affect our society as a whole. Women's health in India can be examined in terms of multiple indicators, which vary by geography and socioeconomic standing. To adequately improve the health of women in India multiple dimensions of wellbeing must be analyzed. Health is an important factor that contributes to human wellbeing and economic growth. Currently, women in India face a multitude of health problems, which ultimately affect the aggregate economy’s output.

In this section an attempt has been made to describe the socio economic-demographic characteristics of the respondents. The socio-economic and demographic variables of the selected married women are coded and analysed.
4.2 Age

It is a fact of life that health declines with age. For the women delaying the age of cervical screening increases the risk of cervical cancer.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>117</td>
<td>23.40</td>
</tr>
<tr>
<td>30-39</td>
<td>216</td>
<td>43.20</td>
</tr>
<tr>
<td>40-49</td>
<td>74</td>
<td>14.80</td>
</tr>
<tr>
<td>50-59</td>
<td>93</td>
<td>18.60</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The data presented in table no.4.1 reveals that more than two fifths of the respondents (43.20 percentage) were in the age group of 30-39 years as against less than a quarter (23.40 percentage) of the respondents in the age group of 20-29 years. Less than one fifths (18.6 percentage) of the respondents were in the age group of 50-59 years followed by only a minor proportion (15.0 percentage) in the age group of 40-49 years.

It can be observed from the above data majority of respondents were in between the ages of 30-39 years. This can be because this age group is the highest peak period of child bearing age of women, describing them as being sexually active, more likely to have exposure to HPV and to develop pre-cancerous lesions. Traditionally the assumption has been that this age group accesses the healthcare system more often in order to receive contraception and pregnancy care.
Table No.4.2: Percentage distribution of Respondents Husbands by their age

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-29</td>
<td>152</td>
<td>30.40</td>
</tr>
<tr>
<td>30-39</td>
<td>171</td>
<td>34.20</td>
</tr>
<tr>
<td>40-49</td>
<td>94</td>
<td>18.80</td>
</tr>
<tr>
<td>50-59</td>
<td>67</td>
<td>13.4</td>
</tr>
<tr>
<td>60-69</td>
<td>16</td>
<td>3.20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The above data reveals that slightly more than one third of the respondents (34.2 percentage) husband’s age group was in between 30-39 years (Table No.4.2) followed by less than one third of the respondents (30.4 percentage) of husband’s age was in between 21-29 years. Less than one fifths (18.8 percentage) of the respondents husbands age is between 40-49 years, 13.4 percent of husbands age group was in between 50-59 years and very fewer proportion (3.2 percentage) of respondents husbands age was in between 60-69 years.

4.3 Age at Puberty

Normally the age of puberty is between 10-11 years of age but can be as early as 8 years or as late as 13 years. As soon as breasts begin to develop, girls begin to grow much more rapidly (this is why girls are often taller than boys at 11-12 years of age). It is at this time there is a need to educate girls menstrual hygiene practices to prevent and maintain healthy life style.
Table No.4.3: Percentage distribution of Respondents by their age at Puberty

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-12</td>
<td>160</td>
<td>32.00</td>
</tr>
<tr>
<td>13-14</td>
<td>320</td>
<td>64.00</td>
</tr>
<tr>
<td>15-16</td>
<td>20</td>
<td>3.20</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

More than two thirds of the respondents (64.0 percentage) puberty age was in between 13-14 years followed by, one third of respondents (32.0 percentage) between by 11-13 years (Table No.4.3) and only a minor proportion (3.2 percentage) of the respondents age at puberty was in between 15-16 years.

4.4 Age at Marriage

Marriage is a universal institution. Entering into marriage relationship is intended to meet sexual and reproductive needs. In Indian society in general people prefer early age at marriage, it may affect health status of women. The studies have found that early married girls have many disadvantages related to health, social, and economic spheres, hampering their ability to negotiate their reproductive health.

