# CHAPTER-IV

CHAPTER - IV

SOCIO-ECONOMIC BACKGROUND OF THE GYNAECOLOGICAL PATIENTS

Socio-economic condition is considered as one of the prime determinant of health. The influence of the socio-economic condition on human health is long been known. For the majority of world's people, health status is determined primarily by their level of socio-economic development. These are economic status, education, occupation, housing, etc. Here all the relevant personal information about the patients, their family patters and composition, economic status, housing, water system, sanitation etc. are described.

Fig.4.1: Age of the patient
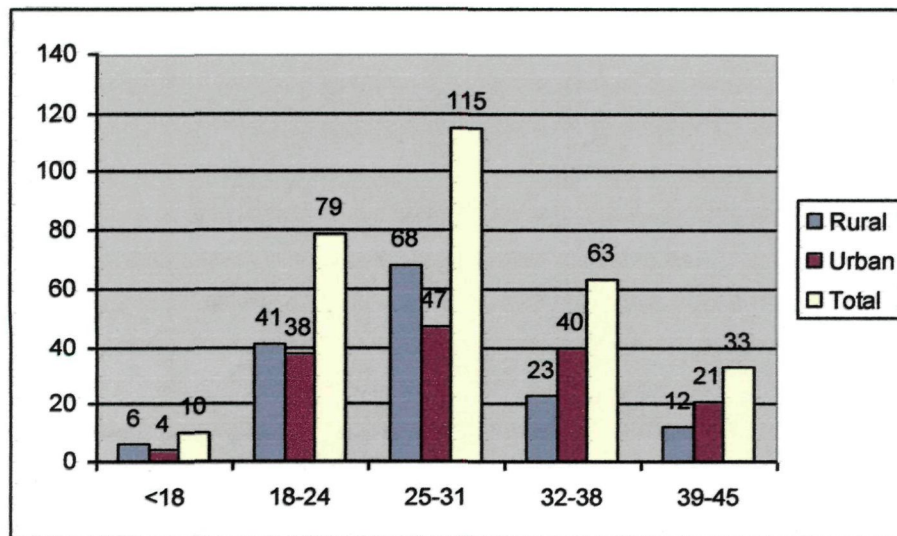
The reproductive age is generally considered from 15 years to 45 years. Fig.4.1 shows that majority of patients (64.7%) attended S.M.C.H. are in age group of 18-31 years, which means this age group is more vulnerable to gynaecological diseases. But the number of patients is more from rural area. This gives an impression that rural women in this age group are more susceptible to gynaecological diseases than their counterparts in urban area. But, the number of patients aged 32 and above attending SMCH is more in urban area. Hence, they are more vulnerable than their

rural counterparts. The mean age of the sample is 28.7 years (the mean age of the rural patients is 27.7 years and the mean age of the urban patients is 29.7 years).

The prevalence of gynaecological disease is more among the rural women compared to the urban women up to the age of 31 years and the prevalence of gynaecological diseases is more among the urban population as compared to the rural ones after 31 years of age. If we divide the reproductive age in two equal parts, from the table it can be assumed that rural women are more vulnerable to gynaecological diseases in the first part of the life i.e. up to 31 years of age and urban women are more vulnerable in the later part of the life i.e. after 31 years of age.

Table-4.1: Religion of the patient

Religion	Address of the patient		Frequency (Percent)
	Rural	Urban	
Hindu	67 (22.3%) 44.7%	97(32.4%) 64.7%	164(54.7%)
Muslim	81 (27%) 54%	53(17.7%) 35.3%	134(44.7%)
Christian	1(0.3%) 0.7%	0	1(0.3%)
Sikh	1(0.3%) 0.7%	0	1(0.3%)
Total	150 (50%) 100%	150(50%) 100%	300(100.0%)

Table-4.1 shows that more than half of the patients (54.7%) are Hindus and more than two fifth of the respondents (44.7%) are Muslims. Only one Christian and one is Sikh patient is there among the sample. In the rural area number of Muslim patients is more and in urban area number of Hindu patients is more as per the table.

So, it can be assumed that, generally Hindu women are more vulnerable than Muslim women to gynaecological diseases. In the rural area, Muslim women are

more susceptible and in the urban area, Hindu women are more susceptible to gynaecological diseases.
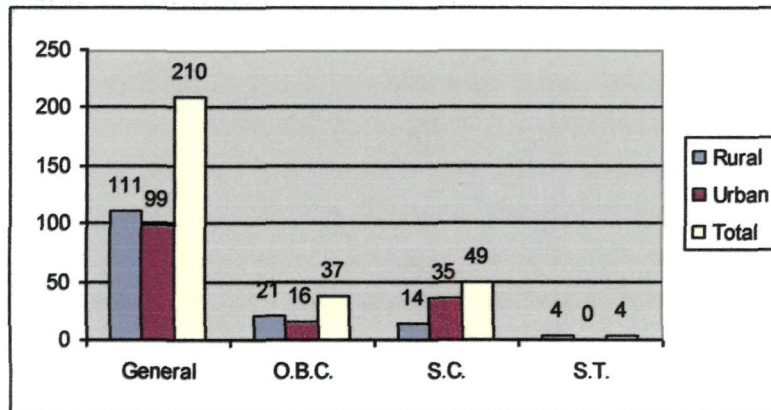
Fig.4.2: Caste of the patient

Fig.4.2 shows that seven tenth of the patients (70%) are from general caste and more than three tenth of the sample (16.7%) are from scheduled caste. Though the table show that majority of the patients are from general caste it will not be right to assume that general caste people are more vulnerable because the overall population may have larger number of general caste people as compared to the others.

In rural area also majority of the patients are from general caste (74%), followed by O.B.C. (14%). In urban area again, majority of the patients are from general caste (66%), followed by scheduled caste (23.3%). Which means vulnerability of the scheduled caste people is more in urban area than in the rural area, though general caste people are the most vulnerable group in both the areas. But again, this may not be a correct one because the population proportion may be so.

Table-4.2: Educational qualification of the patient

Educational qualification of the patient	Number of patient		Frequency (Percent)
	Rural	Urban	
Illiterate	34(11.3%) 22.7%	10(3.3%) 6.7%	44(14.7%)
Primary	31(10.3%) 20.7%	35(11.7%) 23.3%	66(22%)
Middle(up to class viii)	34(11.3%) 22.7%	60(20%) 40%	94(31.3%)
Secondary	45(15%) 30%	39(13%) 26%	84(28.0%)
College & above	6(2%) **4%**	6(2%) 4%	12(4%)
Total	150(50%) 100%	150(50%) 100%	300(100.0%)

According to the table-4.2, almost one third of the patients (31.3%) are educated up to middle level (i.e. up to class 8) and more than one fourth of the patients (28%) are educated up to secondary level.

