

Socio Demographic Profile and Clinical Evaluation of RTIs in Rural Women of Patna

Hemali Heidi Sinha, Manju Gita Mishra

Department of Obstetrics and Gynaecology, Medical College Hospital, Patna, Bihar, India

Summary

A community based survey of 757 married women between 15 and 44 years was carried out in which information on gynaecological problems was elicited and pelvic examination was conducted.

A high prevalence of symptoms of reproductive morbidity was found. Vaginal discharge, menstrual symptoms, pain in abdomen and backache was significantly higher amongst the contraceptive users. A high incidence of STD was also found. RTIs were higher among women who used home made pads during menstruation.

Morbidity associated with RTIs is a common health problem among rural women. The index of reports of symptoms should be used in planning RCH services at the community level.

Introduction

RTIs pose grave threats to women's lives worldwide. These infections may be sexually transmitted, or caused by unsafe medical procedures or due to overgrowth of organisms that normally inhabit the genital tract.

Men also suffer from RTIs, especially the sexually transmitted diseases, but the consequences in women are more severe, often causing lasting morbidity.

This study aims at analysing the socio-demographic profile of RTIs among women in a rural population, and correlation with the clinical presentation and aetiological agents.

Material and methods:

The study was conducted in Naubatpur block of Patna district, Bihar. This was a community-based cross-sectional survey of gynaecological morbidity. A structured interview schedule was used for conducting

interviews during which information on the practice of genital hygiene and symptoms of gynaecological problems were elicited.

A general examination followed by pelvic examination was then conducted.

The sample included married women in the age range of 15 to 44 years. 757 women were interviewed and examined between March and September '98.

Results

96.1% of the women surveyed were Hindu. Only 17.1% of the respondents and 29.3% of their husbands were literate. Most belonged to low socio-economic group. More than half the women and 67.3% of their husbands were agricultural labourers.

85% had home deliveries. In 76% cases, the last delivery was conducted by an untrained birth attendant (Table-1).



Table - I
Sociodemographic profile (n=757)

Mean age (Years)	: 27.3
Mean no. of children	: 3.6
Literacy rate female	: 17.1%
Literacy rate male	: 39.9%
Family Income (upto Rs. 1,000.00)	: 67.45%
% having home deliveries	: 85%
% cases, last del, conducted by untrained dai.:	76%

Spectrum of symptomatology is shown in Table - II. Vaginal discharge was the commonest symptom (57.9%), others being menstrual disturbances (49.1%), backache (28.4%) and pain in lower abdomen (15.3%).

Table II
Presenting symptoms (n= 757)

Symptoms	Frequency (%)	Av. Duration (months)
1. Vaginal discharge	57.9	6
2. Menstrual disturbances	49.1	18
3. Backache	28.4	10
4. Pain in lower abdomen	15.3	7
5. Prolapse	4.9	20
6. Dysuria	3.8	5.5

Some habits of personal hygiene are shown in Table - III. 92% women used home made pads during menstruation. 34% women who used home-made pads during menstruation had symptoms of RTI, while of those who used ready-made pads, only 8.3% had some symptoms. This difference was found to be statistically significant ($p=.01$). No association was found between education of the respondents or their husbands and treatment seeking.

Table - III
Habits of personal hygiene (n=757)

Clean genitalia after urination	60%
Use of homemade pads during menstruation	92%
Wear panty	71%
Vaginal douching	33%

The relation of complaints to obstetric history is shown in Table-IV. Vaginal discharge, menstrual symptoms, pain in lower abdomen and backache were higher among contraceptive users. The association of

Table - IV
Relation of complaints to Obst History

Obst Hist	Vag. Disch %	Mens dist %	Pain in abd %	Backache %	Dysuria %
Abortion	27.0	46.3	16.9	39	3.6
Stillbirth	26.3	31.4	20.3	46	4.5
Delivery by TBA	43.1	37.2	31.7	41.6	3.9
Contraceptive use	21.7	34.6	23.1	42.3	4.3

reproductive morbidity with occurrence of still birth and abortions, points towards complications at delivery.

Table V shows that cervical hypertrophy was the commonest pelvic finding. This reflects chronic infection, since most women reported a long time after onset of symptoms.

Table - V
Clinical findings

Findngs	Frequency %
1. Hypertrophied Cx	48.8
2. Vaginitis	17.48
3. Acute PID	6.1
4. Prolapse	2.1
5. Adnexal mass	1.9
6. Enlarged uterus	9.77
7. No Pathology	11.3

Cytologically 79% had inflammation while mild dysplasia was found in 4.8% cases. A healthy cervix was seen in 11% cases.

