Pak J Med Res
Vol. 56, No. 4, 2017

Original Article

Prevalence of Gynecological Morbidities among Reproductive Age Women in Bhudni Village, Peshawar - Pakistan

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Abstract

Background: Gynecological morbidities is a neglected health issue among women in all developing countries including Pakistan. Lack of awareness and low access to health care facilities led to late diagnosis and increased mortality. Current study was done to assess the prevalence of gynecological morbidities among reproductive age women in Bhudni village.
Study design, settings and duration: It was a community-based survey conducted over a period of 06 months (2016) in Bhudni, a locality in Peshawar, Khyber Pakhtun Khwa.
Subjects and Methods: Bhudni was divided into four clusters and using random sampling technique, 82 ever married women who has delivered at least one baby (15-49 years), were identified from each cluster. After taking informed written consent, data was collected on a pretested questionnaire regarding demographics, changes in body in last 03 months and healthcare consultation for illness. Analysis was done using Epi Info version 7.
Results: A total of 390 completed the interview out of 384 selected females. Median age was 31 years (SD ± 9.1). Out of 365 women, 238 (60.5%) were illiterate, 55 (15%) completed matriculation, 38 (12%) had primary education while 31 (8.4%) had qualification above matriculation. Majority (95%) were house wives. The mean age of the last born child was 4.4 months (SD ± 4.5) and average parity was 4. None of the women had primary infertility. Overall prevalence of gynecological morbidities was 21% which was significantly associated with age (*p*-value = 0.037). However, the perceived perception among participants was 45%. Lower backache/ lower abdominal pain were the most common (71%) symptoms while bacterial vaginitis and urinary tract infections (UTI) were the most prevalent morbidities (21.3%). The prevalence of one gynecological morbidity was 20.1% (95% CI: 0.10-2.20 %). Out of 365 women, 152 (42%) went to health practitioner for treatment and in 123 (80%) cases, this treatment was provided by a lady health visitor. Fear of surgery was the most common reason for not seeking health care. About 212 (58%) did not go for medical advice despite of presence of symptoms of an illness. Fear of surgery and poverty were barriers for poor health seeking behavior among the participants.
Conclusion: A robust health education campaigns is required to bring the change in women's approach towards their health and health seeking behavior in Pakistan especially in Bhudni village.
Key words: Women health, community, prevalence, morbidity, low backache.

Introduction

Gynecological morbidity is a reproductive morbidity apart from those resulting from pregnancy, abortion, childbearing, and contraception. Amongst all, a few especially reproductive tract infections and sexually transmitted infections (RTIs/STIs) may turn out to be fatal if not treated properly.[1] Reproductive morbidities can be divided into three types namely obstetric, gynecological and contraceptive morbidities. Gynecological morbidity is defined as a condition, disease or dysfunction of the reproductive system resulting from sexual behavior.[2]

According to WHO estimates, sexual and reproductive health problems accounted for 18% of the total global burden of diseases in 2001 and 32% of the burden among women in the reproductive age group (15–44 years) worldwide.[3] Regarding types of morbidities, about 144 (72%) of women have experienced reproductive problem, 81 (40%) women faced gynecological problems whereas 51% (48 out of 94)

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Received: 31 May 2017, **Accepted:** 12 December 2017,
Published: 22 December 2017

Authors Contribution

NJA has done the conceptualization of project, statistical analysis and drafting, revision and writing of the manuscript. AK did the data collection. SA and SK have done the literature search. Literature search was done also done by NJA and AK.

suffered from obstetric problems. Health seeking was the least for gynecological morbidity.[4]

Studies from developing countries have reported that almost half of women had reproductive tract infections (RTI), every tenth woman suffered from uterine prolapse (one of the worst gynecological morbidities), half had menstrual problems, and a significant proportion had problems related to infertility.[5-8]

A Pakistani study found that there is poor reproductive health with neglect of women's own health. Compounded with socio-cultural factors, the result is poor treatment seeking behavior and hence poor quality of life.[9] Susilaet al reported that genital prolapse remains the commonest (18.8%) among gynecological morbidities and the prevalence was significantly associated with a lower socio-economic status and presence of chronic illness.[10]

Contrastingly, a study from Oman revealed that though poverty is a known factor for poor health behavior however, provision of free health services did not improve performance as almost 50% of women had one kind of gynecological disease.[11]

To halt the worse consequences associated with gynecological morbidities, women-friendly camps can help in improving health seeking behavior of women especially in rural areas and marginalized groups. Current study was planned to assess the prevalence of reproductive morbidities and health seeking behavior of women. Women are suffering from these hidden morbidities however; the baseline data in this regard is lacking which are required to allocate resources and to monitor progress to achieve Sustainable Development Goals (SGDs). The objective of this study was to assess the prevalence of gynecological morbidities among reproductive age women in Bhudni village.

Subjects and Methods

The study protocol was approved by the Institutional Bioethics Committee of Pakistan Health Research Council, Islamabad. Before administering questionnaires, participants were informed about the purpose of the study, emphasizing that participation was voluntary, and that their answers would be kept confidential. Only participants who gave consent were interviewed.