Table No.4.4: Percentage distribution of Respondents by their Age at Marriage

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-18</td>
<td>277</td>
<td>55.4</td>
</tr>
<tr>
<td>19-22</td>
<td>179</td>
<td>35.8</td>
</tr>
<tr>
<td>23-26</td>
<td>11</td>
<td>2.20</td>
</tr>
<tr>
<td>27-30</td>
<td>17</td>
<td>3.40</td>
</tr>
<tr>
<td>31-34</td>
<td>16</td>
<td>32.20</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The data presented in table 4.4 reveals that more than half of the respondents (55.4 percentage) were married between the age of 15-18 years followed by more than one third of the respondents (35.8 percentage) between the age of 19-22 years and a very minor proportion (3.40 percentage) were married between the age of 27-30 years, 31-34 year (3.2 percent) and 23-26 years (2.20 percent). On the whole an overwhelming proportion of the respondents were married by 22 years of age.

Age at marriage is considered as a proxy measure of age at first sexual intercourse, but it did not come out as an independent risk factor for cervical cancer. Recently a pooled analysis of case control studies on cervical cancer from eight developing countries provide convincing evidence for the risk associated with early age at first sexual intercourse (Mukherjee et al., 1994). Moreover, age at first sexual intercourse, age at marriage and age at first pregnancy were highly interrelated in developing countries, where mostly there is a very short latency period between age at marriage and age at first pregnancy (Louie et al., 2009).

4.5 Number of Children

Number of children in the family is a complex area with many factors combining to influence children’s health and development. A child's health and wellbeing depends on what happens to them as individuals, as part of a family, as members of communities and within society as a whole. More number of children may affect health of mother followed by childs health.
One third of the respondents (33.6 percent) had two children (Table No.4.5) followed by one fourth of respondents (26.0 percent) with 3 children. Nearly one fifth (19.0 percent) of the respondents had one child, and 12.0 percent of respondents with 4 children, 5 children and above (2.8 percent) and 6.6 percent of the respondents does not have children.

Supporting the literature, having four or more children can be a predominant factor for cervical cancer. The results from a case control study in Chennai showed that high parity (>4 vs. ≤ 2 births) was associated with invasive cervical cancer (OR=7.3)

4.6 Number of Pregnancies

Number of in pregnancies refers to the number of pregnancies women got, no matter the pregnancies were completed or not. If the women become more times pregnant it may cause health problem and also risk of developing cervical cancer.
Table No.4.6: Percentage distribution of Respondents by Number of pregnancies

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I\textsuperscript{st} pregnancy</td>
<td>99</td>
<td>19.8</td>
</tr>
<tr>
<td>II\textsuperscript{nd} pregnancy</td>
<td>165</td>
<td>33.0</td>
</tr>
<tr>
<td>III\textsuperscript{rd} pregnancy</td>
<td>138</td>
<td>27.6</td>
</tr>
<tr>
<td>IV\textsuperscript{th} pregnancy</td>
<td>82</td>
<td>16.4</td>
</tr>
<tr>
<td>Above V</td>
<td>16</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

One third (33.0 percent) respondents had II\textsuperscript{nd} pregnancy, followed by more than one fourth of the respondents (27.6 percent) with III\textsuperscript{rd} pregnancy (Table No.4.6). One fifths (19.8 percent) had I\textsuperscript{st} pregnancy, only 16.4 percent of the respondents were with IV\textsuperscript{th} pregnancy and a minor proportion (3.2 percent) with above V.

Birth interval or the rapidity of multiple pregnancies also has an independent influence on the risk for cervical cancer (Mukherjee et al., 1994). The pregnancy induced cervical changes may predispose to malignant transformation, and multiparity may increase the risk of cervical cancer by maintaining the transformation zone on the ectocervical region for several years, resulting direct exposure to HPV and other cofactors (Hinkula et al., 2004).

4.7 Family

Family related health problems fall into two categories: physical and mental illnesses or syndromes. There are several types of illnesses in both categories that are genetically inherited, often passed down strictly through either the maternal or paternal side of the family genealogy.
Table No.4.7: Percentage distribution of Respondents by Type of Family

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuclear</td>
<td>342</td>
<td>68.4</td>
</tr>
<tr>
<td>Joint</td>
<td>157</td>
<td>31.4</td>
</tr>
<tr>
<td>Extended</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

In the present table two third of the respondents (68.4 percent) were in nuclear families as against one third of the respondents (31.4 percent) in joint families followed by a very minor proportion 0.2 percent in extended families (Table No.4.7).

