Gynaecological Morbidity In Rural Areas Of Chandigarh

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Summary: This study was conducted among 362 women of reproductive age-group in 5 randomly selected villages of Chandigarh. In all 133 women (prevalence rate 36.74%) were found to have multiple symptoms of gynaecological morbidity. The prevalence was maximum in the age group of 20-24 (41.77%) and 35-39 (52.78%) years. Higher morbidity was also observed among illiterates, married women and women having five or more children. Reproductive tract infections were responsible for most of gynaecological disorders. Vaginal discharge (16.02%), lower abdominal pain (15.47%) and burning micturation (12.15%) were the common presenting symptoms. A third of the symptomatic subject did not take treatment mainly due to not precieving it as a problem or due to hesitation in communicating.

Intoduction

Reproductive health is one of the major health problems worldwide. Inspite of various maternal health programmes under implementation, nearly 333 million cases of sexually transmitted disease (STD's) were estimated to have occurred according to WHO report in 1996. Besides other reproductive tract infections (RTI's) make the magnitude of reproductive morbidity even larger. In developing countries, out of every 10 women attending family planning and maternal and child health clinics, 1-2 are infected with such diseases (Mahajan & Gupta, 1995). Upto 18% of these patients have gonorrohea, 17% have syphilis and 30% have trichomoniasis (Population report, 1993). In India and other developing countries, the problem of gynaecological morbidity (GYM) is estimated to be enormous. There is paucity of information on epidemiological features of GYM in the community of Indian subcontinent.

Materials and Methods

Union territory of Chandigarh with an area of 114 sq. km. has a population of 0.8 million. Nearly 0.1 million people are residing in 27 villages which are in continuity with the urban areas of the city.

The study was conducted by visiting every tenth house in the three randomly selected villages. The information in relation to family size, symptoms related to gynaecological morbidity and their treatment profile was recorded on a pre-designed and pre-tested schedule. The study group comprised of 362 women-both married and unmarried in the reproductive age-group. The diagnosis of GYM was made on the sole criteria of symptoms as recommended under syndromic approach (Population Report, 1993). Symptoms related to menstrual disorders like scanty or excessive bleeding or irregular cycles, pregnancy and abortion were not taken into consideration. No clinical examination or laboratory investigations were undertaken for the confirmation of diagnosis. The information was collected by the trained staff comprising of lady doctors and female social workers. The study was conducted between December 1996 and March 1997.

Results

In the present study, out of 362 women in the reproductive age group, 133 were having symptoms. Only 63 women presented with a single symptom whereas remaining 70 were having multiple symptoms (2 to 5). Table I reveals that vaginal discharge (16.02%), lower abdominal pain (15.47%) and burning micturation (12.15%) were the commonest clinical presentations.

The prevalence rate of gynaecological morbidity in the study was observed to be 36.74%. Table II shows that the peak prevalence of morbidity was in the age-group of 35-39 years (52.78%) and 20-24 years (41.77%), respectively. The study included 62 unmarried (17.13%) women. The prevalence was higher among married

Table-I

Distribution of Gynaecological Morbidity

Clinical Presentation	Symptom Present	
	Total	Prevalence(%) n=362
1. Vaginal discharge	58	16.02
2. Lower abdominal pain	56	15.47
3. Burning micturation	44	12.5
4. Itching genitalia	37	10.22
5. Ulcer genitalia	2	0.55
6. Something coming out	12	3.34
7. Unable to control urine	11	3.04
8. Pain during intercourse	5	1.38
9. Others	17	4.70

Table II

Agewise Prevalence of Gynaecological Morbidity Cases

Age-groups (in years)	Total number of		
	Respondents	Gynaecological morbidity cases	Prevalence(%)
15-19	59	17	28.81
20-24	79	33	41.77
25-29	111	38	34.23
30-34	53	18	33.96
35-39	36	19	52.78
40 +	24	10	41.67
Total	362	133	36.74

Table III

Gynaecological Morbidity Cases by Marital Status

Marital Status	Gynaecological Morbidity Cases		
	Present	Absent	Total
Unmarried	16 (25.81)	46 (74.19)	62 (100)
Married	117 (39.0)	183 (61.0)	300 (100)
Total	133 (36.74)	229 (63.26)	362 (100)

Parentheses denotes percentages

$X^2=3.85$, df = 1, p value < 0.05

(39.0%) in comparison to that among unmarried (25.81%) and the relationship was found to be statistically significant (Table III).

When the number of children were below 5, the prevalence was between 34.48% and 41.51% but it increased to 57.89% when children were 5 and above (Table IV). It was also observed that 49.17% of the respondents were local natives while remaining were migrants belonging to northern states and the morbidity was 33.71% and 39.67%, respectively.

