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REPRODUCTIVE HEALTH PROBLEMS AND TREATMENT SEEKING BEHAVIOR OF RURAL WOMEN IN PALAKKAD DISTRICT KERALA

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ABSTRACT

This study examines the Reproductive health problems and treatment seeking behavior of rural women in Palakkad district of Kerala. A sample of 60 eligible women in 15-44 years who had at least one living child randomly selected in three blocks of rural areas of Palakkad district Kerala were interviewed. Reproductive health problems and treatment seeking behavior is assessed by considering Reproductive Tract Infections/Sexually Transmitted Infections, Prolapse of Uterus, Menstrual disorders, Acute pelvic inflammatory disease(PID), Dyspareunia, Infertility, Anaemia, Urinary Tract Infection and Contraceptive side effects (Sterilisation/IUD/Pills) and treatment or care seeks and places for treatment for the reproductive health problems .Majority (56 percent) of women had a medium level of standard of living, no women are married before getting the legal age of marriage ie 18 years ,majority of women respondents age of marriage is 18-20 years. Nuclear family system is prominent as 70 percent of the respondents have nuclear family system. Majority (96 percent) of the women went either to Government hospital or to private hospital for treatment and the rest took either home remedy or Ayurvedic/Homeopathic/local indigenous medicines (each 2 percent).Out of 46 women who experienced any reproductive health problem, 30 percent of women had not taken treatment. Among them, twenty-one percent of the women felt that the treatment is too expensive and not affordable. For 19 percent of women their husbands not permitted them to go for treatment. Reproductive health problems is a common health problem among women and represents serious threat to their health and wellbeing

Key words: Reproductive health problems,Treatment seeking behavior,Women

INTRODUCTION

Reproductive health is a complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes (UN, 1994). Reproductive health has gained considerable attention throughout the world. Even in India we have well established RCH programme but still many reproductive morbidities are present as per report of NFHS who conducted survey in over 25 states and UT of India. Approximately 26-77%

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of woman clinically observed to be suffering from one or more reproductive morbidities (Aggarwal D,2001). Health seeking behavior or treatment seeking behavior depends upon the perception of individual and when they think it is normal or non-serious they do not take treatment (who,1991) . WHO reported that nearly one third of all healthy life lost among adult woman, because of reproductive health problems. Gynecological disorders have a substantial impact on female reproductive ability, mental health ability to work and to perform routine physical activities. Leucorrhoea, uterine prolapse are most common causes of gynecological morbidity (Kulkarni RN, Durge PM 2000).

Reproductive tract infection is a common problem among women and represents serious threat to their health and wellbeing. The exact prevalence however is often not known since woman either does not consider that significant health problems or else are reluctant to talk about them. Illiteracy, ignorance, gender discrimination and poor social status further compounds the problem, especially in socially and economically backward areas (Gaash B, Kausar R, Bhan SB,2004) In India, married woman are reluctant to seek medical advice because of lack of privacy, lack of female doctor at the health facility the cost of treatment and their subordinates social status (Prasad J.H et al ,2005) . The prevalence of lower reproductive tract infections in Omani was 22.4%, upper reproductive tract infections 2.7% and cervical dysplasia was very rare. Genital prolapses were present in 10%, 11% had a urinary infections. 27% anemic, 23%were hypertensive and 54% either over-weight or obese (Asya AR, Mustafa A, Mohammad MF ,2004) is scarcity of literature in this area of reproductive health among currently married women therefore, The present study was conducted with the objective to determine prevalence of reproductive morbidities and identify treatment seeking behavior towards reproductive morbidities among married women.