This cross-sectional study was conducted in Bhudni, Peshawar for duration of 6 months (2016). Sample size was calculated using a standard formula for cluster sampling, with a 95% confidence interval, margin of error of 5%, and a design effect of 2. At non-response rate of 10%, the final calculated sample size was 390. Ever married woman who had delivered at least one baby (live, stillbirth, aborted) between 15-49 years of age were included. Those suffering from any psychological illnesses and currently pregnant were excluded from the study.

The study was conducted in Bhudni village, situated at distance of 30-32 KM from PHRC Research Centre, Khyber Medical College Peshawar. In 1984, Pakistan Health Research Council selected this village as an intervention site and a health care center was established. The center had one doctor and four lady health workers along with dispenser providing medical services for this community. The community of Bhuddni belongs to middle and lower socio economic class. The ultimate goal of the establishment of health center in this village was to develop a model for rural health care delivery in the area.

A meeting was arranged with the lady health workers of the Bhudni area and list of the households was generated. Bhudni was divided into four clusters and using random sampling technique, 82 eligible woman were identified from each area. As the study was on a sensitive issue, so to accommodate for refusals/ withdrawal from study, 390 women were selected. Selected women were explained about the nature of the study. The participants were informed that the study contain questions about bodily changes occurred in past 3 months, especially in the reproductive system. Those agreed were invited to participate after giving informed written consent.

A questionnaire was developed to collect information. Most of the questions were close ended. After validating the questionnaire, pretesting was carried out in the nearby community. Difficulties faced by the staff in delivering questions to the audience were re-evaluated and modified. Data was collected in three sections including demographics, changes in body in last 03 months and healthcare consultation in case the woman had developed any symptoms and reasons for not doing so. After recording all the responses, those participant who had symptoms strongly indicating the presence of gynecological morbidity, were assessed for gynecological morbidities using standard definitions.

Collected information was analyzed using epi Info version 7. Descriptive data was presented as frequencies and percentages while Chi-square test was done to compare the association between gynecological morbidities and its determinants.

Results

Out of 390 women invited to participate in the study, 365 participated in the study, achieving a response rate of 95%. Mean age of the study participants was 31 years with (SD ± 9.1). Out of 365, 238 (60.5%) women were illiterate, 55 (15%) completed matriculation, 38 (12%) had primary education, while 31(8.4%) had qualification above matriculation. Among them, 346 (95%) were housewives and rest were doing some kind of

job. Out of 365, 08 were widows and only 01 got married second time while rest 354 (98%) were currently married. The mean age of the last-born child was 4.4 months (SD ± 4.5). Among study population, average parity was 4. None of the women had primary infertility.

Overall prevalence of gynecological morbidities among study population was 21%. However, the perceived perception among participants was 45%. Lower backache/ lower abdominal pain (71%) were the most common symptoms followed by foul smelling discharge (41%) and burning micturition (Table-1). Other symptoms included menstrual irregularities, vaginal itching, pressure symptoms, incontinence and pain in the breasts.

Table 1: Frequency of symptoms among study participants.

Gynecological symptoms	*Frequency*	*%*
Symptoms of UTI	150	41.0
Incontinence symptoms	42	12.0
Pressure symptoms	54	15.0
Vaginal discharge	150	41.0
Lower abdominal pain	258	71.0
Menstrual irregularities	143	39.0
Women with one gynecological symptom	77	21.0
Women with two gynecological symptoms	63	17.2
Women with more than two gynecological symptoms	58	16.0

Urinary tract infections (UTI) were the most prevalent morbidities among 77 (21.3%) participants followed by dysfunctional uterine bleeding in 71 (19.4%), vaginal prolapse in 54 (5%), urinary incontinence in 42 (12%) and secondary infertility in 19 (5.2%) (Figure-1).

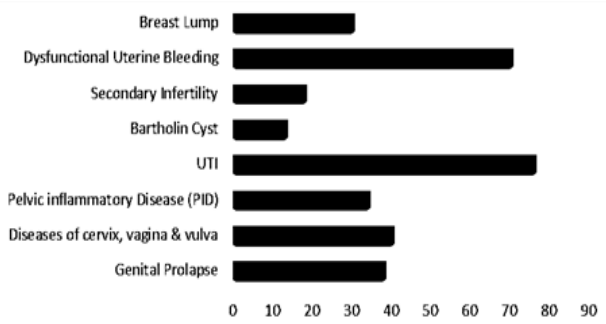

Figure 1: Frequency of different gynecological morbidities found in the study population.

The prevalence of one gynecological morbidity was 20.1% (95% CI: 0.10-2.20 %). The prevalence of at least one, two and three gynecological symptoms were 71%, 52% and 16% among the study participants. Among study participants, none had premature menopause at the time of study. Urinary incontinence, urinary tract infection, and urethral caruncle were common ailments in lower urinary tract diseases.