As shown in Table - VI, RTI cases were lowest in the condom users, but higher in those who used other methods of contraception or no method at all.

The pathology of the RTI cases is shown in table - VII. The prevalence of bacterial vaginosis was found to be highest in the prime reproductive age group 20-29 years.

Table - VI
Relation of contraceptive use to RTI

Method	Frequency % of RTI
No contraceptive	62.3
CuT	74.1
Oral Pill	58.7
Condom	8.4
Ligation	61.5

Table - VII
Pathology of RTI cases

Pathology	Frequency %
Trichomonas	23.14
Candida	30.78
Syphylis	5.26
Chlamydia	1.6
Bacterial Vaginosis	36.29
Others	3.53

Discussion

We found a high prevalence of symptoms associated with reproductive morbidity. 72% women suffered from at least one symptom, some for as long as one and half years. In the study by Kumar & Aggarwal (1998) in rural Harvana, 61% women were found suffering from symptoms associated with reproductive morbidity, while Bang et al (1989) reported that 55% women had gynaecological complaints though on examination the prevalence was found to be 92%.

Vaginal discharge (57.9%), backache (25.4) and pain in lower abdomen (15.3%) were common presenting symptoms. A similar finding has been reported by Bhatia and Swami (1999) from Chandigarh. Similar findings were observed by other workers (Bang et al, 1989; Kumar and Aggarwal 1998). This shows that RTIs are a common cause for morbidity among women in developing countries. Control measures should aim at diagnosing and treating RTIs in the community, for success of the National Reproductive and Child Health Programme.

Cervicitis, vaginitis, pelvic inflammatory disease (PID), were common clinical findings in our study as well as in the study by Mishra et al (1997) from Delhi. RTIs are known to cause a number of long-term sequelae, important among these being infertility, ectopic pregnancy as well as facilitating the transmission of AIDS.

More than 60% cases had vaginal discharge due to high frequency of mixed infection including bacterial vaginosis, Trichomoniasis and Chlamydia.

Apte and Athwal (1999) in a study among women in urban Pune, found that education and treatment seeking did not have any association. They were of the opinion that this showed a tendency on the part of the women to neglect their own health. Swami et al (1997) found that in spite of a strong health infrastructure at Chandigarh, more than a third of symptomatic women did not contact health care providers for treatment. We found that economic pressures, lack of autonomy to make decisions regarding treatment seeking, and limited mobility contributed to lower degree of medical care. Common gynaecological problems can be managed by imparting training to grassroot level workers. This approach should be given serious thought in the rural areas.

Less than optimal aseptic conditions during deliveries conducted by traditional birth attendants may be responsible for the high incidence of reproductive illness.

The use of contraceptive methods is perceived by women to contribute to reproductive tract symptoms though this may also suggest chronic infection. A similar association has been reported by Wasserheit et al (1989) from Bangladesh, by Bang et al (1989) as well as Bhatia and Cleland (1995).

We feel that abandonment of the barrier contraceptives in favour of hormonal contraceptives and the IUCD has deprived women of potentially effective methods of preventing RTIs.

Conclusion

Through the major determinants of RTI in India have not been investigated in detail, and it is not clear what the contribution of personal and menstrual hygiene is, this study has shown the association between genital hygiene and symptoms of RTI.

Morbidity levels associated with RTIs constitute a major health problem among rural women. Routine screening for RTIs is necessary to minimize morbidity and loss of fertility in women.

The index of reproductive morbidity as shown by self reports of symptoms should be used in planning RCH services at the community level.

Acknowledgement

The authors are grateful to the Integrated Development Foundation, Patna and UNICEF for supporting this work.

References

1. Apte H., Athwal S., AIDS Research and Review 2:2 (1999)
2. Bang RA, Bang A.J., Bartulec M, Choudhary Y, Sarmukaddam S, Tale O. The Lancet 1:85 (1989)
3. Bhatia JC, Cleland J. Studies in Family Planning 26:203 (1995)
4. Bhatia V, Swami H.M., J. Obst Gyn India 49:90 (1999)
5. Mishra TN, Chawla SC, Bajaj P, Goyal U, Pillai B. P. Ind. J. of Community Medicine 3:104 (1997)
6. Kumar R, Aggarwal A K., J. Obst Gyn India 48: 68 (1998)
7. Swami H. M., Bhatia V, Bhatia S P S, Singh K Kaur M, Kaur A., Ind J. of Community Medicine 3:110 (1997)
8. Wasserheit J.N., Harris E.R., Chakraborty J, Kay B.A, Mason K J., Studies in Family Planning 20:69 (1989)