

**“A CROSS-SECTIONAL STUDY OF
GYNECOLOGICAL PROBLEMS OF
MARRIED WOMEN IN AN URBAN
FIELD PRACTICE AREA OF
J.N.MEDICAL COLLEGE, BELGAUM”**

DISSERTATION
By Dr. Poornima. S.

***SUBMITTED TO THE
KLE UNIVERSITY, BELGAUM, KARNATAKA,
IN PARTIAL FULFILLMENT OF
THE REGULATIONS FOR THE AWARD OF
M.D. DEGREE
(COMMUNITY MEDICINE)***

Under the Guidance of

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BELGAUM.
MAY - 2009***

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Dr. Poornima. S

LIST OF ABBREVIATIONS

ANC - Ante natal care

BP - Blood pressure

BMI - Body Mass Index

CHC - Community Health Center

Cms – Centimeters Df - Degree of freedom

FP - Family planning

Hpf – High Power Field

SES - Socio Economic Status

ICMR - Indian Council of Medical Research

ICRW - International Center for research on Women

Kgs - Kilograms

NACO - National Aids Control Society

NFHS - National Family Health Survey

N – Number % - Percent

PID – Pelvic Inflammatory Diseases

PHC - Primary Health Centre

RBC - Red Blood Corpuscles

RTIs - Reproductive Tract Infections

STDs - Sexually Transmitted Diseases

UHC - Urban Health Center

UTI - Urinary Tract Infections

WHO - World Health Organization

Yrs – Years

ABSTRACT

Research question : What is the prevalence of gynecological problems among married reproductive age women of urban Belgaum?

Objectives:

- 1) To estimate the prevalence of gynecological problems of the married women in reproductive age group (15-49 years)
- 2) To know the different patterns of contraceptive methods used by these couples

Study Design: Cross-Sectional

Study Settings: Khasbagh, Urban field practice area of J. N. Medical College

Participants: 400 married women of age 15-49 yrs

Study Period: Jan 2007 to Dec 2007

Statistical analysis: Percentages, Chi-square tests

Results: The prevalence of the various gynecological problems were urinary tract infection 27.00 %, chronic PID 24.25 %, acute PID 19.25 %, oligomenorrhea 10.25 %, menorrhagia 6.75 %, conceiving difficulty 6.75 %, polymenorrhea 3.75 %, breast swelling 2.25 %, stress incontinence 0.75 % and prolapse of uterus 0.75 %. The mean prevalence of gynecological symptom per women was 1.51. There was no significant association between, age, education, socio-economic and gynecological problems of the participants.

63.00 % had undergone permanent sterilization, 17.25 % couples were using temporary FP method and 19.75 % were not using any FP methods. The number and sex of living children had a significant association with the practice of any method of family planning.

Conclusion: There was a moderately high prevalence of gynecological problems like menstrual problems and reproductive tract infections but the treatment seeking behavior was low.

The knowledge about modern and traditional spacing methods is not adequate among our study participants.

Key Words: Gynecological problems, Reproductive health, Reproductive age group, Urban married women, Contraceptive pattern use.

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Limitations of the study

Examinations like per vaginal and per speculum could not be done as most of the women were not willing to undergo them. Hence the prevalence is based on self-reporting of symptoms by the women.

Other laboratory investigations like Pap smear, gram staining, VDRL, HIV testing, culture and sensitivity could not be done.

Recommendations

- 1) Information, education and communication activities regarding the gynecological symptoms, importance of early detection and proper treatment are to be emphasized. This can be done through community education programs or self help groups like Mahila Mandal, Stri Shakthi meetings etc.

- 2) Re-orientation training of the lab technician and up-gradation of the laboratory facilities at Urban Health Centre to help diagnosis and treatment of RTI / STDs.

- 3) Grass root level workers like Anganwadi workers' are to be sensitized to deliver quality family planning education to the eligible couples and help them in practicing the same.

Annexure I

Informed Consent form

Greeting the participant

Namasthe

Introduction

I am Dr. Poornima. S., a post graduate student of Department of Community Medicine, Jawaharlal Nehru Medical college, Belgaum. I am conducting a study in Khasbag area ward no. 21, under the guidance of Dr. S. M. Katti, Professor of Community Medicine, JNMC, Belgaum.

Purpose of the study

The Study is done to know the prevalence of gynecological problems of the married women in the reproductive age group (15-44 years).

Aim of the study

The study is intended to help our department of community medicine to understand the problems and needs of reproductive married women and hence improve our preventive and curative services at the urban health centre, Khasbag.

Methodology

I (Dr. Poornima. S.) will be asking the randomly selected participants about various gynecological problems they have and will be subjecting them to simple investigations. Depending on the requirements of the individual case, we shall treat the participants to the extent possible in the community and or give a referral to higher centers for the needful.

Risks involved in the study for the participants

This survey does not contain any new intervention or major procedure hence has no adverse effects on the participants. However, if the participant has any further queries or wants clarifications after the interview, she can contact Dr. Poornima. S. on her personal mobile no. 9886729953.

Benefits for the participants

The participant found to have any gynecological problems by clinical and laboratory investigation will be provided with the basic treatment and referred to an appropriate place for further treatment. The participants will be given an opportunity to clarify any of their health related queries from the examiner.

Monetary Benefits

The participants will not be eligible for any monetary payment or any other free services by virtue of their participation in the study. It is purely a voluntary participation and not a paid service.

Publication Rights

The results of the survey will be used for teaching and medical publications however the participant's identity will be kept confidential.

Alternatives

The participant's willingness, to participate or not to participate in the study will not influence the care being provided at the urban health center, Khasbag.

Introduction

Women in the reproductive age group of 15-49 yrs constitute 25.00 % of the population. They form one of the most important and vulnerable sections of the society. The women in this age group are exposed to many vital events like marriage, child birth, divorces, immigration, emigration etc.¹ These, in turn shall determine the demographic trends in a country. Women's education and empowerment has an important bearing on the country's health planning, policies and programs. Thus, promoting women's health improves not only individual health but also the health and survival of their families, communities and countries.

“When women are healthy, educated and free to take the opportunities life affords them, children thrive and countries flourish, reaping a double dividend for women and children ”

Kofi . A. Annan

Ex - Secretary General of United Nations

Women's health is a personal and social state of balance and well being in which a women feels strong, active, creative, wise and worthwhile, where her own body's power of healing is intact, where all her diverse capacities and rhythms are valued, where she may make choices, express herself and move about freely.² Since time immemorial developing countries have equated women's health with reduction of pregnancy and its complication and or fertility control. With reduction in the crude birth rate, death rate, increase in female literacy, life

expectancy, marked changes in marriage and fertility patterns, the focus of health care today has shifted to improving the quality of life.³

Addressing reproductive health issues of women is now on the global social agenda for the forthcoming century. Primary health care for women had been limited to family planning and to some antenatal care. Maternal mortality has long been the only indicator of women's health even though reproductive morbidity occurs far more frequently and seriously affects women's lives. There is very little information on prevalence of reproductive health problems in the community and their perceived needs, knowledge and attitudes. Assessing morbidity is a complex process. The process becomes more difficult for gender related sensitive health problems of the women. The attitudes of the interviewer and the respondent contribute considerably to the problem of estimating morbidity. The launch of Reproductive and Child Health program in 1997, by the government of India was the beginning of a new era in women's health in our country. It emphasizes on providing integrated, target free, client oriented, demand driven and high quality need based reproductive health services.^{1,3}

A WHO working group defined reproductive morbidity as "any morbidity or dysfunction of the reproductive tract or any morbidity which is a consequence of reproductive behavior including pregnancy, abortion, childbirth or sexual behavior (and) may include those of psychological nature." Broadly, reproductive morbidities can be classified into three categories: Obstetric, gynecological and contraceptive morbidities. The obstetric morbidities and gynecological morbidities can be further classified as direct morbidities, indirect morbidities and

psychological morbidities. The contraceptive morbidities resulting from the modern or traditional fertility regulators can be classified as local morbidities and systemic morbidities.^{4, 5} It is important to note that both obstetric and contraceptive morbidities in the long run can give rise to one or more of gynecological morbidities.

Gynecological morbidity includes any condition, disease or dysfunction of the reproductive system which is not related to pregnancy, abortion or childbirth, but which may be related to sexual behavior (Fortney, 1995). Systematic estimate of gynecological morbidity are not easily available. Our knowledge of gynecological morbidity is based on few studies in parts of the state and some studies in India. Also obtaining data on gynecological morbidities are difficult because of the numerous causes, symptoms and diverse clinical presentation. The women suffer silently out of pain or even shame. This is sometimes described as the “silent culture”.^{6, 5} Appropriate treatment and prevention of these gynecological morbidities can save lot of physical and mental trauma to the women. This requires understanding of the myths, misconceptions and the inhibitions that prevent women from accessing the health services for gynecological problems.⁷

The changing economic scenario, social and cultural environment of the societies play a role in determining and quantifying contraceptive preferences of the women and their families. The choice of married women to conceive or not to conceiving has an important bearing on their health. Appropriate choice of

contraception can not only prevent, but also reduce gynecological morbidities.⁸

Thus helping the women lead a better and more productive life.

This community based cross-sectional study was taken up at Khasbag, the urban field practice area of J. N .Medical College, Belgaum. The area was adopted as the urban field practice area by J. N. Medical College on April 2004. We do not have any community based knowledge or data about the gynecological problems of the married women of this area. The universality of gynecological problems among women, diversity of prevalence, the morbidity they cause and the sensitivity of the issue prompted us to take up this study. The study is done with an aim to know the prevalence of the various gynecological problems of the married women so as to make the services at our urban health centre more community friendly.

OBJECTIVES

- 1) To estimate the prevalence of gynecological problems of the married women in reproductive age group (15-49 years)

- 2) To know the different patterns of contraceptive methods used by these couples

REVIEW OF LITERATURE

International conference of population development ICPD (1994), Cairo, has defined Reproductive Health as “a state of complete physical, mental and social wellbeing, not merely an absence of disease or infirmity in all matters relating to the reproductive system, its functions and processes”.

The state of women in developing countries is still far from satisfactory. Women are socially, educationally and economically disadvantaged. These inequalities are reflected as increase in mortality and morbidity of female sex at every stages of life. In order to address this issue, the decade 1991-2000 was celebrated as the decade of the girl child.⁹

The need of the hour is to reorient India’s traditional population program to go beyond demographic targets, contraceptive prevalence and female sterilization to a more comprehensive reproductive health needs and services. The launch of RCH program in 1997 by the Government of India is a welcome sign. The emphasis now is particularly on devising ways which are not only effective but also sensitive to the socio-cultural environment of women and adolescent girls.¹⁰

Gynecological Problems includes the structural and functional problems of genital tract not related to pregnancy, delivery or puerperium. Gynecological problems includes menstrual problems, reproductive tract infections, cervical cell changes, genital prolapse, sexually transmitted diseases, urinary tract infection

and such other conditions as hypertension, anemia, chronic energy deficiency and obesity. Gynecological problems of women are universal irrespective of the age, socio-economic class, place of residence and even countries. It is the prevalence, the severity and socio-cultural perceptions about the gynecological problems that varies from country to country and from time to time.

Gynecological problems are not synonymous with reproductive health problems. Reproductive health problems are a broader umbrella term used for all issues related to women's health as a whole. It encompasses issue like social justice, women empowerment, economic and cultural equality of women. It also includes addressing and the medical problems like anemia, diabetes, hypertension, chronic deficiencies like under-nutrition, specific deficiencies, etc and the gynecological problems of women like menstrual problems, reproductive tract infections including STDs and HIV/AIDS, Urinary tract infections, difficulty in conceiving, uro-gynecological problems like prolapse, stress incontinence, cervical cell changes and breast swellings. Hence it can be stated that gynecological problems are a smaller subset of reproductive health.¹¹

The gynecological problems more are less specific and unique over the different age groups. In adolescent period the gynecological problems include precocious or delayed puberty, puberty menorrhagia, spasmodic dysmenorrhea, anemia, undernutrition etc.¹² These problems if not addressed with adequate care, support and education by parents, relatives and doctors could magnify or continue after marriage well into the active sexual life of the women and present as multiple

gynecological problems. Inadequately addressed or unaddressed adolescent gynecological problems could breed wrong attitudes and harmful socio-cultural practices into the children.

Factors like early marriages, teenage pregnancies, illegal abortion seeking, unwanted births, inappropriate antenatal care; untrained, unhygienic home delivery practices, missed post natal care, poor quality and neglected follow-up of family planning services have all contributed to increasing obstetric, gynecological and reproductive morbidities. These morbidities have a profound effect on the physical, mental, psychological and social health of the women.^{7, 13}

Studying gynecological morbidities is difficult simply because of the reason that it includes various problems difficult to define. It encompasses all the problems of women, like the menstrual problems, excessive white discharge caused due to any reason, urinary tract infections, itching, swelling or ulcers of the genitals or genital regions, problems of abnormal swellings in the breast, general or specific tiredness for any routine work, under nutrition, any complications of the above mentioned conditions. It is important to note that almost all the gynecological problems have numerous causes, the detection of which could be difficult, requiring sophisticated laboratory thus increasing the expenses of medical treatment.³

The complications could be physical, psychological or social stigma. The physical complications like painful coitus, acute or chronic pelvic pain, lower abdominal pain, low back etc.¹³ The psychological complication arising out of

gynecological problems include depression, low self esteem and decreased productivity. The social complications are stigmatized and hence more serious. These include the problems of difficulty in conceiving or infertility.¹⁴

Epidemiology

Global scenario

According to WHO (1995) over one third of all healthy life among the adult women is lost due to reproductive health problems. Globally, 333 million new cases of curable sexually transmitted infections occur annually (WHO 1996).¹⁵

The annual incidence of two of the most common RTIs, namely gonorrhoea and Chlamydia are 62 million and 89 million respectively. The prevalence of menstrual problems, urogynecological problems along with undernutrition may vary from 50.00 % to 300.00 %. It is higher among women than in men. Highest prevalence is in Sub-Saharan Africa followed by South and South East Asia.¹⁶

The World Bank estimates gynecological problems are the second most important cause of morbidity and account for a significant loss of healthy productive life. The prevalence of gynecological problems varies from 52-92% and fewer than half of the women recognize the condition as abnormal. These include problems of contraceptive morbidities.¹⁷

STDs including HIV is the second common cause of healthy life lost in women aged 15-44 yrs after maternal morbidity and mortality. STDs as a single entity,

excluding HIV rank five most important cause of loss of productivity in the developing countries.