Among the rural population, three tenth (30%) of the patients are educated up to secondary level and more than one fifth of the patients (22.7%) are illiterate and educated up to middle level (up to class 8). Among the urban population, two fifth of the patients (40%) are educated up to middle level (up to class 8) and more than one fourth of the patients (26%) are educated up to secondary level. Which means majority of the patients are educated up to middle and secondary level in the urban area.

From the above table it is quite understandable that women with higher educational qualification are less likely to develop gynaecological diseases as compared to the illiterate or less educated one. This can lead to a conclusion that level

of education has a distinct relation with the disease situation. If we consider the rural and the urban population, illiterate population is higher in the rural area.

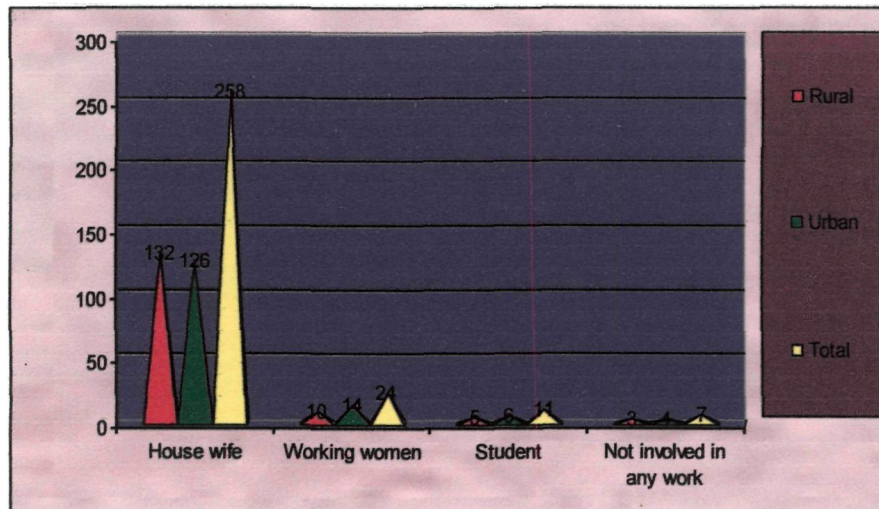**Fig.4.3:** Occupation of the patient

Fig.4.3 shows that more than four fifth of the patients (86%) are housewives and less than one tenth (8%) are working women. Rests of the patients are either students or those who are not involved in any work. This indicates that number of working women is less in this area. Again, there is another noticeable fact that number of working women is relatively less in rural area as compared to the urban area (10 out of 150 rural patients and 14 out of 150 urban patients).

House wives are more susceptible to gynaecological diseases than the working women. Or may be the total populations have less working women in this area. In the urban area number of working women is more than that in rural area though the difference is not much. In the urban area students are slightly more vulnerable to gynaecological diseases as compared to the students of rural area.
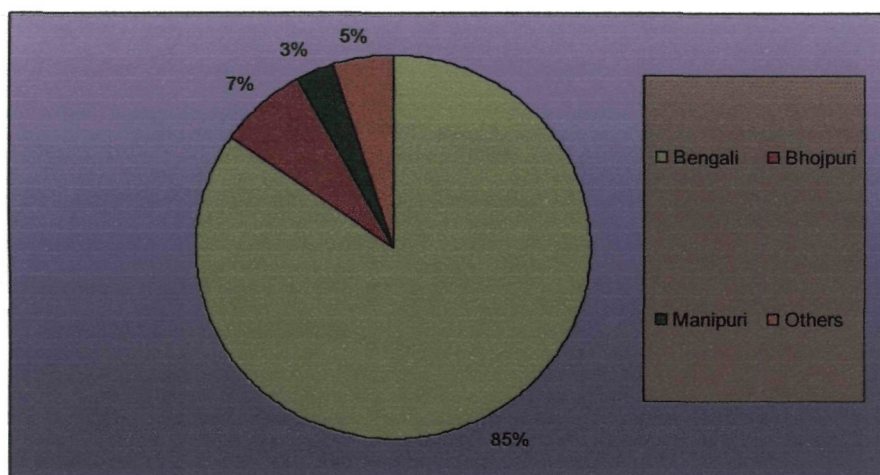
Fig.4.4: Mother-tongue of the patient

Fig.4.4 shows that more than four fifth of the patients (84%) are Bengali, followed by Bhojpuri (7%) and Manipuri (5%). Others include Tamil, Hindi, Assamese, Oriya, Santhal, Punjabi, Khashi and Dimasa.
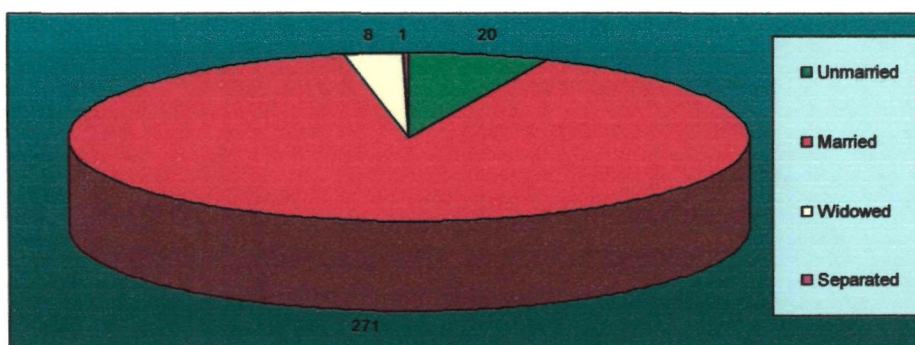
Fig.4.5: Marital Status

Fig.4.5 reveals that more than nine tenth of the patients (90.3%) are married, followed by unmarried (6.7%). Rest are widowed and separated. The disease incidence is more among the married women, or may be sexually active group is more vulnerable to gynaecological disease.

The above table gives an impression that married women of the reproductive age group are the high risk group for developing any gynaecological disease. This

means, the sexual behaviour may have a direct co-relation with the probability of developing the gynaecological diseases. The trend is same in both the rural and the urban area with a slight difference in the percentage. The number of unmarried patient is equal in rural and urban area. In the rural area, the number of widowed patient is a little less than that in urban area.

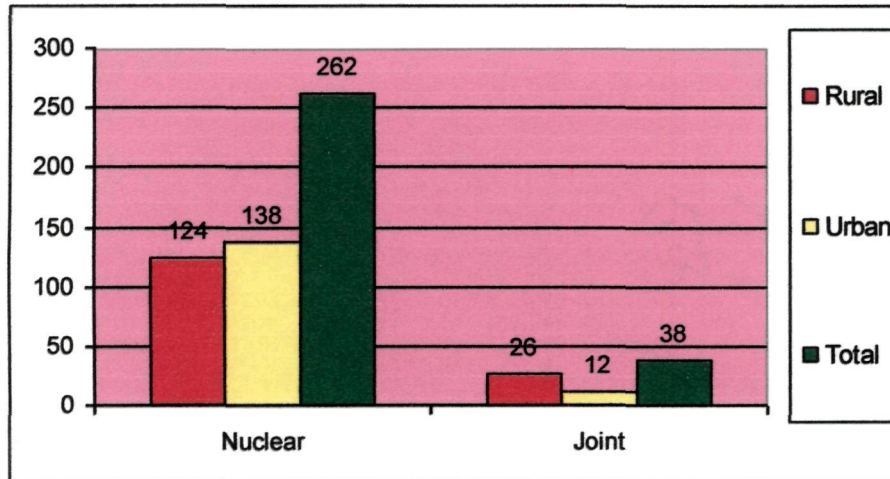**Fig.4.6:** Type of the family

Fig.4.6 shows that more than four fifth (87.3%) of the patients belong to nuclear family and only 12.7 percent belong to joint family.