BACKGROUND OF THE STUDY

In spite of several developmental, activities, policies and programs, women are still treated as secondary citizens and are experiencing relatively lower status andhence theirreproductive health status is poor in India. Therefore, a brief review of some studies conducted in India as well as in other places of the world, related to the reproductive health problems of women and treatment seeking behavior is presented. Studies conducted India have documented a high prevalence of reproductive health problems such as abnormal vaginal discharge, irregular vaginal bleeding, lower abdominal pain, infertility, menstrual problems, and genital prolapse among women of reproductive age (Bang et al. 1989; Wasserheit 1989; Bhatia et al. 1995; Singh et al. 1995). The recognition of a perceived disorder and its outcomes, rather than a clinical diagnosis per se, may determine a woman‟s care-seeking behavior and related actions (Bhatia and Cleland 1995). Related studies suggest that the majority of symptomatic women do not seek formal treatment (Bang and Bang 1994; Narayan and Srinivasan 1994), or they seek treatment only when their symptoms increase in severity (Kanani et al. 1994; Mulgaonkar et al. 1994; Bhatia and Cleland 1995). Women with certain types of reproductive health

problems, such as vaginal discharge and infertility, may also face serious social consequences in terms of marital disharmony and exclusion from social or religious life (Bang and Bang 1994). Untreated reproductive health problems such as reproductive tract infections can cause pregnancy-related complications, congenital infections, infertility, and chronic pain. Such infections also significantly increase the risk of acquiring pelvic inflammatory disease (PID) and the likelihood of infection with HIV (Falindes 1994; Natraj 1994; Population Council 1999). In Asia, RTIs are responsible for almost 34 percent of hospital admissions for pelvic inflammatory disease (Brabin 1993). Beyond adverse health consequences.Gynecological morbidity is an important public health issue as well as a social problem in most developing countries

Reasons behind in low levels of care-seeking for gynecological symptomsinclude sociocultural barriers and taboos associated with diseases connected with sexuality and reproduction (Luthra and Saxena 1991; Bang and Bang 1994; Bhatia and Cleland 1995); women‟s reluctance to undergo an internal gynecological examination; women‟s lack of time and money (Kanani et al. 1994; Mulgaonkar et al. 1994); and the poor availability of healthcare facilities (Bang and Bang 1994; Narayan and Srinivasan 1994). Women‟s trust in the efficacy of home-based remedies for such symptoms may also dissuade them from seeking formal medical care. Most of the previous studies that examined careseeking behavior for reproductive health problems in India or elsewhere were concerned with small geographical areas (Bang and Bang 1994; Bhatia and Cleland 1995) or were based on small, non-representative samples (Wasserheit et al. 1989; Bhatti and Fikree 2002).

METHODS AND MATERIALS

The study was conducted in threeblocks of Palakkad district, Kerala.Currently Married Women (CMW) in the age group of 15-44 years who had at least one living childconstitutes the study.60 (20 each from three blocks) currently married women in 15-44 years with at least one living child were selected and interviewed. Questionnaire was developed and used to collect information from currently married women.The questionnaire covered the following sections:

Section-I: Back-ground characteristics: In this section, information on religion, caste, age, educational status, occupation, income and information on exposure to mass media were collected.

Section-II deals with the reproductive health of problems the women in termsof menstrual disorder, RTI/STI, Pelvic inflammatory disease, Dyspareunia, Prolapse of Uterus and Urinary problems, and current reproductive health status of the women after getting a chance for treatment for their problem if they had any. Utilization of health services, treatment seeking behavior, decision maker for treating the health problems, place of treatment and accessibility of the health facility.

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The currently married women were contacted at their residence and interviewed by trained female investigators.

RESULTS AND DISCUSSION

Socio-economic characteristics

Socio-economic characteristics of the sampled women are presented in Table-1. Eighty percent of the respondents were Hindus, only twentypercentwere Muslims and Christians. Thirty percent belonged to scheduled caste and 70 percent belonged to either backward or forward castes.Nearly three-fourths (72 percent) of the women belonged to nuclear family and 28 percent belonged to joint family.

More than half of the respondents,56.6 percent had high school education (6-10 years of education) and the remaining 43.3 had higher education. Educational attainment of the husbands is slightly better than their wives regarding higher education, only few 3.3 percent of respondents are studied up to 5th standard. Nearly one-half (45 percent) had high school education and 51.6 percent had higher education.