4.8 Education

Education has been universally acknowledged as one of the single most powerful factor of socio economic development that helps in the maintenance of health.

Education is the fundamental factor among the socio demographic and reproductive determinants of cervical cancer in low resource settings. Public awareness through education and improvements in living standards can play an important role in reducing the high incidence of cervical cancer in India.

Table No.4.8. Percentage distribution of Respondents by their Education

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterates</td>
<td>278</td>
<td>55.6</td>
</tr>
<tr>
<td>Primary education</td>
<td>167</td>
<td>33.4</td>
</tr>
<tr>
<td>Secondary education</td>
<td>55</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
More than half of the respondents (55.6 percent) were illiterates (Table No.4.8) as against one third of the respondents (33.4 percent) had primary education followed by only 11.0 percent of the respondents with secondary education.

Studies by Lockwood-Rayermann (2004, p. 355) and Lee (2000) have reported that the level of education is a contributing factor to a woman's ability to understand the importance of healthcare, the diagnosis of cervical cancer and the benefits of screening. Generally, the better educated a woman is, the healthier she is likely to be. The better the education, the more likely the women is to adopt healthy behaviours and healthy lifestyles. However, Breitkopf, Pearson and Breitkopf (2005) advised health care providers to exercise caution when using reported education level as a guideline for educating and communicating the clients about cancer screening, as many clients have low reading levels. Health care providers should use effective educational techniques which tailor information to populations with low literacy like the use of pictures and videos as well as clarifying with clients what particular words mean to them.

Table No.4.9: Percentage distribution of Respondents Husbands by their Education

<table>
<thead>
<tr>
<th>Husbands Education</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterates</td>
<td>253</td>
<td>50.60</td>
</tr>
<tr>
<td>Primary education</td>
<td>172</td>
<td>34.40</td>
</tr>
<tr>
<td>Secondary education</td>
<td>61</td>
<td>14.0</td>
</tr>
<tr>
<td>College education</td>
<td>14</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Half of the respondent’s husbands (50.6 percent) were illiterates followed by one third of respondent’s husbands (34.4 percent) with primary education (Table.4.9) and only 14.0 percent of the respondents husbands had secondary education and very fewer proportion (2.8 percent) of them had college education.

4.9 Occupation

Occupation is an indicator of the status or class of a person. It is one of the important socio-economic variable.

Table No.4.10: Percentage distribution of Respondents by their occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooli</td>
<td>296</td>
<td>59.2</td>
</tr>
<tr>
<td>House wife</td>
<td>153</td>
<td>30.6</td>
</tr>
<tr>
<td>Petty Trade</td>
<td>51</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Nearly three fifths of the women (59.2 percent) were coolie / daily labourers (Table No.4.10) as against less than one third (30.6 percent) were house wives and only 10.2 percent of the respondents were in petty trade like selling fruits, vegetables and milk.

Lockwood-Rayermann (2004, p. 355)’s study have found that economic circumstances (environmental resources) are vitally important factors in the health promotion of any community. Employment is expected to provide a source of income to the individual as well as an opportunity for access to the employer providing insurance coverage at either minimal or no expense to the employee (Gosschalk and Carrozza, 2009).
Occupation, type of house and family income were the measures to assess the economic status of the women who participated in this study and those are interrelated. Manual workers were mainly the labourers working in the agricultural sector and housewives/others included those women who were taking care of their family and doing house works or working in public or private sectors.

**Table No.4.11: Percentage distribution of Husbands by their occupation**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>245</td>
<td>49.0</td>
</tr>
<tr>
<td>Cooli</td>
<td>145</td>
<td>29.0</td>
</tr>
<tr>
<td>Migrated</td>
<td>110</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>500</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Half of the respondents husbands (49.0 percent) were in agricultural occupation (Table No.4.11) whereas more than a quarter (29.0 percent) of the husbands were cooli / daily labourers and more than one fifths (22.0 percent) of the respondents husbands migrated to kuwait for occupation.

### 4.10 Income

The income health relationship occupies a central place in the domain of research on factors influencing household decision making in health care services.