The reproductive tract infections found in participants were Pelvic Inflammatory Disease (PID), candidiasis and Trichomonas vaginalis. Duration of symptoms varied from weeks to years with a mean of 8.5 months.

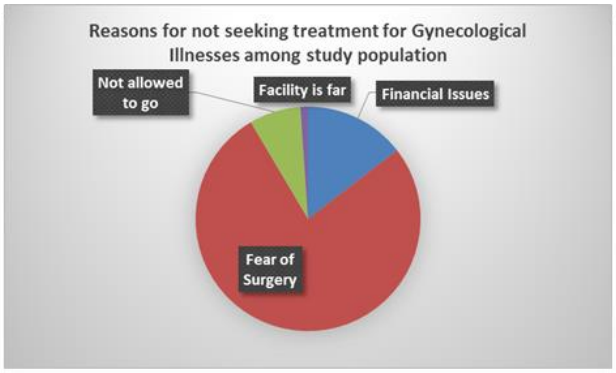

Figure 2: Reasons for poor seeking health behavior among study participants

Out of 365 participants having some sort of chronic illness, only 152 (42%) took any type of medical/expert advice. Among which, 123 (80%) took opinion of Lady Health Visitors (LHVs). A large proportion of about 213 (58%) participants did not avail any medical care. However, a subset of population including 129 (35%) women self-treated their illness usually following the traditional methods or through faith healing while 85 (23%) did not took any treatment at all. There were different reasons for non-consultation and financial issues were the commonest one (Figure-2). Age was significantly associated with prevalence of gynecological morbidities (Table-2).

Table 2: Association of gynecological morbidities with age, education, occupation and parity.

A	*B*	*C*	*D*	*E (%)*	*F*
Age group (years)					
18-28	153	106	25	24	.037
29-38	111	87	19	22	
39-48	69	50	17	34	
≥49	58	23	15	65	
Education					
Illiterate	238	178	51	29	
≤ Matriculation	96	71	21	23	
>Matriculation	31	17	2	12	
Employment status					
Employed	346	247	73	30	.509
Unemployed	19	11	3	27	
Parity					
Primipara	53	7	3	43	.261
Multipara	308	219	70	31	
Grand multipara	4	3	2	67	

A=Characteristics, B=No. of participants (N=365), C=Self-reported illness, D= Confirmed Gynecological morbidity, E= Prevalence (%), F= *p*-value

Discussion

The present study showed that prevalence of at least one gynecological morbidity was 20% compared to an Indian study where prevalence of one gynecological morbidity and gynecological symptom was 44.4 % (95%CI: 38.0–50.8%) and 25.9% (95% CI: 20.3–31.5%) respectively.[11] Another study from India[12] also reported the higher prevalence of morbidities (57%), while the commonest (99%) were RTI/STI-related symptoms. Total 68% women had menstruation-related problems consistent with our findings. A local study showed a higher prevalence of gynecological morbidity (37.2%) however it was a facility based study.[13] The difference may be due to the fact that current study is community based and also the population was from one same area with same belief and practices regarding their health issues. It may be attributed to low literacy as many women may not think that they have some problem and so did not reported during study.

An Iranian study [14] showed that reproductive tract infection (RTIs), pelvic organ prolapse (POP) and menstrual dysfunction were the three main morbidities with a prevalence of 37.6%, 41.4% and 30.1% respectively and the mean age of the women was 33.2 ± 7.7. However in this study, bacterial vaginitis and urinary tract infections (UTI) were the commonest (21.3%) and vaginal prolapse was present in 54 (5%) women only. Age group is comparable as it was 31 years with (SD ±9.1).

In the current study, majority of the women were illiterate. Susila et al[11] reported in her study that only 11% of the women were primary passed. However literacy was not associated with gynecological morbidity. Regarding health seeking behavior, out of 365 participants, 152 (42%) went to health practitioner while 213 (58%) did not. Out of this 213, 129(35%) self-treated their illness. Fear of surgery and financial issue was the commonest one. Only few women (8.4%) reported accessibility issues. Our findings are comparable to results of a study [14] in which majority (87%) of respondents stated that "no treatment required". Poverty (28%), lack of time (26%), inaccessibility of health facilities (19%), sufficiency of home remedies (11%), restricted autonomy (9%), poor quality of care (8%), and no privacy (6%) were other barriers for not seeking health care. [14]

We found low prevalence of gynecological morbidity in our study. Reason may be the fact that women in this culture do not care about their health as compared to their children, husbands and elderly at home and if they discuss their problems, they are usually discouraged regarding visiting health facility. In addition, due to poverty and illiteracy, most the time women do not consider some problems as health issues and correlate it with their age and child bearing experience.

Fear of surgery and financial were identified obstacles for poor health seeking behavior among the participants.

Acknowledgement

This research project is funded by Pakistan Medical Research Council. We are thankful to the participants who spared their time for this study.

Limitation of study: As the study was carried out in a community setting situated outside the main city of Peshawar, KPK, results of the study could not be generalized.

Conflict of interest: None declared.

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