Although women are universally involved in unpaid household work, economic independence is usually measured interms of wage-earning and economic activity. Fifty five percent of the sample women were housewives. 21.6 percent were agricultural labour, and the remaining 23.3 percent were engaged in other works.26.6 percent of the husbands were engaged in cultivation. 21.6 percent were agricultural labour,23.3 percent were other labour and nearly half (41.3 percent) were engaged either in business or in other allied activities.

Nearly half of the respondents (46.6 percent) of the women had low exposure of media. Thirtypercent had medium level of media exposure and 16.6 percent had higher exposure of mass media. Only 6.6 percent had no exposure to mass media.

Table-1 Percent distribution of women by their socio-economic characteristics

Socio-economic characteristics	Number	Percent
Religion		
Hindu	48	80
Non-Hindu	12	20
Caste		
Scheduled Caste	18	30
Non- Scheduled Caste	42	70

Family type		
Nuclear	43	71.6
Joint	17	28.3
Education of women		
Non-literate	0	0
1-5	0	0
6-10	34	56.6
11 and above years	26	43.3
Education of husband		
Non-literate	0	0
1-5	2	3.3
6-10	27	45
11 and above years	31	51.6
Occupation of wife		
House wife	33	55
Agricultural labour	13	21.6
Others	14	23.3
Occupation of husband		
Own agriculture (Cultivator)	16	26.6
Agricultural labour	13	21.6
Non-agricultural labour	14	23.3
Others	17	41.3
Mass media exposure		
No exposure	4	6.6
Low exposure	28	46.6
Medium exposure	18	30
High exposure	10	16.6

ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Table-2 provides the economic and demographic characteristics of the respondent. 36.6 percent of the respondents had an annual family income of Rs. 20,000 or less. 30 percent had on annual income of Rs. 20,000-30,000.18.3 percent had income of Rs.30,000-40000 and a very few 15 percent having income of Rs. 40000 or moreper annum. Using the information available on consumer goods and assets owned by the household and other amenities present in the house, a composite standard of living index was constructed following the procedure adopted in the NFHS-2. Based on the score of the index the households were classified into those having a low, medium and high standards. According to the index, 31.6 percent of the households belonged to low standard of living. Little more than half

(56.6 percent) were in medium standard of living, and only a few (11.6 percent) belonged to high standard of living.

31.6 percent were in the age group of 15-24 yearsand 46.6percent were in the age group of 25-29 years. Regarding husbands age nearly one-fourth (23.3 percent) were less than 30 years. 43.3 percent were in the age group of 30-34 years, 20 percent belonged to 35-39 years and 13.3 percent were above 40 years.noneof the respondent women were married before attaining the legal age at marriage, of 18 years. Sixty five percent got married in the age of 18-20 years and 35 percent married at the age of 21 or above years.Majority of the marriages were -consanguineous (65 percent). Only 35 percent of the marriages were Non-consanguineous, i.e., the women married her close relatives either her maternal uncle, or paternal/ maternal cousin. The age gap between spouses ranges from 1 to 15 years. One-third (33.3 percent) of the couples had the age difference (age of husband is more than wife‟s age) of less than five years. 48.3 percent had an age difference of 5-9 years and 18 percent have age difference of 10 and above years.

Table-2 Percent distribution of women by economic and demographic characteristics

Economic and Demographic characteristics	Number	Percent
Annual income (in Rs.)		
20,000 or less	22	36.6
20,001-30,000	18	30
30,001-40,000	11	18.33
40,001 or above	9	15
Standard of Living		
Low	19	31.6
Medium	34	56.6
High	7	11.6
Age of wife (in years)		
Less than 25	19	31.6
25-29	28	46.6
30-34	10	16.6
35 or above	3	5
Age of husband (in years)		
Less than 30	14	23.3
30-34	26	43.3

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35-39	12	20
40-44	4	6.6
45 or above	4	6.6
Age at marriage of women(in years)		
Less than 18	0	0
18-20	39	65
21 and above	21	35
Type of marriage		
Consanguineous	39	65
Non-consanguineous	21	35
Age difference between husband and wife		
Less than 5 years	20	33.3
5-9 years	29	48.3
10 and above years	11	18.3

REPRODUCTIVE HEALTH PROBLEMS

Women were enquired whether they had any reproductive health problem during the past three months prior to the survey. The results are presented in Table-3**.**21.7 percent of the women had heavy or scanty bleeding during menstruation and 23.9 percent had painful menstruation. Respondents mentioned about interrupted and prolonged bleeding are only 4.3 percent.

