CHAPTER-V

CHAPTER – V

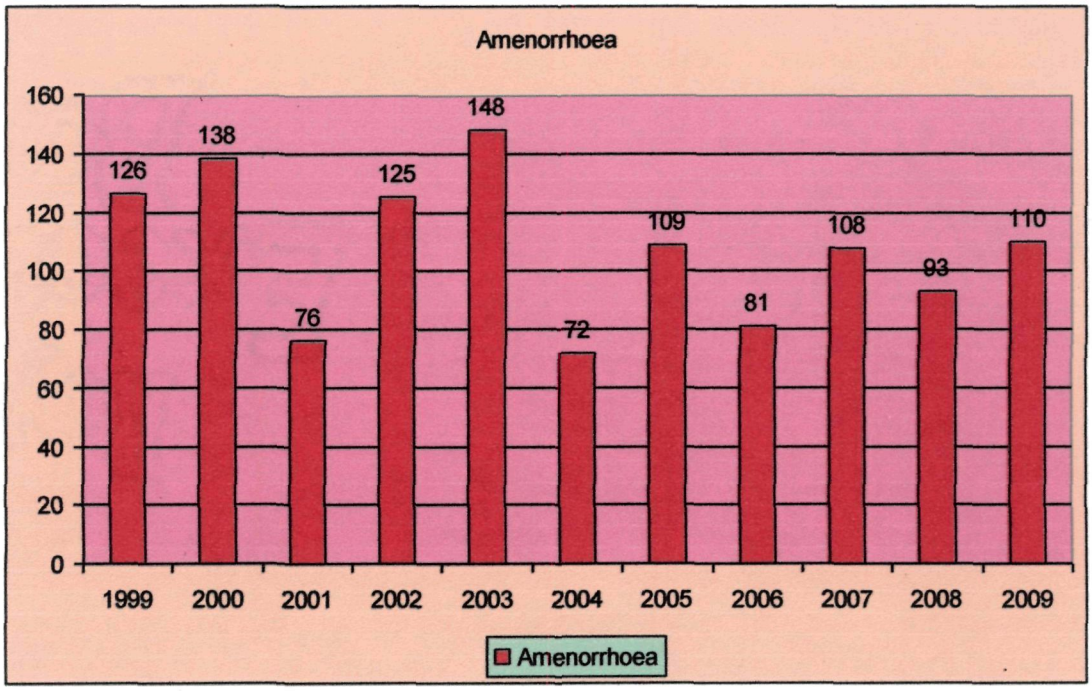
GYNAECOLOGICAL DISEASES AMONG THE WOMEN OF REPRODUCTIVE AGE IN BARAK VALLEY: TRENDS, CAUSES, SOCIAL PATHOLOGY, HEALTH SEEKING BEHAVIOUR, RELATED SOCIAL ISSUES AND TREATMENT FACILITIES

The trends of the major gynaecological diseases of the patients coming to the Silchar Medical College & Hospital during last eleven years is collected and presented here . Then the causes, social pathology, health seeking behaviour, other related social issues and treatment facilities all are discussed. The data are presented in graphical, tabular or pictorial form along with the probable explanations. Both the qualitative and quantitative analyses are done on the basis of the available data.

Trends of the diseases over the last eleven years

For finding the trends of the major gynaecological diseases over last 11 years, raw data are extracted from the out patient register of the Department of Obstetrics & Gynaecology. Then the data reselected and only the gynaecological cases are taken. The major gynaecological diseases under the study are amenorrhoea, dysmenorrhoea, menorrhagia, leucorrhoea, prolapse, cervicitis, pelvic inflammatory disease (PID) and vaginitis. The incidence of these major gynaecological diseases over eleven years (from the year 1999 to the year 2009) are shown below. The row data are presented in pictorial and graphical form. The average number of all the diseases per year is found out and it is seen that leucorrhoea and pelvic inflammatory disease (PID) are more commonly occurring diseases. As per the available records if we organize the major gynaecological diseases under the study in the descending order of their average occurrences per year we find the serial as leucorrhoea, pelvic inflammatory disease (PID), dysmenorrhoea, prolapse, amenorrhoea, menorrhagia, vaginitis and cervicitis.

Fig.5.1: Incidence of Amenorrhoea over eleven years



From the fig.5.1, we see that the incidence of amenorrhoea is noticed highest in the year 2003 and lowest in the year 2004. The average number of patients per years is approximately 108. In the year 2004, there was a great flood in the Barak Valley region which may be a cause of sudden fall in the number of the patients. From the year 1999 to the year 2000 there is an increase in the number though not much. From the year 2000 to 2001 there is a huge decline and again it follows an increasing pattern up to the year 2003. Again there is decrease in the number of patients in the year 2004 followed by a rise in the number of patients in the year 2005. In 2006 there is a fall in the number and in 2007 again there is a rise in the number. The year 2008 has a decline in the number of patients followed by an increase in the year 2009. From the figure it is seen that the number of amenorrhoea patients follow a zigzag pattern over the years.

Fig.5.2: Incidence of Dysmenorrhoea over eleven years

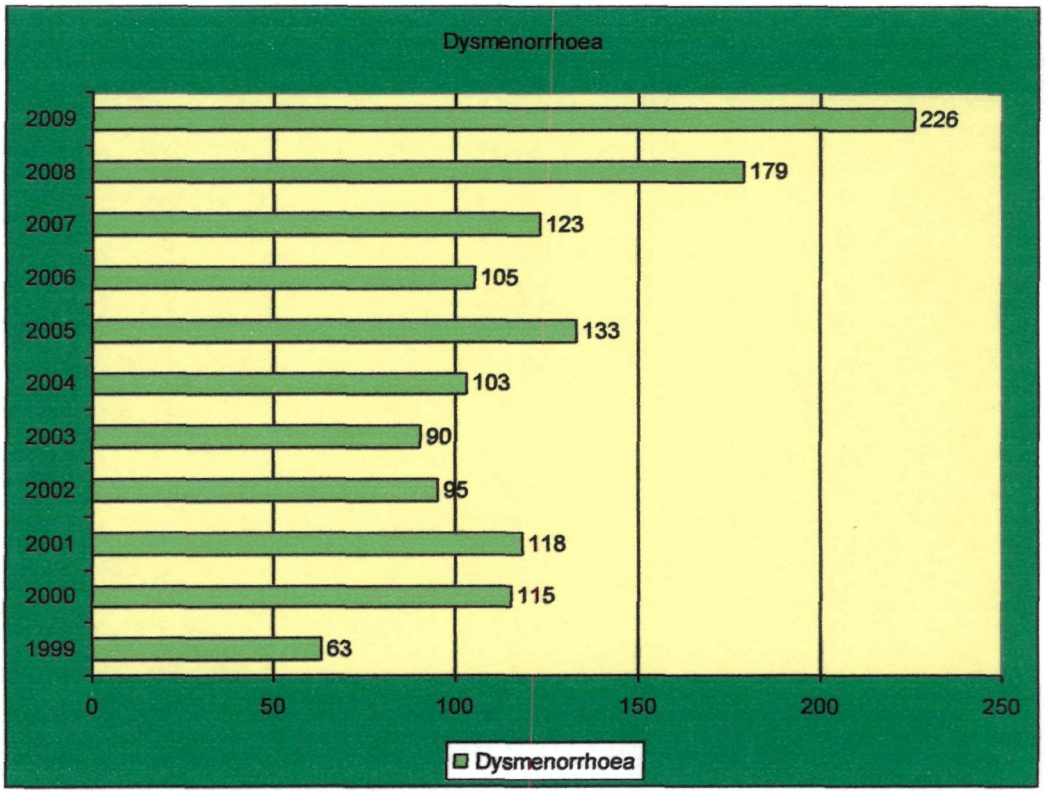
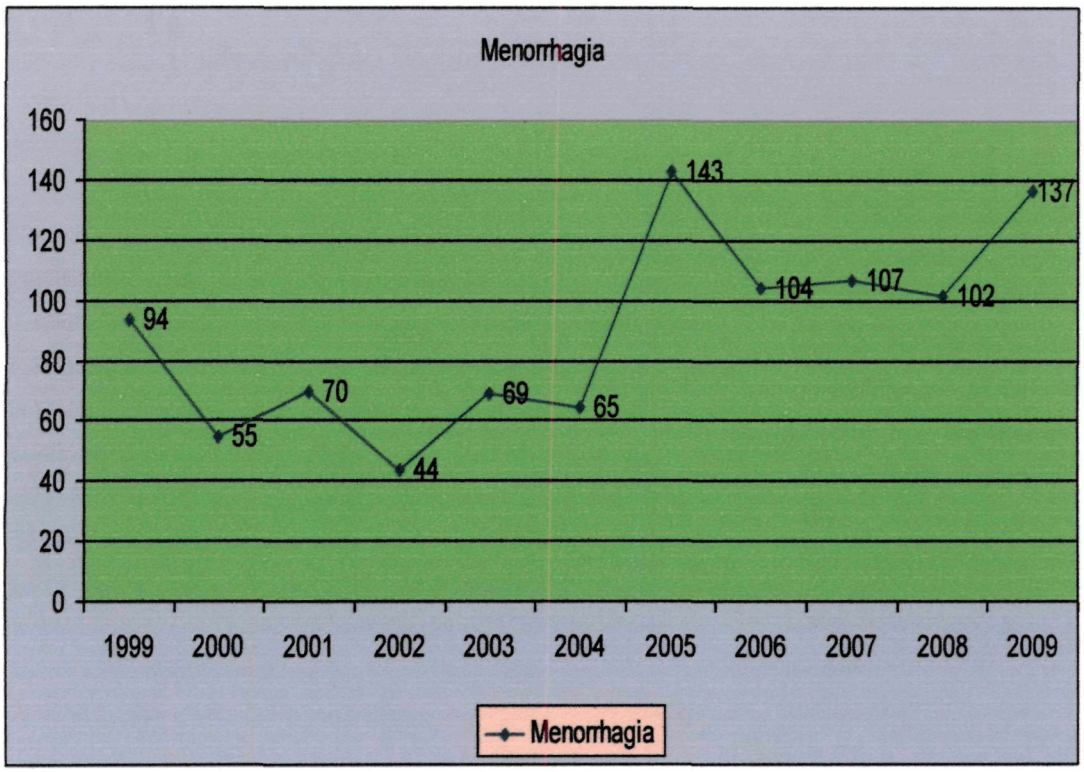


Fig.5.2 shows that there is a gradual increase in the number of dysmenorrhoea patients from the year 1999 to the year 2001. Again there is a gradual decline up to the year 2003. From the year 2003 to 2005, again the number goes on increasing showing a sudden decline in the year 2006. After 2006, there is a gradual increase in the number of dysmenorrhoe patients up to the year 2009. The year 2009 shows the highest number of patients and the year 1999 shows the lowest number of patients. The average number of patients per year is approximately 123.

Fig.5.3: Incidence of Menorrhagia over eleven years



From fig.5.3, we see that in the year 2002 the number of menorrhagia patients is lowest i.e. 44 and in the year 2005 the number of menorrhagia patients is highest i.e. 143. Generally, we see that from the year 1999 up to the year 2004 the disease incidence of menorrhagia follows a zigzag pattern. But suddenly in the year 2005 there is a sudden increase. In the year 2006 there is a decline followed by a slight increase in the year 2007. Year 2008 shows a minor decline followed by an increase in the number of patients in the year 2009. The average number menorrhagia cases per year is 90 .

Fig.5.4: Incidence of Leucorrhoea over eleven years

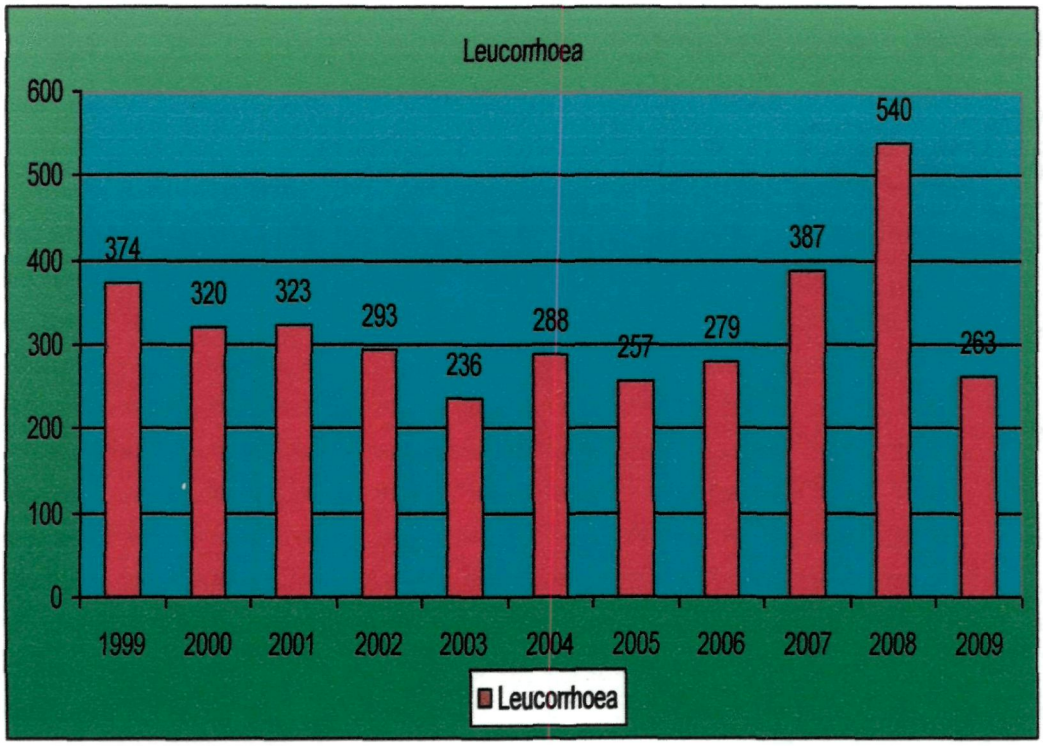


Fig.5.4 shows the distribution of the leucorrhoea patients over eleven years from the year 1999 up to the year 2009. In the year 2003 the disease incidence is the lowest i.e. 236 and in the year 2008 the disease incidence is the highest i.e. 540. From the year 1999 to the year 2002 the number of leucorrhoea patients shows a zigzag pattern. In the year 2003 there is a decline followed by an increase in the year 2004. Again there is a decrease in the number of patients in the year 2005 followed by a gradual increase up to the year 2008. In 2009 there is a sudden decrease in the number of patients. The average number of patients per year is approximately 324. In the year 2007, again there was a flood in the Barak Valley region. This may have some consequence in the sudden increase in the number of the patients in the year 2008.