The wide difference in prevalence may be attributed to various factors like difference in education level, socio cultural milieu, economic independence, treatment seeking behavior.¹¹

Indian scenario

Indian subcontinent is known for its cultural diversity. The diversity is reflected in its health care system as well. The Vedic concepts of health and disease have there roots deep in the minds of the people.

According to Ayurveda, the food we eat gets sequentially converted into seven different constituents. Our body is made up of these seven constituents. Rasa (chyle), Rakta (blood), Maans (flesh), Meda (fat), Asthi (bone), Majja (marrow) and Veerya (semen). It is believed that Rasa (Chyle) is the essence of food. The blood (rakta) is made from rasa hence is the essence of rasa. Similarly maans (flesh) is the essence of blood, fat (meda) is the essence of flesh, bone (asthi) is the essence of fat, marrow (majja) is the essence of bone and semen (veerya) is the essence of marrow. In women the vaginal discharge is equated with semen. Thus the ayurvedic concept makes diet, weakness and heat as the dominant themes in context of women's illness.¹³

Even today, in some of the parts of India it is believed that the consumption of hot western medicines (allopathic drugs) or of the food grown in the fields where western fertilizers are used causes heat which in turn causes white discharge, urinary, menstrual and other gynecological problems.

This cultural belief is one of the important factors which makes majority of the women seek consultation from the practitioners of alternative medicines like Ayurveda, Homeopathy, Sidda, Unani, etc. Women seeking treatment may even resort to quacks or to home remedies for the gynecological problems. As these sectors are not well organized or less accountable to the health information system the generation of exact problem statement of gynecological problems has been difficult.¹⁸

This has been a major obstacle in national level data gathering exercises like National Family Health Survey (NFHS). Thus good quality data and information on the gynecological problems or reproductive health situation continues to be meager, incomplete and patchy.^{19, 3}

Gynecological problems and there causes

a) Menstrual problems.

Let us take a look at simple menstrual problems of women like menorrhagia and investigation the same in a clinical scenario. The causes could be as simple as post pregnancy or post abortal bleed, hormonal imbalance, inherited diseases like

Idiopathic thrombocytic purpura, inherited coagulopathy, systemic lupus erythematosus, systemic disease like hypothyroidism, liver or kidney diseases etc.^{12, 20} These require systematic approach and sophisticated laboratory for identification of the cause. Hence finding the cause and treating the same may not be possible in a resource poor or developing country scenario.

b) Reproductive Tract Infections.

RTIs have varied spectrum of presentations. Some of the common presentations include abnormal vaginal discharge, lower abdominal pain, genital ulcer, swelling or itch, inguinal bubo, low backache and acute pelvic pain. Each of these symptoms could again be caused by any of the bacteria like *Gardnerella vaginalis*, *Trichomonas vaginalis*, *Neisseria gonorrhoea*, *Chlamidia trachomatis*, *Haemophilus influenzae*, Group A Streptococci, Pneumococci, *Treponema pallidum*, Virus like Herpes simplex, fungi like *Candida albicans* etc.²¹ The specific isolation of the causative organisms may not be always possible but history and several clinical presentations are suggestive of specific diagnosis. The morbidity and associated sequelae of these various infections could be Pelvic inflammatory disease, endometriosis, urinary tract infection, cervical dysplasia, abdominal sepsis either directly or indirectly following the surgical interventions etc. In the subsequent pregnancies it can cause premature labor, premature rupture of membranes, chorioamnionitis etc.^{12, 22}

Keeping this in mind, the syndromic approach for management of Sexually Transmitted Infections and Reproductive tract infections were proposed by WHO. Now, the syndromic management of STD / RTIs is a well established and integrated national program in many countries including India. However, the syndromic approach is modified and tailor-made to suit various field circumstances in the resource poor settings where even a speculum examination or laboratory investigations cannot be performed.

An oral questionnaire is developed for administration in the community where no examination is possible, a flow chart is developed for dispensaries where clinical examination is possible but not speculum and guideline charts are prepared for all the major symptoms of RTI to aid implementation at a PHC or CHC where speculum, gloves and trained manpower are available along with a laboratory support.²³ Every symptom of RTI has been spelt out as algorithms to aid management in a uniform manner, with minimal training in health care workers. These charts are available at all STD / RTI clinics, family planning centers, ANC clinics, etc.

c) Other gynecological problems

Problems of infertility, sub-fertility, cancer of cervix and breast, prolapse of uterus etc do contribute to substantial proportion of the problems of women. These problems have gained momentum as potential research areas in the recent

years. All these conditions do require adequate resources and systematic guidelines for management.²⁴

Identification of the symptoms as abnormal is the first step, followed by making an attempt to seek treatment early in the course of the disease.

Risk factors for gynecological problems

Poor nutrition, illiteracy, early marriages, repeated childbearing, inadequate spacing, large families, repeated abortions, home deliveries, food fads, cultural myths, unhygienic practices associated with menstruation, delivery and puerperium are all potential barriers for reproductive health.^{22, 24}

Methodological issues in studies on gynecological problems

Gynecological morbidities perceived by women are not confined to special clinic-based population but is widespread in community.

Woolsey et al noted that the differences between self reported and observed morbidities provide evidence that the “dividing line between a healthy state and diseases state is not sharp; in fact this phenomenon has the features of a continuum that can be investigated along more than one scale.”²⁵

In another study, Mechanic and Newton reported that morbidities are likely to be reported when conditions are likely to be silent for an individual and where the psychological and social barriers for reporting are absent. These early studies and

reviews documented that self-reported morbidities are slightly or moderately associated with observed morbidity for a range of conditions. The high degree of false-negative self reports is likely to prevent estimation of prevalence of morbidity, especially at the individual level. In addition, psychological and behavioral factors along with health and medical knowledge influence self-reporting of the morbidities.²⁶ However, even today efforts to develop a scientific, practical, useful and effective approach to study the gynecological problems of women are ongoing.

Hill et al provided a comprehensive review of many recent studies and described three approaches for studying gynecological problems. These are as follows:

First approach is national level survey like the national representative sample surveys undertaken in 1970s, which basically addressed the problem of fertility and contraception use, but also included the questions on gynecological problems. Other surveys on similar lines included The World Fertility survey (WFS), Demographic and health Surveys (DHS), Center for Disease Control and prevention (CDC) Reproductive Health Surveys, PAPCHILD Gulf state surveys preclude adult mortality and morbidity focusing on international priorities and child health. Secondary analysis of the data collected from these surveys offer an indirect estimate of reproductive morbidities like sterility. These surveys could hardly elicit any quality data on sensitive issues like gynecological problems among women due to lack of time and appropriate personnel to do the adequate probing into the issues.

A second approach is a more recent advances and involved inclusion of specific modules on reproductive morbidities in the large scale surveys. This again suffered from the disadvantage of not tackling gender differences, socio-cultural and sexual issues.

A third approach is population based or community household based surveys primarily dedicated to estimating the prevalence of morbidities. These studies rely on self-reported symptoms, clinical observations and sometimes a combination of both. These studies represent a multinational collaborative work including gynecological examination, self reporting and laboratory investigation and treatment.²⁵

Studies from India indicate that cross-sectional study design is the best for baseline data collection. This could be backed by the longitudinal studies, as they are more informative. Longitudinal studies are the best to reinforce trust in the participants. They help to know the incidence of gynecological problems, the total number of episodes and the treatment seeking behavior for the same. The cost and time constraints are the most important limitations. These could be used for the urban population where self reporting of a greater number of less severe symptoms and morbidities like menstrual disorder and anemia are likely. However, potentially serious conditions like lower reproductive tract infection, acute and chronic pelvic inflammatory disease are equally likely to be reported by both urban and rural women in both cross sectional and longitudinal surveys.²⁷

Though various studies have reported high levels of morbidity ranging from 50.00 % to over 90.00 % depending on the problem, person interviewing and method of collection of the data, limitations of the almost all the urban or rural community based studies were reluctance of the women to acknowledge the fact that they are suffering from gynecological problems and resistance to undergo per vaginal and per speculum examinations. Hence the recent community based cross sectional surveys relies solely on self reporting of symptoms and morbidities for the estimation of prevalence. Having critically reviewed many study designs for its flaws it is still the cross-sectional studies which are accepted as the quick method for generation of a problem statement in any community for program and action.²⁶

Some of the international studies like the field-based methods for diagnosing RTI done in China reported that, the prevalence of self reported symptoms of abnormal discharge was 37.00 % sensitive and 66.00 % specific, genital itching was 58.00 % sensitive and 65.00 % specific and abdominal pain was 82.00 % specific and pain during intercourse was 95.00 % specific.²⁷

In a study done in a rural community of Lebanon of the 500 married women interviewed 24.50 % reported having abnormal vaginal discharge, 38.30 % had vulval itching and burning, 41.10 % had lower abdominal pain, 40.70 % had pain during intercourse and 32.50 % had menstrual irregularities.²⁸

In spite of various hurdles in investigating the gynecological problems like framing uniform definitions, difficulty in probing into problem to find a cause, requirement of trained manpower and sophisticated laboratory, various socio-cultural beliefs, myths, misconceptions, rampant and unregulated use of alternative medicines and economic dependence of women and their inability to make decisions regarding treatment seeking behavior, there are a few studies done in resource poor countries on gynecological problems of women.

A meta-analysis conducted on 12 community studies on the symptoms and signs of reproductive tract infections with prevalence more than 30.00 % showed that excessive vaginal discharge was 42.17 % sensitive and 59.60 % specific. The same meta-analysis also showed that lower abdominal pain was 38.16 % sensitive and 70.01 % specific for RTIs. ²

One of the urban studies conducted in Baroda city, showed that the prevalence of various gynecological problems among the 548 women interviewed was as follows: menstrual problem 58.00 %, low back ache 24.10 %, excessive vaginal discharge 22.40 %, lower abdominal pain 9.30%, dysuria 2.70 %, childlessness 1.80 % and prolapse of uterus 1.10 %. The mean number of gynecological problems reported was 1.96 per women.

In another study conducted in Bombay slum with 715 married women as participants, the prevalence of menstrual problems was 40.70%, excessive vaginal discharge 30.80%, low backache 39.30 %, lower abdominal pain 21.50

%, childlessness 5.00%, dysuria 5.60% and prolapse of uterus 2.70 %.The mean number of gynecological problems reported was 2.19 per women.

In a community based study conducted in two villages of Gadchiroлки district of Maharashtra with 650 married women, 55.00% has gynecological complaint and 45.00% were symptom free. Other problems contributing to the physical illness among women was 92.00% and average number of diseases per women was as high as 3.6 per women on follow up study. ⁵

In a study conducted in an urban resettlement colony of Delhi the prevalence of dysmenorrheal was 69.30%, menorrhagia 17.10 %, hypomenorrhea was 12.60%, polymenorrhea 7.20% and oligomenorrhea 3.60%. The study also reported a high prevalence of dysparuenia was 70.00% among women in the age group of 15-20 yrs and 76.90 % among 36-40 yrs old married women. ²⁶

In rural community based study done in Gujarat the prevalence of menstrual problems were 59.00%, excessive vaginal discharge 57.00%, low backache 30.00%, PID 8.00% and prolapse 3.00%. Women reporting one or more gynecological problems were 84.00%. ²⁸

A similar study in Rajasthan showed that prevalence of menstrual problems was 48.00%, excessive vaginal discharge 78.00%, lower abdominal pain 10.00%, low backache 16.00%, dysparuenia 48.00%and PID was 36.00%. Women experiencing one or more gynecological problems were 100.00 %. ²⁹

This community based cross sectional study was taken up as an exercise to collect baseline data on gynecological problems of married women in our urban field practice area.

Contraceptive pattern use

Worldwide

The number of contraceptive users worldwide in 1987 was estimated to be 460 million in approximately 51.00 % of couples exposed to the risk of pregnancy. Specific method use was as follows voluntary female sterilization 26.00 %, intrauterine devices (IUDs) 19.00 %, oral contraceptives 15.00 %, voluntary male sterilization 10.00 %, withdrawal 8.00 %, natural family planning methods 7.00 %, vaginal barriers 2.00 %, injectable contraceptives 1.00 % and other methods 2.00 %.³⁰

Patterns of contraceptive use in different regions

Contraceptive prevalence and method use patterns differ significantly from region to region. Overall contraceptive use is much higher in developed than in developing regions. It is 70.00 % in developed countries as compared to 46.00 % in developing countries.

Developed regions rely heavily on oral contraceptives, condoms and methods such as vaginal barriers and natural family planning where as the developing regions rely greatly on female sterilization and IUDs.

Developing regions

Contraceptive prevalence and method use patterns also vary considerably among developing regions. Overall use is highest in East Asia (including China) and Latin America, lowest in South Asia and Africa. East Asia relies heavily on female sterilization, male sterilization and IUDs, whereas in Latin America the emphasis is on female sterilization and oral contraceptives with virtually no male sterilization.

In a study done on quality of family planning services in India, Philippines and Sri Lanka the percentage of married women knowing any contraceptive method was 95.80 %, 97.20 % and 99.30 % respectively. The knowledge about any modern method was least among Indian women about 66.20 % for oral contraceptive pills, 60.80 % for Intra uterine devices and 58.10% for condoms. The knowledge about traditional methods like periodic abstinence and withdrawal was less than 40.00 % in India. The similar figure for the Sri Lanka and Philippines were all consistently about 80.00 %.³¹

Differences in method use patterns between regions can be attributed to program factors (especially method availability) as well as client factors such as cultural preferences. For example, the low prevalence of condom use and vasectomy in many regions may result in part from a cultural bias against male methods.

The trends in method use patterns over time can be caused by a variety of factors, including availability of methods, availability of medical facilities and skilled personnel, use of targets or incentives, use of campaigns to promote specific

methods and changes in user preferences. Availability of more family planning method choices leads to increased acceptance, higher continuation rates, greater use of more effective methods. This in turn will result in higher contraceptive prevalence, lower fertility, fewer abortions and thus lesser gynecological problems and better reproductive health.