In the rural area, more than four fifth of the patients (82.7%) belong to nuclear family and less than one fifth (17.3%) belong to joint family. Among the urban patients also more than nine tenth (92%) belong to nuclear family and less than one tenth (8%) belong to joint family.

Two assumptions can be drawn from the above fact. The first one is, respondents from the nuclear family are more likely to develop gynaecological diseases as compared to those from the joint family. The second assumption is that joint families are less in number in the population distribution now-a-days as a result of rapid change in the social system. Again, if we go area wise, we will notice that joint families are more in the rural area, as compared to the urban area. But, in both the rural and urban area respondents from the nuclear family are more susceptible to gynaecological diseases.

Fig.4.7: Number of family members
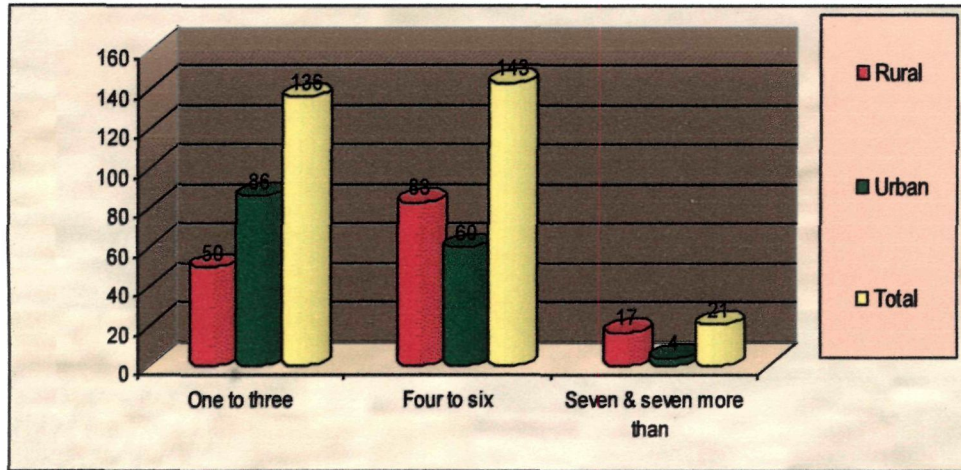
From the Fig.4.7, it is clear that 47.7 percent respondents have family members from 4 to 6, 45.3 percent have family members from 1 to 3 and 7 percent have 7 or more family members.

In rural area, more than half of the families (55.3%) have 4 to 6 family members, almost one third of the families (33.3%) have 1 to 3 family members and more than one tenth of the families (11.3%) have 7 or more family members. In urban area, more than half of the families (57.3%) have 1 to 3 family members, two fifth of the families (40%) have 4 to 6 family members and only 2.7 percent families have 7 or more family members.

Thus, it can be interpreted that respondents having family members four to six are more likely to develop gynaecological diseases. In the rural area also the story is same. But in the urban area, respondents having family members one to three are more vulnerable. Another aspect of the above data is in the rural area such families having more members are more in number. So a conclusion can be drawn that small families are more prevalent in urban area and big families are more prevalent in rural area. But in general there is tendency that bigger families are more vulnerable to gynaecological diseases. Statistical significance is also found between the number of family members and the address of the patient (Pearson Chi Square value is 21.276 at p< .0001 level).

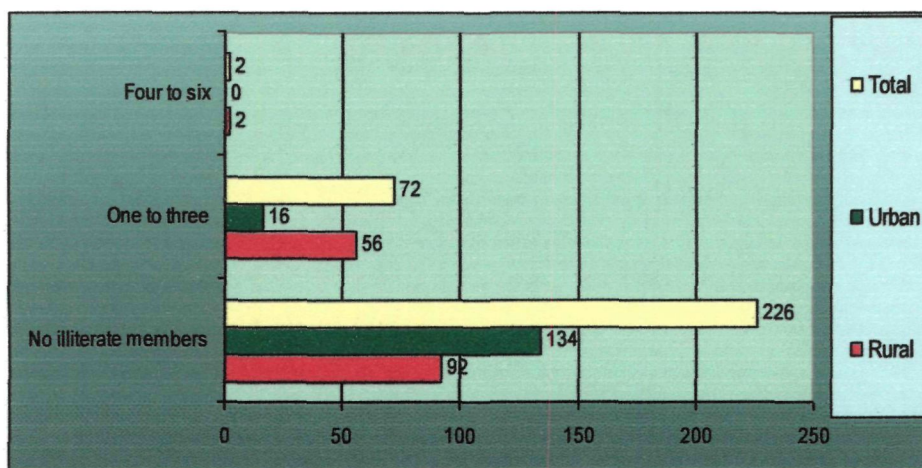**Fig.4.8:** Number of illiterate members in the family

Fig.4.8 shows that more than three fourth of the families (75.3%) do not have any illiterate member in the family, more than one fifth of the families (24%) have 1 to 3 illiterate family members and only very few families (0.7%) have 4 to 6 illiterate family members. Number of families having no illiterate member rank high which is indicative of a good literacy level.

In the rural area more than three fifth of the families (61.3%) do not have any illiterate family member and in the urban area, less than nine tenth families (89.3%) do not have any illiterate family member. This means literacy rate is more in the urban area as compared to the rural area.

It is quite evident from the above table that the literacy levels of the respondent's families are quite high. So it is difficult to establish any direct relation between the disease situation and the literacy levels of the families. Again, if we consider area wise the literacy levels of the families in urban area are higher than that of rural area. If we find out the Chi Square value, we see a strong significance between the residence of the patients and number of illiterate family members (Pearson Chi Square value is 32.028 at p< 0.0001 level)

Table-4.3: Number of persons having primary level education

No. of persons having primary level education	Number of patients		Frequency (Percent)
	Rural	Urban	
No member educated up to primary level	59(19.7%) 39.3%	78(26%) 52%	137(45.7%)
1 – 3	85(28.3%) 56.75	71(23.7 %) 47.3%	156(52%)
4 – 6	6(2%) 4%	1(0.3%) 0.7%	7(2.3%)
Total	150(50%) 100%	150(50 %) 100%	300(100%)

Table-4.3 shows that more than half of the families (52%) have 1 to 3 family members who are educated up to primary level and less than half of the families (45.7%) have no primary educated family member.