28.2 percent of women had abnormal vaginal discharge with itching and 36.9 percent had back ache. Women experienced abnormal vaginal discharge with lower abdominal pain (8.6 percent) and Boils/Ulcers/wards around the vulva (4.3 percent) were meager.15.2 percent of the women had severe lower abdominal pain and 4.3 percent had vaginal discharge with fever. 15.2 percent had pain during sexual intercourse. Bleeding after sexual intercourse was not reported. Women reported about the feeling of prolapse of uterus and involuntary movement of uterus while coughing, sneezing or laughing was 4.3 percent.Anemia related information was also collected from the respondents. Thirteen percent reported about weight loss and 28.2 percent reported general tiredness. 2.1 percent had swelling in hands and feet, 23.9 percent felt that they became lean and 10.8 percent loss their attention at times.

Table-3.Percent distribution of women by symptoms of reproductive health Problems

Symptoms of reproductive health problems	Percent	
	Yes	No
Menstrual disorder		
Heavy or light/irregular bleeding	21.7	78.3
Pain full menstruation	23.9	76.1
Interrupted bleeding	4.3	95.7
Prolonged bleeding	4.3	95.7
RTI/STI		
Discharge with itching over vulva	28.2	71.8
Boils ulcers/wards around vulva	4.3	95.7
Discharge with pain in lower abdomen	8.6	91.4
Back ache	36.9	63.1
Pelvic inflammatory disease		
Sever lower abdominal pain	15.2	84.8
Vaginal discharge with fever	4.3	95.7
Foul smelling vaginal discharge with itching	4.3	95.7
Dyspareunia		
Pain during sexual intercourse	15.2	84.8
Bleeding after sexual intercourse	0.0	100.0
Prolapse of Uterus		
Feeling of heaviness, feeling of movement in uterus	4.3	95.7
Involuntary movement of uterus while coughing, sneezing or laughing	4.3	95.7
Urinary problem		
Burning/pain full passage of urine	19.5	81.4
Frequent urination	8.6	93.0
Difficulty in urination	2.1	97.9
Anaemia		
Weight loss	13.04	86.96
Tired ness	28.2	71.8
Swelling in hands and feet	2.1	97.9
Become lean	23.9	76.1
Loss of attention	10.8	89.2

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TREATMENT SEEKING BEHAVIOR FOR REPRODUCTIVE HEALTH PROBLEMS

Usually women are not giving much importance for treatment of their sickness compared to men. Among the women who had health problems during the three months prior to the survey,three-fourths of the women discussed about their problems with others and nearly one-fourth (23.9 percent) did not discuss about their problem and they kept it as a secret.Among those discussed 56.5 percent of them discussed with their husband, 36.9 percent discussed with their relatives/friends/neighbours, and few women discussed with their mother-in-law (2.1 percent), and with others (4.3 percent).

Nearly forty percent of the women took treatment for their health problems. Among those who took treatment, 73.9 percent take self-decision, husbands took the decision for 19.5 percent of women and mother-in-laws took the decision for remaining 6.5 percent of women.