Experience suggests that expanded method choice can lead to improved client satisfaction. It can also lead to increased prevalence through increased acceptance, better continuation rates and the use of more effective methods. The analysis indicated that the biggest demographic impact of introducing a new method will come from attracting non-users rather than from users switching from another method. Making one additional modern method widely available could increase contraceptive prevalence by about 6%. Continuation of contraceptive use and level of satisfaction with the program are likely to increase as more methods become available. Providing high quality services can improve program outcomes by increasing acceptance and continuation.

Studies on socio-cultural determinants of contraceptive method choice in states like Goa and Kerala showed that variables like education of the wife, occupation of the husband, age at marriage of wife, religion, SC/St status, landholding of household, housing facilities, place of residence, number of living children, number of living male children and child loss experiences influence the choice and pattern of use. Current use of contraception varies greatly increases from 34.00 % for women with one child to 74.00 % for women with three children.

Contraceptive pattern use shows a declining trend for women with four or more children. Women who have sons are more likely to be using contraception than women who have no sons.⁶

In India the highest contraceptive prevalence rate was found in the states of Himachal Pradesh and Kerala 54.40 % and lowest prevalence in states like Assam 19.80 %, Uttar Pradesh 18.50 % and Bihar 21.60 %.³²

NFHS – 3 revealed an unmet need for family planning among currently married women as 13.00 %, a declining from 16.00 % in NFHS-2. Unmet need also showed a declining trend with age, from 27.00 % for women in the age group 15-19 yrs, to 2.00 % for women in the age group 45-49 yrs. Younger women (age 15-24 yrs) have a greater unmet need for spacing than for limiting the family. Another fact pertaining to contraceptive pattern use is that the rural women have higher unmet need than urban women for both spacing and limiting.³²

The whole concept of studying the contraceptive pattern use among married women is based on the hypothesis that a woman who is using contraception is more likely to have a smaller family size, better spacing of children, healthy children and more opportunity for interaction with the health personnel. Hence she stands a better opportunity for health. The whole process of acquiring knowledge about various family planning methods, becoming aware of advantages and disadvantage of these methods, deciding on one particular method, build consensus with her husband and family for practicing the method

makes her more responsible not only for her own health but also the family health. It is an opportunity for the women's to voice her opinions and demand better quality reproductive health services. It is an important component and also a yardstick to measure the degree of women empowerment.

Effective and appropriate choice of family planning method can reduced or even cures some of the common gynecological problems. For example a women complaining of excessive menstrual bleeding when given a hormonal contraceptive pill or Levonorgestrol intrauterine device may no longer suffer from the problem. Abnormal vaginal discharge can be taken care of by effective treatment and proper barrier method of contraception. Through asepsis during invasive procedures can reduce the incidence of iatrogenic pelvic infections.²¹

Thus reproductive health and family planning are two sides of the same coin.

Observations and results

Presented under the following heading

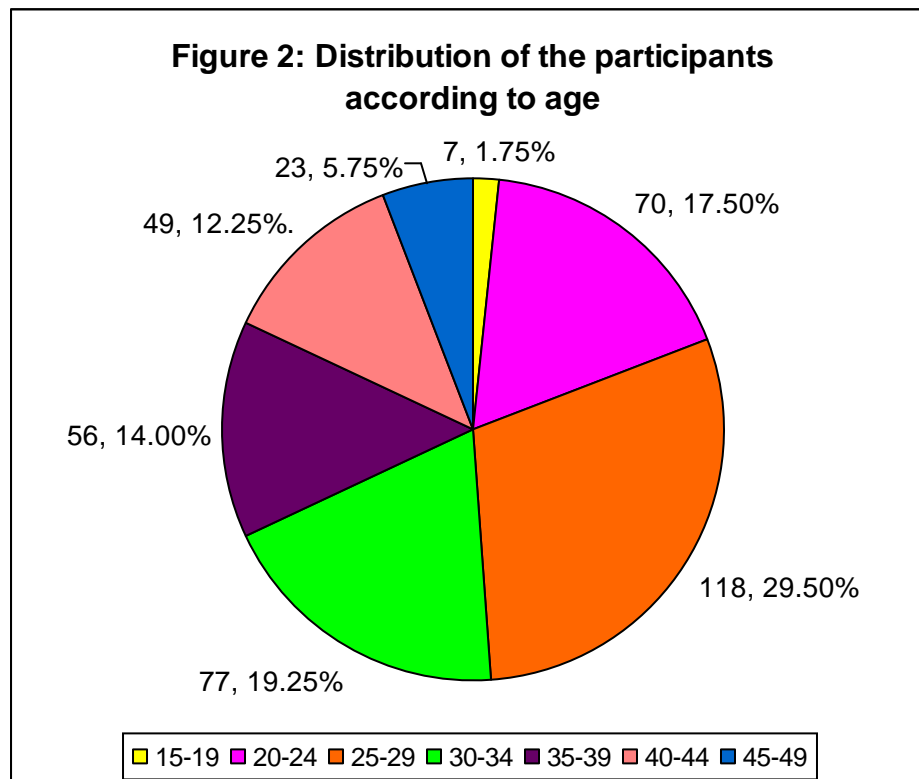
- 1. Demographic profile of the study participants*
- 2. Prevalence of various gynecological problems*
- 3. Knowledge and prevalence of family planning practices among study participants*

I Demographic profile of the study participants

Table 1: Age-wise distribution of Study participants

N = 400

Age in years	Number of participants	Percentage
15-19	7	1.75
20-24	70	17.50
25-29	118	29.50
30-34	77	19.25
35-39	56	14.00
40-44	49	12.25
45-49	23	5.75
Total	400	100.00

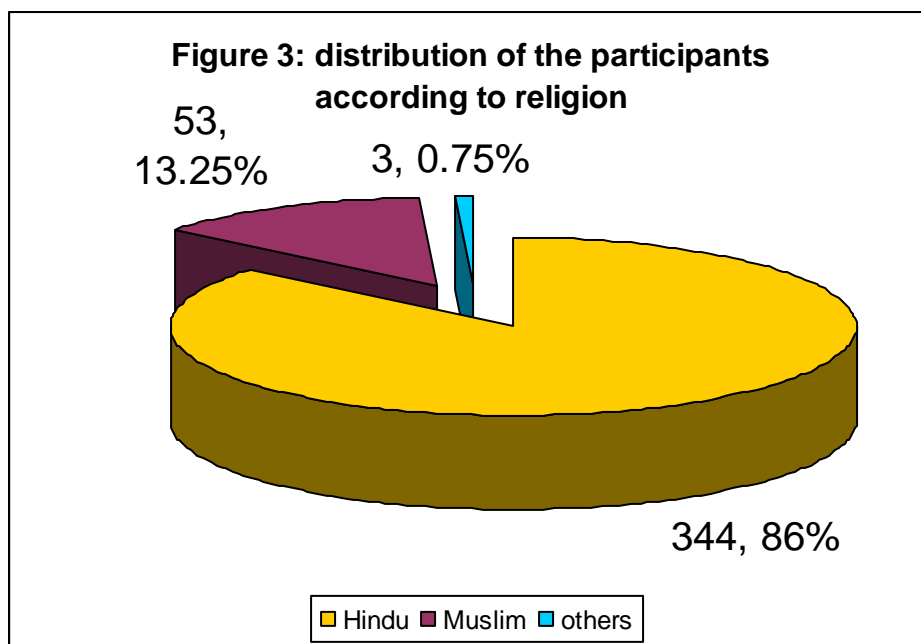


In the present study, out of 400 married women, 118 (29.75 %) were in the age group of 25-29 yrs, 77 (19.25%) were in the age group of 30-34 yrs, 70 (17.50 %) were in the age group of 20-24 yrs. women with the age \leq 19 yrs (teenage) were 7 (1.75%) and age \geq 45 yrs (menopausal) are 23 (5.75 %).

Table 2: Distribution of study participants according to religion

N = 400

Religion	Number of participants	Percentage
Hindu	344	86.00
Muslim	53	13.25
others	3	0.75
Total	400	100.00

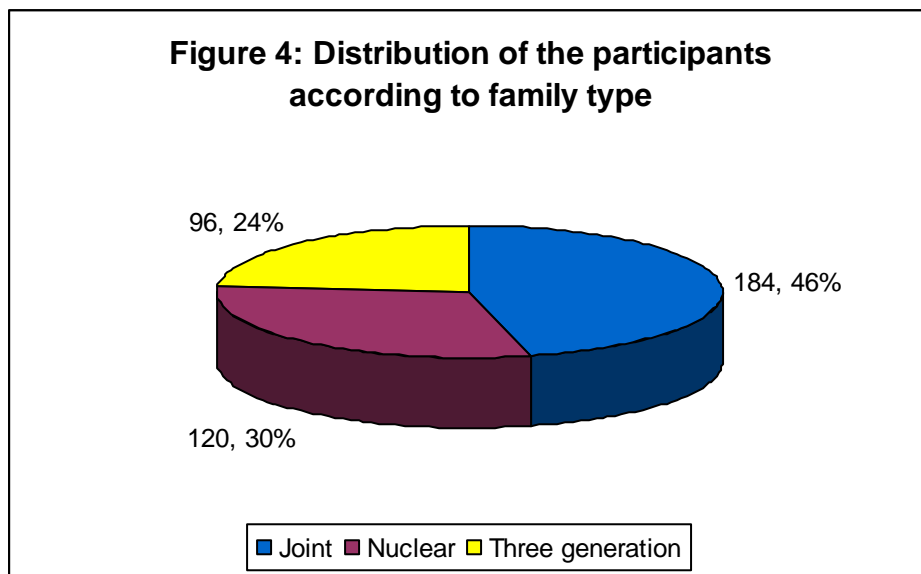


In our study, of the 400 participants majority 346 (86%) were Hindus, 53 (13.25%) were Muslims and 3 (0.75%) belong to other religion which included 2 Christians and 1 was a Jain.

Table 3: Distribution of study participants according to type of the family

N = 400

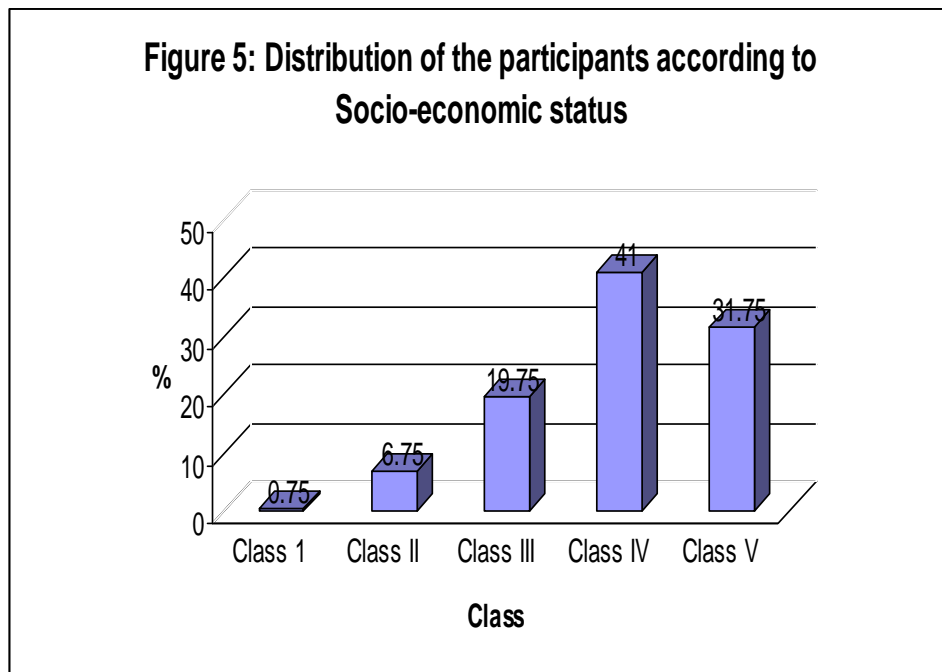
Type of the family	No. of participants	percentage
Joint	184	46.00
Nuclear	120	30.00
Three generation	96	24.00
Total	400	100.00



In our study, majority of the study participants 184 (46.00%) were from joint families, followed by 120 (30.00%) from nuclear families and 96 (24.00%) were from three generation families.

Table 4: Distribution of study participants according to Socio-Economic**Status****N = 400**

Socio-Economic Status	Number of study participants	Percentage
Class I	3	0.75
Class II	27	6.75
Class III	79	19.75
Class IV	164	41.00
Class V	127	31.75
Total	400	100.00

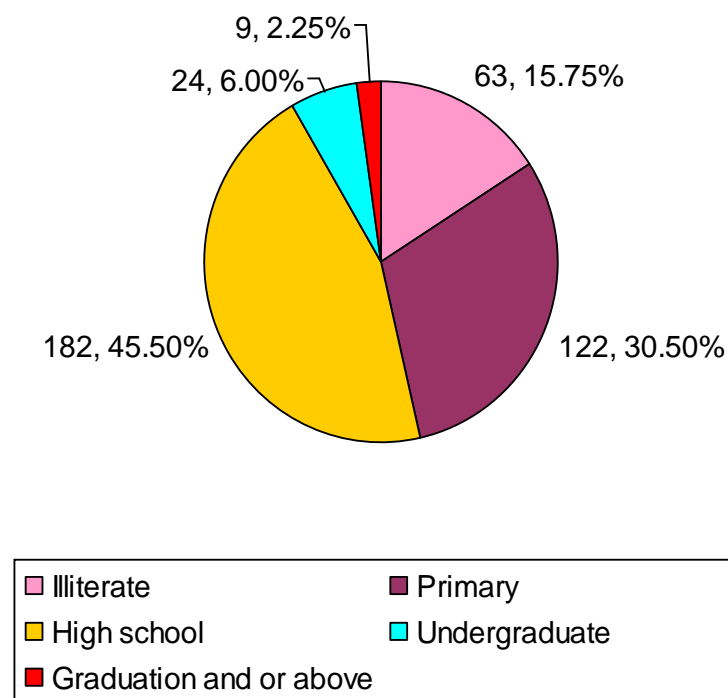


In our study, out of 400 participants majority 164 (41.00%) belonged to class IV of Modified B.J. Prasad's, followed by 127 (31.75%) and 79(19.75%) in Class V and Class III respectively. Class I and Class II together contributed to 30 (7.50%) of the study participants.