Fig.5.5: Incidence of Prolapse over eleven years

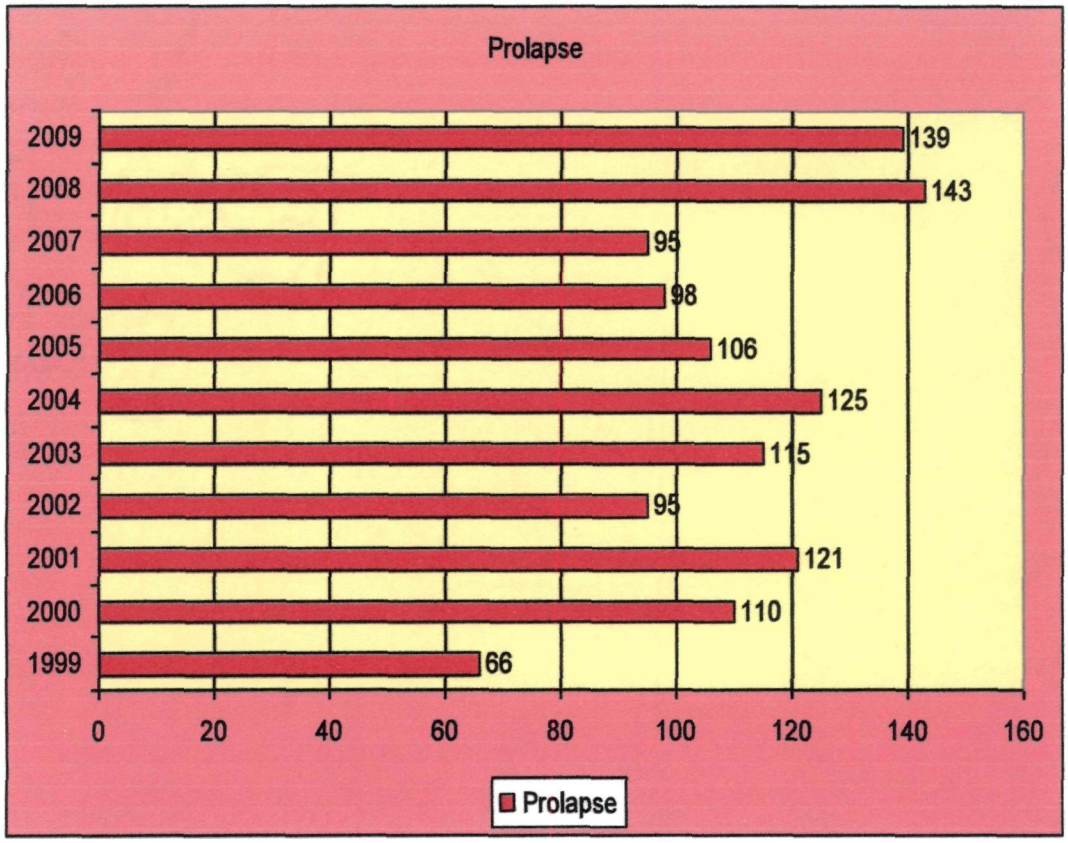


Fig.5.5 shows the distribution of the disease prolapse (all the kinds like rectal, urethral, genital etc.) over the eleven years from 1999 to 2009. In the year 1999 number of prolapse patients was the lowest i.e. 66 and in the year 2008 the disease incidence of prolapse reaches to its peak value i.e. 143. From the year 2007 to the year 2008, there is sudden increase in the number of the prolapse patients is seen. From the year 1999 up to the year 2001 gradual increase in the number of patients is seen followed by a decline in the year 2002. From 2002 to 2004 there is a gradual increase in the number of patients again from 2004 to 2007 there is a gradual decrease. There is a sudden increase in the number of prolapse patients in the year 2008 followed by a slight decline in 2009. If we calculate the mean, the average number of patients per year it is approximately 110.

Fig.5.6: Incidence of Cervicitis over eleven years

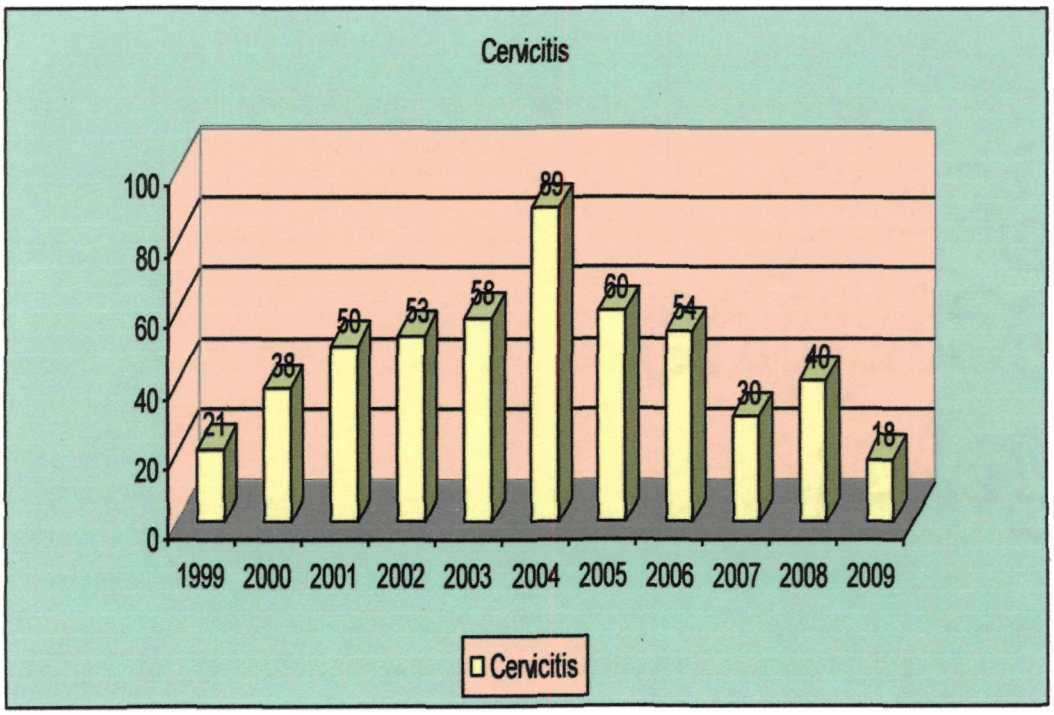
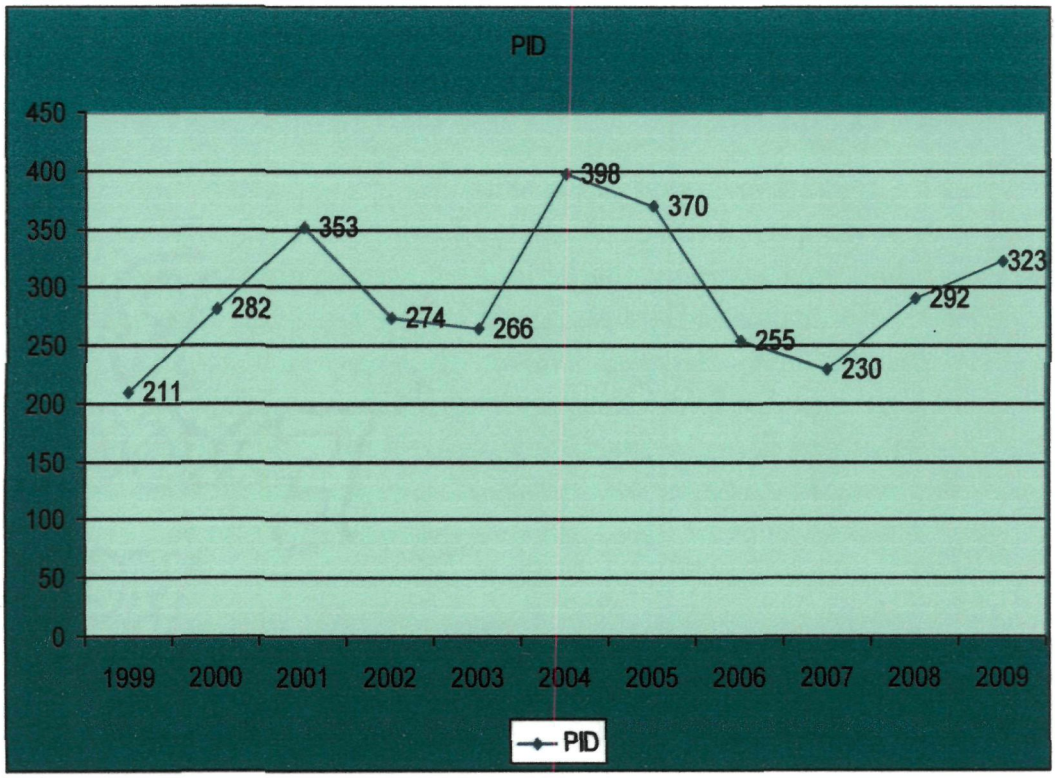


Fig.5.6 shows a gradual increase of the disease cervicitis from the year 1999 to the year 2004. After 2004 a gradual decline is noticed up to the year 2007. In the year 2008 again there is a slight increase followed by a decrease in the number of the cervicitis patients in the year 2009. In the year 2004 there was the highest number of cervicitis patients i.e. 90 patients and in the year 2009 there was the lowest number of cevicitis patients i.e. 18. Infection is one of the important causative factors in case of cervicitis. May be the great flood in the year 2004 in Barak Valley has some contributory factor in the sudden rise in the number of patients in 2004. The chance of spreading infections during flood is very common. The average number of cervicitis patients per year is approximately 47.

Fig.5.7: Incidence of Pelvic Inflammatory Disease (PID) over eleven years



From the graphical representation it is clearly seen that from the year 1999 to the year 2001 there is gradual increase in the number of PID (Pelvic Inflammatory Disease) patients followed by a gradual decline up to 2003. In the year 2004 there is a sudden increase in the number of the patients which is the highest incidence over the eleven years i.e. 398 patients. After that we see a gradual decline in the number of patients up to the year 2007 followed by a steady increase till 2009. In the year 1999 the incidence was the lowest i.e. 211 patients. The average number of PID (Pelvic Inflammatory Disease) patients per year is approximately 296. Infection is one of the important causative factors in case of PID (Pelvic Inflammatory Disease). May be the great flood in the year 2004 in Barak Valley has some contributory factor in the sudden rise in the number of patients in 2004. The chance of spreading infections during flood is very common.

Fig.5.8: Incidence of Vaginitis over eleven years

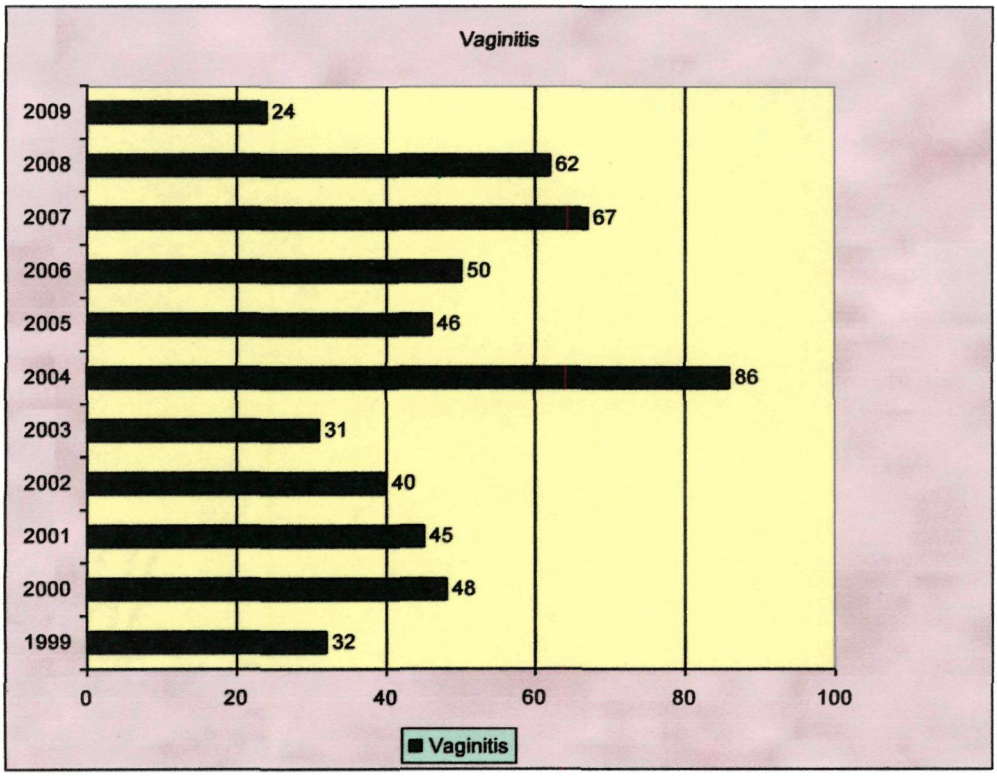


Fig.5.8 shows that the number of patients suffering from the disease vaginitis increases from the year 1999 to the year 2000 and then gradually decreases up to the year 2003. After that there is a sudden increase in the number of the patients in the year 2004 which shows the highest incidence i.e. number of patients increases up to 86. In the year 2005 again there is a sudden fall in the number of the vaginitis patients followed by a steady increase up to the year 2007. In the year 2008 there is a slight decrease in the number of patients and in the year 2009 again there is a sudden decrease. The average number of vaginitis patients per year is 48. The most common causative factor in case of vaginitis is infection. In the year 2004 there was a great flood in the Barak Valley region and again in the year 2007 there was a flood. During the flood spread of infections are more likely to happen. This may be a cause for the sudden increase in the number of patients in the year 2004 and 2007.

Causes of the major gynaecological diseases under the study

The present study is confined with the major gynaecological diseases. These are amenorrhoea, dysmenorrhoea, menorrhagia, leucorrhoea, prolapse (genital), cervicitis, pelvic inflammatory disease (PID) and vaginitis. Brief informations regarding the causative factors associated with these diseases are collected from the doctors as well as from the review of the literature. From the various causal factors, factors related to the life style of the patients explains the social pathology.

Amenorrhoea

Amenorrhoea is defined as the absence of menstrual periods. Apart from during childhood, pregnancy, breastfeeding and menopause, the absence of periods might be due to a problem with the reproductive system. One of the most common causes of amenorrhoea is hormonal disruption. There are two types of amenorrhoea:-

(a) Primary amenorrhoea – Primary amenorrhoea is defined when menstruation fails to begin by the age of 14 years, or in presence of well developed secondary sex characters, menses do not start by the age of 16 years.

(b) Secondary amenorrhoea – In secondary amenorrhoea menstrual periods stop after establishment of puberty.

Amenorrhea can occur for a variety of reasons. Some are part of the normal course of a woman's life, while others may be a side effect of medications or a sign of a medical problem.

1. Natural amenorrhea: during the normal course of her life, a woman may experience amenorrhea for natural reasons, such as: pregnancy, breast-feeding and menopause.

2. Contraceptives: some women who take birth control pills may not have periods. When oral contraceptives are stopped, it may take three to six months to resume regular ovulation and menstruation. Contraceptives that are injected or implanted also may cause amenorrhea, as can some types of intrauterine devices.

3. Medications: certain medications can cause menstrual periods to stop, including some types of: antipsychotics, cancer chemotherapy, antidepressants and blood pressure drugs.

4. Lifestyle factors

(a) Mental stress can temporarily alter the functioning of hypothalamus, an area of the brain that controls the hormones that regulate the menstrual cycle a woman. Ovulation and menstruation may stop as a result. Regular menstrual periods usually resume after the stress decreases.

(b) Excessively low body weight interrupts many hormonal functions in our body, potentially halting ovulation. Women who have an eating disorder, such as anorexia or bulimia, often stop having periods because of these abnormal hormonal changes.

(c) Women who participate in sports that require rigorous training, such as ballet, long-distance running or gymnastics, may find their menstrual cycle interrupted. Several factors combine to contribute to the loss of periods in athletes, including low body fat, stress and high energy expenditure.

5. Hormonal imbalance: Many types of medical problems can cause hormonal imbalance, including: polycystic ovary syndrome (PCOS), thyroid malfunction, pituitary tumor and premature menopause.

6. Structural problems: Problems with the sexual organs themselves also can cause amenorrhea. Examples include: uterine scarring, lack of reproductive organs and structural abnormality of the vagina.

Dysmenorrhoea

Dysmenorrhoea, or painful menstruation, is one of the most frequent of gynaecological complaints. Severe dysmenorrhoea is most prevalent in young single women leading sedentary lives, and its frequency has some economic importance, for the patients are often incapacitated from work for one or more days during each period.