In the rural area, more than half of the families (56.7%) have 1 to 3 members who are educated up to primary level and a little less than two fifth of the families (39.3%) have no member educated up to primary level. Among the urban families, more than half of the respondents (52%) have no members educated up to primary level and less than half of the families (47.3%) have 1 to 3 primary educated family members. The trend is not same in rural and urban areas. If we find out the Chi Square value, we see negligible significance between the residence of the patients and number of primary educated family members (Pearson Chi Square value is 7.463 at p=0.024 level).

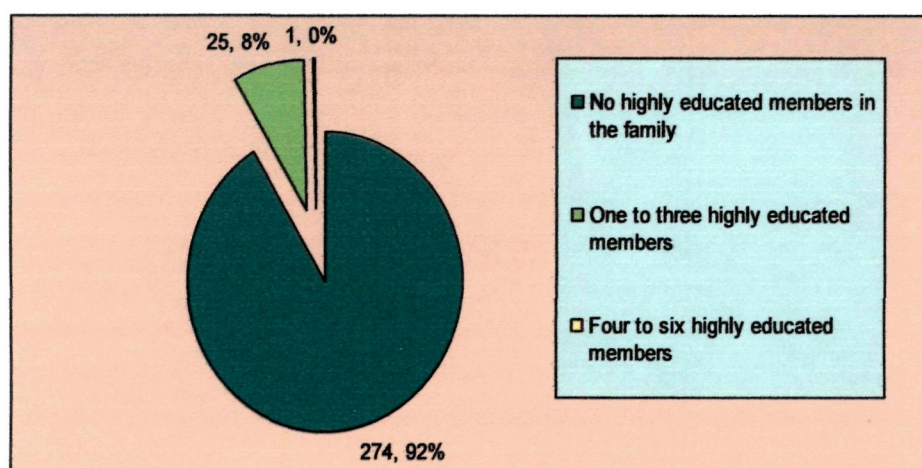**Fig.4.9:** Number of highly educated members in the family

Fig.4.9 shows that, more than nine tenth of the families (91.3%) do not have any highly educated member in the family, less than one tenth of the families (8.3%) have 1 to 3 highly educated members in the family and only a single family (0.3%) has 4 to 6 highly educated members in the family. Majority of the families do not have any highly educated member in the family. May be the disease incidence is much among the families having no highly educated member.

Among the rural population, nine tenth of the families (90%) have no highly educated family members, one tenth of the families (10%) have 1 to 3 highly educated family members and no family has 4 to 6 highly educated family members. Among the urban population, more than nine tenth of the families (92.7%) have no highly educated family member, less than one tenth of the families (6.7%) have 1 to 3 highly educated family members and only one family which has 4 to 6 highly educated family members. Statistical significance is not found among the place of residence and the number of highly educated members in the family (Pearson Chi Square value is 2.058 at p=0.357 level).

Table-4.4: Number of dependent family members

Number of dependents family members	Number of patients		Frequency (Percentage)
	Rural	Urban	
No dependent family members	4(1.3%) 2.7%	0	4(1.3%)
1 – 3	108(36%) 72%	139(46.3%) 92.7%	247(82.3%)
4 – 6	37(12.3%) 24.7%	11(3.6%) 7.3%	48(16%)
7 & more than 7	1(0.3%) 0.7%	0	1(0.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-4.4 it is clear that, more than four fifth of the families (82.3%) have 1 to 3 dependent family members and less than one fifth of the families (16%) have 4 to 6 dependent family members. Families having no dependent family member and families having 7 and more dependent family members are less in number. Families having less number of dependent family members are having more number of patients.

In the rural area, more than seven tenth of the families (72%) have 1 to 3 dependent family members and almost one fourth of the families (24.7%) have 4 to6 dependent family members. In the urban area, more than nine tenth of the respondents (92.7%) have 1 to 3 dependent family members and less than one tenth of the respondents (7.3%) have 4 to 6 dependent family members. A strong statistical significance is found between the place of residence and the number of dependents in the family (Pearson Chi Square value is 22.974 at $p < 0.0001$ level).

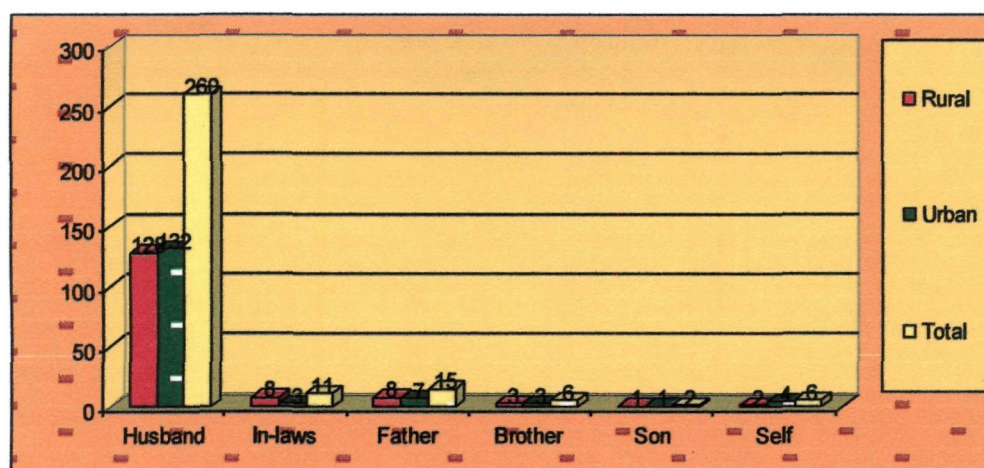**Fig.4.10:** Head of the family

Fig.4.10 shows that in more than four fifth of the families (86.3%), husbands are the head of the family and in only 5 percent families; fathers are the head of the family. This is indicative of the prevailing patriarchal society. In case of married women husbands are the head of the family and in case of unmarried women fathers are the head of the family. In case of joint families, sometimes, in-laws are the head of the family. Only where there is no adult male member, a woman can become the head of the family.

Among the rural population, in more than four fifth of the families (85.3%) husbands are the head of the family and only in 5.3 percent families, fathers are the head of the family. Among the urban population, in more than four fifth of the families (88%) husbands are the head of the family and only in 4.7 percent families, fathers are the head of the family.