**Table No.4.12: Percentage distribution of Respondents by their family income per month**

<table>
<thead>
<tr>
<th>Income (Rs.)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000-5000</td>
<td>341</td>
<td>68.2</td>
</tr>
<tr>
<td>6000-10000</td>
<td>95</td>
<td>19.0</td>
</tr>
<tr>
<td>11000-15000</td>
<td>50</td>
<td>10.0</td>
</tr>
<tr>
<td>16000-20000</td>
<td>14</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>500</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
More than two third of the (68.2 percent) respondents monthly family income was in between is Rs.1000-5000 (Table No.4.12) followed by one fifths (19.0 percent) of the respondents had monthly family income between Rs.6000-10000. Only 10.0 percent of the respondents family monthly income was in between Rs.11000-15000, a very minor proportion 2.80 percent of the respondents monthly family income was in between Rs.16000-20000.

4.11 Abortions

Abortions are categorized as safe or unsafe using World Health Organization definitions. WHO defines unsafe abortion as a procedure meant to terminate an unintended pregnancy that is performed by individuals without the necessary skills, or in an environment that does not confirm to the minimum medical standards, or both this practices makes women to become ill health.

**Table No.4.13: Percentage distribution of Respondents by their Abortions**

<table>
<thead>
<tr>
<th>Abortions</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous abortions</td>
<td>40</td>
<td>60.6</td>
</tr>
<tr>
<td>Induced abortions by doctor</td>
<td>7</td>
<td>10.6</td>
</tr>
<tr>
<td>Induced abortions by self</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Among those who had abortions less than two thirds of respondents (60.6%) (Table No.4.13) had spontaneous abortions followed by a more than quarter (28.8%) had induced abortions by self using traditional practices and only 10.6% of the respondents had induced abortions by doctor.
4.12 Religion

Religion is usually asked in order to ensure whether patients have the appropriate religious attention if required. However it is also important in considering the medical needs and preventive health practices based on their cultural acceptance.

Table No.4.14: Percentage distribution of Respondents by their Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindu</td>
<td>319</td>
<td>63.80</td>
</tr>
<tr>
<td>Muslim</td>
<td>145</td>
<td>29.0</td>
</tr>
<tr>
<td>Christian</td>
<td>36</td>
<td>7.2</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Nearly two third of the respondents (63.8 percent) belonged to Hindu religion followed by more than quarter (29.0 percent) were Muslims and only 7.2 percent of respondents were Christians (Table No.4.14).

Dunn et al. (2005)’s study found that churches have a strong social influence in their communities as they can facilitate access to information of cancer screening to the lay communities. As they exist in practically every community and have the ability to influence the hardest to reach populations, church members have the potential to receive life saving messages and to disseminate health information to others in the community who do not attend a particular faith community. The oral culture of inseminating health information is vital in decreasing the morbidity and mortality of rural community.
4.13 Habits

Un-healthy habits can often damage our health. They can make the person feel unwell. They can have long-term effects on their physical condition. If the person want to live a long and healthy life, there may be some unhealthy habits that he / she needs to overcome to maintain good health.

Table No.4.15: Percentage distribution of Respondents by their habits

<table>
<thead>
<tr>
<th>Habits</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>195</td>
<td>39.0</td>
</tr>
<tr>
<td>No</td>
<td>305</td>
<td>61.0</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Three fifths of the respondents (61.0 percent) do not had any habits as against the remaining two fifths (39.0 percent) had habits like chewing betal leaves and tobacco (Table No.4.15). Pan chewing with or without tobacco was common among manual workers and low educated women in the community.

To sump up

In the present study majority of women were within 20-39 years of age groups. The mean age of puberty was in between 13-14 years. More than half of the respondents were married before the legal age at marriages of 18 years. Majority of the respondents had 2 to 3 children and with II & III pregnancies. Nuclear families were predominantly observed in the sample population. More than half of the women are illiterates followed by primary education. The same pattern has also been observed in their husband’s educational level. Nearly two three fifths of the women are daily labourers. Hindus were more in the sample population. Two fifths of the women had habits like chewing betal levels and tobacco chewing.