Table-4. Percent distribution of women by Treatment seeking behaviour for their reproductive health problems

Treatment seeking behavior	Percent
Problems discussed	
Yes	76.08
No	23.92
Persons discussed	
Relatives/friends/neighbor	36.9
Parental house member	4.3
Mother-in-law	2.1
Husband	56.5
Treatment taken	
Yes	39.1
No	60.8
Persons decided for treatment	
Respondent	73.9
Mother-in-law/	6.5
Husband	19.5
Type of treatment	
Home remedy	2.1
Ayurvedhic/Homeopathi/indigenous	2.1
GH/Private hospital	95.6
Frequency of treatment	

Not bothered	2.1
Occasionally	52.1
Regularly	45.6

Majority (95.6 percent) of the women went either to Government hospital or to private hospital for treatment and the rest took either home remedy or Ayurvedic/Homeopathic/local indigenous medicines (each 2.1 percent).Among those who had taken treatment, 52.1 percent took treatment occasionally and45.6 percent took regular treatment for their reproductive health problems (Table-4).Out of 46 women who experienced any reproductive health problem, 30.4 percent of women had not taken treatment. Among them, 21.7 percent of the women felt that the treatment is too expensive and not affordable. For 19.5 percent of women their husbands not permitted them to go for treatment. 6.5percent of the women had no faith in treatment and mother in law had not permitted in 2.1 percent of cases. 19.5 percent of the women mentioned other reasons.

Table-5. Treatment seeking behavior of women with reproductive health problems

Treatment seeking behavior	**Percent**
Women with RH problems	
Not taken treatment	30.4
Too expensive and not affordable	21.7
Husbands not permitted them to go for treatment	19.5
No faith in treatment	6.5
Mother in law had not permitted	2.1
Others	19.5

CONCLUSION

The male-female disparity in health and wellbeing has been well documented in developing countries (Das Gupta, 1987; Santow, 1995). High levels of morbidity and mortality in women and girl children can often be indicative of female disadvantage relative to males.The quality of reproductive health care and the services provided to them are very poor in our country, as the awareness of the reproductive health problems is lacking in the community. Hence it is essential to create women friendly health services. To sensitize the women regarding availability and utilization of reproductive health care services and reproductive health programs and aggressive involvement of policy makers and stake holders in the planning and implementation is needed.

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REFERENCES

Aggarwal D. Reproductive tract infections- challenges and responses. Health for Millions 2001; 27(3): 21-22.

Asya AR, Mustafa A, Mohammad MF.Gynecological and related morbidities among Ever-married Omani women.AfrReprod Health 2004;8(3):188-197

Bang, Rani A. and Ajay T. Bang. 1992. “Why women hide them: Rural women‟s viewpoints on reproductive tract infections.” Manushi, A journal about Women and Society 69: 27-30.

Bang, Rani A., Ajay T. Bang, M. Baitule, Y. Chaudhury, S. Sarmukaddam, and 0. Tale. 1989. “High prevalence of gynecological diseases in rural Indian women.” Lancet 1(8,629): 85-88.

Bhatia, Jagdish C., John Cleland, LeelaBhagavan, and N.S.N. Rao. 1997. ”Levels and determinants of gynecological morbidity in a district of South India.” Studies in Family Planning 28(2): 95-103.

Bhatti, LubnaIshaq and Fariyal F. Fikree. 2002. “Health seeking behavior of Karachi women with reproductive tract infections.” Social Science 6 Medicine 54(1): 105-117.

Brabin, Loretta. 1993. ”Pelvic inflammatory disease.” Africa Health 15(3): 15-17. Chakraborty, Sarbani, Sister Ann D,,Souza, and Robert Northrup. 2000. “Involving private practitioner care of sick children: Testing new approaches in rural Bihar.” Health Policy and Planning 15(4): 400-407.

Faundes, Anibal. 1994. ”Reproductive tract infections.” International 92-97. Journal of Gynecology and Obstetrics 46(2): 181-187.

Gaash B, Kausar R, Bhan SB. Prevalence of reproductive tract infection in Kargil. Health and population perspective and issues.JanMarch 2004; 1-7.

International Institute for Population Sciences (IIPS), 2007, National Family Health Survey (NFHS-3), Fact Sheet, 2006-2007, Tamil Nadu, Mumbai-IIPS

Jejeebhoy, S.J. 2000. “Women‟s autonomy in rural India: Its dimensions, determinates, and the influence of context” In Women‟s empowerment and demographic processes: Moving beyond Cairo. H.Presser and G.Sen (ed). New York: Oxford University Press.