There are two types of dysmenorrhea:

(a) Primary dysmenorrhea is menstrual pain that's not a symptom of an underlying gynecologic disorder but is related to the normal process of menstruation. Primary dysmenorrhea is the most common type of dysmenorrhea, affecting more than 50% of women, and quite severe in about 15%. Primary dysmenorrhea is more likely

to affect girls during adolescence. Fortunately for many women, the problem eases as they mature, particularly after a pregnancy. Although it may be painful and sometimes debilitating for brief periods of time, it is not harmful.

(b) Secondary dysmenorrhea is menstrual pain that is generally related to some kind of gynecologic disorder. Most of these disorders can be easily treated with medications or surgery. Secondary dysmenorrhea is more likely to affect women during adulthood.

Causes of dysmenrrhoea

1. Primary dysmenorrhea is thought to be caused by excessive levels of *prostaglandins*, hormones that make the uterus contract during menstruation and childbirth. Its pain probably results from contractions of the uterus that occur when the blood supply to its lining (*endometrium*) is reduced.

Usually, the pain will happen only during menstrual cycles in which an egg is released. The pain may progressively become worse as endometrial tissue shed during a menstrual period passes through the cervix, particularly when the cervical canal is narrow.

Other factors that may make the pain of primary dysmenorrhea even worse include a uterus that tilts backward (retroverted uterus) instead of forward, lack of exercise, and psychological or social stress.

2. Secondary dysmenorrhea may be caused by a number of conditions, including:

(a) Fibroids - benign tumours that develop within the uterine wall or are attached to it,
(b) Adenomyosis - the tissue that lines the uterus (called the endometrium) begins to grow within its muscular walls,
(c) A sexually transmitted infection (STI),
(d) Endometriosis - fragments of the endometrial lining that are found on other pelvic organs,
(e) Pelvic inflammatory disease (PID), which is primarily an infection of the fallopian tubes, but can also affect the ovaries, uterus, and cervix,
(f) An ovarian cyst or tumour,

(g) The use of an intrauterine device (IUD), a birth control method.

Menorrhagia

In menorrhagia, the menstrual cycle is unaltered but the duration and quantity of the mensrual loss are increased.

Causes of Menorrhagia:

Pelvic causes

1. Uterine fibroid,
2. Pelvic inflammatory disease,
3. When retroversion is associated with chronic metritis, prolapse of the overies,
4. Pelvic endometriosis,
5. Endometrial hyperplasia or polyp,
6. Carcinoma of endometrium,
7. Ovarian tumour,
8. Uterine malformation,
9. Intrauterine contraceptive device (IUCD) also may be a cause.

Endocrinal disorder

Dysfunctional uterine haemorrhage is an important cause of menorrhagia. Hypothyroidism also can cause menorrhagia.

General diseases

1. Some cases of chronic hypertension can cause menorrhagia,
2. Heart diseases with chronic congestive failure,
3. Chronic nephritis,
4. Undernutrition-avitaminosis and defective nutrition may be the cause,
5. Hepatic dysfunction,
6. Blood disorders like severe anaemia, leukaemias etc.
7. Emotional disturbances like worry, sorrow, sexual excesses, etc.
8. Drugs – prolonged taking of aspirin, anticoagulants, psychotropic medications also can cause menorrhagia.

Leucorrhoea

This is a symptom of pouring out white discharge per vagina. Vaginal infection is the commonest cause of leucorrhoea.

Causes of leucorrhoea

1. Infections from bacteria, fungi or other parasites. Urinary tract infections also very common female discharge causes.
2. Injuries or trauma to the vagina, the womb or the cervix, which is very common during pregnancy
3. Lack of cleanliness or poor hygienic measures
4. Irritation from objects like an intrauterine contraceptive device
5. The use of sprays, lubricants or jellies
6. Contraceptives used by men or women which could cause irritation
7. Sexually transmitted diseases
8. Following a diet that is low on nutrition

Prolapse

Prolapse may be of various kinds such as genital prolapse, uterine prolapse, rectal prolapse etc. It is the weak ness of the pelvic supporting structures causing a decent of the pelvic organs into the vagina.

Some risk factors associated with genital prolapse are:

1. Childbirth (especially multiple births): Childbirth is stressful to the tissues, muscles, and ligaments in and around the vagina. Long, difficult labors and large babies are especially stressful to these structures. Childbirth is the risk factor most commonly associated with cystoceles, in which the bladder prolapses into the vagina. A cystocele is usually accompanied by a urethrocele, in which the urethra becomes displaced and prolapses. A cystocele and urethrocele together are called a cystourethrocele.

2. Menopause: Estrogen is a hormone that helps to keep the muscles and tissues of the pelvic support structure strong. After menopause, the estrogen level decreases; this means that the support structures may weaken.

3. Hysterectomy: The uterus is an important part of the support structure at the top of the vagina. A hysterectomy involves removing the uterus. Without the uterus, the top of the vagina may gradually fall toward the vaginal opening. This condition is called a vaginal vault prolapse. As the top of the vagina droops, added stress is placed on other ligaments. Hysterectomy is also commonly associated with an enterocele, in which the small bladder herniates near the top of the vagina.

4. Dysfunction of the nerves and tissues.

5. Abnormalities of the connective tissue.

6. Strenuous physical activity.

7. Prior pelvic surgery.

Cervicitis

Cervicitis is inflammation of the cervix -- the lower end of the uterus that opens into the vagina. Cervicitis is common. It may be caused by a number of factors including infections, chemical or physical irritations, and allergies. The infection can spread beyond the cervix to the uterus and fallopian tubes. This may cause problems with fertility --the ability to become pregnant. Or it may cause problems with the unborn baby if the patient is already pregnant.

Causes of cevicitis are:

1. Infection during abortion or child birth,
2. Severe cases of inflammation are usually caused by infections that are passed during sexual activity. Sexually transmitted diseases (STDs) that may cause cervicitis include: gonorrhea, chlamydia, genital herpes and trichomoniasis.
3. Allergies to chemicals in spermicides, douches, or to the latex rubber incondoms.
4. Irritation or injury from tampons, pessaries, or from birth control devices like diaphragms.

5. Bacterial imbalance. Normal, healthy bacteria in the vagina are overwhelmed by unhealthy or harmful bacteria. This is also called bacterial vaginosis.
6. Hormonal imbalance. Having relatively low estrogen or high progesterone may interfere with the body's ability to maintain healthy cervical tissue.
7. Cancer or cancer treatment. Rarely, radiation therapy or cancer may cause changes to the cervix consistent with cervicitis.
8. Unprotected sex or having sex with multiple partners.
9. Previous incidence of cervicitis also may be considered as a risk factor.
10. Sexual intercourse at an early age.

Pelvic Inflammatory Diseases (PID)

It implies inflammation of the upper genital tract involving the fallopian tubes as well as the ovaries. It is caused by a combination of micro organisms. PID can cause scarring inside the reproductive organs, which can later cause serious complications, including chronic pelvic pain, infertility, ectopic pregnancy (the leading cause of pregnancy-related deaths in adult females), and other dangerous complications of pregnancy.

Causes of PID:

1. Contraception: Induced abortion, use of an IUD, non-use of barrier contraceptives such as condoms, and frequent douching are all associated with a higher risk of developing PID.

2. Lifestyle: High risk behaviors, such as drug and alcohol abuse, early age of first intercourse, number of sexual partners, and smoking all are associated with a higher risk of developing PID.

3. Types of sexual practices: Intercourse during menses and frequent intercourse may offer more opportunities for the admission of pathogenic organisms to the inside of the uterus.

4. Earlier history: A prior episode of PID increases the chances of developing subsequent infections.

Vaginitis

Vaginitis is an inflammation of the vagina. It can result in discharge, itching and pain, and is often associated with an irritation or infection of the vulva. It is usually due to infection. The three main kinds of vaginitis are bacterial vaginosis (BV), vaginal candidiasis, and trichomoniasis. A woman may have any combination of vaginal infections at one time.

Causes of Vaginitis

There are many different causes of vaginitis:

1. Non-infectious vaginitis refers to vaginal inflammation that is due to chemical irritants or allergies. Spermicides, douches, detergents, fabric softeners, and latex condoms can all irritate the vaginal lining. Also, some sanitary napkins can cause irritation at the entrance to the vagina.

2. Atrophic vaginitis may occur after a woman has reached menopause. It results from lower hormone (estrogen) levels and the thinning of the vaginal lining caused by them. This makes the vagina more prone to irritation.

Infectious vaginitis is caused by an infection with bacteria or yeast. *Trichomoniasis*is caused by a parasite called *Trichomonas vaginalis* and spreads through unprotected sex with an infected partner. Other types of vaginal infections can occur when a woman has a *fistula*, an abnormal passage connecting the intestine to the vagina. This allows stool to enter the vaginal area, greatly increasing the risk of infections.

Bacterial vaginosis may be due to an imbalance between normally occurring bacteria that protect the vagina and potentially infectious ones. Cigarette smoking, using intrauterine devices, douching, and having multiple sexual partners have all been shown to increase the risk of infection. Bacterial vaginosis is not considered a

sexually transmitted infection, however, since it can occur in women who have never had vaginal intercourse.

Yeast infection, also known as *vaginal candidiasis*, occurs when there is an overgrowth of the yeast called *Candida* that normally lives in the vagina. Yeast infections can occur if a woman is taking antibiotics, if a woman have high levels of estrogen (for instance, during pregnancy), if a woman have uncontrolled diabetes, or if the immune system of the woman is suppressed. Stress, poor diet, lack of sleep, illness, taking of oral contraceptives are considered as high risk factors in case of vaginal yeast infection.

Thus we see that there are various life style factors which are regarded as causative factors in case of the major gynaecological diseases under the study. If we combine the causative factors of all the major gynaecological diseases which are associated with the life style we get the following factors:

1. Nutritional deficiency,
2. Stress,
3. Infection,
4. Unhygienic conditions,
5. Heavy work,
6. Unprotected sex or having sex with multiple partners,
7. Early marriage and early coitus,
8. Unsafe abortion practices,
9. Delivery by unskilled persons,
10. Use of IUD or oral pills etc.

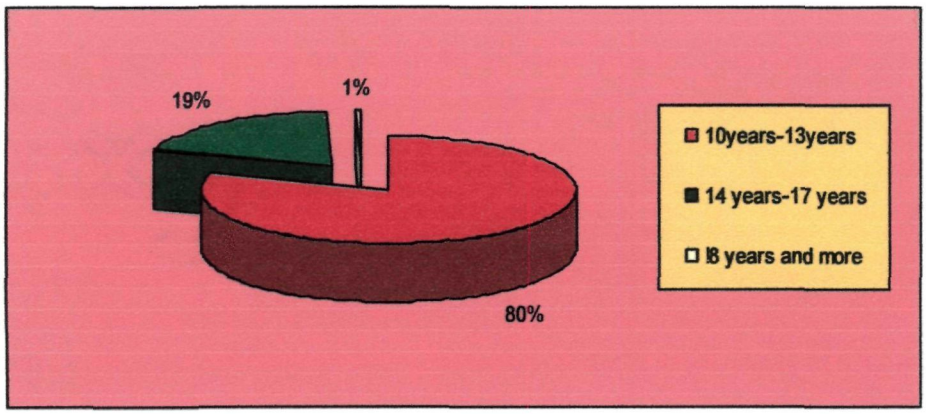
Social Pathology, Health Seeking Behaviour, Related Social Issues and Treatment Facilities

Menstrual history and practices

Menstruation, or period, is a woman's monthly bleeding. Every month, a woman's body prepares for pregnancy. If no pregnancy occurs, the uterus sheds its

lining. The menstrual blood is partly blood and partly tissue from inside the uterus, or womb. It passes out of the body through the vagina. Periods usually start around age 12 and continue until menopause, at about age 51. Having regular menstrual cycles is a sign that important parts of a women's body are working normally. The menstrual cycle provides important body chemicals, called hormones, to keep a woman healthy. It also prepares the body for pregnancy each month. A cycle is counted from the first day of 1 period to the first day of the next period. The average menstrual cycle is 28 days long. Any alteration in the onset, offset or regular cycle of menstruation can lead to various diseases especially gynaecological diseases. Here the various information regarding the menstrual history are given along with the menstrual practices such as device used during menstrual cycle, duration of changing pads/cloths, disposal etc.

Fig.5.9: Age at menarche



Age at menarche means the age when menstrual cycle of a girl starts for the first time. Fig.5.9 shows that four fifth of the respondents (80%) have their menarche in between 10 to 13 years and near about one fifth of the sample (19.3%) have their menarche in between 14to17 years. So it is clear that majority of the respondents have early menarche.

In the rural area also four fifth of the respondents (80%) have their menarche in between 10 to 13 years and even in the urban area the trend is same.

Fig.5.10: Pain during menstruation

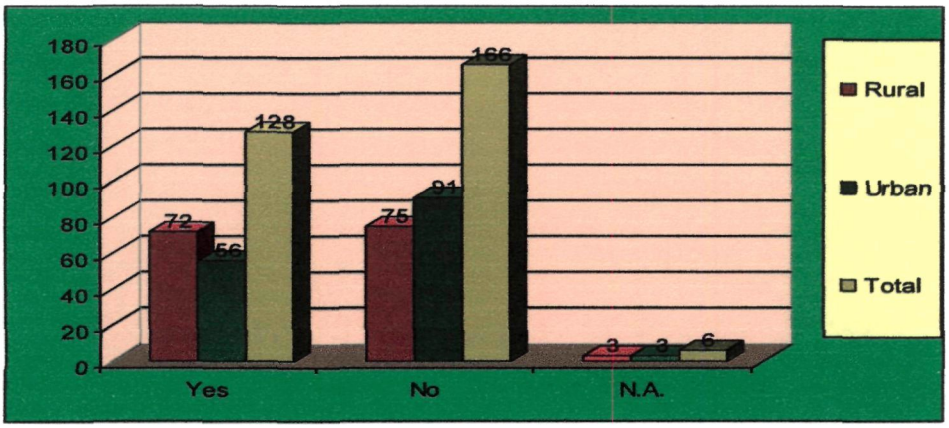
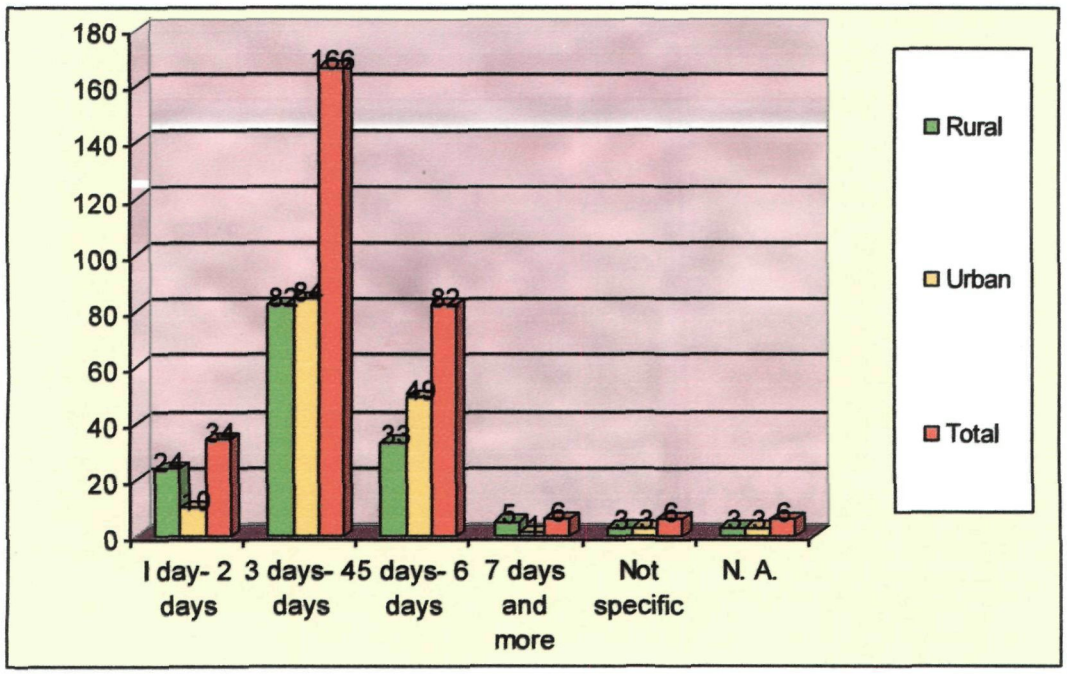


Fig.5.10 shows that more than half of the patients (55.3%) do not feel pain during menstruation and in more than two fifth of the patients (42.7%), they complain about feeling pain during menstruation. In 2 percent cases, either menstruation has not started yet or it has been stopped.