Table 5: Distribution of study participants according to the education

N = 400

Level of education	Number of participants	Percentage
Illiterate	63	15.75
Primary	122	30.50
High school	182	45.50
Undergraduate	24	6.00
Graduation and or above	9	2.25
Total	400	100.00

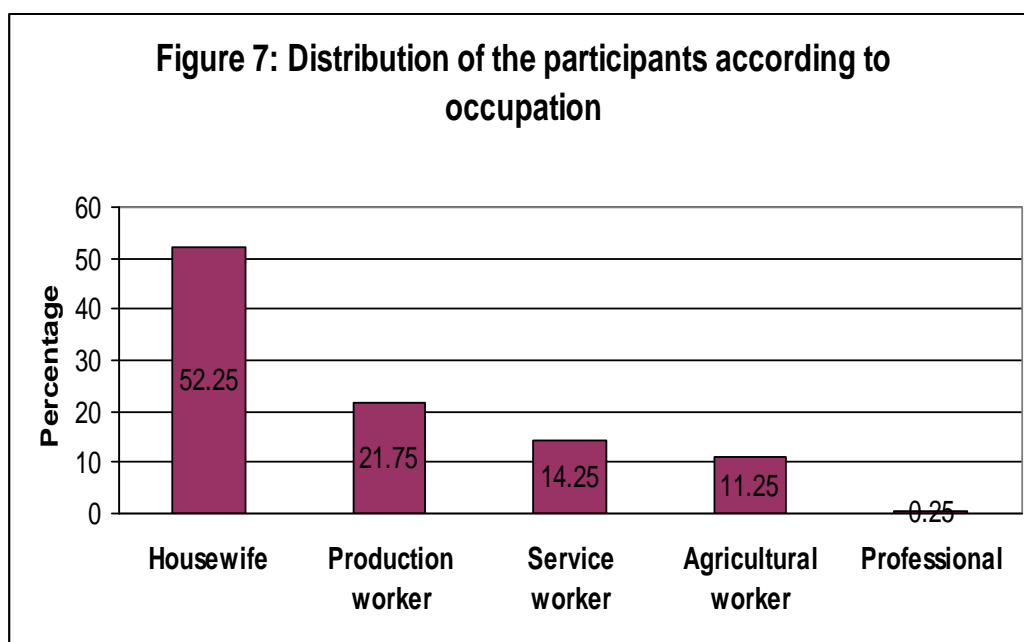
Figure 6: Distribution of the participants according to education

In our study, out of the 400 participants, majority 182 (45.50%) were educated till high school and 122 (30.50%) had completed primary education. 63 (15.75%) were illiterate and 24 (6.00%) had completed undergraduation and 9 (2.25%) of them were graduates.

Table 6: Distribution of the study participants according to occupation

N = 400

Type of occupation	Number of participants	Percentage
Housewife	209	52.25
Production worker	87	21.75
Service worker	57	14.25
Agricultural worker	45	11.25
Professional	1	0.25
Total	400	100.00



In our study, out of the 400 participants, majority 209 (52.25%) were housewives. This was followed 87 (21.25%) involved in production work like weaving of sarees, making garlands, making sweets etc and 57 (14.24%) participants were involved in service work like teaching, tailoring, maids, etc. However, 45 (11.25%) were agricultural laborers.

Table 7: Distribution of the study participants according to Husband's education

N = 400

Level of education	Number of participants	Percentage
Illiterate	31	7.75
Primary	122	30.5
High school	139	34.75
Under-graduation	85	21.25
Graduation and or above	23	5.75
Total	400	100.00

Of our 400 study participants, majority of their husbands 139 (34.75%) were educated till high school and 122 (30.50%) had a completed primary education. 108 (27.00%) of the study participants reported that their husbands had completed undergraduation and 31 (7.75%) of them were illiterate.

Table 8: Distribution of the study participants according to husband's occupation

N = 400

Type of occupation	Number of participants	Percentage
Production worker	202	50.50
Service worker	97	29.25
Sales worker	57	14.25
Agricultural worker	22	5.50
Professional	17	4.25
Total	400	100.00

In our study, majority of the husbands of study participants 202 (50.50%) were involved in production work, followed by 97 (29.25%) service work and 57 (14.25%) sales work. The number of professions and farmers were almost comparable with 17 (4.25%) and 22 (5.50 %) respectively.

Table 9: Distribution of study participants according to duration of married life

N = 400

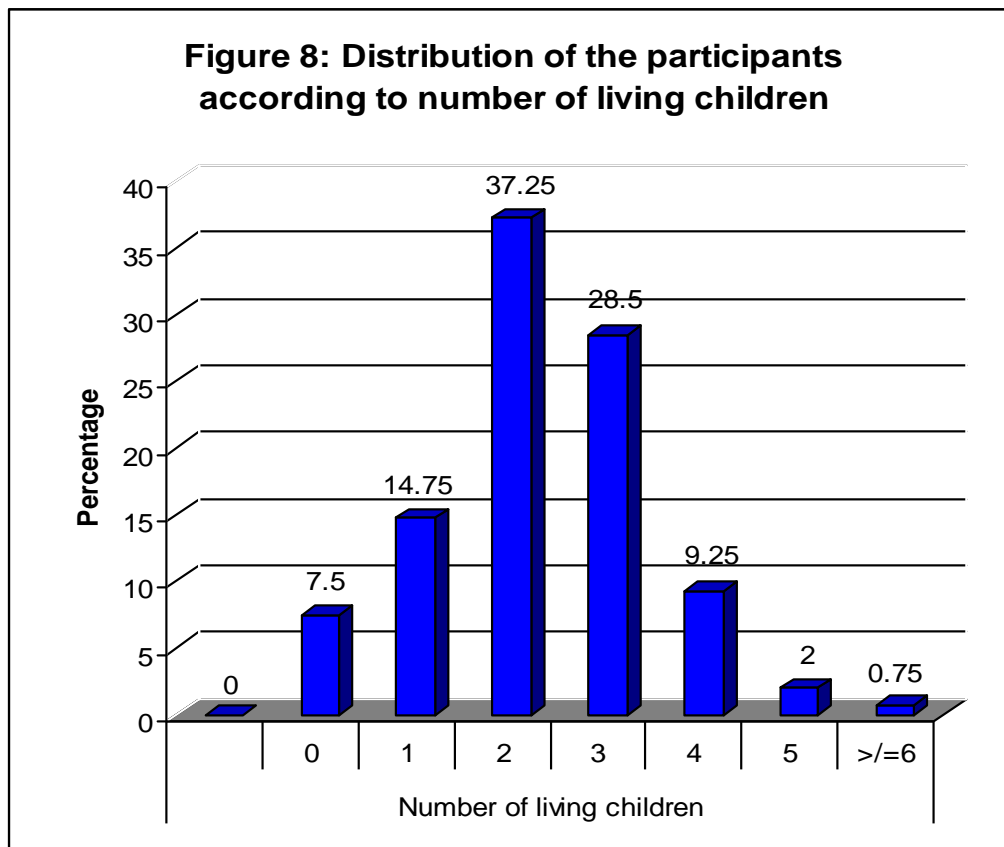
Duration in years	Number of participants	Percentage
Less than 5	77	19.25
6-10	111	27.25
11-15	83	20.75
16-20	61	15.25
>21	68	17.00
Total	400	100.00

In our study, the duration of married life of the study participants ranged from 1-32 years, with mean of 12.59 years and standard deviation of 7.37 years. Majority of the study participants 271(67.75%) were married for less than or equal to 15 years and the remaining 129 (32.25%) were married for more than 15 years.

Table 10: Distribution of the study participants according to the number of living children

N = 400

Number of living children	0	1	2	3	4	5	>=6	Total
Number of participants	30	59	149	114	37	8	3	400
Percentage	7.5	14.75	37.25	28.50	9.25	2.00	0.75	100.00



In our study, out of the 400 participants majority 149 (37.25%) had two living children, 114 (28.50%) had three living children and 59 (14.75%) had only one living child. 48 (12.00%) of the women had four or more living children. However, 30 participants (7.5%) did not have any living children at the time of the study.

Table 11: Distribution of the study participants according to the number of living male children

N = 400

Number of living male children	0	1	2	3	4 and more	Total
Number of participants	66	196	112	20	6	400
Percentage	16.50	49.00	28.00	5.00	1.50	100.00

In our study, out of the 400 participants, majority of them 196 (49.00%) had one living male child, 113 (38.25%) had two living male children. However, 66 (16.50%) had no male children and <7% had three or more male children.

Table 12: Distribution of the study participants according to the number of living female children

N = 400

Number of living female children	0	1	2	3	4 and more	Total
Number of participants	109	173	88	26	4	400
Percentage	27.25	43.25	22.00	6.50	1.00	100.00

In our study, out of the 400 participants, majority of them 173 (43.25%) had one living female child, followed by 88 (22.00%) with two living female children. However, 109 (27.25%) had no living female children. Only 30 (7.50%) of the study participants had three or more living female children.

II Prevalence of various gynecological problems

Table 13: Distribution of the study participants according to gynecological symptoms**

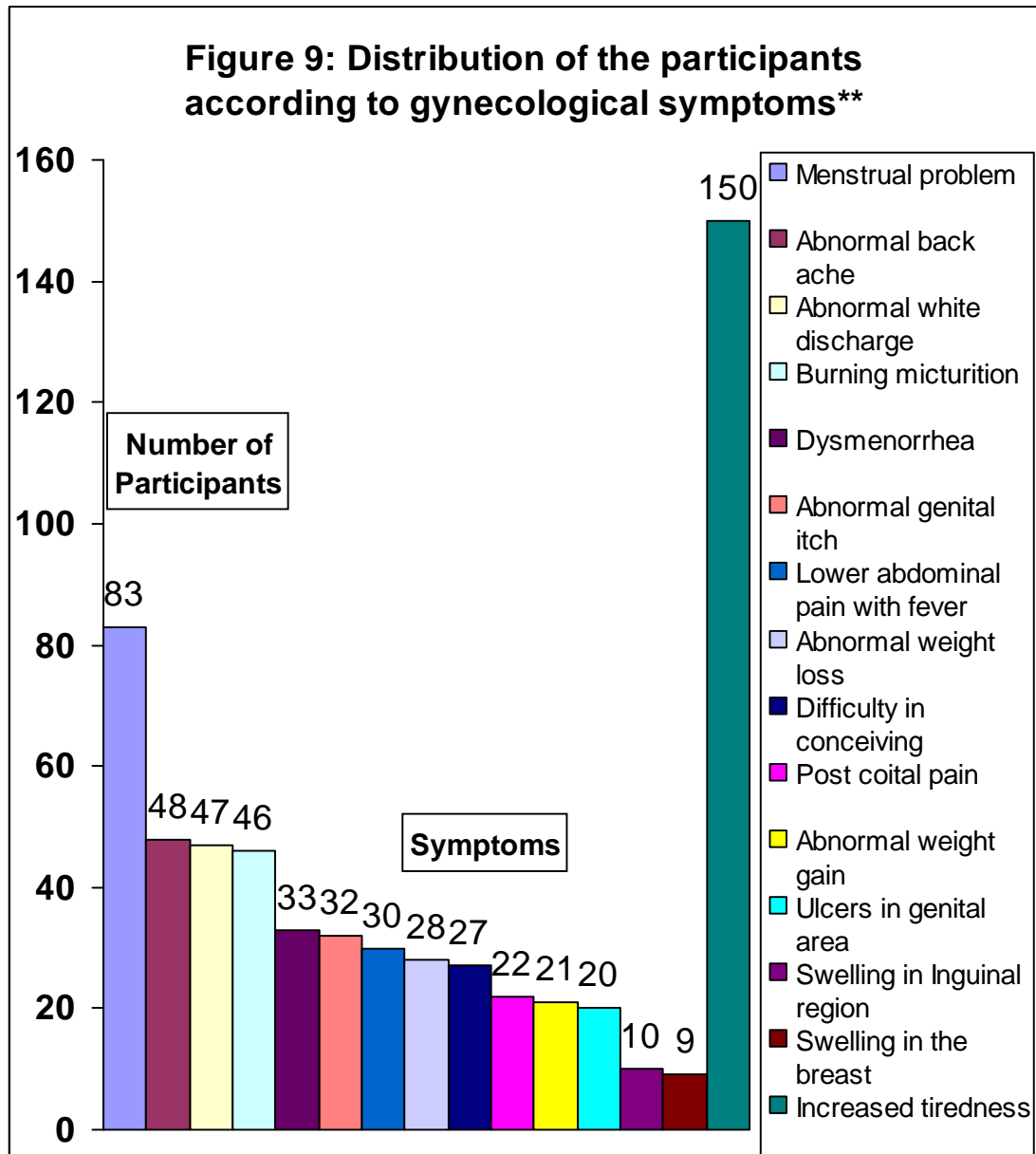
Problem	Number of participants	Percentage
Menstrual problem	83	20.75
Abnormal back ache	48	12.00
Abnormal white discharge	47	11.75
Burning micturition	46	11.50
Dysmenorrhea	33	8.25
Abnormal genital itch	32	8.00
Lower abdominal pain with fever	30	7.50
Abnormal weight loss	28	7.00
Difficulty in conceiving	27	6.75
Post coital pain	22	5.50
Abnormal weight gain	21	5.25
Ulcers in genital area	20	5.00
Swelling in Inguinal region	10	2.50
Swelling in the breast	9	2.25
Increased tiredness	150	37.50
Total	605	1.51 per woman

** multiple responses

Self reported symptom wise distribution of the study participants showed that menstrual problems were the most common 83 (31.00%), followed by abnormal low back ache 48 (12.00%), abnormal whitish vaginal discharge 47 (11.75%), burning micturition 46 (11.50%), dysmenorrhea 33 (8.25%), genital itch 32 (8.00%), lower abdominal pain with fever 30 (7.50%), conceiving difficulty 27 (6.75%), post coital pain 22 (5.50%), genital ulcers (5.00%) and increased tiredness for routine work 150 (37.50%).

There were totally 605 reproductive problems reported by 400 study participants.

The mean gynecological symptoms prevalence per women was 1.51.