Jejeebhoy.S.J., 1995, Women‟s education, autonomy and reproductive behaviour: experience from developing countries. Clanrendon press, Oxford

Kanani, Shubhadara, K. Latha, and Mona Shah. 1994. "Application of qualitative methodologies to investigate perceptions of women and health practitioners regarding women‟s health disorders in Baroda slums." In Listening to Women Talk about Their Health: Issues and Evidence from India. Eds. Joel Gittelsohn, Margaret E. Bentley, Pertti J. Pelto, Moni Nag, SarojPachauri, Abigail D. Harrison, and L.T. Landman. New DeLhi: HarAnand Publications. Pp. 116-130.

Kulkarni RN, Durge PM. A study of leucorrhoea in reproductive age group women of Nagpur city. Quarterly journal of the Indian Public Health Association; 2005:49(2): 238-239.

4. Kumari S, Walia I, Singh A. Self reported uterine prolapse in a resettlement colony of North India. Journal of Midwifery and women's health. 2000; 45(4):343-344.

Luthra, U.K. and B.N. Saxena. 1991. "Reproductive tract infections in India: The need for comprehensive reproductive health policy and programs." Paper presented at the International Women‟s Health Coalition Confefence, Bellagio, Italy, 29 April-3 May.

Mulgaonkar, Veena B., Indumati G. Parikh, Vijyalaxmi R. Taskar, Neela D. Dahrap, and Veena P. Pradhan. 1994. "Perceptions of Bombay slum women regarding refusal to participate in a gynecological health program." In Listening to Women Talk About Their Health: Issues and Evidence from India. Eds. Joel Gittelsohn, Margaret E. Bentley, Pertti J. Pelto, Moni Nag, SarojPachauri, Abigail D. Harrison, and L.T. Landman. New Delhi: HarAnand Publications. Pp. 145-167.

Narayan, N. and S. Srinivasan. 1994. "Some experiences in the rapid assessment of women‟s perceptions of illness in rural and urban areas of Tamil Nadu." In Listening to Women Talk About Their Health: Issues and Evidence from India. Eds. Joel Gittelsohn, Margaret E. Bentley, Pertti J. Pelto, Moni Nag, SarojPachauri, Abigail D. Harrison, and L.T. Landman. New Delhi: HarAnand Publications. Pp. 67-78.

Natraj, Shyamala. 1994. "The magnitude of neglect: Women and sexually transmitted diseases in India." In Private Decisions, Public Debate: Women, Reproduction and Population. Eds. J. Mirsky, M. Radlett, W. Davies, and 0. Bennett. London: Panos Publication. Pp. 7-20.

Population Council. 1999. Reproductive Tract Infections: A Set of Factsheets. Bangkok Population Council.Rohde, John and HemaViswanathan. 1995. The Rural Health Practitioner. New Delhi: Oxford University Press.

Prasad J.H et al. Reproductive tract infections among young married women in Tamilnadu, India.International Family Planning Perspective. 2005; 31(2): 73-82.

Sabarwal, Shagun&Santhya, K.G.. (2012). Treatment-Seeking for Symptoms of Reproductive Tract Infections Among Young Women in India. International perspectives on sexual and reproductive health. 38. 90-8. 10.1363/3809012.

Singh, V., M.M. Gupta., L. Satyanarayana, A. Parashari, A. Sehgal, D. Chattopadhya, and P. Sodhani. 1995. ”Association between reproductive tract infections and cervical tract infections and cervical inflammatory epithelial changes.“ Sexually Transmitted Diseases 22(1): 25-30.

Wasserheit, Judith N., Jeffrey R. Harris, J. Chakraborty, Bradford A. Kay, and Karen J. Mason. 1989. ”Reproductive tract infections in a family planning population in rural Bangladesh.” Studies in Family Planning 20(2): 69-80.