Fig.4.11: Relationship with neighbours
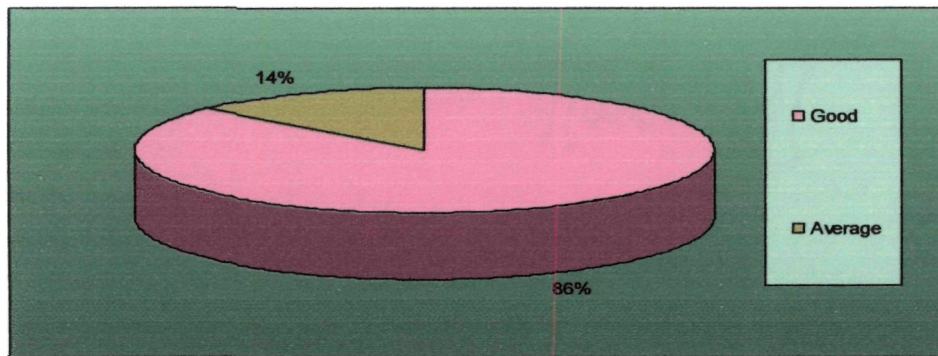
It is clear from the fig.4.11, in more than four fifth of the families (86.3%) have good relationship with neighbours and more than one tenth of the families (13.7%) have average relation with their neighbours. But, no one has reported of having bad relationship with their neighbour. In both the rural (86.7% have good relationship and 13.3% have average relationship with neighbours) and urban area (86% have good relationship and 14% have average relationship with neighbours) the trend is same.
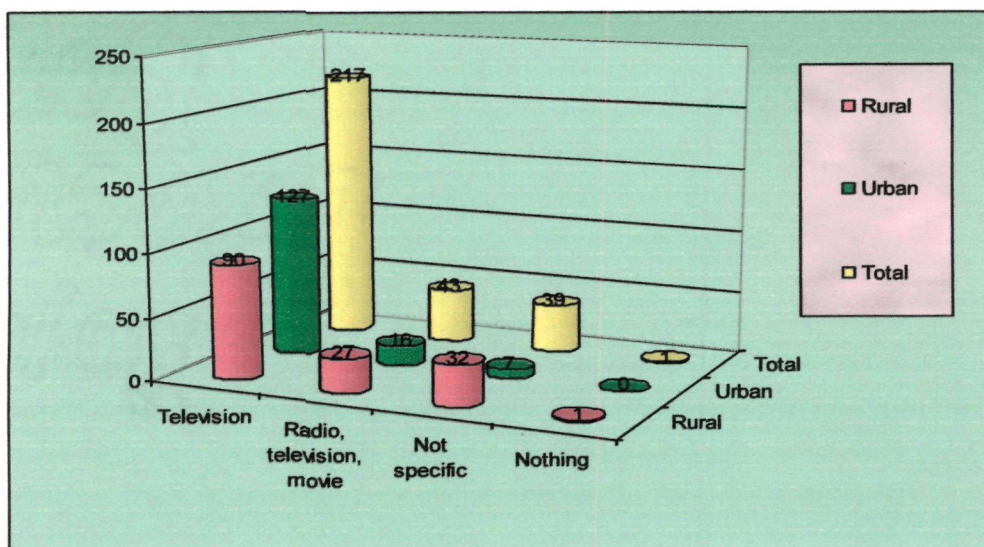
Fig.4.12: Mode of recreation

Fig.4.12 shows that, more than seven tenth of the patients (72.3%) use only television for recreation, more than one tenth of the patients (14.3%) use radio, television and movie all together for recreation.

Among the rural population, six tenth of the rural patients use only television as a mode of recreation and more than one fifth of the rural patients (21.3%) do not have any specific mode of recreation. In the urban area, more than eight tenth of the urban patients (84.7%) use only television for their recreation purpose and more than one tenth of the patients (10.7%) use radio, television and movie for their recreation. It is seen from the table that more number of rural patients are not having specific mode of recreation as compared to urban patients.

Fig.4.13: Reading habits of the patients
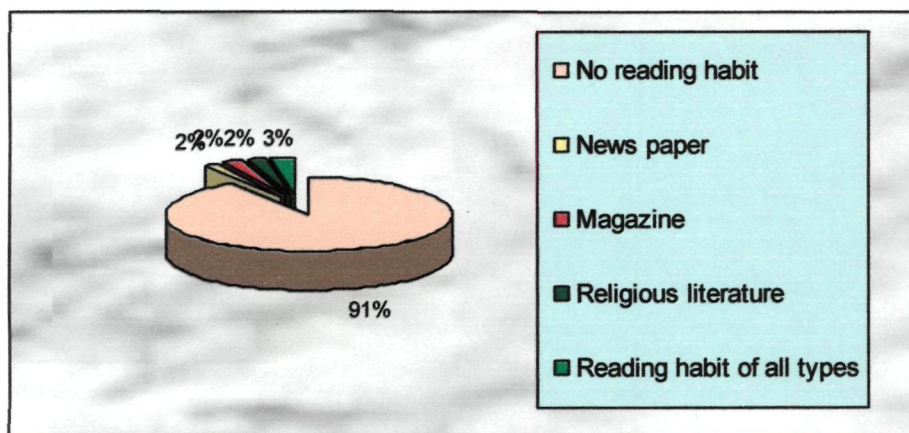
It is seen from the fig.4.13 that more than nine tenth of the patient (91%) under the study do not have any reading habit and less than one tenth of the patients (9%) only have reading habit. Though not shown in the table separately, in both the rural and urban area the trend is same.

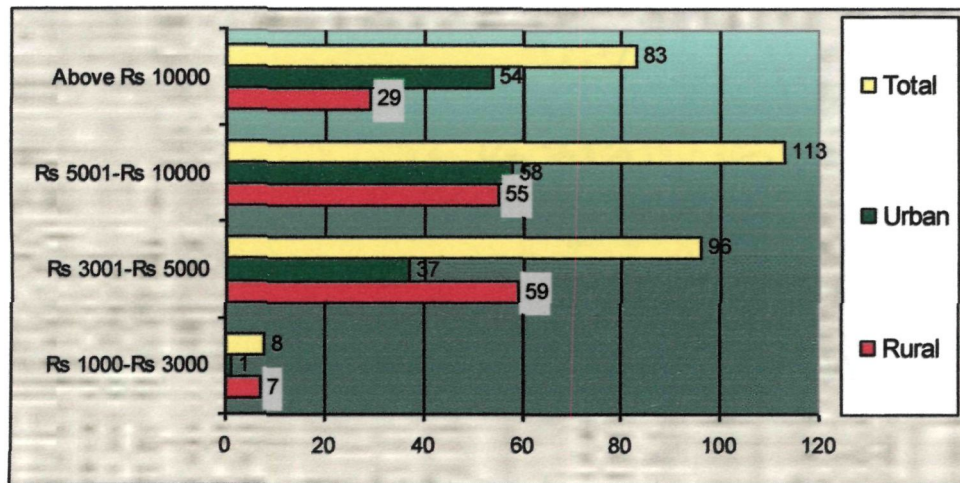**Fig.4.14:** Family income per month in rupees (approximately)

Fig.4.14 shows that majority of the patients (69.7%) have family income ranging from rupees 3001 to rupees 10,000, 37.7 percent have family income ranging from rupees 5001 to rupees 10,000 and 32 percent have family income ranging from rupees 3001 to rupees 5000. The arithmetic mean of the monthly family income of the sample population is approximately rupees 6600.