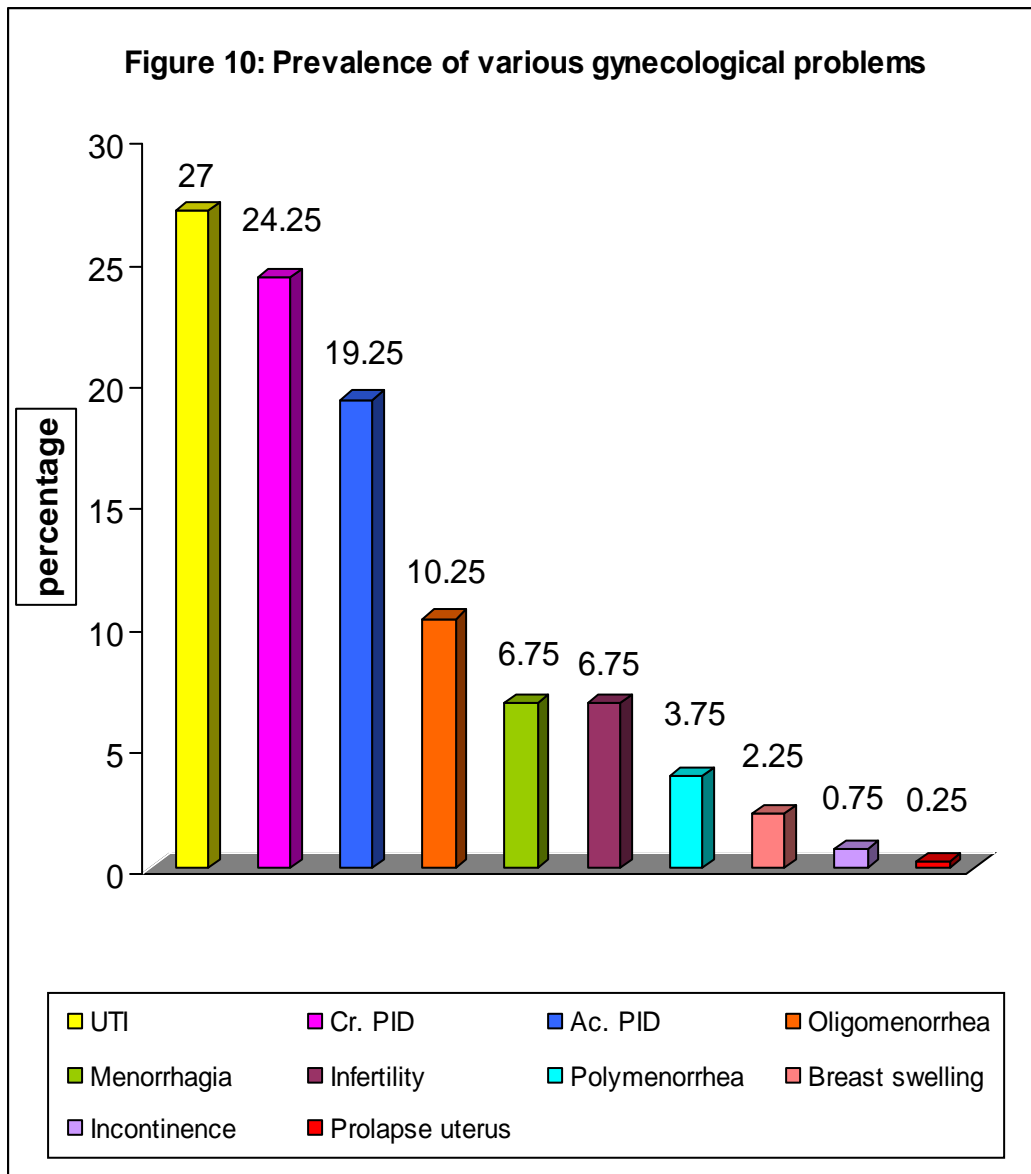
** multiple responses

Table 14: Prevalence of gynecological problems

(arranged in decreasing order)

N = 400

Gynecological problems	Number of participants having problem	Prevalence of the gynecological problems (%)
Urinary Tract Infection	108	27.00
Chronic PID	97	24.25
Acute PID	77	19.25
Oligomenorrhea	41	10.25
Menorrhagia	27	6.75
Infertility	27	6.75
Polymenorrhea	15	3.75
Breast swelling	09	2.25
Stress incontinence	03	0.75
Prolapse of uterus	01	0.25



In our study, the prevalence of the various gynecological problems were Urinary tract infection 108 (27.00%), chronic PID 97 (24.25%), Acute PID 77(19.25%), Oligomenorrhea 41 (10.25%), menorrhagia 27(6.75%), conceiving difficulty 27 (6.75%), polymenorrhea15 (3.75%), breast swelling 9 (2.25%), stress incontinence 3 (0.75%) and prolapse of uterus 1 (0.75%).

Table 15 A: Distribution of the Study participants according to Menstrual problems

N = 400

Menstrual problems	Number of participants	Percentage
Oligomenorrhea	41	10.25
Menorrhagia	27	6.75
Polymenorrhea	15	3.75
Metrorrhagia	00	00.00
Total	83	20.75

In our Study, the overall prevalence of menstrual problem among the study participants were 83 i.e., 20.75%. Of these 41 (10.25%) women complained of oligomenorrhea where as remaining 42 (10.50%) had polymenorrhea and or menorrhagia. None of them reported intermenstrual bleed as a complaint.

Table 15B: Distribution of the study participants according to Dysmenorrhea

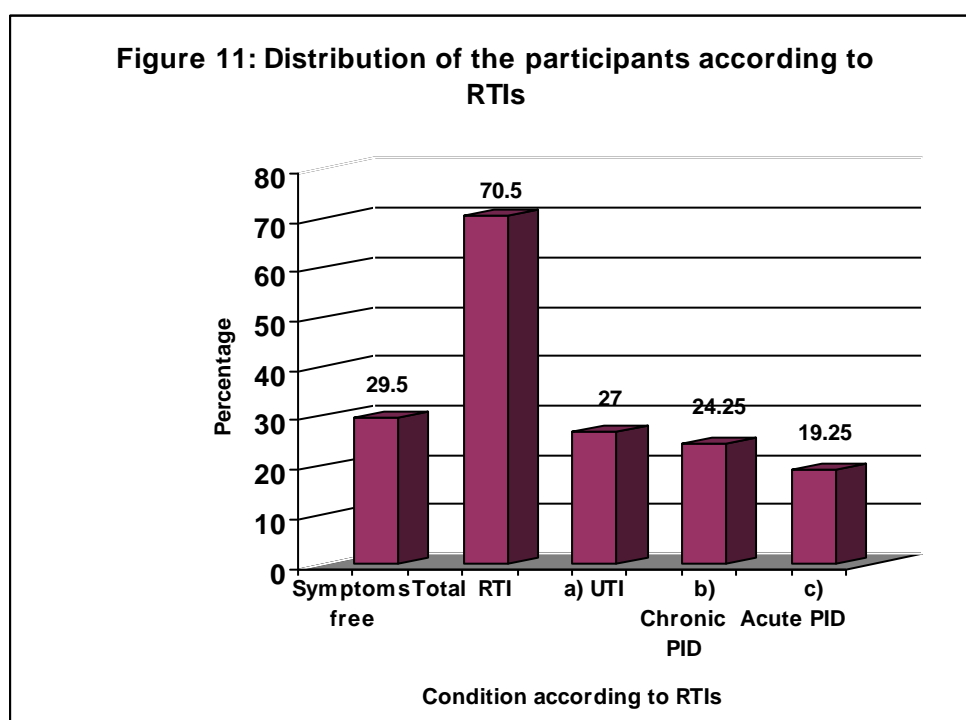
N = 33

Type of Dysmenorrhea	Number of participants	Percentage
Primary	09	2.25
Secondary	24	6.00
Total	33	8.25

In our study of the 400 participants, self reported prevalence of dysmenorrhea was 33 (8.25%). Majority of them 24 (73.00%) had secondary type of dysmenorrhea and 09 (27.27 %) had primary type of dysmenorrhea. The self reported prevalence of secondary type of dysmenorrhea was 6.00 % and primary type was 2.25%.

Table 15 C: Distribution of the study participants according to reproductive tract infections

Type of reproductive tract infection	Number of participants	Percentage
Symptoms free	118	29.50
Total RTI	282	70.50
a) UTI	108	27.00
b) Chronic PID	97	24.25
c) Acute PID	77	19.25
Total	400	100.00



In our study, out of the 400 study participants, 282 (70.50 %) had one or the other symptoms of reproductive tract infections. Among them majority 108 (27.00%) had UTI symptoms, followed by 97 (24.25 %) Chronic PID and 77(19.25%) had Acute PID symptoms. Only 118 women (29.5%) were free of any RTI symptoms.

Table 15 D: Distribution of the study participants according to difficulty in conceiving

N = 400

Difficulty in conceiving	Number of participants	Percentage
Primary	16	4.0
Secondary	11	2.75
Total	27	6.75

In our study, of the 27 (6.75%) of 400 participants reporting conceiving problem, 16 (4.00%) were of primary type and remaining 11 (2.75%) had secondary type of problem. However, 12 (3.00%) couples had consulted an infertility specialist (allopathic) and taken some form of treatment. The remaining 15 (3.75%) had never consulted any allopathic doctor.

Table 15 E: Distribution of the study participants according to swelling in the breast

N = 400

Swelling in the breast	Number of participants	Percentage
Unilateral	8	2.00
Bilateral	1	0.25
Total	9	2.25

In our study, 9 of the 400 study participants had an abnormal swelling in the breast. The prevalence of unilateral swelling in the breast was 2.00%. Abnormal discharge from the nipple as a symptom was reported by only 2 (0.50%), pain associated with the swelling was reported in 7 (1.75%).

Table 15 F: Prevalence of other medical conditions

Problems	Number of participants	Prevalence in percentage
Anemia	224	56.00
Underweight	92	24.00
Overweight	53	14.25
Obesity	10	2.50
Hypertension	08	2.00
Diabetes mellitus	05	1.25
Rheumatic heart disease	02	0.50
Thyroid problems	02	0.50

In our study, the prevalence of other medical conditions and symptoms, anemia 224 (56.00 %), underweight 92 (24.00%), overweight 53 (14.25%), obesity 10 (2.50%), hypertension 08 (2.00%), diabetes mellitus 05 (1.25%), rheumatic heart disease 02 (0.50%) and thyroid problems 02 (0.50%)

Table 15 G: Distribution of the study participants according to treatment taken for any Gynecological problems

N = 95

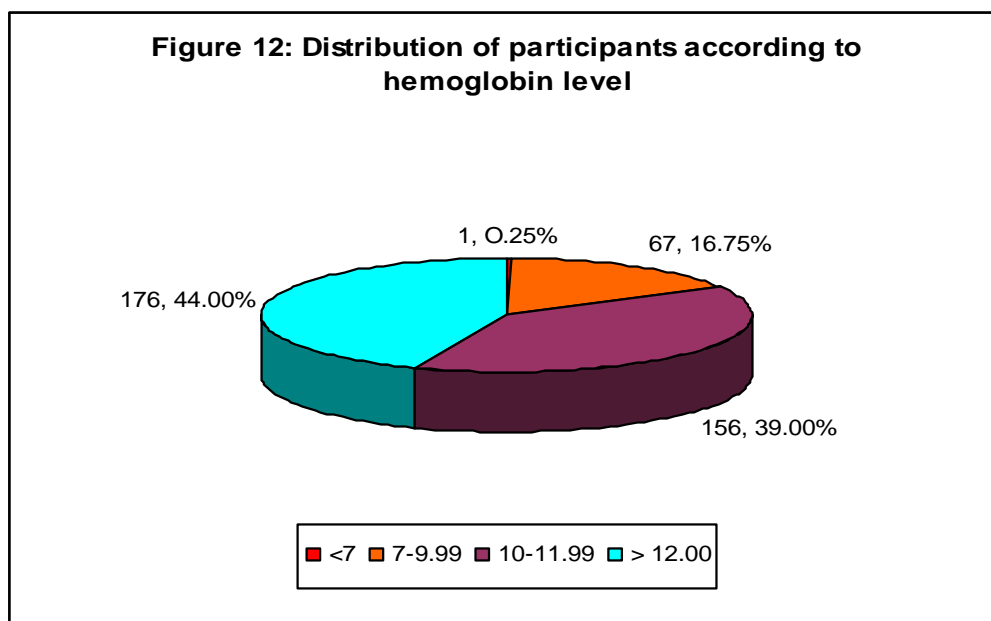
Type of Problem	Number of participants	Percentage
Menstrual	15	18.07
RTI	27	9.57
Conceiving	13	48.14
Others	40	19.41
Total	95	15.72

In our study it was found that less than 20.00 % of the women resorted to treatment for menstrual problems only 9.57 % reported to treatment for STD / RTIs. However the women opting for treatment for conceiving difficulty was 48.14%.In our study, the overall treatment seeking behavior was 15.72% (95/604).

Table 15 H: Distribution of the study participants according to hemoglobin level.

N = 400

Hemoglobin g %	Number of participants	Percentage
<7	01	00.25
7-9.99	67	16.75
10-11.99	156	39.00
> 12.00	176	44.00
Total	400	100.00

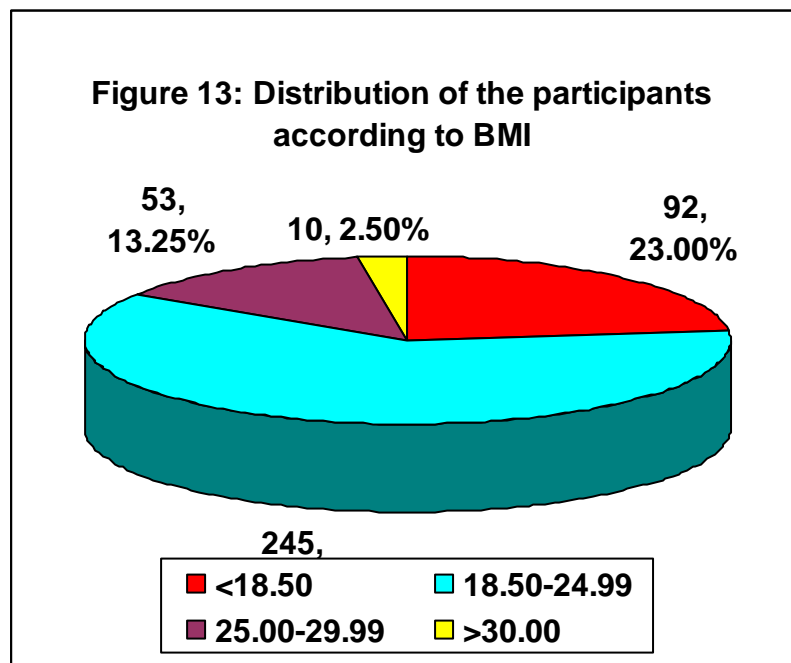


Out of the 400 study participants, 156 (39.00%) were mildly anemic, 67 (16.75%) were moderately anemic and one participant was severely anemic. 176 (44.00%) of the study participants had normal hemoglobin levels.