In the rural area, in more than half of the respondents (50.7%), patients do not feel pain during menstruation and in 48 percent cases patients feel pain during menstruation. In the urban area, in three fifth of the cases (60%), patients do not feel pain during menstruation and in more than one third of the cases (37.3%), patients feel pain during menstruation. No statistical significance is found between the place of residence and the pain during menstruation (Pearson Chi Square value is 3.542 at p=0.170 level).

Fig.5.11: Number of days of menstruation



It is clear from the fig.5.11, more than half of the patients (55.3%) have a menstrual cycle of 3 to 4 days and more than one fourth patients (27.3%) have a menstrual cycle of 5 to 6 days. More than three fourth of the patients (76.7%) have menstrual cycle ranging from 3 to 6 days. In 2 percent cases where it is not specific, is indicative of the irregular pattern of menstrual cycle.

In the rural area, more than half of the patients (54.7%) have a menstrual cycle of 3 to 4 days and more than one fifth of the patients (22%) have a menstrual cycle of 5 to 6 days. In the urban area, more than half of the patients (56%) have a menstrual cycle of 3 to 4 days and a little less than one third of the patients (32.7%) have a menstrual cycle of 5 to 6 days.

Table-5.1: Maintenance of proper hygiene during menstruation

Maintenance of proper hygiene during menstruation	*Number of patients*		*Frequency (Percentage)*
	Rural	***Urban***	
Maintained	20(6.7%) 13.3%	17(5.7%) 11.3%	37(12.3%)
Not maintained	127(42.3%) 84.7%	130(43.3%) 86.7%	257(85.7%)
Not applicable	3(1%) 2%	3(1%) 2%	6(2%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.1 shows that more than four fifth of the respondents (85.7%) do not maintain proper hygiene during menstruation. In 2 percent cases, either menstruation has not started yet or it has been stopped.

In the rural area, more than four fifth of the respondents (84.7%) do not maintain proper hygiene during menstruation. In the urban area, more than four fifth of the respondents (86.7%) do not maintain proper hygiene during menstruation In the urban area more number of respondents who do not maintain proper hygiene during menstruation as compared to the rural area. As a answer to this question, majority (95%) replied that the maintain proper hygiene during menstruation, but when they are further asked about the frequency of changing cloths or pads per day, the veiled information came out.

Fig.5.12: Device used during menstruation

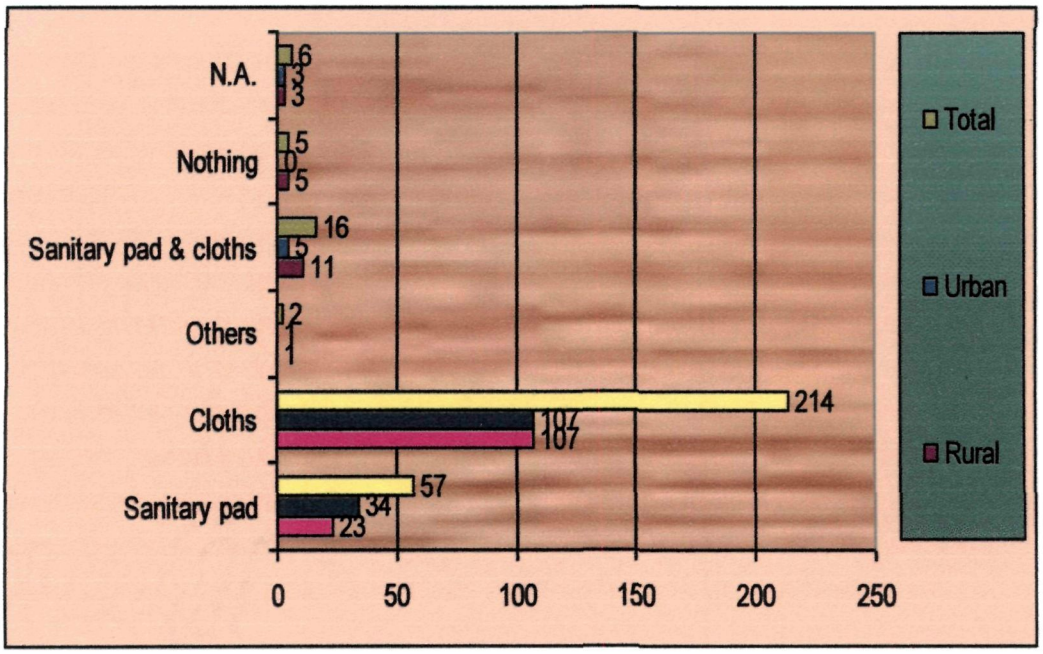


Fig.5.12 exposes that majority of the respondents (71%) use cloths during menstruation and near about one fifth of the respondents (19%) use sanitary pads during menstruation. Only 5.3 percent respondents use both cloths and sanitary pad.

In the rural area, majority of the respondents (71.3%) use cloths during menstruation and more than one tenth of the respondents (15.3%) use sanitary pads during menstruation. In the urban area, majority of the respondents (71.3%) use cloths during menstruation and near about one fifth of the respondents (22.7%) use sanitary pads during menstruation. The use of sanitary pad is relatively more prevalent in urban area as compared to rural area.

Table-5.2: Frequency of changing pads/cloths in a day

Frequency of changing pads/cloths in a day	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Less than one time a day	8(2.7%) 5.3%	2(0.7%) 1.3%	10(3.3%)
One time a day	29(9.7%) 19.3%	13(4.3%) 8.7%	42(14%)
Two times a day	90(30%) 60%	115(38.3%) 76.7%	205(68.3%)
Three times a day	14(4.7%) 9.3%	12(4%) 8%	26(8.7%)
More than three times a day	6(2%) 4%	5(1.7%) 3.3%	11(3.7%)
Not applicable	3(1%) 2%	3(1%) 2%	6(2%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.2 we get to know that in majority of the cases (68.3%) pads/cloths are changed two times a day and in more than one tenth of the cases (14%) pads/cloths are changed one time a day. But for maintenance of proper hygiene pads/cloths should be changed at least three times a day.

In the rural area, in three fifth of the cases (60%) pads/cloths are changed two times a day and in almost one fifth of the cases (19.3%) pads/cloths are changed one time a day. In the rural area, in more than three fourth of the cases (76.7%) pads/cloths are changed two times a day and in less than one tenth of the cases (8.7%) pads/cloths are changed one time a day. There is not much statistical significance found between the place of residence and the frequency of changing pads/cloths (Pearson Chi Square value is 12.989 at p=0.023 level).

Fig.5.13: Disposal

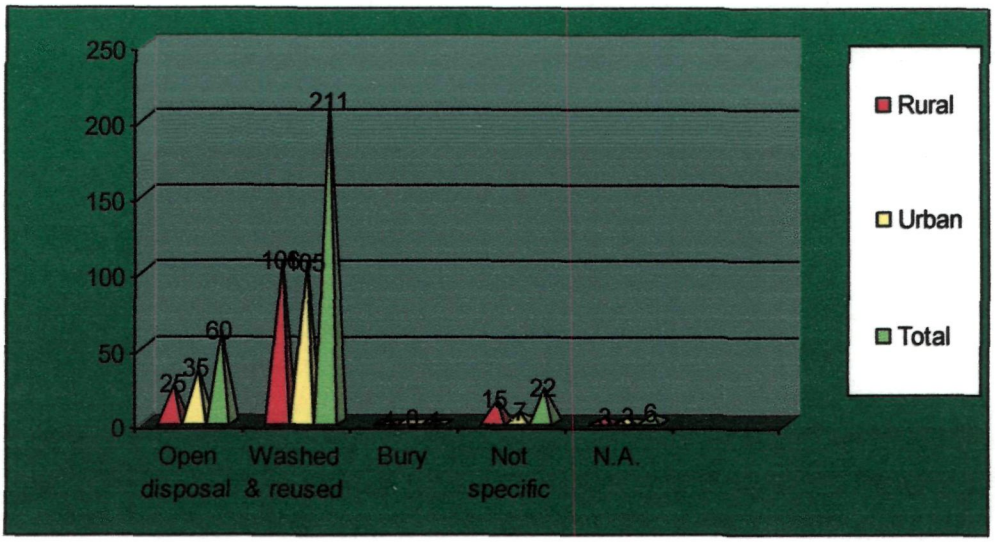
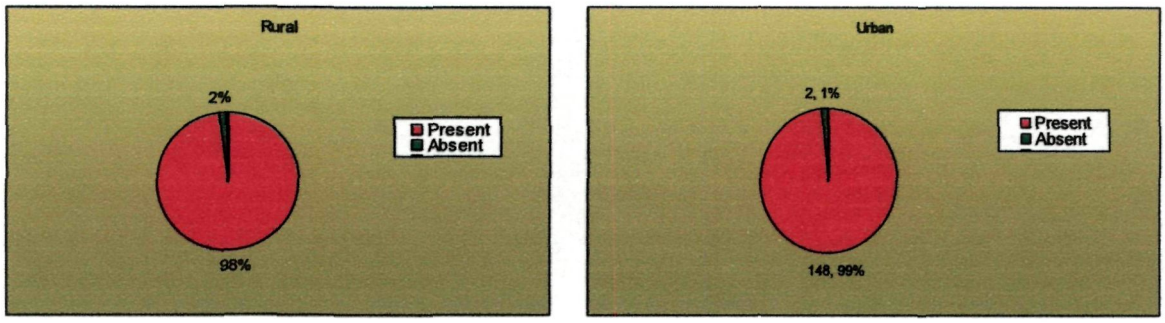


Fig.5.13 shows that in majority of the cases (70.3%) cloths are washed and reused and in one fifth of the cases (20%) there is open disposal.

In the rural area in majority of the cases (70.7%) cloths are washed and reused and in more than one tenth of the cases (16.7%) there is open disposal. In the urban area also in majority of the cases (70%) cloths are washed and reused and in near about one fourth of the cases (23.3%) there is open disposal. This shows open disposal is more in urban area as compared to rural area though in both the areas washing and reusing is the most popular. Still there is no strong statistical significance is found between the place of residence and the disposal of used pads/cloths during menstruation (Pearson Chi Square value is 5.580 at p=0.233 level).

Fig.5.14: White Discharge



In a great majority of the patients (98.3%) white discharge is present and in 1.7 percent of the patients white discharge is absent. White discharge is the most common gynaecological problem a woman faces.

In the rural area, in a huge majority of the patients (98%) white discharge is present and in 2 percent of the patients white discharge is absent. In the urban area, in a grand majority of the patients (98.7%) white discharge is present and in 1.3 percent of the patients white discharge is absent.

History related to the reproductive behaviour and practices

Reproductive behaviour of a woman tells about the age at coitus, child bearing age, use of family planning device etc. Here various relevant information about the reproductive behaviour of the sample are given along with some related information such as patients' consent at intercourse, frequency of intercourse, use of family planning device and any problem associated with it, child bearing age, nature and place of delivery etc.

Fig.5.15: Age at first coitus

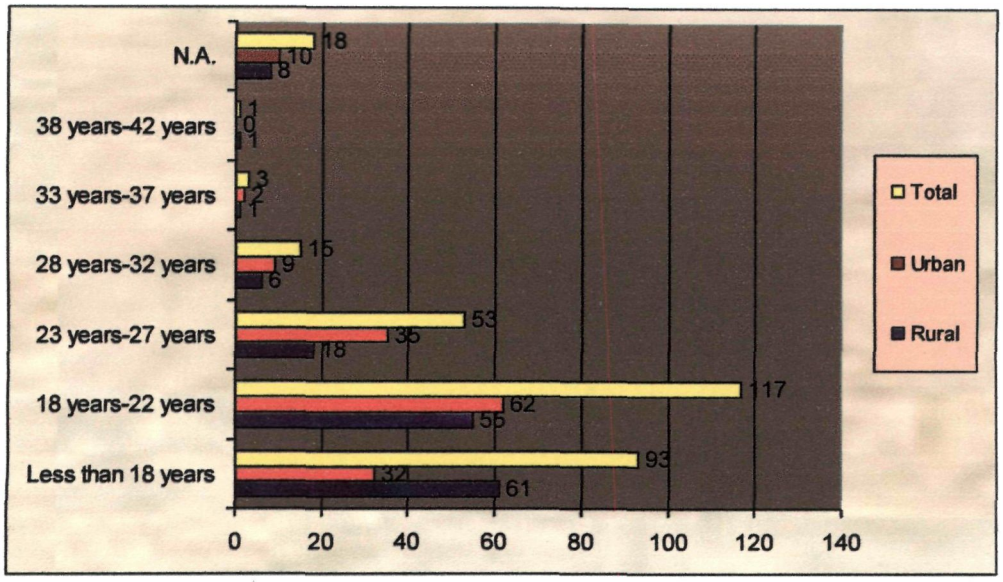


Fig.5.15 reveals that more than one third of the respondents (39%) have their first coitus in life in between 18 years to 22 years and less than one third (31%) have first coitus when they are aged below 18 years. Seven tenth of the patients (70%) have their first coitus within the age of 22 years, which is indicative of the prevalence of early marriage in the society.

In the rural area, more than two fifth of the patients (40.7%) have their first coitus before they attain the age of 18 years and more than one third of the patients (36.7%) have their first coitus in between 18 years to 22 years. Approximately more than three fourth of the patients (77.4%) in the rural area have their first coitus within the age of 22 years. In the urban area, more than two fifth of the respondents (41.3%) have their first coitus in between 18 years to 22 years and almost one fourth of the respondents (23.3%) have their first coitus in between 23 years to 27 years. Approximately more than three fifth of the patients (64.6%) in the urban area have their first coitus in between 18 years to 27 years. Age at first coitus is higher in urban area as compared to the rural area. The reason behind this may be the prevalence of early marriage in rural areas. Statistical significance is also found between the place of residence and the age at first coitus though not very strong (Pearson Chi Square value is 17.070 at p=0.009 level).

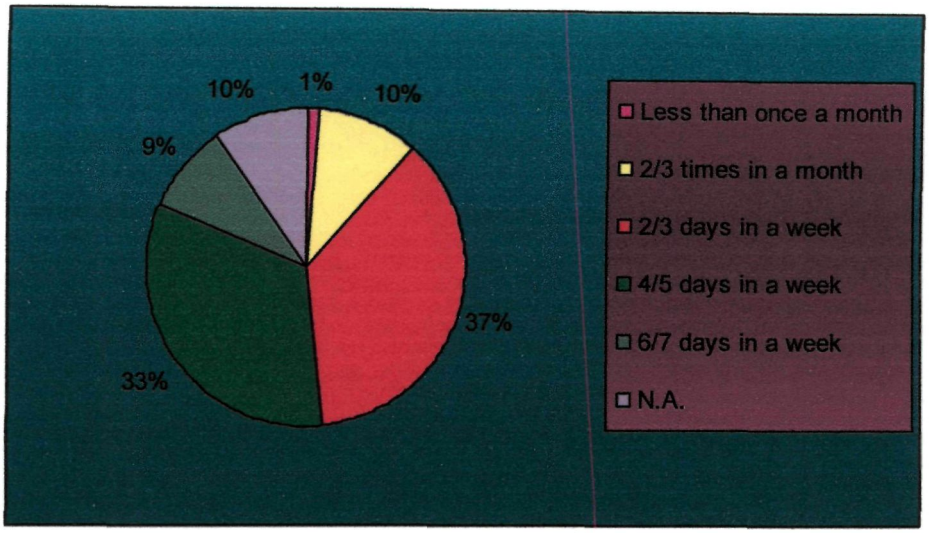
Tabble-5.3: Patient's consent at first coitus

Patient's consent at first coitus	*Number of patients*		*Frequency (Percentage)*
	Rural	***Urban***	
Yes	85(28.3%) 56.6%	114(38%) 76%	199(66.3%)
No	57(19%) 38%	26(8.7%) 17.3%	83(27.7%)
Not applicable	8(2.7%) 5.3%	10(3.3%) 6.7%	18(6%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.3, we see that almost two third of the patients (66.7%) gave consent at their first coitus and in more than one fourth of the cases (27.7%) first coitus is done against their will. Coitus against the will of the women is representative of the male domination of the society where consent from a girl before having sex is not a must.