In the rural area also, majority of the patients (76%) have family income ranging from rupees 3001 to rupees 10,000 (39.3% from rupees 3001-rupees 5000 income group and 36.7% from rupees 5001- rupees 10,000 income group). In the urban area, majority of the patients (74.7%) have family income ranging from rupees 5001 to above rupees 10,000 level (38.7% from rupees 5001- rupees 10,000 income group and 36% from above rupees 10,000 income group). This indicates a disparity among the family income of the rural patients and the urban patients. In the urban area, majority of the patients have higher family income as compared to that of rural area. There is a statistical significance found between the place of residence and the family income per month (Pearson Chi Square value is 17.151 at p=0.001 level).
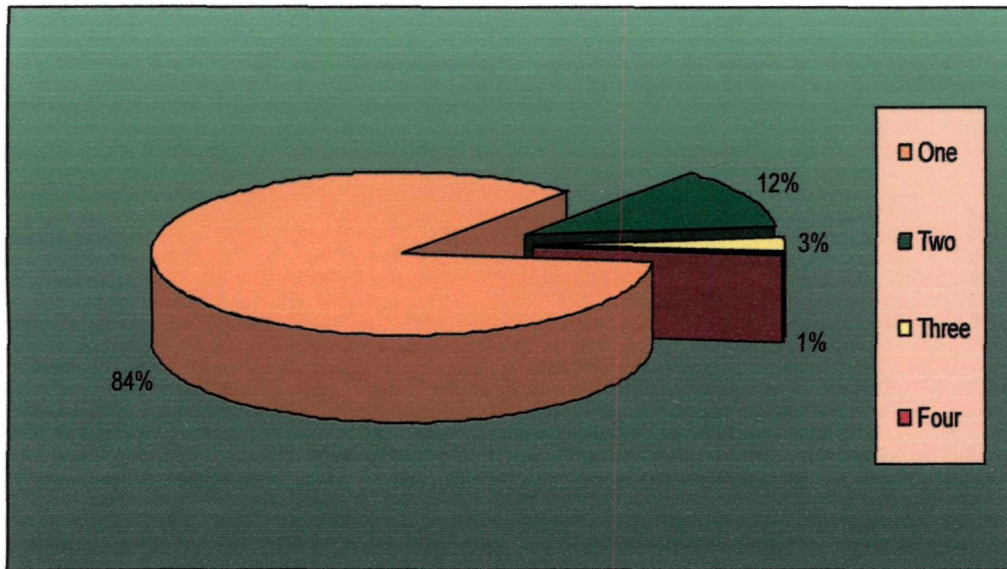
Fig.4.15: Number of earning members

Fig.4.15 shows that majority of the families (96.7%) have only one or two earning members in their family (84.7% families have one earning member and 12% families have two earning members). The trend is same in rural and urban areas though not showed separately in the table.

In the rural area also majority of the families (95.3%) have only one or two earning members in their family (82% families have one earning member and 13.3% families have two earning members). In the urban area, a greater number of the families (98%) have only one or two earning members in their family (87.3% families have one earning member and 10.7% families have two earning members). No major significance is found between the place of residence and the number of earning members (Pearson Chi Square value is 2.696 at p=0.441 level).
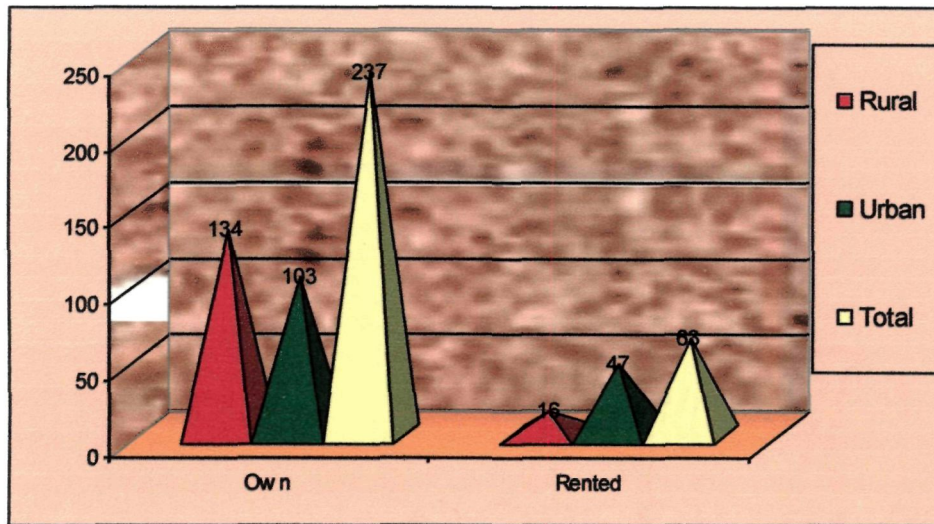
Fig.4.16: Type of house

Fig.4.16 shows that almost four fifth of the respondents (79%) live in their own house and more than one fifth of the respondents (21%) live in rented house.

In the rural area, almost nine tenth of the respondents (89.3%) live in their own house and almost one tenth of respondents (10.7%) live in rented house. In the urban area, more than two third of the respondents (68.7%) live in their own house and less than one third of the respondents (31.3%) live in rented house. This shows that number of respondents living in the rented house is more in the urban area as compared to the rural area. A high statistical significance is found between the place of residence and the type of the house (Pearson Chi Square value is 19.309 at p<0.0001 level).

Fig.4.17: Kind of house
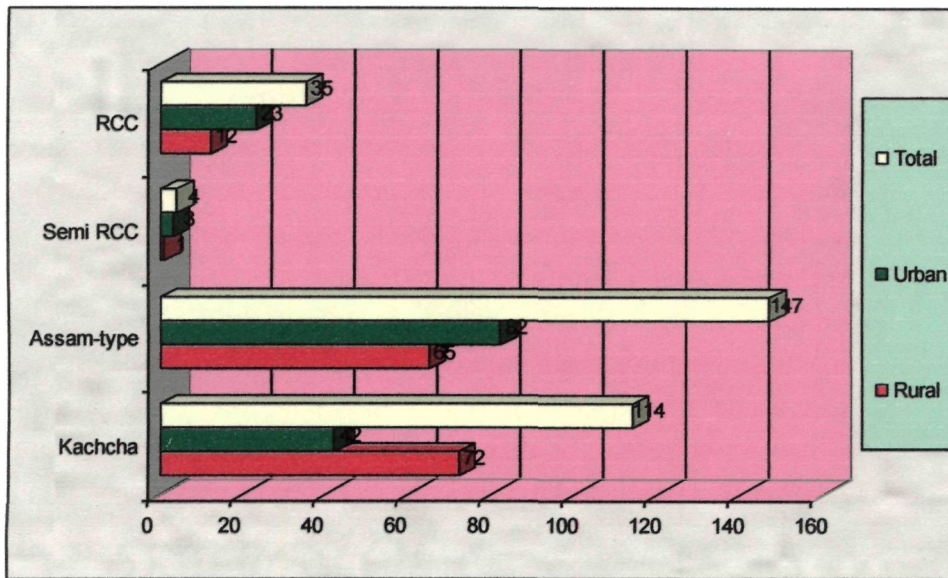
From the fig.4.17, it is seen that almost the half of the respondents (49%) live in Assam-type house and more than one third of the respondents (38%) live in kachcha house.