Table 15 I: Distribution of the study participants according to Body Mass**Index.**

N = 400

BMI	Number of participants	Percentage
<18.50	92	23.00
18.50-24.99	245	61.25
25.00-29.99	53	13.25
>30.00	10	2.50
Total	400	100.00



In our study, out of the 400 participants 92 (23.00%) were undernourished, 245 (61.25%) had normal BMI. However, 53 participant (13.25%) were overweight and 10 (2.50%) were obese. The mean BMI was 21.2 with a standard deviation of 3.64 and range 13.60 - 35.84.

The mean height in our study participants was 153.9 cms with a standard deviation 4.88 cms. The range was 140 – 176 cms. The mean weight in our study participants was 50.1 kgs with a standard deviated of 8.36 kgs. The range was 31 – 85 kgs.

Table 16 A: Association of education of the women with menstrual problems

N = 400

Education	Menstrual problems				Total
	YES	%	NO	%	
Illiterate	23	36.50	40	63.50	63
Primary	33	27.04	89	72.96	122
Secondary	48	26.37	134	73.63	182
Undergraduation and above	12	36.36	21	63.64	33
Total	116	29.00	284	71.00	400

$$X^2 = 3.43$$

$$df = 3$$

$$p = 0.33$$

In our study, there was no significant association between the education of the women and the menstrual problems.

Table 16 B. Association of White discharge with age of the participants

Age in years	Vaginal discharge				Total
	YES	%	NO	%	
15-19	01	12.50	07	87.50	08
20-24	07	10.00	63	90.00	70
25-29	13	11.01	105	88.98	118
30-34	10	12.98	67	87.01	77
35-39	08	14.54	47	85.45	55
40-44	08	16.32	41	83.67	49
45-49	00	0.00	23	100.00	23
Total	47	11.75	353	88.25	400

$$X^2 = 4.881$$

$$df = 6$$

$$p = 0.559$$

In our study, there was no significant association found between age of the study participants and white discharge per vagina.

Table 16 C: Association of education level of the women with white discharge

Education	White discharge				Total
	YES	%	NO	%	
Illiterate	09	14.28	54	85.71	63
Primary	13	10.65	109	89.34	122
Secondary	23	12.63	159	87.36	182
Under graduation and above	02	6.06	31	93.93	33
Total	47	11.75	353	88.25	400

$$X^2 = 1.64$$

$$df = 3$$

$$p = 0.65$$

In our study, there was no significant association found between white discharge and the level of education of the married women.

Table 16 D: Association of socio-economic status of the women with white discharge

Socio-economic Status	White discharge				Total
	YES	%	NO	%	
Class I, II, III	09	8.41	100	91.59	109
Class IV	18	10.97	146	89.03	164
Class V	20	15.74	107	84.26	127
Total	47	11.75	353	88.25	400

$$X^2 = 3.34$$

$$df = 2$$

$$p = 0.18$$

The number of participants with white discharge in class I was Zero, Class II was 02 and Class three was 07. However the association between socio-economic class and white discharge was statistically not significant.

Table 16 E: Association of White discharge with number of living children of the participants

Number of living children	White discharge				Total
	YES	%	NO	%	
0	02	6.67	28	93.33	30
1	06	10.17	53	89.83	59
2	17	11.49	131	88.51	148
3	18	15.79	96	84.21	114
>4	04	8.84	44	91.16	48
Total	47	11.75	353	88.25	400

$$X^2 = 3.227$$

$$df = 4$$

$$p = 0.521$$

In our study, there was no significant association found between number of living children and white discharge per vagina.

Table 16 F: Association of conceiving difficulty with Socio-economic status of the participants

Socio-economic Status	Conceiving difficulty				Total
	YES	%	N0	%	
Class I, II and III	04	3.66	105	96.34	109
Class IV and V	23	7.90	268	92.10	291
Total	27	6.75	373	93.25	400

$$X^2 = 3.18$$

$$df = 2$$

$$p = 0.2039$$

In our study, there was no significant association found between conceiving difficulty and socio-economic status of the participants.

Table 16 G: Association of conceiving difficulty with education status of the participants

Education	Conceiving difficulty				Total
	YES	%	NO	%	
Illiterate and primary	12	6.48	173	93.51	185
Secondary and above	15	6.97	200	93.03	215
Total	27	6.75	373	93.25	400

$$X^2 = 2.97$$

$$df = 1$$

$$p = 0.0848$$

In our study, there was no significant association found between conceiving difficulty and education status of the participants.

Table 17: Findings of the urine examination

N = 380

Urinary constituents	Number of samples positive	Percentage
Reducing Sugar	14	3.68
Albumin	22	5.78
Pus cells > 10 / hpf	78	20.52
Epithelial cells >15 / hpf	98	25.78
RBC's > 5 / hpf	16	4.21
Other abnormal findings – RBC / hyaline casts	00	0.00

Of the 380 samples (95.00%) submitted for urine examination, 14 (3.68%) samples tested positive for sugar, 22 (5.78%) were positive for albumin, 78 (20.52%) had high pus cells counts, 98 (25.78%) had high epithelial cells counts, 16 (4.21%) had high RBC counts and all the samples tested negative for abnormal casts in urine.

Remaining 20 (5.00 %) of the samples could not be collected as some of the participants were unable to give the samples due to various reasons like menstruation, religious festivals or social problems.

III Knowledge of family planning methods and contraceptive prevalence among study participants

Table 18: Distribution of study participants depending on knowledge of family planning methods

N = 400

Knowledge about FP	Number of participants	percentage
YES	380	95.00
NO	20	5.00
Total	400	100.00

In our study, out of 400 participants, majority of them 380 (95.00%) of them had knowledge of any family planning methods and 20 (5.00%) reported to have no knowledge of any family planning methods.

Table 19: Distribution of study participants according to knowledge of permanent family planning methods

N = 380

Permanent methods	YES	Percentage	NO	Percentage
Tubectomy	380	100.00	00	00.00
Vasectomy	282	74.21	98	25.79

In our study, out of the 380 participants who had knowledge of family planning method, only 282 (74.21%) knew about vasectomy as a permanent method and remaining 98 (25.79%) did not know about it. However, the knowledge about tubectomy was universal as seen by the fact, all the 380 participants knew about it as a permanent method.

Table 20: Distribution of the study participants according to knowledge of temporary FP methods N = 380

Temporary method	Number of participants	Percentage
YES	299	78.68
NO	81	21.32
Total	380	100.00

In our study out of the 380 participants who had knowledge of FP methods, 299 (78.68%) knew about any temporary method, whereas 81 (21.32%) did not know about any temporary method of family planning.

Table 21: Distribution of the study participants according to knowledge of different spacing methods N = 299

Name of the method	Knowledge YES	Percentage
Oral pills	296	98.99
IUD's	263	87.95
Condoms	236	78.92
Natural methods	56	18.72
Injectable hormones	12	4.01

In our study, out of the 299 study participants who had knowledge about spacing FP methods majority 296 (98.99%) knew about oral contraceptive pills, where as 263 (87.95%) knew about intrauterine devices and 236 (78.92%) knew about condoms only 12 (4.01 %) knew about injectable hormonal contraceptives. Only 56 (18.72%) of the participants were aware of natural FP methods implying that majority of the participants 243 (81.27%) did not have knowledge about natural FP methods. The knowledge about spacing methods is not adequate among our study participants.

Table 22: Distribution of the study participants according to the Sources of information about FP methods** N = 400

TYPE OF MEDIA	NUMBER OF PARTICIPANTS	PER CENTAGE
Single source		
Mass Media	64	16.00
Social contacts	55	13.75
Health professional	25	6.25
Husband	01	0.25
Total	145	38.15
Two sources		
Mass media + Social contact	125	31.25
Mass media + Health professional	38	9.50
Mass media + Husband	16	4.00
Social contact + Health professional	28	7.00
Social contact +Husband	4	1.00
Total	211	55.52
Three sources		
Mass media + social contact + health professional	17	4.25
Mass media + social contact + husband	4	1.00
Mass media + health professional + husband	3	0.75
Total	24	6.31

** multiple response

In our study, out of 380 participants who had knowledge of FP methods, majority 211 (55.52%) of them had acquired the knowledge from two sources, followed by 145 (38.15%) of the participants had acquired the knowledge from one source. Among the two sources, mass media and social contacts accounted for the majority 125 out of 211 (59.24%) and the single most important source of information was found to be mass media accounting for 44.13 %, followed closely by social contacts 37.93 %.

It is also evident from the table that husbands were the poor source of imparting knowledge to their wives, accounting for 7.00 % of all the sources put together.

Table 23: Distribution of Study participants according to FP practices

N = 400

Family planning method	Number of participants	Percentage
Yes	321	80.25
No	79	19.75
Total	400	100.00

In our study, out of the 400 participants 321 (80.25%) were using one or the other FP methods, remaining 79 (19.75%) were not using any FP methods.

Table 24: Distribution of Study Participants according to permanent method of FP.

N = 321

FP method	Number of Participants	Percentage
Permanent	252	63.00
Temporary /spacing	69	17.25
Total	321	100.00

In our study, 321 (80.25%) participants out of 400, were using one or the other FP method. 252 (63.00%) had undergone permanent sterilization. It was noted that all the 252 permanent sterilizations were tubectomies. Only 69 (17.25%) of the couples were using one or the other type of temporary FP method.

In our study, the number of years since tubectomy varied widely, ranging from 1 to 21 years with a mean of 8.43 years. The median number of years for tubectomy was 11 years. The standard deviation was 5.34 years.

Table 25: Distribution of the Study participants according to spacing**methods being used****N = 400**

FP method	Number of Participants	Percentage
Condom	23	5.75
IUD	15	3.75
OCP	13	3.25
Natural Methods	18	4.50
a) lactational amenorrhoea	06	1.50
b) abstinence	05	1.25
c) coitus interrupts	04	1.00
d) rhythm method	03	0.75
Total	69	17.25

In our study, among the 69 couples practicing temporary methods of FP, condoms were on top of the list 23 (33.33 %), followed by Natural methods 18 (26.08 %), IUD 15 (21.73 %) and OCP 13 (18.84 %). Among the natural methods, lactational amenorrhea method 7 (1.75 %) was the most popularly practiced, coitus interrupts and rhythm accounting for 04 (1.00 %) and 03 (0.75 %) respectively.

Table 26: Distribution of the Study participants with unmet need among the**non FP method users.****N = 79**

Unmet need	Number of participants	Percentage
Yes	36	9.00
No	43	10.75
Total	79	19.75

In our study, among the 79 couples not using FP methods, 43 (54.43%) wanted to conceive and 36 (45.56%) did not want any more children. The Unmet need for family planning is 9.00 %.

Table 27: Reasons for unmet need as given by the study participants

N = 36

Reasons for unmet need	Number of participants	Percentage
Will not conceive	12	33.33
Family wants male child	9	25.00
Shy to talk to husband on FP	8	22.23
Family wants more children	5	13.88
Will go for MTP	2	5.55
Total	36	100.00

In our study, among the 36 participants who had an unmet need for FP, 12 (33.33%) thought they would not conceive, 9 (25.00%) said the family wants a male child, 8 (22.22%) were shy to talk to their husbands regarding FP, 5 (13.88%) participants reported that the family wanted more children. 2 (5.55%) of the women said they would resort to MTP if they conceive.

Table 28: Association of practice of any FP method and women's education

N = 400

Level of education	Practicing FP		Not practicing FP		Number of participants
	Number	%	Number	%	
Illiterate	54	85.71	09	14.28	63
Primary	104	85.24	18	14.75	122
High school	136	74.72	46	25.27	182
Undergraduation	19	79.16	05	20.83	24
Graduation and or above	08	88.88	01	11.11	9
Total	321	80.25	79	19.75	400

$X^2 = 0.55$

$df = 4$

$p = 0.083$

The association between literacy status of study participants and family planning practice by the couples was not found to be statistically significant.

Table 29: Association of practice of any FP method and husband's education

N = 400

Level of education	Practicing FP		Not practicing FP		Total
	Number	%	Number	%	
Illiterate	24	77.41	07	22.59	31
Primary	99	81.41	23	18.86	122
High school	120	86.33	19	13.67	139
Undergraduation	62	72.94	23	27.06	85
Graduation and or above	16	69.56	07	30.44	23
Total	321	80.25	79	19.75	400

$\chi^2 = 7.983$

df = 4

p = 0.092

The association between literacy status of husbands and family planning practice by the couples was not found to be statistically significant.

Table 30: Association of practice of any FP method and socio-economic class

N = 400

Socio-economic class	Practicing FP		Not practicing FP		Total
	Number	%	Number	%	
Class 1 and II	19	63.33	11	36.67	30
Class III	67	84.81	12	15.19	79
Class IV	130	79.26	34	20.74	164
Class V	105	82.67	22	17.33	127
Total	321	80.25	79	19.75	400

$\chi^2 = 7.025$

df = 3

p = 0.071

In our study, the association between socio-economic class and family planning practice was not found to be statistically significant.

Table 31: Association of practice of any FP method and religion

N = 400

Religion	Practicing FP		Not practicing FP		Total
	Number	%	Number	%	
Hindus	279	81.10	65	18.89	344
Muslims and others	42	75.00	14	25.00	56
Total	321	80.75	79	19.25	400

$$X^2 = 1.132$$

$$df = 1$$

$$p = 0.287$$

There was no significant association found between religion and practice of any FP method.