In the rural area, more than half of the patients (56.6%) gave consent at their first coitus and in more than one third of the cases (38%) first coitus is done against their will. In the urban area, more than three fourth of the patients (76%) gave consent at their first coitus and in more than one tenth of the cases (17.3%) first coitus is done against their will. Number of women having their first coitus against their will is higher in rural areas as compared to the urban areas. Statistical significance is also found between the place of residence and the patients' consent at their first coitus (Pearson Chi Square value is 16.027 at p=0.0003 level).

Fig.5.16: Frequency of intercourse



It is clear from fig.5.16 that more than one third of the respondents (37%) have sexual intercourse 2 to 3 days in a week and almost one third of the respondents (33%) have sexual intercourse 4 to 5 days in a week. Majority of the patients (70%) have sexual intercourse 2 to 5 days in a week. In almost one tenth of the cases (9.7%) there is no question of regular sexual intercourse because this is the unmarried, widowed and separated women.

In the rural area, more than one third of the respondents (37.3%) have sexual intercourse, 2 to 3 days in a week and more than one fourth of the respondents (27.3%) have sexual intercourse 4 to 5 days in a week. In the urban area, more than one third of the respondents (38.7%) have sexual intercourse 4 to 5 days in a week and 36.7 percent respondents have sexual intercourse 2 to 3days in a week. In the urban area more number of people is having sex 4 to 5 days in a week as compared to the rural area.

Table-5.4: Patient's consent in each intercourse

Patient's consent in each intercourse	*Number of patients*		*Frequency (Percentage)*
	Rural	***Urban***	
Yes	16(5.3%) 10.7%	41(13.7%) 27.3%	57(19%)
No	35(11.7%) 23.3%	23(7.7%) 15.3%	58(19.3%)
Not specific	86(28.7%) 57.3%	70(23.3%) 46.7%	156(52%)
Not applicable	13(4.3%) 8.7%	16(5.3%) 10.7%	29(9.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.4 we see that in more than half of the cases (52%) patient's consent in intercourse is not specific, i.e., sometimes consent is taken and sometimes not. In almost one fifth of the cases (19.3%) consent is not taken or sexual intercourse is done against their will.

In the rural area, we see that in more than half of the cases (57.3%) patient's consent in intercourse is not specific, i.e., sometimes consent is taken and sometimes not and in less than one fourth of the cases (23.3%) consent is not taken or sexual intercourse is done against their will. In the urban area, in more than two fifth of the cases (46.7%) patient's consent in intercourse is not specific, i.e., sometimes consent is taken and sometimes not and in more than one fourth of the cases (27.3%) consent is taken from the patient. In the urban area from more number of women consent before sexual intercourse is taken, which may be indicative of relatively higher status of women in the urban area as compared to the rural area. But, as a whole, status of women is not very pleasing. There is statistical significance found between the place of residence and the patients' consent at each intercourse (Pearson Chi Square value is 15.399 at p=0.002 level).

Table-5.5: Age of the patient at first child birth

Age of the patient at first child birth	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Nil	33(11%) 22%	64(21.3%) 42.7%	97(32.3%)
Less than 18 years	31(10.3%) 20.7%	19(6.3%) 12.7%	50(16.7%)
18 years – 22 years	54(18%) 36%	21(7%) 14%	75(25%)
23 years – 27 years	19(6.3%) 12.7%	30(10%) 20%	49(16.3%)
28 years – 32 years	2(0.7%) 1.3%	6(2%) 4%	8(2.7%)
38 years – 42 years	1(0.3%) 0.7%	0	1(0.3%)
Not applicable	10(3.3%) 6.7%	10(3.3%) 6.7%	20(6.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is clear from the table-5.5, almost one third of the respondents (32.3%) do not have children, one fourth of the respondents (25%) have their first child between 18 to 22 years and more than one tenth of the respondents (16.7%) have their first child before they attain the age of 18 years. This is indicative of the prevalence of early marriage and early child bearing practices in the society.

In the rural area, more than one fifth of the respondents (22%) do not have children, more than one third of the respondents (36%) have their first child between 18 to 22 years and more than one fifth of the respondents (20.7%) have their first child before they attain the age of 18 years. In the urban area, more than two fifth of the respondents (42.7%) do not have children, one fifth of the respondents (20%) have

their first child between 23 to 27 years and more than one tenth respondents (14%) have their first child between 18 to 22 years. This data reveals the fact that early marriage and child bearing practice is more prevalent in the rural areas as compared to the urban areas. A high statistical significance is also found between the place of residence and the age at first child birth (Pearson Chi Square value is 32.777 at $p<0.0001$ level).

Fig.5.17: Type of delivery

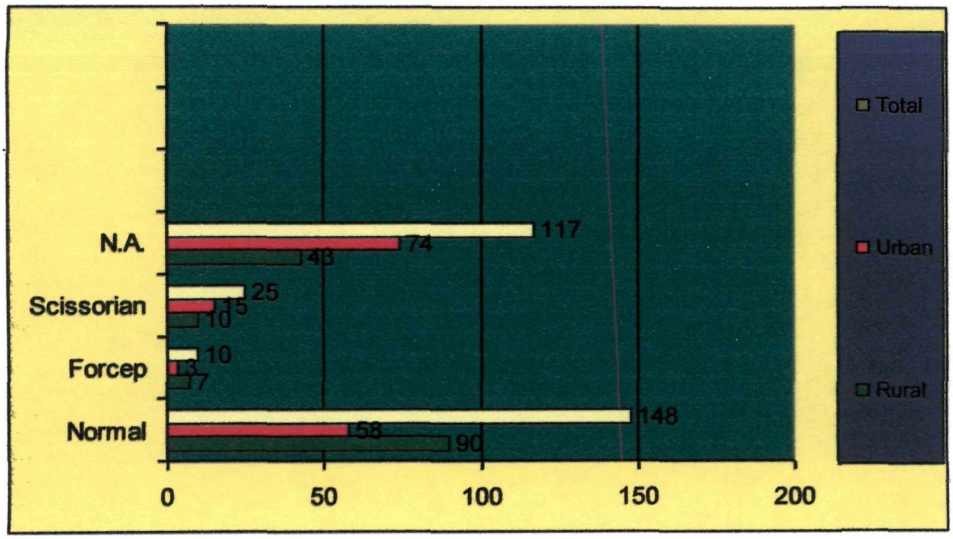


Fig.5.17 shows that almost half of the patients (49.3%) have normal delivery and 8.3 percent patients have scissorian type. More than one third cases (39%) are not applicable which means they are unmarried, widowed, separated and child less women.

In the rural area, three fifth of the cases (60%) have normal delivery and 6.7 percent patients have scissorian type. In the urban area, more than one third (38.7%) have normal delivery and one tenth of the patients (10%) have scissorian type. So we can assume that normal delivery is more popular in the rural area. High statistical significance is found between the place of residence and type of delivery (Pearson Chi Square value is 17.733 at $p=0.0005$ level).

Table-5.6: Place of delivery

Place of delivery	*Number of patients*		*Frequency (Percentage)*
	Rural	***Urban***	
Home	72(24%) 48%	32(10.7%) 21.3%	104(34.7%)
Govt. Hospital	34(11.3%) 22.7%	35(11.7%) 23.3%	69(23%)
Private Hospital	1(0.3%) 0.7%	7(2.3%) 4.7%	8(2.7%)
Nursing home	0	2(0.7%) 1.3%	2(0.7%)
Not applicable	43(14.3%) 28.7%	74(24.7%) 49.3%	117(39%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is clear from the table-5.6, in more than one third of the cases (34.7%) place of delivery is home and in more than two fifth of the cases (23%) place of delivery is government hospital. More than one third cases (39%) are not applicable which means they are unmarried, widowed, separated and childless women.

In the rural area, in more than two fifth of the cases (48%) place of delivery is home and in more than one fifth cases (22.7%) place of delivery is government hospital. In the urban area, in almost half of the cases (48%) place of delivery is not applicable which means they are unmarried, widowed, separated and child less women and in more than one fifth cases (23.3%) place of delivery is government hospital. A high statistical significance is also found between the place of residence and the place of delivery (Pearson Chi Square value is 30.113 at $p<0.0001$ level).

Fig.5.18: Number of children

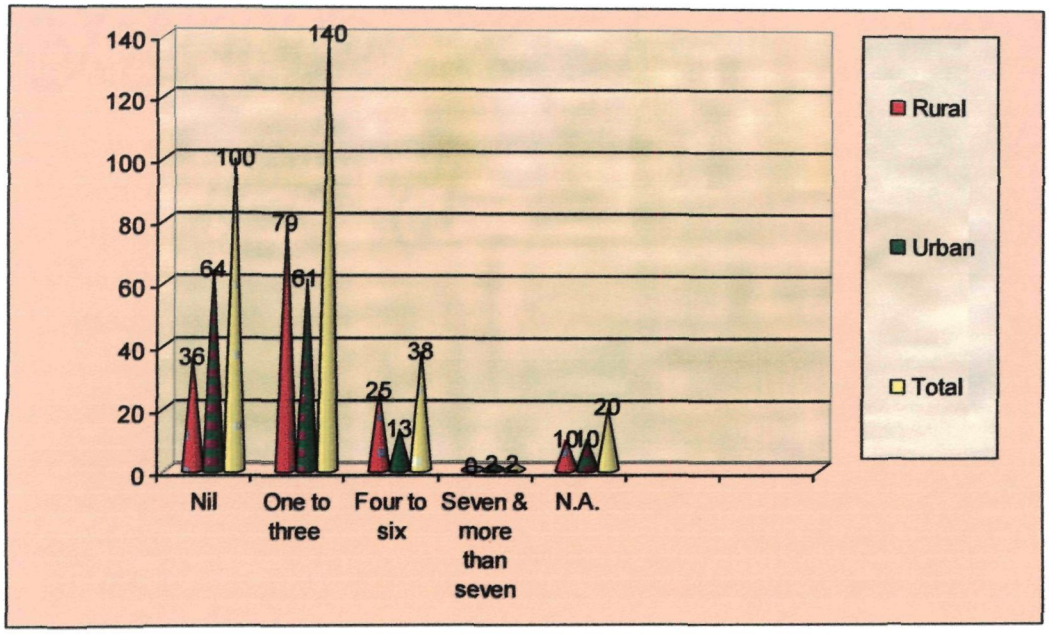


Fig.5.18 reveals that more than two fifth of the patients (46.7%) have number of children ranging from 1 to 3 and more than one tenth of the patients (12.7%) have number of children ranging from 4 to 6. One third of the patients (33.3%) do not have any living children.

In the rural area, more than half of the patients (52.7%) have number of children ranging from 1 to 3 and more than one tenth of the patients (16.7%) have number of children ranging from 4 to 6. In the urban area, more than two fifth of the patients (40.7%) have number of children ranging from 1 to 3 and nearly about one tenth of the patients (8.7%) have number of children ranging from 4 to 6. Statistical significance is found between the place of residence and the number of children though not much strong (Pearson Chi Square value is 15.944 at p=0.003 level).

Table-5.7: Family planning device used

Family planning device used	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Copper-T	10(3.3%) 6.7%	13(4.3%) 8.7%	23(7.7%)
IUD insertion	8(2.7%) 5.3%	9(3%) 6%	17(5.7%)
Condom	3(1%) 2%	1(0.3%) 0.7%	4(1.3%)
Oral pills	13(4.3%) 8.7%	13(4.3%) 8.7%	26(8.7%)
Female sterilization	15(5%) 10%	3(1%) 2%	18(6%)
No device used	75(25%) 50%	77(25.7%) 51.3%	152(50.7%)
Not specific	16(5.3%) 10.7%	24(8%) 16%	40(13.3%)
Not applicable	10(3.3%) 6.7%	10(3.3%) 6.7%	20(6.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is clear from table-5.7 that in more than half of the cases (50.7%) no family planning device is used, in 13.3 percent cases no specific family planning device is used and in 8.7 percent oral pills are used.

In the rural area, in half of the cases (50%) no family planning device is used, in one tenth of the cases (10.7%) no specific family planning device is used and in one tenth cases (10%) female sterization is done. In the urban area, in more than half of the cases (51.3%) no family planning device is used and in more than one tenth of the cases (16%) no specific family planning device is used. No significant relation is

found between the place of residence and the type of family planning device used (Pearson Chi Square value is 11.076 at p=0.135 level).

Fig.5.19: Duration of using family planning method

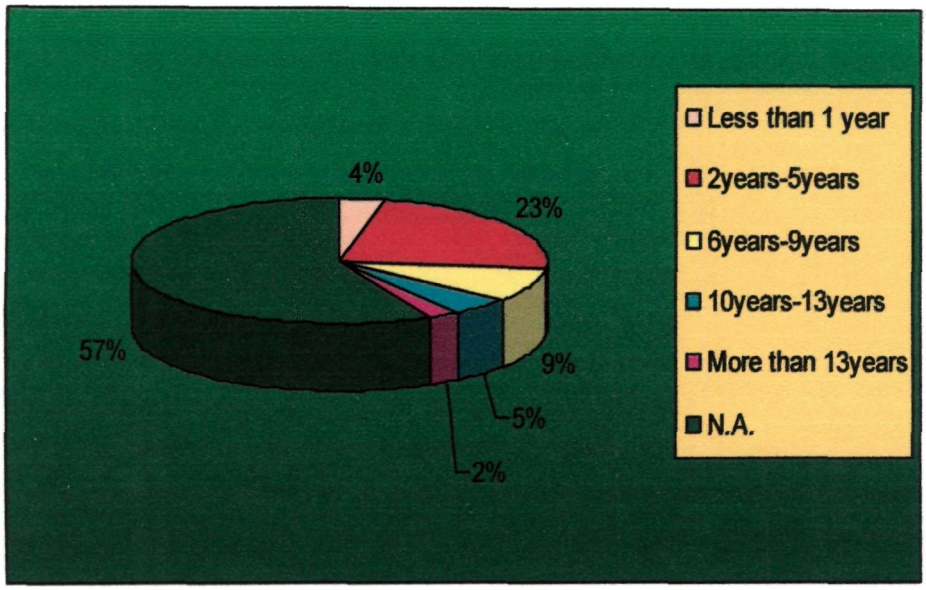
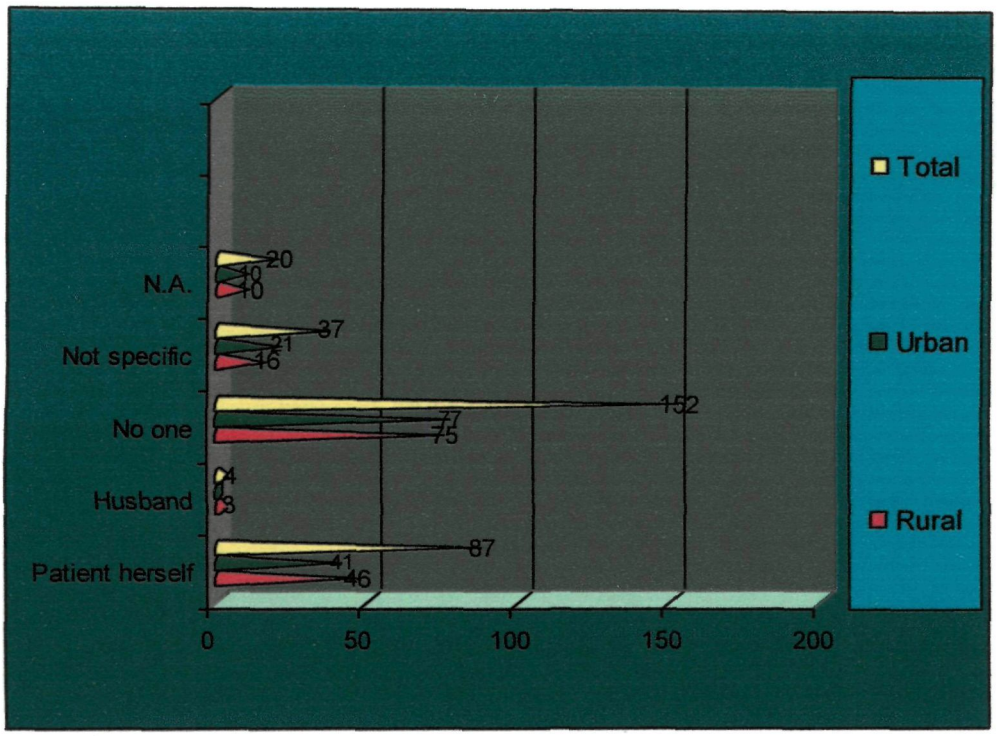


Fig.5.19 shows that, more than one fifth of the patients (23%) are using family planning device from 2 to 5 years and in almost one tenth cases (9%), they are using family planning device from 6 to 9 years. More than half cases (57%) are not applicable i.e. they are the women not using family planning device and the unmarried, widowed and separated women.