In the rural area, less than the half of the respondents (48%) live in kachcha house and more than two fifth of the respondents (43.3%) live in Assam-type house. In the urban area, more than half of the respondents (54.7%) live in Assam-type house and less than one fifth of the respondents (28%) live in kachcha house. From the above table it can be assumed that number of people living in kachcha house is more in rural area than urban area. Statistical significance is also found between the place of residence and the kind of house (Pearson Chi Square value is 14.318 at p=0.003 level).
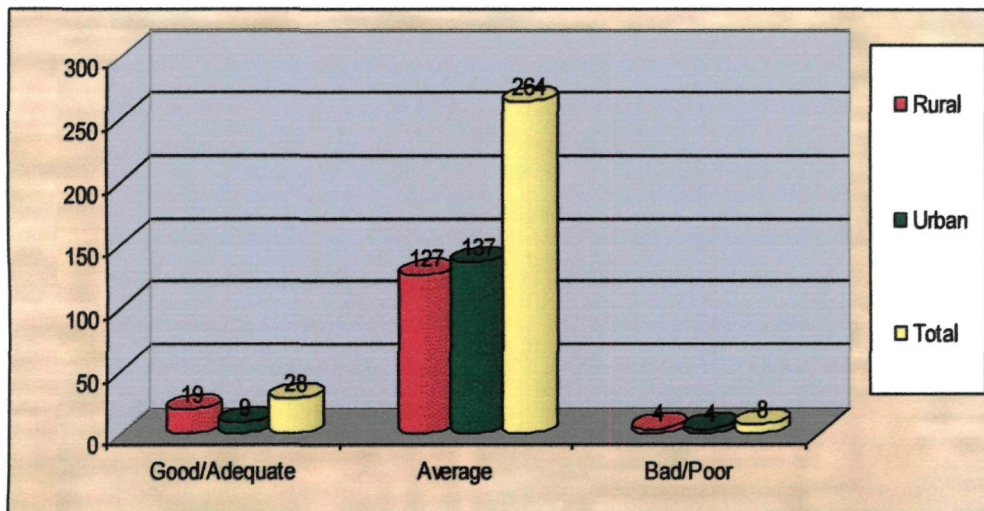
Fig.4.18: Ventilation

Fig.4.18 shows that more than four fifth of the patients (88%) have adequate ventilation in their houses. Problem of poor ventilation is found to be less among the respondents.

In the rural area, more than four fifth of the respondents (84.7%) have average ventilation in their houses and more than one tenth of the patients (12.7%) have good ventilation in their houses. In the urban area, more than nine tenth of the respondents (91%) have average ventilation whereas only 6 percent have good ventilation. Number of houses having good ventilation is more in the rural area as compared to the urban area.

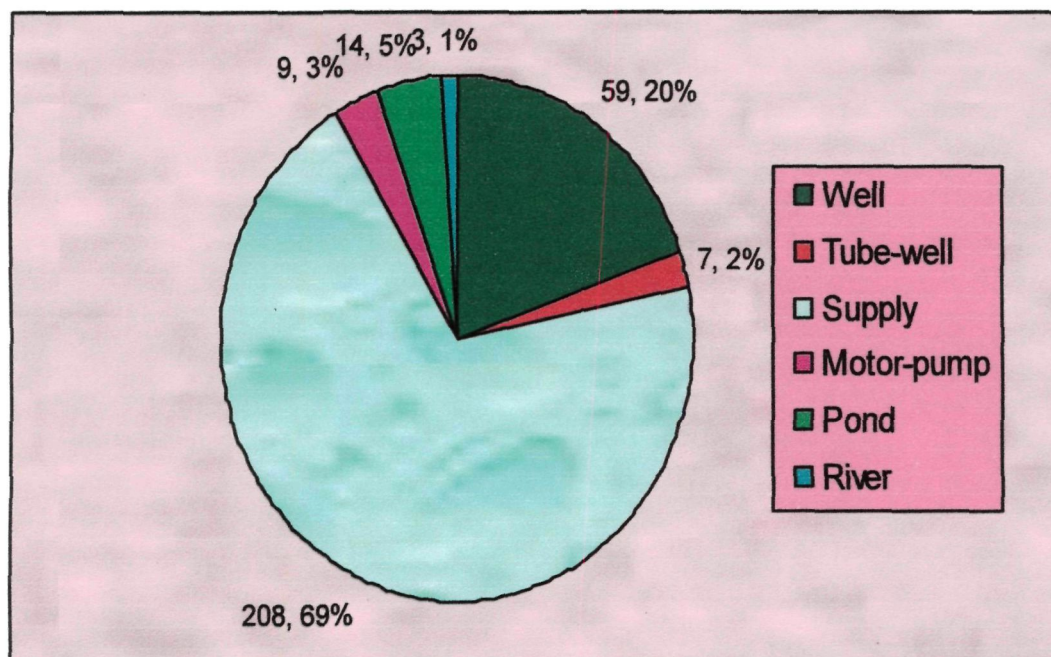**Fig.4.19:** Water system for drinking purpose

Fig.4.19 shows that more than two third of the respondents (69.3%) are dependent on the supply water for drinking purpose and almost one fifth (19.7%) are dependent of well.

In the rural area, more than half of the respondents (51.3%) collect water from supply for drinking purposes and almost one third (32.7%) collect drinking water from well. In the urban area, more than four fifth of the respondents (87.3%) are dependent on supply for drinking water and only 6.7 percent are dependent on well for drinking water. So, it can be concluded that urban people are more dependent on supply for drinking water than rural area. Though not represented in the above picture these are the facts collected from the respondents through interview. In the rural area people even take drinking water from pond and river which is not seen in the urban area.

Table-4.5: Water system for other purposes

Water system for other purposes	Number of patients		Frequency (Percentage)
	Rural	*Urban*	
Well	67(22.3%) 44.7%	35(11.7%) 23.3%	102(34%)
Tube-well	5(1.7%) 3.3%	33(11%) 22%	38(12.7%)
Supply	12(4%) 8%	62(20.7%) 41.3%	74(24.7%)
Motor-pump	5(1.7%) 3.3%	3(1%) 2%	8(2.7%)
Pond	57(19%) 38%	17(5.7%) 11.3%	74(24.7%)
River	4(1.3%) 2.7%	0	4(1.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From the table-4.5, it is seen that more than one third families (34%) use well for other purposes and almost one fourth (24.7%) use supply and pond for other purposes.