Table 32: Association of practice of any FP method and type of family

N = 400

Type of the family	Practicing FP		Not practicing FP		Total
	Number	%	Number	%	
Nuclear	95	79.16	25	20.84	120
Joint	148	80.43	36	19.57	184
Three generation	78	81.25	18	18.75	96
Total	321	80.25	79	19.75	400

$$X^2 = 0.152$$

$$df = 2$$

$$p = 0.926$$

In our study, there was no significant association between type of family and practice of any family planning method.

Table 33: Association of practice of any FP method and number of living

Children		N = 400			
Practicing FP	0 and 1	2	3	>4	Total
YES	38	133	104	46	321
NO	51	16	10	02	79
Total	89	149	114	48	400

$$X^2 = 102.849$$

$$df = 3$$

$$p = 0.001$$

In our study, there was a significant association between number of living children and practice of any family planning method.

It was interesting to note that none of the participants were practicing any family planning methods newly after marriage. The number of participants practicing family planning after one child was 38.

Table 34: Association of practice of any FP method and number of living male

children		N = 400		
Practicing FP	0	1	2 or more	Total
YES	07	182	132	321
NO	59	14	06	79
Total	66	196	138	400

$$X^2 = 242.286$$

$$df = 2$$

$$p = 0.001$$

In our study, there was a statistically significant association found between number of living male children and family planning practice. Of the 26 couples who were having 3 or more male children and all of them practicing one or the other FP method.

Table 35: Association of practice of any FP method and number of living female Children

N = 400

Practicing FP	0	1	2	>3	Total
YES	74	141	80	26	321
NO	35	32	08	04	799
Total	109	173	88	30	400

$$X^2 = 17.765$$

$$df = 3$$

$$p = 0.0001$$

In our study, there was a statistically significant association found between number of living female children and family planning practice.

Table 36: Association of practice of any invasive FP method and gynecological problems

N = 267

Type of FP	Number practicing	Number with gynecological problem					
		0	%	1	%	2	%
Tubectomy	252	58	23.02	92	36.50	102	40.47
IUD	15	02	13.33	09	60.00	04	29.36
Total	267	69	25.84	101	40.44	106	39.70

$$X^2 = 3.336$$

$$df = 2$$

$$p = 0.189$$

In our study, there was no significant association found between gynecological problems and practice of invasive family planning methods.

Table 37: Association of practice of any noninvasive FP methods and gynecological problems

Type of FP	Number practicing	Number with any gynecological problem			
		YES	%	NO	%
Condoms	23	07	30.43	16	69.56
OCPs	13	08	61.53	05	38.46
Natural methods	18	03	16.66	15	83.33
Total	54	18	33.33	35	66.66

$$X^2 = 6.991$$

$$df = 2$$

$$p = 0.030$$

In our study, there was a significant association found between gynecological problems and practice of non invasive family planning method.

DISCUSSION

Table 1: Age distribution

In our study, majority of the women 66.25 % were in the early reproductive age group of 20-35 yrs. The findings are comparable with the community based study conducted in parts of Rajasthan where 66.00 % of the participants were in the 20-35 yrs age group.²⁹

Table 2: Religion

In our study, 86.00 % were Hindus, 13.25 % were Muslims and 0.75% belongs to other religion. The findings are similar to studies done on gynecological problems in urban slum of Delhi where it was observed that majority of the study participants 91.50 % were Hindus and 8.50 % belonged to other religious groups.²⁶ In another study in rural Maharastra 97.00 % were Hindus.⁵

Table 3: Type of the family

In our study, 46.00 % were residing in joint families, 30.00 % in nuclear families and 24.00 % in three generation families. In a similar study conducted in rural area of Rajasthan the nuclear families and joint families accounted for 56.50 % and 43.50 % respectively.²⁹

Traditional Indian society is predominantly made up of joint family system. An increasing number of nuclear families could be because of industrialization and urbanization. Typical picture of transitional societies is seen.

Table 4: Socio Economic Status

In our study, 72.75% belonged to Socio-economic class IV and V, 19.25% belong to class III and 7.50 % belonged to high income group of Class I and II.

In a similar study done in urban slum of Delhi, 50.00 % belonged to the low income group, 45.80 % in the middle and 4.20% were in the higher income category.²⁶

Table 5 & 6: Education and occupation of married women

In our study, 45.50 % were educated till high school, 30.50 % had completed primary education and 7.75 % were illiterate. In our study, 52.25 % participants were housewives, 21.25% involved in production work 14.25 % participants were involved in service work.

Findings are similar to NFHS -3 findings were just over half 55.00 % of the women age 15-49 are literate. NFHS-3 shows that among those in the age group 15-19, only 74.00 % of women are literate.¹⁹

In a study done in urban slum, 33.30 % were literate and remaining 66.70 % were illiterate. Majority of them 83.30 % were housewives and 16.70 % were working as maid servants.²⁶

The findings suggest that the literacy has increased substantially over time, with recent cohorts being more literate than older cohorts.

Table 7 & 8: Husband's education and occupation

In our Study, 34.75 % were educated till high school, 30.50 % had a completed primary education, 27.00 % had completed under-graduation and 7.75 % of them were illiterate. Most of the husbands 50.50 % were involved in production work,

29.25 % service work and 14.25 % sales work. NFHS-3 shows that among those in the age group 15-19 yrs 89.00 % of men were literate. 78.00 % of men in the age group 15-49 yrs are literate. Education levels vary widely throughout India from state to state.¹⁹

Table 9, 10, 11 and 12: Married life, number and sex of the living children.

In our study, 67.75 % were married for less than or equal to 15 years and 32.25 % were married for more than 15 years. 37.25 % of the study participants had two living children, 28.50 % had three living children. 49.00 % had at least one male child where as only 43.25 % had at least one female child. This clearly depicts the adverse sex ratio in the community. 16.50 % had no male child where as 27.25 % of the couples did not have a female child.

According to NFHS – 3, the median age at first marriage is 17.2 years for women age 20-49 years. The current total fertility rate of 2.7 is down slightly from 2.9 children per woman at the time of NFHS-2, but is still well above the replacement level of just over two children per woman.³³

Our study findings are slightly different from the information obtained from the national Sample Registration System, 2005, which shows that nearly 35.00 % of the births are of the first order, 28.90 % of the births are of the second order, 16.40 % of the order three and 19.70 % fourth and higher order. This could be due to difference in educational level, changing marriage and fertility patterns. Our study clearly depicts the prevailing adverse sex ratio in the community. The findings are very similar to the national female to male sex ratio. According to 2001 census is 933, a gain of 6 points from the previous census of 1991. The sex ratio is not favorable to the women.²⁷

Table 13 and 14: Prevalence of gynecological symptoms and problems

In our study, leading causes of self reported symptom of gynecological problems were menstrual problems 31.00 %, low back ache 12.00%, whitish vaginal discharge 11.75 %, burning micturition 11.50 %, dysmenorrheal 8.25 %, genital itch 8.00 %, lower abdominal pain with fever 7.50%, weight loss 7.00 %, difficulty in conceiving 6.75 %, post coital pain 5.50 %. weight gain 5.25 %, ulcers in genital area 5.00 %, genital swelling 2.50 %, swelling in the breast 2.25 % and increased tiredness 37.50 %. The total prevalence of any gynecological problem per women was 1.51.

The findings are much less compare to the study done at Delhi slum, where it was 2.6 per women.²⁶ Our findings are similar to ICMR task force study were self reported gynecological problems from twenty three districts of India was 24.40 %. The commonest problem was backache 10.40 % followed by low abdominal pain 8.30 %.²⁸ Similar prevalence of gynecological problems was observed in a major baseline survey in the state of Bihar, Rajasthan and Himachal Pradesh conducted by Center for Operations Research and Training, varying from 28.00 to 30.00 %. Excessive vaginal discharge and menstrual problems were commonly reported problems.²⁹

The findings are similar to four community based studies conducted in rural and urban areas of Baroda, Mumbai and West Bengal where per person morbidity was reported as 2. Vaginal discharge 22.00 to 57.00%, lower backache in 5.00 to 39.00 % and lower abdominal pain in 9.00 to 22.00 % were the most common symptoms to be reported.⁵

The wide variation in the prevalence of gynecological morbidity in different studies can be explained by the fact that

India is a vast country with different cultures, taboos, health care seeking practices which influence the prevalence of reproductive morbidity.

Table 15 A and B: Prevalence of menstrual and dysmenorrhea problems

In our Study, 10.25 % women complained of oligomenorrhea where as remaining 10.50 % had polymenorrhea and or menorrhagia. None of them reported intermenstrual bleed as a complaint. Dysmenorrhea was complained by 8.25 %. Two thirds had secondary type of dysmenorrhea and about one third had primary type of dysmenorrhea.

In a study conducted in Delhi slum, the menstrual problems accounted for 25.80 %, oligomenorrhea 10.80%, menorrhagia 7.60%, dysmenorrheal 2.40% and dysfunctional uterine bleeding 5.00%.²⁶ In a study done in four districts of Maharashtra, 13.70 % had oligomenorrhea, 22.30 % had menorrhagia, 4.70 % had intermenstrual bleeding and 44.80 % had dysmenorrheal.⁵

Table 15 C: Prevalence of RTIs.

In our study, 70.50 % reproductive tract infections symptom were reported by the participants. Majority 27.00 % of them had UTI symptoms, 24.25 % had Chronic PID symptoms and 19.25% had Acute PID symptoms. In a study done in four districts of Maharashtra the prevalence of RTI symptoms varied from 38.6% to 63.8%.⁵

The prevalence is much greater than the prevalence of RTI in Shimla city, the prevalence of RTI was 36.30 %.¹⁷ In a study done in Delhi slum, the RTI symptoms like vaginal discharge accounted to be 56.80 %,

pain in lower abdomen 42.10 %, lower backache 63.90 %, urinary complaints 20.50 %, genital ulcers 2.90 %, Post coital pain 23.00%.²⁶

In a study conducted at by the ICRW at CMC Vellore, majority of women 87.00 % were identified with atleast one symptom that could indicate the presence of RTI symptom. In our study burning micturition was reported by 11.50 % of the participants. In a study done at CMC Vellore, the burning micturition was the most common symptom 40-45.00 % next only to vaginal discharge. It was the most commonly untreated symptoms.³³

Table 15 D, E and F: Prevalence of Conceiving difficulty, breast swelling and other problems.

The prevalence of infertility in our study was 6.75%. The primary infertility was 4.00% and secondary accounted for 2.75% which was much more than the prevalence found in a study done at Shimla city where it was only 3.00 %. Primary infertility was 2.20 % and secondary infertility 0.8%.¹⁷

The findings are similar to other studies like the Delhi slum study showing infertility prevalence of 8.20 %, primary infertility 5.80 %, secondary infertility 2.40 %²⁶ and also the prevalence of infertility in the Tamil Nadu study was 9.00 %.³⁴ In our study, the prevalence of swelling in the breast was 2.25 %.

Table 15 G: Treatment seeking for any Gynecological problems

In our study, overall treatment seeking for any gynecological problems was just about 15.00%. It was found that less than 20.00 % of the women resorted to

treatment for menstrual problems only 9.57 % reported to treatment for STDs / RTIs. Treatment seeking for conceiving difficulty was 48.14%.

This is comparable to the health seeking behavior of women in the ICMR task force study, which was 14.20%. However the same study also had revealed that majority 80.40 % of the women did not know, from where to seek services.²⁷ This was markedly less when compare to international studies conducted in developing countries, where RTI treatment seeking was 30.00 % and conceiving difficulties was about 80.00 %.⁴ In a study done in CMC vellore among adolescent married women the treatment seeking was reported for any symptom of RTI ranging from 57-75%. However the least treatment sought was for urinary tract infections about 10.00 %.³³

Table 15 H: Hemoglobin level

In our study, 39.00 % were mildly anemic, and 16.75 % were moderately anemic and 44.00 % had normal hemoglobin values.

This is similar to pattern of NFHS - 3 data which shows anemia is a major health problem for adults as well as children, affecting 55.00 % of women. The prevalence of anemia for ever-married women has increased from 52.00 % in NFHS-2 to 56.00 % in NFHS-3.³²

Table 15 I: Body Mass Index.

In our study, 23.00 % were undernourished, 61.25 % had normal BMI and 15.75 % of the participants were overweight and /obese. In our study, the association between anemia and BMI was found to be statistically significant.

This is slightly less than the national average as shown by NFHS – 3 where more than 36.00 % of women age 15-49 years in India have a BMI below 18.5 indicating chronic nutritional deficiency. The proportion of ever-married women who are thin 33.00 % has decreased slightly from 36.00 % in NFHS-2.

Women who are undernourished are likely to have children who are undernourished. Obesity is a substantial problem particularly among urban, well-educated women, women from households with high standard of living and among Sikhs. 15.00 % of ever-married women are overweight or obese, increasing from 11.00 % in NFHS - 2. Obesity is particularly prevalent for women in Delhi, Kerala, and Punjab.³²

In a study done in Lebanon rural community, 40.00 % were overweight, 30.00 % obese. Obesity in other countries like Egypt was 20.00 %, United Kingdom 12.00 %, France, Italy, Sweden 7.00%.²⁶

Table 16 A, B, C, D, E, F and G: Association of gynecological problems with education, Age, Socio-economic status and parity.

In our study, no significant association was found between menstrual problems, white discharge per vagina and conceiving difficulty with education, socio-economic status, age or parity of the participants.

The findings are contrary to the Rajasthan study where the level of education, age and parity of the participants had a significant association with the gynecological problems.³⁵ In Shimla study, births order of four or more had a significant association with the women complaining of gynecological problems.¹⁷

Table 17: Finding of urinary examination

95.00 % participants gave urine samples for urine examination of which 3.68 % samples tested positive for sugar, 5.78 % were positive for albumin, 20.52 % had more than ten pus cells per high power field 25.78 % had high epithelial cells counts, 4.21 % had high RBC counts and all the samples tested negative for abnormal casts in urine.

Table 18: Knowledge about family planning methods

In our study 95.00 % of the participants had knowledge about any family planning methods. 5.00 % of them reported to have had no knowledge of any family planning methods.