In rural and urban both the areas, more than one fifth of the patients (23%) are using family planning device from 2 to 5 years and less than one tenth (8.7%) are using family planning device from 6 to 9 years.

Fig.5.20: User of family planning device



From fig.5.20, we find that in more than half of the cases (50.7%) no one uses the family planning device, in more than one fourth cases (29%) patient herself uses the family planning device and in more than one tenth cases (12.3%), it is not specific.

In the rural area, in half of the cases (50%) no one uses the family planning device, in less than one third of the cases (30.7%), patient herself uses the family planning device. In the urban area, in more than half of the cases (51.3%), no one uses the family planning device, in more than of fourth of the cases (27.3%) patient herself uses the family planning device.

Table-5.8: Any problem in using family planning method

Problem in using family planning method	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Yes	18(6%) 12%	26(8.7%) 17.3%	44(14.7%)
No	47(15.7%) 31.3%	37(12.3%) 24.7%	84(28%)
Not applicable	85(28.3%) 56.7%	87(29%) 58%	172(57.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

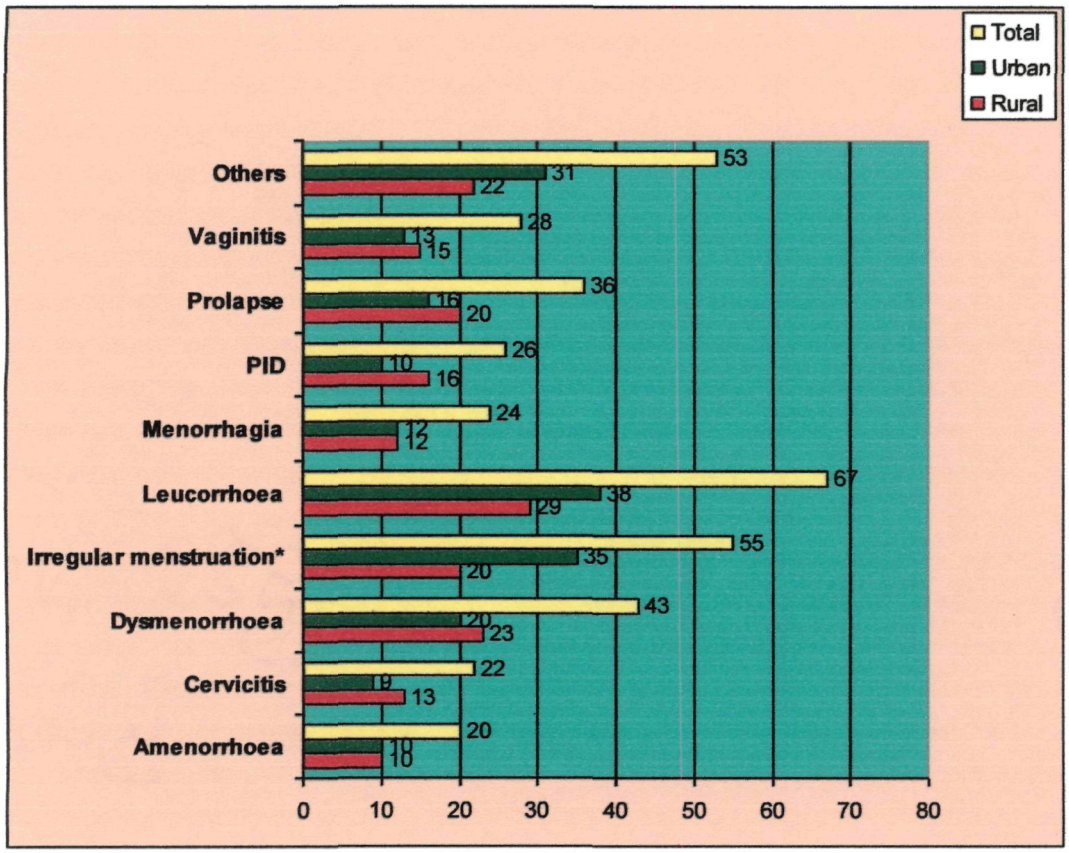
Table-5.8 shows that more than one forth of the patients (28%) do not have any problem in using the family planning device and more than one tenth (14.7%) face problem in using the family planning device. More than half of the cases (57.3%) are not applicable i.e. they are the women not using family planning device and the unmarried, widowed and separated women.

In the rural area, less than one third of the patients (31.3%) do not have any problem in using the family planning device and more than one tenth of the respondents (12%) face problem in using the family planning device. In the urban area, almost one fourth of the patients (24.7%) do not have any problem in using the family planning device and less than one fifth (17.3%) face problem in using the family planning device. This shows urban women are facing more problem in using family planning device as compared to their counter part in the rural area.

Disease related history

The sample population is the patients suffering from one or more gynaecological diseases. Various associated factors with the disease are mentioned here such as types of diseases, occurrence history, diagnosis of the disease, recognition by the family members, and restriction of work done by the diseases. Reason for the diseases according to the doctors is also mentioned wherever possible. To assess the perception of the patients and their family members they are also separately asked about the reason for their diseases.

Fig.5.21: Name of the diseases



(* Irregular menstruation is not a disease, it is a gynaecological problem though mentioned with the other diseases. Here the patients are grouped diseases wise. A single patient is taken more than one time if the patient has multiple diseases.)

The prevalence of the major gynaecological diseases under the study over the sample population is shown in the above figure. This shows leucorrhoea is found in more than one fifth of the respondents (22.3%) and is the most commonly prevailing

diseases among the sample. Less than one fifth of the respondents (18.3%) suffer from irregular menstruation. Though irregular menstruation is not a disease but it is recorded with the other gynaecological diseases as a major gynaecological complain. If we arrange the diseases in descending order like - leucorrhoea (22.3%), irregular menstruation (18.3%), dysmenorrhoea (13.3%), prolapse (12%), vaginitis (9.3%), PID (8.7%), menorrhagia (8%), cervicitis (7.3%), amenorrhoea (6.7%) etc. are the prominent diseases.

In the rural area also, leucorrhoea is the most commonly prevailing disease among the respondents. Almost one fifth of the respondents (19.3%) are suffering from leucorrhoea. Dysmenorrhoea is the second common disease which is found among 15.3 percent of the respondents. If we arrange the diseases in descending order like - leucorrhoea (19.3%), dysmenorrhoea (15.3%), irregular menstruation (13.3%), prolapse (13.3%), PID (10.7%), vaginitis (10%), cervicitis (8.7%), menorrhagia (8%) amenorrhoea (6.7%) etc. are the prominent diseases.

In the urban area also, leucorrhoea is the most common complain among the respondents. More than one fourth of the respondents (25.3%) are suffering from leucorrhoea. More than one fifth of the respondents (23.3%) complain about irregular menstruation. If we arrange the diseases in descending order like - leucorrhoea (25.3%), irregular menstruation (23.3%), dysmenorrhoea (13.3%), prolapse (10.7%), vaginitis (8.7%), menorrhagia (8%), amenorrhoea (6.7%), PID (6.7%), cervicitis (6%) etc. are the prominent diseases.

The diseases amenorrhoea and menorrhagia are found equally present in both the rural and urban patients among the sample. Vaginitis, cervicitis, pelvic inflammatory disease (PID) and prolapse patients are found more in the rural area and patients having leucorrhoea and irregular menstruation are found more in the urban area.

Fig.5.9: Kind of diseases

Kind of diseases	***Rural patients***	***Urban patients***	***Frequency***
Single kind of disease	107(35.7%) 71.3%	100(33.3%) 66.7%	207(69%)
Multiple kind of diseases	43(14.3%) 28.7%	50(16.7%) 33.3%	93(31%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

In more than two third of the sample (69%), the patients suffer from a single kind of a disease and in less than one third of the sample (31%), the patients suffer from multiple kind of diseases.

In the rural area, in more than seven tenth of the sample (71.3%), the patients suffer from a single kind of a disease and in more than three tenth of the sample (31%), the patients suffer from multiple kind of diseases. In the urban area, in exactly two third of the sample (66.7%), the patients suffer from a single kind of a disease and in one third of the sample (33.3%), the patients suffer from multiple kind of diseases. Number of patients with multiple kinds of diseases is more in the urban area as compared to the rural area.

Fig.5.22: Reasons for the disease (according to the patient)

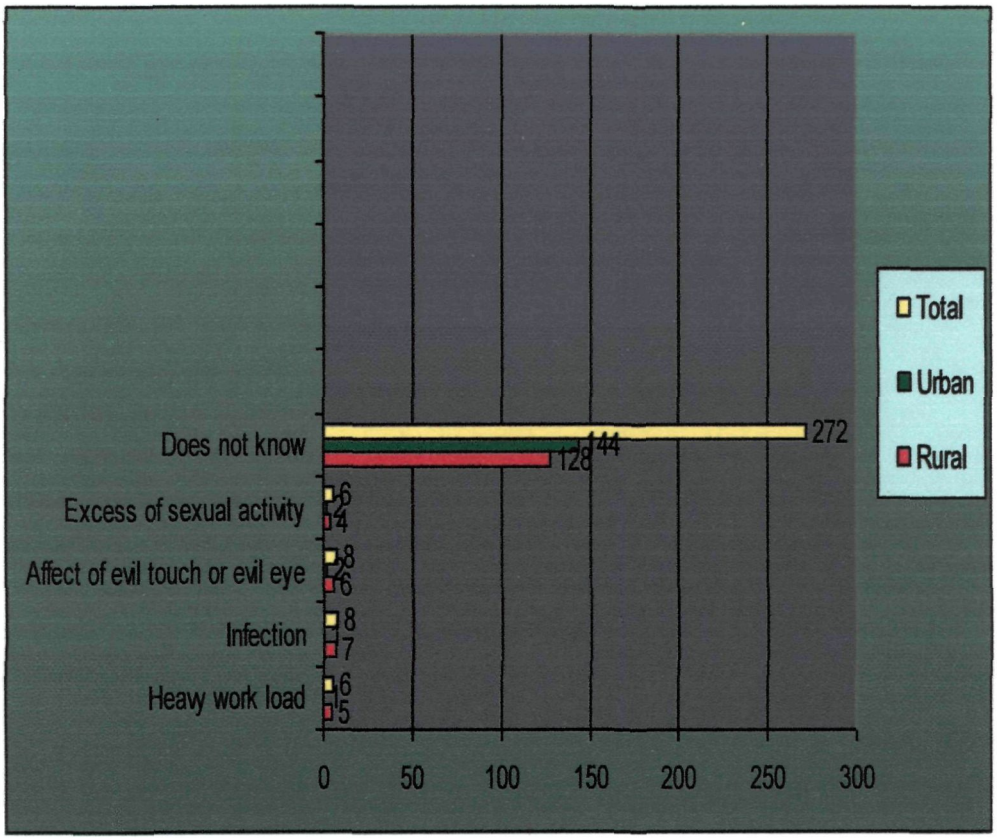


Fig.5.22 reveals that more than nine tenth of the patients (90.7%) do not know the reason for their disease and 2.7 percent think that their disease is due to infection. Though percentage is less still there are respondents who think that cause behind their disease is evil touch or evil eye.

In the rural area, more than four fifth of the patients (85.3%) do not know the reason for their disease and in the urban area, more than nine tenth of the respondents (96%) do not know the reason for their disease. There is a noticeable fact that no patient from the urban area thinks that cause behind their disease is evil touch or evil eye.

Fig.5.23: Reasons for the disease (according to the family member)

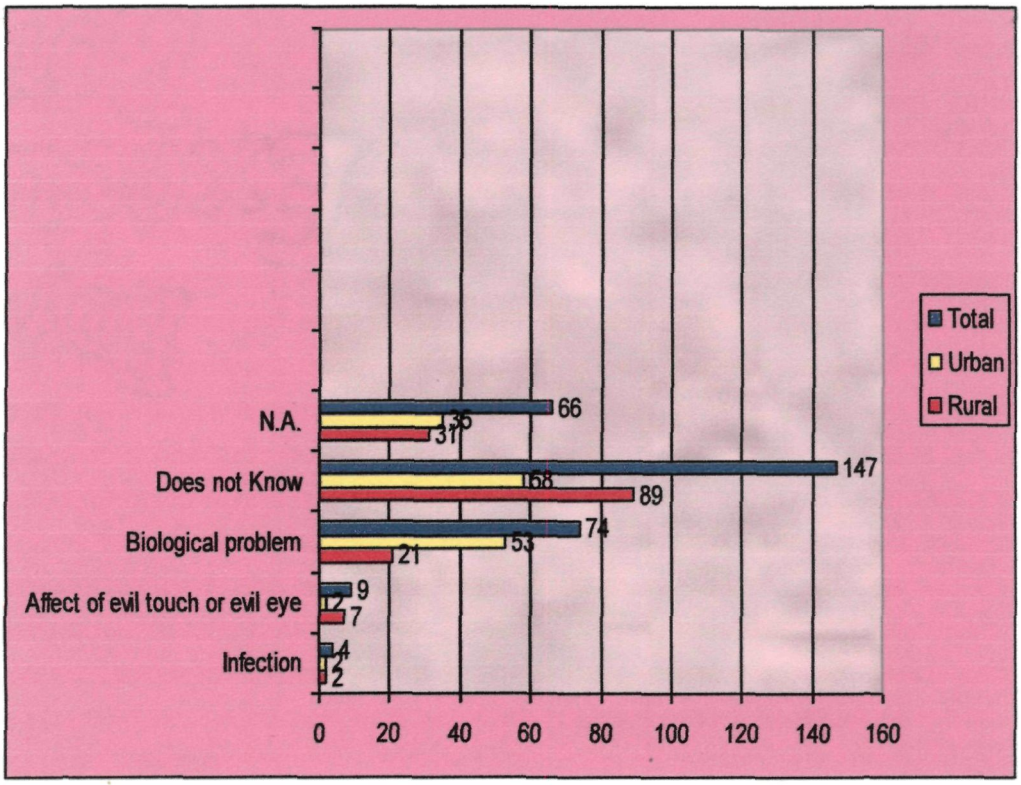


Fig.5.23 shows that almost half of the family members (49%) do not know the reason for the patient's disease and almost one fourth (24.7%) think that the disease is due to biological problem of the patient. More than one fifth of the respondents (22%) are not applicable, i.e. they do not know at all about the patient's disease.