Table IV

Gynaecological Morbidity Among Married Women By **Number of children**

No. of Children	Total number of		
	Respondents	Gynae Morbidity Cases	Prevalence (%)
0	29	10	34.48
1	53	22	41.51
2	94	37	39.36
3	75	26	34.67
4	30	11	36.67
>5	19	11	57.89
Total	300	117	39.00

Table V

Gynaecological Morbidity by Duration of Marriage

Duration of Married Life(Yrs)	Total Number of		
	Respondents	Gynae. Morbidity Cases	Prevalence (%)
1-4	91	41	45.05
5-9	103	37	35.92
10-14	50	18	36.00
15-19	38	14	36.84
>20	18	7	36.89
Total	300	117	39.00

Table V reveals that GYM was maximum (45.05%) in the first 4 years of married life and thereafter it came down and did not show much variation (35.92% to 38.89%). As the educational status of the women improved from illiteracy to middle and further to secondary and above levels,a decline in the GYM was noticed from 38.59% to 37.72% and 34.16% respectively. Not much of a difference in morbidity was noticed in relation to occupations among husbands of married respondents.

Of the 133 symptomatic women, 63.16% contacted health care provider. Majority (57.14%) of them took treatment from a qualified allopathic doctor followed by quacks or

Table VI

Treatment Profile of Gynaecological Morbidity Cases

Treatment profile	No. of respondent
A) Treatment taken (n=133)	
Yes	64 (63.16)
No	49 (36.84)
B) Health care provider contacted (n=64)	
Unqualified doctors/ quack	24 (28.57)
Indigeneous system doctor	3 (3.57)
Female health worker/Nurse	5 (5.95)
Qualified allopathic doctor	48 (57.14)
Others	4 (4.76)
C) Reasons for not taking treatment (n=49)	
Hesitation	22 (44.90)
Economic constraints	05 (10.20)
Not preceived as problem	22 (44.90)

unqualified doctor (28.57%). A large number of women did not take treatment for not perceiving gynaecological diseases as the problem (44.90%) and the similar number expressed hesitation in communicating these problems either to their husbands or health care provider (TableVI).

Discussion

Prevalence and Clinical Presentation:

The present study revealed that more than a third (36.74%) of the women in rural areas of Chandigarh were having one or more symptoms related to gynaecological disorders (except menstrual problem). Only limited information on gynaecological disorders is available from the community based studies. Bang et al in 1989 recorded a very high prevalence of 92% among rural women though only 55% of them were having symptoms. Similar observations were made in the Delhi series where out of 130 women, 111 were having such disorders (Mishra et al, 1997). The criterion to diagnose on the basis of clinical presentation and symptoms is likely to miss a few asymptomatic patients, but this criterion was taken in the present study for various reasons. National reproductive and child health (RCH) programme which was introduced in1996, has incorporated a newer component in form of control and prevention of RTI's and STD's. Only common gynaecological problems can be managed by imparting some training to grassroot level workers, by adopting the syndromic approach. Moreover, the health infrastructure in India lacks laboratory facilities and skilled personnel to conduct internal examination in the remote and peripheral areas.

Another feature of this study was a high prevalence of symptoms related to RTI's i.e. out of 133 women with GYM, 128 (96.24%) were having either RTI's only or along with other non-infectious GYM. Vaginal discharge (16.02%), lower abdominal pain (15.47%), and burning micturition (12.15%) were the common presenting symptoms. RTI's have been reported to be the common cause of morbidity among the women of reproductive age-group in the developing world. Cervicitis, pelvic inflammatory diseases (PID), vaginitis, trichomoniasis, candidiasis were the common RTI's in rural women of Delhi (Mishra et al, 1997). Similar findings were observed by Bang et al, (1989). Forty-nine percent of the women were found to be bacteriologically positive for the vaginal discharge (Bali & Bhujwala, 1969). Control measures should aim at reducing the prevalence of RTI's in the community because these are known to cause a number of sequelae. Without treatment, 55-85% of women with PID may become infertile. The risk of ectopic pregnency is enhanced by 7 to 10 folds (Westrom & Mardh, 1990) and nearly 40% of the infected pregnancies end in spontaneous abortions, stillbirths or perinatal deaths (De Schryver and Meheus, 1990). The transmission of AIDS is observed to be ninefold in presence of STD's (Population Report, 1993).

Epidemiological Features

A higher prevalence of GYM was observed in two age-groups of 20-24 and 35-39 years. The women in 20-24 years of age are exposed to marriage and first pregnancy. Relationship between marriage and higher GYM was observed in the present study as well. High GYM in the 35-39 years age-group is possibly due to the reason that women had undergone multiple pregnancies by this age-group. Delivering five or more children was not noticed to be a high risk factor in increase of gynaecological morbidity.

Treatment Profile

Inspite of a strong health infrastructure in Chandigarh (Swami & Bhatia, 1997) more than a third symptomatic women did not contact health care providers for the treatment. Women in India, fail to utilize health services for various social and economic constraints or due to not perceiving GYM as a problem. Although majority of women who took treatment, contacted a qualified allopathic doctor, nearly one-fourth visited quacks or an unqualified doctor.

Conclusion

The gynaecological morbidity especially RTI's is a major public health problem. Inclusion of prevention and control of RTI's and STD's in the National RCH programme in India is a significant step toward improving women's health. In order to make this programme successful, it is essential to train grassroot level workers to identify and manage common gynaecological diseases, and provide appropriate drugs at peripheral health centers and create awareness among women about her reproductive health.

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