In the rural area, less than half (44.7%) use well and more than one third (38%) use pond as source of water for other purposes. In the urban area, more than two fifth of the families (41.3%) use supply and more than one fifth (23.3%) use well as a source of water for other purposes. Use of pond is more prevalent in rural areas as compared to urban areas.

Table-4.6: Means used for purification of water

Means used for purification of water	Number of patients		Frequency (Percentage)
	Rural	Urban	
Boil	16(5.3%) 10.7%	7(2.3%) 4.7%	23(7.7%)
Lime	3(1%) 2%	0	3(1%)
Alum	21(7%) 14%	12(4%) 8%	33(11%)
Filter	16(5.3%) 10.7%	58(19.3%) 38.7%	74(24.7%)
Nothing	94(31.3%) 62.7%	73(24.3%) 48.7%	167(55.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-4.6 shows that more than half of the families (55.7%) do not use any means to purify water and almost one fourth of the families (24.7%) use filter.

Among the rural population, majority of the families (62.7%) do not use any means to purify water and only 14 percent use alum to purify water. Among the urban population, less than half of the families (48.7%) do not use any means to purify water and more than one third (38.7%) use filter. It is an alarming fact that majority of the people do not use any means to purify water before drinking. Again, among the rural folk the percentage is higher than that of urban folk. Statistical significance is also found between the place of residence and the means used for the purification of water (Pearson Chi Square value is 35.455 at $p < 0.0001$ level).

Fig.4.20: Sanitation
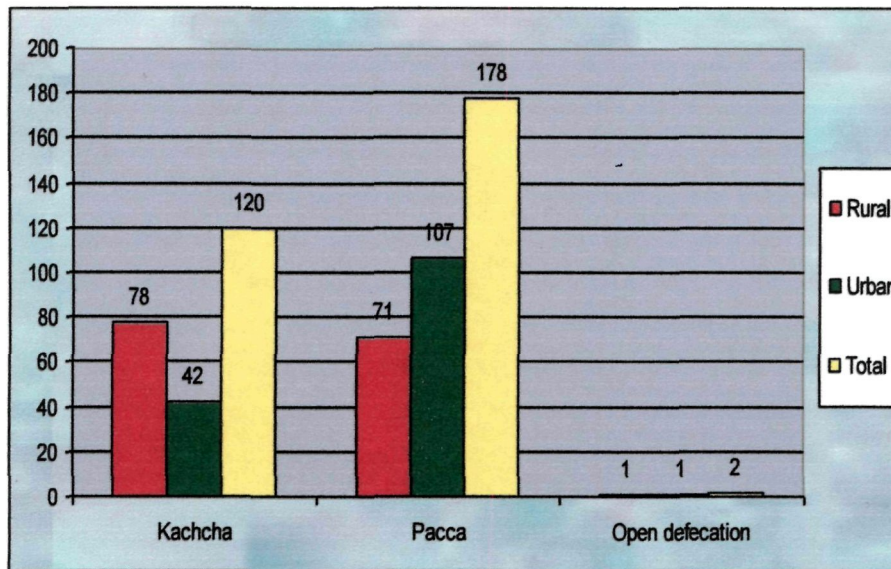
From the fig.4.20, it is seen that almost three fifth of the families (59.3%) have pacca sanitation and two fifth (40%) have kachcha sanitation.

Among the rural population, more than half (52%) families have kachcha sanitation and more than two fifth (47.3%) have pacca sanitation. Among the urban population, more than seven tenth families (71.3%) have pacca sanitation and more than one fourth families (28%) have kachcha sanitation. In the rural area, kachcha sanitation is much prevalent than urban area. Statistical significance is found between the place of residence and the sanitation system (Pearson Chi Square value is 18.081 at p=0.0001 level).

Fig.4.21: Gardening
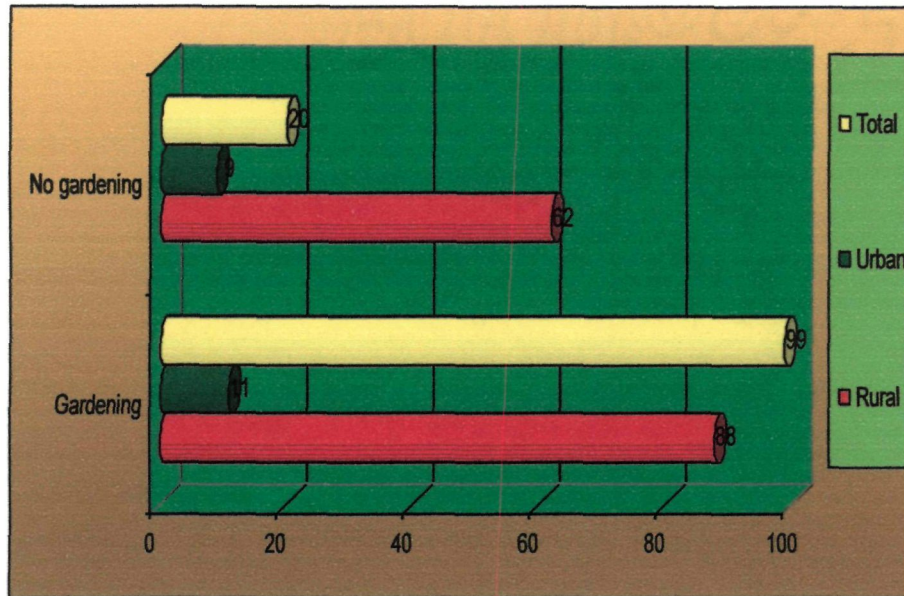
It is clear from the fig.4.21, majority of the families (67%) do not have gardening and almost one third families (33%) have gardening.

In the rural area, more than half of the families (58.7%) do gardening and in the urban area only 7.3 percent families do gardening. So it can easily be assumed that in the rural area gardening is much more prevalent. It may be the feasibility of gardening in the rural area which makes gardening more popular in rural areas. A high statistically significant relationship is found between the place of residence and the gardening (Pearson Chi Square value is **87.080** at p<0.0001 level).

Table-4.7: Domestic animals/birds

Types of animals or birds	Number of patients		Frequency (Percentage)
	Rural	Urban	
Single kind	49(16.3%) 32.7%	4(1.3%) 2.7%	53(17.7%)
Multiple kind	29(9.7%) 19.3%	2(0.7%) 1.3%	31(10.3%)
Nothing	72(24%) 48%	144(48%) 96%	216(72%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-4.7 shows that more than seven tenth families (72%) do not have any domestic animal or bird and more than one fourth of the families (28%) have domestic animals and birds (including both the single kind and multiple kinds).

In the rural area, more than half of the families (52%) have domestic animals or birds (including both the single kind and multiple kinds). In the urban area, only four percent of the families have domestic animals and birds (including both the single kind and multiple kinds). Number of families having domestic animals and birds are more in rural area as compared to the urban area.