In the rural area, almost three fifth of family members (59.3%) do not know the reason for the patient's disease and more than one fifth of the family members (20.7%) do not even know that the patient is suffering from gynaecological problem. In the urban area, less than two fifth of the family members (38.7%) do not know the reason for the patient's disease and more than one third of the family members (35.3%) think that the patient has some biological problem.

Table-5.10: Reasons for the disease (according to the doctor)

Reasons for the disease (according to the doctor)	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Nutritional deficiency	11(3.7%) 7.3%	3(1%) 2%	14(4.7%)
Heavy work load	7(2.3%) 4.7%	1(0.3%) 0.7%	8(2.7%)
Infection	43(14.3%) 28.7%	43(14.3%) 28.7%	86(28.7%)
Unhygienic condition	2(0.7%) 1.3%	1(0.3%) 0.7%	3(1%)
Unprotected sex/Malpractices	6(2%) 4%	0	6(2%)
Early pregnancy	1(0.3%) 0.7%	4(1.3%) 2.7%	5(1.7%)
Abortion by unskilled person	4(1.3%) 2.7%	0	4(1.3%)
Functional disorder	3(1%) 2%	2(0.7%) 1.3%	5(1.7%)
Does not reply	4(1.3%) 2.7%	1(0.3%) 0.7%	5(1.7%)
Others	2(0.7%) 1.3%	5(1.7%) 3.3%	7(2.3%)
Multiple causes	58(19.3%) 38.7%	75(25%) 50%	133(44.3%)
Not sure	9(3%) 6%	15(5%) 10%	24(8%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.10 shows that as per the doctor in more than two fifth of the cases (44.3%), there are multiple causes. The multiple causes include infection, nutritional

deficiency, unhygienic condition etc. In more than one fourth of the cases (28.7%), diseases are solely due to infection.

In the rural area, in more than one third of the cases (38.7%) there are multiple causes and in a little less than one tenth of the cases (7.3%) the cause is nutritional deficiency. In the urban area, in half of the cases (50%), there are multiple causes and more than one fourth of the cases (28.7%), diseases are solely due to infection.

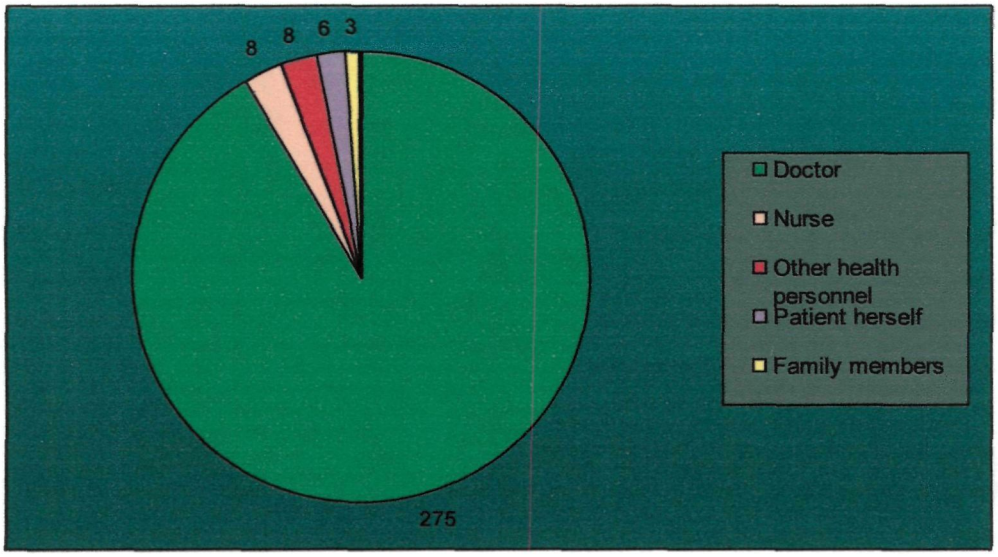
Table-5.11: Patient's realization about the disease

Patient's realization about the disease	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Within 15 days	11(3.7%) 7.3%	9(3%) 6%	20(6.7%)
15 days – 1 month	3(1%) 2%	4(1.3%) 2.7%	7(2.3%)
2 months – 5 months	103(34.3%) 68.7%	87(29%) 58%	190(63.3%)
6 months – 1 year	8(2.7%) 5.3%	4(1.3%) 2.7%	12(4%)
More than 1 year	24(8%) 16%	46(15.3%) 30.7%	70(23.3%)
Not able to tell exactly	1(0.3%) 0.7%	0	1(0.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is very much clear from the table-5.11 that in more than three fifth of the cases (63.3%) the patient came to know about the disease within 2 to 5 months and in near about one fourth of the cases (23.3%) the patient came to know about the disease after 1 year. This indicates the reluctance of the patients about the health matters.

In the rural area, in more than two third of the cases (68.7%) the patient came to know about the disease within 2 to 5 months and in more than one tenth of the cases (16%) the patient came to know about the disease after 1 year. In the urban area, in more than half of the cases (58%) the patient came to know about the disease within 2 to 5 months and in more than one fourth of the cases (30.7%) the patient came to know about the disease after 1 year.

Fig.5.24: Diagnosis for the first time



From the fig.5.24 it is very much clear that in most of the cases (96%) first diagnosis is done by the doctor.

In the rural area, in majority of the cases (92.7%) first diagnosis is done by the doctor. In the urban area, in almost all of the cases (99.3%) first diagnosis is done by the doctor.

Table-5.12: Restriction of work due to the disease

Restriction of work due to the disease	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Restriction of movement	8(2.7%) 5.3%	5(1.7%) 3.3%	13(4.3%)
Restriction of house hold work	38(12.7%) 25.3%	15(5%) 10%	53(17.7%)
Restriction of job/outside work	4(1.3%) 2.7%	1(0.3%) 0.7%	5(1.7%)
Restriction of movement, restriction of job/outside work	0	2(0.7%) 1.3%	2(0.7%)
Restriction of house hold work, restriction of job/outside work	1(0.3%) 0.7%	1(0.3%) 0.7%	2(0.7%)
Restriction of movement, restriction of house hold work, restriction of job/outside work	0	1(0.3%) 0.7%	1(0.3%)
No restriction	99(33%) 66%	125(41.7%) 83.3%	224(74.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.12 shows that in almost three fourth of the cases the patients (74.7%) do not face any restriction in their work due to the disease and in a little less than one fifth of the cases (17.7%) they face restriction in the household work. One thing should be added here that majority of the patients under the study do not restrict their work until the suffering is severe.

In the rural area, in almost two third of the cases (66%) the patients do not face any restriction in their work due to the disease and in more than one fourth of the cases (25.3%) they face restriction in the household work. In the urban area, in more than four fifth of the cases the patients (83.3%) do not face any restriction in their

work due to the disease and in one tenth of the cases (10%) they face restriction in the household work.

Fig.5.25: Time when the family members came to know about the disease

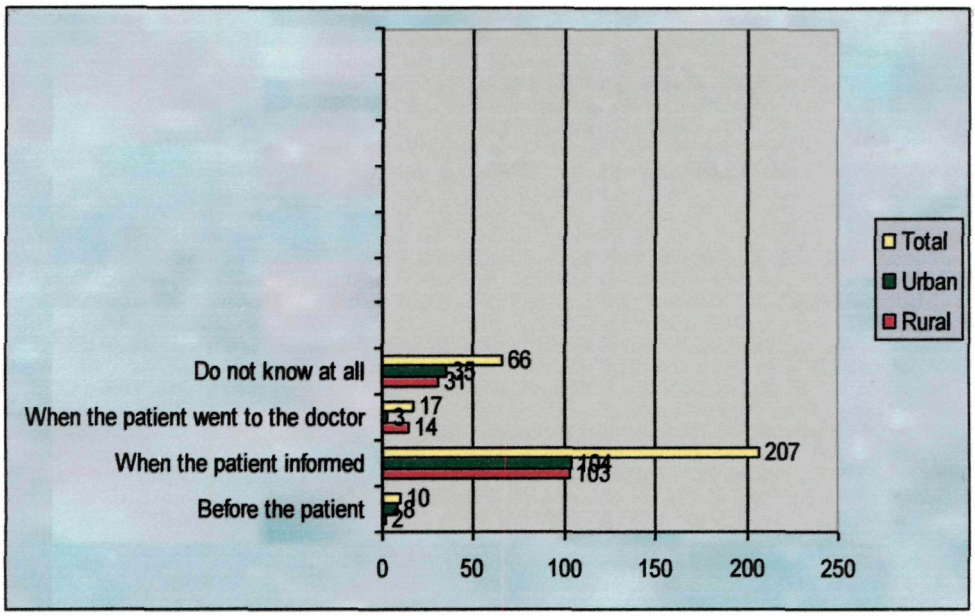


Fig.5.25 reveals that in more than two third of the cases (69%), the family members came to know only when the patient informed them about the disease and in more than one fifth of the cases (22%) the family members do not at all know about the disease of the patient. This reflex the reluctance of the family members about health matters and lack of caring attitude towards the patient.

In the rural area, in more than two third of the cases (68.7%), the family members came to know only when the patient informed them about the disease and in more than one fifth of the cases (20.7%) the family members do not at all know about the disease of the patient. In the urban area, in more than two third of the cases (69.3%), the family members came to know only when the patient informed them about the disease and in more than one fifth of the cases (23.3%) the family members do not at all know about the disease of the patient.

Table-5.13: Family members' consideration of the problem as a disease

Family members' consideration of the problem as a disease	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Consider	103(34.3%) 68.7%	111(37%) 74%	214(71.3%)
Do not consider	16(5.3%) 10.7%	4(1.3%) 2.7%	20(6.7%)
Not applicable	31(10.3%) 20.7%	35(11.7%) 23.3%	66(22%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is clear from table-5.13 in more than two third of the cases (71.3%) the family members of the respondents consider the gynaecological problems of the respondents as a disease and in more than one fifth of the cases (22%) the family members do not even know about the disease of the respondents.

In the rural area, in more than two third of the cases (68.7%) the family members of the respondents consider the gynaecological problems of the respondents as a disease and in more than one fifth of the cases (20.7%), the family member do not even know about the disease of the respondents. In more than one tenth of the cases (10.7%), family members do not consider the problem of the respondent as a disease. In the urban area, in almost three fourth of the cases (74%) the family members of the respondents consider the gynaecological problems of the respondents as a disease and in more than one fifth of the cases (23.3%) the family member do not even know about the disease of the respondents. In 2.7 percent cases, family members do not consider the problem of the respondent as a disease. Acceptance of the patient's problem as a disease is relatively more in the urban area as compared to the rural area.

Table-5.14: Reason behind not accepting the disease

Reason behind not accepting the disease	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Ignorance	11(3.7%) 7.3%	4(1.3%) 2.7%	15(5%)
Lack of caring attitude towards the patient	5(1.7%) 3.3%	0	5(1.7%)
Not applicable	134(44.7%) 89.3%	146(48.7%) 97.3%	280(93.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.14 illustrates the causes behind the non acceptance of the problem of the patient as a disease by their family members. It shows 5 percent of them are ignorant for which they do not consider the problems of the patient as a disease and 1.7 percent do not have caring attitude towards the patient. Whereas, 93.3 percent cases are not applicable because either the family members consider the patient's problem as a disease or they do not even know about the disease.

In the rural area, in 7.3 percent of the cases family members are ignorant and in 3.3 percent cases they do not have caring attitude towards the patient for which the family members do not consider the patient's problem as a disease. In the urban area, in 2.7 percent of the cases family members are ignorant for which the family members do not consider the patient's problem as a disease but there is no such family where the family members do not have caring attitude towards the patient. As per this observation a view can be shaped that in rural areas there are families where family members lack caring attitude towards female patients.

Abortion related history

In order to find out the disease consequences, the abortion related history of the patients is also collected. Details regarding the abortion history such as age of the respondent and the fetus at the time of abortion, procedure used for abortion, patient's consent at abortion, cause of abortion etc. are collected.

Fig.5.26: Any incidence of abortion in patient's life

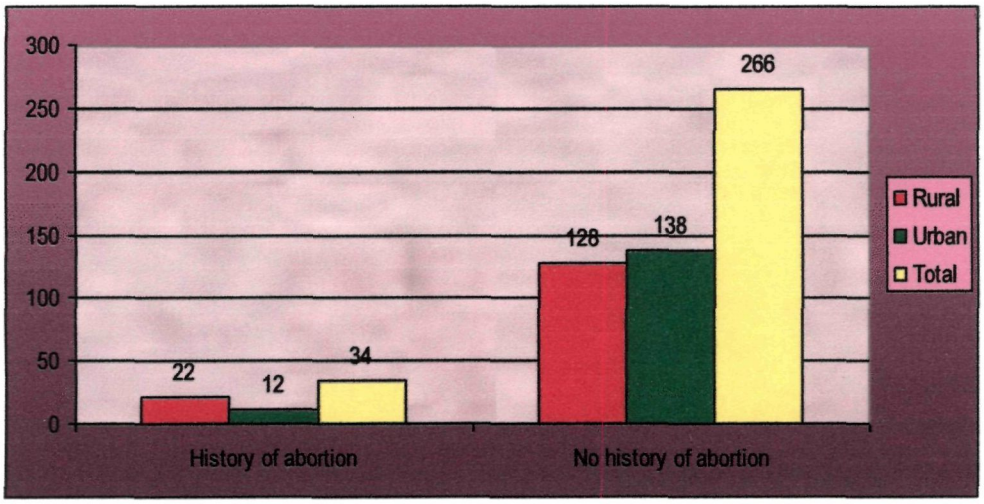


Fig.5.26 reveals that more than one tenth of the respondents (11.3%) have faced the incidence of abortion in their life whatever may be the cause.

In the rural area, more than one tenth of the respondents (14.7%) have faced the incidence of abortion in their life and in the urban area, less than one tenth of the respondents (8%) have faced the incidence of abortion in their life. The incidence of abortion is relatively higher in the rural area as compared to the urban area.

Table-5.15: Age of the patient at the time of abortion

Age of the patient at the time of abortion	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Below 15 years	2(0.7%) 1.3%	0	2(0.7%)
15 years – 19 years	7(2.3%) 4.7%	3(1%) 2%	10(3.3%)
20 years – 24 years	7(2.3%) 4.7%	3(1%) 2%	10(3.3%)
25 years – 29 years	6(2%) 4%	6(2%) 4%	12(4%)
Not applicable	128(42.7%) 85.3%	138(46%) 92%	266(88.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.15 we see that 4 percent of the abortions are between 25 to 29 years, 3.3 percent are in between 20 to 24 years and again 3.3 percent are in between 15 to 19 years. So, we can say 6.6 percent of the abortions are in between 15 to 24 years. More surprisingly, there are 0.7 percent cases where the age of the mother at the time of abortion was less than 15 years.

In the rural area, 4.7 percent cases are in between 15 to 19 years and again 4.7 percent cases are in between 20 to 24 years. Together we can say 9.4 percent cases are in between 15 to 24 years. 4 percent abortion cases are in between 25 to 29 years and 1.3 percent is below 15 years. In the urban area, 4 percent cases are in between 25 to 29 years and 2 percent cases are in between 20 to 24 years and again 2 percent cases are in between 15 to 19 years. Numbers of abortion cases are more in the rural area as compared to the urban area.