The findings are similar to the NFHS - 3 showed that knowledge of contraception is nearly universal with 98.00 % of women 15-49 years knowing one or more methods of contraception.³³

Table 19: Knowledge about permanent family planning methods

In our study, the knowledge about tubectomy as a permanent method was 95.00 %. Only 74.21 % knew about vasectomy as a permanent method.

The findings are similar to NFHS 3 which found that over 94.00 % of women knew about female sterilization and 79.00 % knew about male sterilization.³³

Table 20 and 21: Knowledge about temporary / spacing FP methods

In our study, 78.68 % knew about two or more temporary method of contraception. 98.99 % knew about oral contraceptive pills, 87.95 % knew about

intrauterine devices, 78.92 % knew about condoms only 14.01 % knew about injectable hormonal contraceptives and only 18.72 % knew natural FP methods.

The findings are slightly different from NFHS - 3, where 98.00 % of women knew about two or more modern methods and 49.00 % knew about traditional methods. NFHS - 3 revealed 74.00 % of the women knew about condoms, 80.00 % about oral contraceptive pills and 56.00 % women knew about traditional or natural methods.³³

Table 22: The Sources of information about Family Planning methods

In our study, 55.52 % of the participants had acquired the knowledge about any family planning method from two sources, 38.15 % had acquired the knowledge from only one source.

Mass media and social contacts accounted for the 59.24 %. 5.00 % reported husbands as a source of knowledge. The findings are similar to the findings from NFHS - 3.

Table 23, 24 & 25: Pattern of use of FP methods

In our study, 80.25 % were using some FP method. 63.00 % had undergone permanent sterilization, 17.25 % couples were using temporary FP method and 19.75 % were not using any FP methods.

Among the users of temporary methods of FP, condoms were the most popular 33.33 %, followed by natural methods 26.08 %, IUD 21.73 % and OCP 18.84 %. Of the natural methods, lactational amenorrhea

was the most common, coitus interruptus and rhythm accounting to less than one percent each.

In a study done in the urban slums of Rohtak, the use of use of spacing methods was 36.10 %. Cu T was the most common method of spacing with 16.00 % usage, followed by condoms 12.90% and OCPs 7.30 %.³⁶

Table 26 & 27: Unmet need

In our study, the unmet need for FP was found to be 9.00 %. 33.33 % thought they would not conceive, 25.00 % said the family wants a male child, 22.22 % were shy to talk to their husbands regarding FP, 13.88 % participants reported that the family wanted more children.

Estimate of unmet need by NFHS – 3 was 13.00 %.

Table 28 & 29: Association of FP practice with education and SES

In our study, the association of family planning practices with education status of women, the education status of their husband and the socio-economic class was not found to be significant.

The findings were contrary to the finding of studies done in urban slums of Rhotak, where higher education status was found to be significantly influencing the practice of family planning practices.³⁶ NFHS - 3 also revealed that contraceptive use among currently married women varies markedly by education and wealth. Higher the education and Socio-economic status higher is the practice of family planning.³³

It is a known fact that with increase in education the percentage of women using any FP method increases. Punjab and Kerala states in

India have high literacy rate and also have maximum couple protection rate of 65.00 to 75.00 %.

Table 31 and 32: Association of FP practice with religion and type of family

In our study, no significant association was found between the family planning practice and religion or type of family. This could be due to the fact that most of the study subjects were married early and underwent tubectomy early. Also there was no equal representation of the various religions or family type.

According to NFHS – 3, contraceptive use among currently married women varies markedly by religion and caste. Overall 52.00 % of women use any FP method. The use of FP was 62.00 % for those with at least an undergraduate education. Contraceptive prevalence is highest among Jains about 75.00 %, Buddhists/Neo-Buddhists 68.00 % and Sikhs 67.00 %. In another study the contraceptive use ranges from 46.00 % to 58.00 % among Muslims, Hindus and Christians. It is a known fact that the couples in nuclear families have higher chances of family planning being practiced than joint or extended families.

33

Table 33, 34 and 35: Association of FP practice with number and sex of living children.

There was a significant association found between number and sex of living children in the family and practice of any method of FP. The finding is similar to many demographic surveys which reveal that couples practicing permanent method of family planning increased once their ideal family size is met and also ideal number of sons / daughters are achieved.

In our study, optimum family size was 3. Most of the couples with optimum family size practiced permanent method of family planning. In families with no male child the FP practice was very low 10.00 %. However, the FP practice was 80.00 % among the couples with no female child. The findings concord with the findings of other studies like the NFHS – 3.³³

This could be due to the preference for a male child which is deep rooted in our culture

Table 36 and 37: Association of invasive and non invasive FP methods and gynecological problems

In our study, there was a significant association with gynecological problems and practice of non invasive family planning method. However, there was no significant association found between gynecological problems and practice of invasive family planning methods. Findings are similar to the findings of the Rajasthan study which found that users of invasive FP methods had an increased prevalence of gynecological problems and vice versa.²⁹

Conclusion

The prevalence of gynecological problem was moderately high. Two out of three women had at least one RTI problem and one out of every five women had menstrual problems. More than half of the women were anemic and one fifth were under nourished.

Education and socio-economic status of the women did not have a significant association with the gynecological problems.

Three fifth of the participants had undergone tubectomy, one fifth were practicing spacing methods and one fifth were not practicing any family planning method.

The knowledge about modern and traditional spacing methods is not adequate among our study participants.

The practice of any family planning method was significantly associated with the number and sex of the living children.

SUMMARY

The present study was a community based cross-sectional study conducted in Khasbag area of Belgaum, the urban field practice area of the Department of Community Medicine, J.N. Medical College, Belgaum. The study period was between 1-1-2007 to 31-12-2007.

The main objectives of the study were:

- 1) To estimate the prevalence of gynecological problems of the married women in reproductive age group (15-49 years)
- 2) To know the different patterns of contraceptive methods used by these couples

The sample size for the study was 400 married women in the age reproductive age group, chosen by systematic random sampling technique. All the study participants were interview using a pre-designed pre-tested structured questionnaire, following which they were subjected to detail clinical and laboratory investigations like hemoglobin estimation and urine examination.

In our study, 66.25 % of the participants were in the early reproductive age group of 20-35 yrs, 86.00 % were Hindus, 46.00 % were residing in joint families, 72.75 % belonged to Socio-economic Class IV and V, 45.50 % were educated till high school, 52.25 % participants were housewives, 67.75 % were married for less than or equal to 15 years and 37.25% had two living children.

The prevalence of the various gynecological problems were urinary tract infection 27.00 %, chronic PID 24.25 %, acute PID 19.25 %,

oligomenorrhea 10.25 %, menorrhagia 6.75 %, conceiving difficulty 6.75 %, polymenorrhea 3.75 %, breast swelling 2.25 %, stress incontinence 0.75 % and prolapse of uterus 0.75 %. The common self reported gynecological symptoms were increased tiredness for routine work 37.50 %, menstrual problems 31.00 %, abnormal low back ache 12.00 %, abnormal vaginal discharge 11.75 % and post coital pain 5.50 %. The mean prevalence of gynecological symptoms were 1.51 per women.

The treatment seeking for any of the gynecological problem was 15.72 %. There was no significant association between, age, education and socio-economic status with gynecological problems. Practice of non-invasive method of family planning was associated with reduced number of gynecological problems. 66.00 % of the women were anemic, 23.00 % were undernourished and 15.00 % were overweight.

Knowledge about permanent FP methods tubectomy and vasectomy was 95.00 % and 74.21 % respectively. 78.68 % knew about two or more spacing method of family planning and 18.72 % knew natural FP methods. Mass media and social contacts were the most popular sources of FP information about 59.24 %. 63.00 % had undergone permanent sterilization, 17.25 % couples were using temporary FP method and 19.75 % were not using any FP methods. Unmet need for family planning was 9.00 %. Women's education, her husband's education, socio-economic class, religion and type of family did not seem to have significant association with the practice of family planning. The number and sex of living children had a significant association with the practice of any method of family planning.

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Key to the Master Chart

Keys for Columns A to AY

A - Serial number

B – Age

C – Women’s education

1 = illiterate, 2 = primary up to 7th, 3 = high school up to 10th, 4 = puc, diploma, tch, 5 = graduate, 6 = post graduation

D – Women’s occupation

1 = professional, 2 = sales worker, 3 = service worker, 4 = unskilled manual worker, 5 = agriculture farmer, 6 = others unemployed, housewife

E – Husband’s education

F – Husband’s occupation

G – Religion

H - hindu, M – muslim, C – Christian , O - others jains, sikhs etc

H – Type of family

J = joint family, N = nuclear family, TG = three generation family

I – Per capita income

1 = > 2800 rs, 2 = 1400-2799 rs, 3 = 840-1399 rs, 4 = 448-839 rs, 5 = 280-447 rs

J – Married life

K – Number of living children

L – Number of male children

M – Number of female children

N – Knowledge about family planning

The answered were coded as YES = 1 and NO = 0 from column N onwards.

O – Permanent method

P – Tubectomy

Q – Vasectomy

R – Temporary methods

S – OCP

T – Copper T

U – Condoms

V – Others

W – Source of information

MM= mass media, Television, radio, newspaper,

SC = social contacts relatives, peers, friends

HP = health professional doctor, nurse, anganwadi worker, ANM,

HS= husband

X – Present contraceptive use

Y – Permanent

Z – Tubectomy

AA – Temporary Type

AB – Type

CN = condoms, OC = oral contraceptive pills, CU = Copper T, NR =

Natural rhythm method, NA = Natural abstinence method, NL = Natural

lactational amenorrhea method, NC = Natural coitus interrupts method.

AC – Unmet need, AD – Reason for unmet need

A - family wants a male child, B - family want more children, C - shy to talk to husband for contraception, D - opposition from family, E - will not conceive due to death, divorce, hysterectomy, F - will go for MTP

AE – Menstrual problem

Substitute 1 = Yes and 0 = No

AF – Painful menstruation

AG – White discharge pervaginum

AH – Genital Itch

AI – Burning Micturition

AJ – Genital Ulcers

AK – Swelling in genital region

AL - Lower abdominal pain

AM –Associated fever

AN – Post coital pain

AO – Taken any treatment

AP – Any conceiving difficulty

AQ – Taken treatment for conceiving difficulty

AR – Abnormal swelling in the breast

AS – Any increased tiredness for previous routine work

AT – Abnormal weight loss, AU – Abnormal weight gain

AV – height in centimeters, AW – Weight in Kilograms

AX – Pallor and AY – Hemoglobin gram %

Annexure II

“A CROSS-SECTIONAL STUDY OF THE GYNECOLOGICAL PROBLEMS OF MARRIED WOMEN IN AN URBAN FIELD PRACTICE AREA OF J. N. MEDICAL COLLEGE, BELGAUM”

Questionnaire

Part I

Demographic information

- 1) What is your Name?
- 2) What is your Age?
- 3) What is your Education?
- 4) What is your occupation?
- 5) What is your husband's name?
- 6) What is your husband's Occupation?
- 7) What is your husband's education?
- 8) Who all live in your family?
- 9) What is your religion?
- 10) What is your total monthly income?

Part II

Family Planning information

- 11) How long have you been Married Now? Life: years Months
- 12) How many Children do you have? (No. of living Children)
- 13) How many male children?
- 14) How many female children?
- 15) Do you want more children? Y/N

16) If yes when do you want to have it?

17) If No how do you plan to achieve it?

18) Do you know about any methods to stop having children? Y/ N

19) Do you know about any methods to post pone having children? Y/ N

If yes Name 1) permanent

2) Temporary

20) How did you come to know about the above methods?

(tick the sources as reported)

Source of information:

TV,

Radio,

Peers,

Relatives,

Doctor,

Anganwadi worker,

Nurse,

husband,

others specify

Present Contraceptive Use:

21) Are you using any method to stop having children? Y/N

if yes go to question no. 23 part a

22) Are you using any method to postpone children? Y/N

if yes go to question 23 part b

23 a) Permanent method; Y/ N

Tubectomy since yrs months

Vasectomy since yrs months

23 b) Spacing methods; Y/N Duration of use

Reasons for discontinuation

OCP

IUCD

CONDOMS

INJECTABLES

NATURAL METHODS; Y/N

- a) Abstinence
- b) Rhythm method
- c) Basal Body temp
- d) Coitus interrupts
- e) Combined a to d

24) Have you used any other method in the past? Y/N

If yes..... method

Duration

Reasons for discontinuation

25) Is there any unmet need for family planning? Y/N

26) If yes, Reason for the same?

Part III

Gynecological problems

27) Do you have any menstruation problem? Y/ N if yes duration

No. of days of bleeding

cycle length

number of pads per day

dysmenorrhoea

intermenstrual bleed

post coital bleed

28) Do you have any problem of abnormal white discharge per vagina? Y/ N

if yes duration

Consistency - curdy, muciod,

Colour - blood tinged, greenish

Smell – foul/ non foul

Itching Y/N

Associated with lower abdominal pain

Associated with lower back pain

Post coital pain

Taken any treatment?

29) Do you have any problem of the following? Y/N if yes duration

Burning micturition

Ulcers in the genital region

Swelling in the inguinal region

Lower abdominal pain with fever

Similar complaints with your husband

Taken treatment

30) Do you have any difficulty in conceiving? Y/N if yes duration

Primary

Secondary

Treated

History of MTP Y/N

31) Do you have any abnormal Swellings in the breast? Y/N

if yes duration

Right /Left

Discharge through nipples

Associated pain

Relation to menstrual cycle

32) Do you have any history of “something coming out of the vaginal region”

(prolapse)? Y/N if yes duration

33) Do you have any difficulty in urination, (resisting, initiation or voiding)

Y/N if yes duration

34) Do you have any other problems like Y/N If yes duration

a) history of increasing tiredness

b) history of weight gain (last 3months)

c) history of weight loss (last 3months)

d) any other problem

Part IV

General physical examination

Pallor Icterus Edema Clubbing Cyanosis Lymphadenopathy

Height in centimeters

Weight in kilograms

Vitals:

Temperature Pulse (Beats/min)

Respiratory Rate (/min) Blood Pressure (mm of Hg)

Oral cavity:

ENT examination:

Thyroid examination:

Breast examination:

Systemic examination (write only positive findings)

CVS

RS

PA

CNS

Lab investigations:

Hemoglobin gram percent:

Urine routine

Sugar -

Albumin -

Microscopy –