Fig.5.27: Duration of conception at the time of abortion

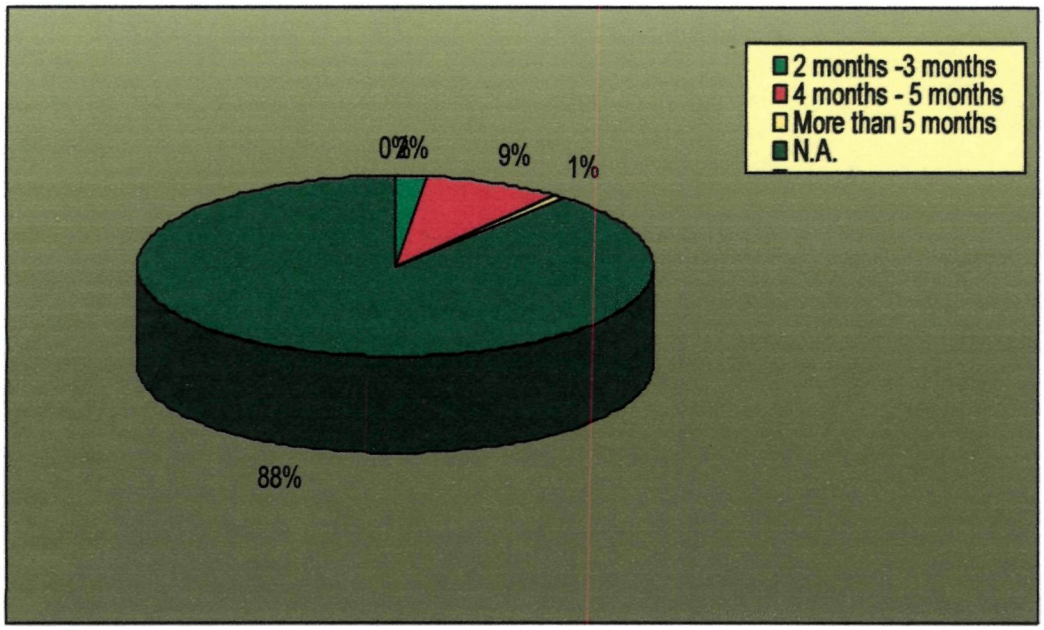


Fig.5.27 shows that in 8.7 percent of the cases the age of the fetus was 4 to 5 months, in 2 percent cases it was 2 to 3 months and in 0.7 percent of the cases the fetus age was more than 5 months which is not generally preferred.

In the rural area, in 10 percent of the cases the age of the fetus was 4 to 5 months, in 3.3 percent cases it was 2 to 3 months and in 1.3 percent of the cases the fetus age was more than 5 months which is not quite risky. In the urban area, in 7.3 percent of the cases the age of the fetus was 4 to 5 months and in 0.7 percent cases it was 2 to 3 months. There is no such incidence in the urban area where the age of the fetus is more than 5 months at the time of abortion.

Table-5.16: Reason for abortion

Reason for abortion	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Illegitimacy	2(0.7%) 1.3%	0	2(0.7%)
Unwanted	9(3%) **6%**	5(1.7%) 3.3%	14(4.7%)
Failure of contraception	2(0.7%) 1.3%	1(0.3%) 0.7%	3(1%)
Accident	9(3%) 6%	5(1.7%) 3.3%	14(4.7%)
Medical cause	0	1(0.3%) 0.7%	1(0.3%)
Not applicable	128(42.7%) 85.3%	138(46%) 92%	266(88.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.16 we see it clearly in 4.7 percent cases abortions are due to accident and equally in 4.7 percent cases abortions are done only because the parents did not want the baby and in 1 percent case the cause is failure of contraception.

In the rural area, in 6 percent cases abortions are due to accident and equally in 6 percent cases abortions are done only because the parents did not want the baby. There are two causes which have been ranked in the second position. These are illegitimacy and accident. In the urban area, in 3.3 percent cases abortions are due to accident and equally in 3.3 percent cases abortions are done only because the parents did not want the baby. In the urban area there is no such case where the reason behind the abortion is illegitimacy.

Fig.5.28: Patient's consent was taken or not before abortion

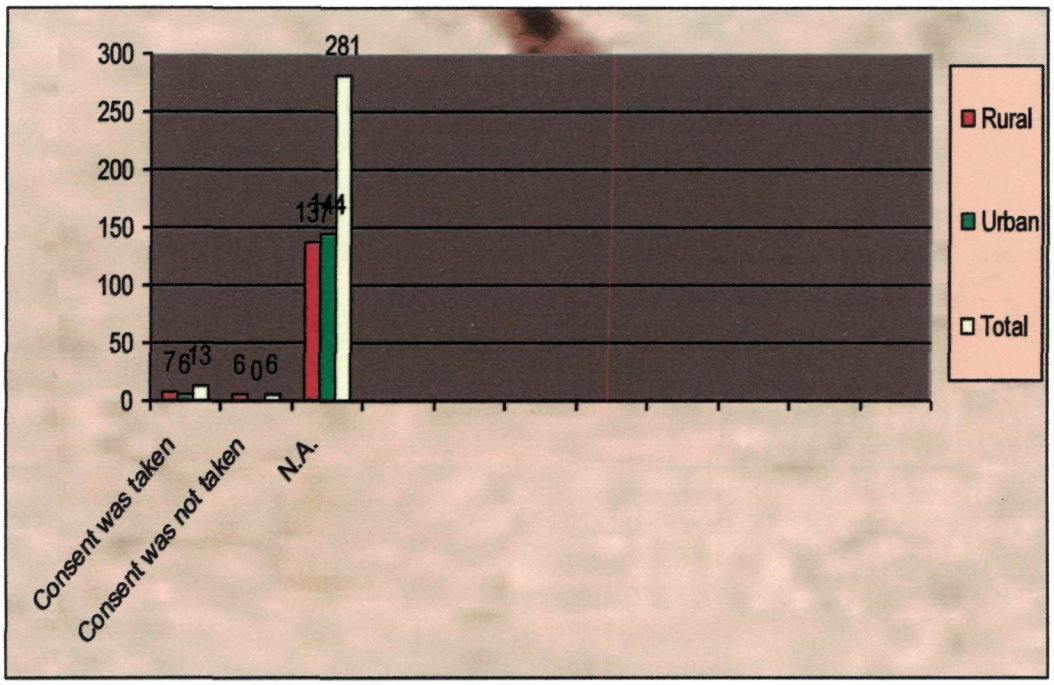


Fig.5.28 shows that in 4.3 percent cases patient's consent was taken before the abortion and in 2 percent cases patient's consent was not taken before the abortion. This reveals the fact that there are still cases though few where abortions are done against a woman's will.

In the rural area, in 4.7 percent cases patient's consent was taken before the abortion and in 4 percent cases patient's consent was not taken before the abortion. But in the urban area there is no such case where abortion is done against the patient's will. From this we may come to a conclusion that position of woman is more horrific in the rural area.

Table-5.17: Procedure used for abortion

Procedure used for abortion	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Pills	6(2%) 4%	2(0.7%) 1.3%	8(2.7%)
Surgical abortions	1(0.3%) 0.7%	1(0.3%) 0.7%	2(0.7%)
Vacuum aspiration	0	1(0.3%) 0.7%	1(0.3%)
Abortion by quack	6(2%) 4%	2(0.7%) 1.3%	8(2.7%)
Not applicable	137(45.7%) 91.3%	144(48%) 96%	281(93.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.17, we see that in 2.7 percent cases abortions are done by using oral pills and equally that in 2.7 percent cases abortions are done by quacks. This is a shocking fact that still abortion by quacks are preferred by the people which is very much dangerous and the consequence of which may lead to various infectious diseases.

In the rural area, in 4 percent cases abortions are done by using oral pills and equally that in 4 percent cases abortions are done by quacks. In the urban area, in 1.3 percent cases abortions are done by using oral pills and equally that in 1.3 percent cases abortions are done by quacks. Abortion by quacks are equally popular in rural as well as in the urban area. Sometimes in case of illegitimacy, to maintain confidentiality people go to quacks.

Health seeking behaviour

Every individual wants to be healthy and be free from diseases. To lead a healthy and disease free life people sometimes have to seek help from others. This may be health centre, private practitioner, traditional healers etc. On the basis of the perception and personal likings, individual select the system of medicines. All the information related to the patients health seeking behaviour are collected such as system of medicine preferred, system of medicine used, vaccination status, treatment follow up pattern about the current disease, frequency of visit to the hospital, distance from the hospital, preference for the child delivery place etc.

Fig.5.29: Whether the patient has taken vaccination or not

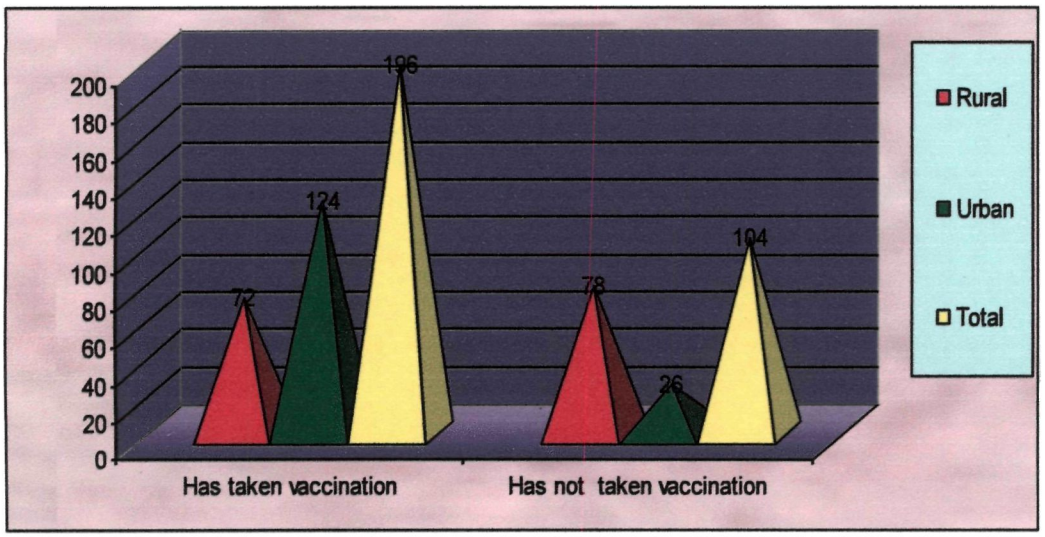


Fig.5.29 clearly depicts us that less than two third of the patients (65.3%) has taken vaccination and more than one third of the patients (34.7%) has not taken vaccination. Though majority of the patient has taken vaccination still a large number are lagging behind. The causes behind this will be mentioned in the next table.

In the rural area, less than half i.e.48 percent has taken vaccination and more than half, i.e., 52 percent has not taken. This means majority of the people in rural area are not vaccinated. In the urban area, more than four fifth of the respondents, i.e., 82.7 percent has taken vaccination and less than one fifth, i.e., 17.3 percent has not

taken. From this we can easily assume that in rural area people are less health conscious than urban area. High statistical significance is found among the place of residence and the vaccination pattern (Pearson Chi Square value is 39.796 at $p<0.0001$ level).

Table-5.18: Reason for not taking vaccination

Reason for not taking vaccination	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Ignorance	11(3.6%) 7.3%	2(0.7%) 1.3%	13(4.3%)
Reluctance	58(19.3%) 38.7%	22(7.3%) 14.7%	80(26.7%)
Others	1(0.3%) 0.7%	0	1(0.3%)
Ignorance & reluctance both	2(0.7%) 1.3%	0	2(0.7%)
Ignorance & stigma both	4(1.3%) 2.7%	2(0.7%) 1.3%	6(2%)
Ignorance, reluctance & stigma	2(0.7%) 1.3%	0	2(0.7%)
Not applicable	72(24%) 48%	124(41.3%) 82.7%	196(65.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.18 analyses the causes why all the respondents are not immunized properly. More than one fourth of the respondents (26.7%) did not take vaccination because of their reluctance towards health matters and 4.3 percent did not take vaccination because of their ignorance about health matters.

In the rural area, more than one third of the respondents (38.7%) did not take vaccination because of their reluctance towards health matters and 7.3 percent did not take vaccination because of their ignorance about health matters. In the urban area, more than one tenth of the respondents (14.7%) did not take vaccination because of their reluctance towards health matters and 1.3 percent did not take vaccination because of their ignorance about health matters.

Table-5.19: Place preferred for delivery of a child

Place preferred for delivery of a child	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Home	26(8.6%) 17.3%	11(3.7%) 7.3%	37(12.3%)
Govt. hospital	48(16%) 32%	82(27.3%) 54.7%	130(43.3%)
Private nursing home	5(1.7%) 3.3%	13(4.3%) 8.7%	18(6%)
Nothing specific	71(23.7%) 47.3%	44(14.7%) 29.3%	115(38.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.19 we get to know that more than two fifth of the patients (43.3%) prefer govt. hospital for delivery of a child and more than one third of the patients (38.3%) do not have any specific choice. Respondents having no choice reflect their reluctance.

In the rural area, less than half of the patients (47.3%) do not have any specific choice and near about one third of the patients (32%) prefer govt. hospital for delivery of a child. In the urban area, more than half of the patients (54.7%) prefer govt. hospital for delivery of a child and more than one fourth of the patients (29.3%) do

not have any specific choice. In the rural area people are more reluctant about the health service regarding delivery of a child.

Fig.5.30: System of medicine preferred

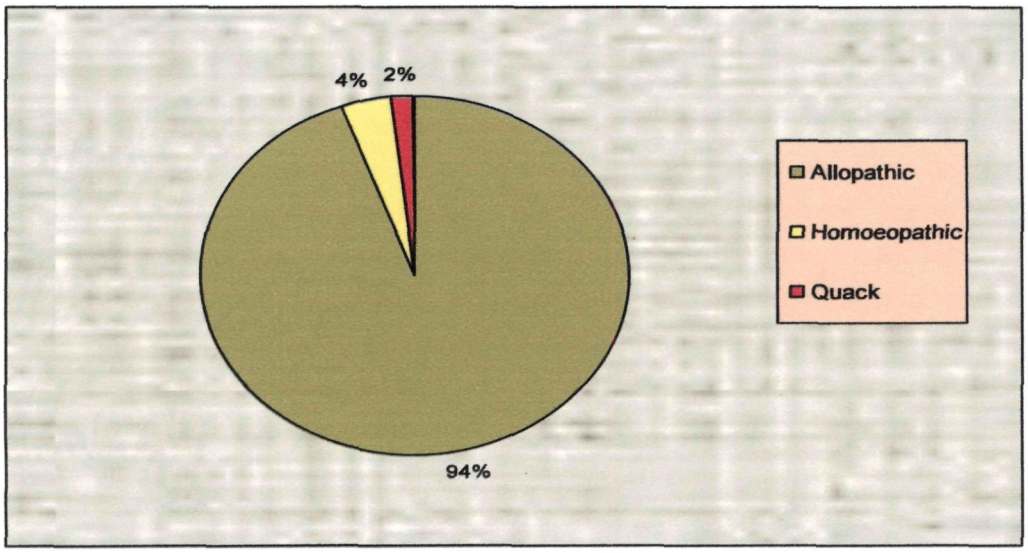


Fig.5.30 depicts that greater part of the patients (94%) prefer allopathic system of medicine.

In the rural area, most of the patients (92.7%) prefer allopathic system of medicine. In the urban area, majority of the patients (96%) prefer allopathic system of medicine.

Fig.5.31: Reason for such preference

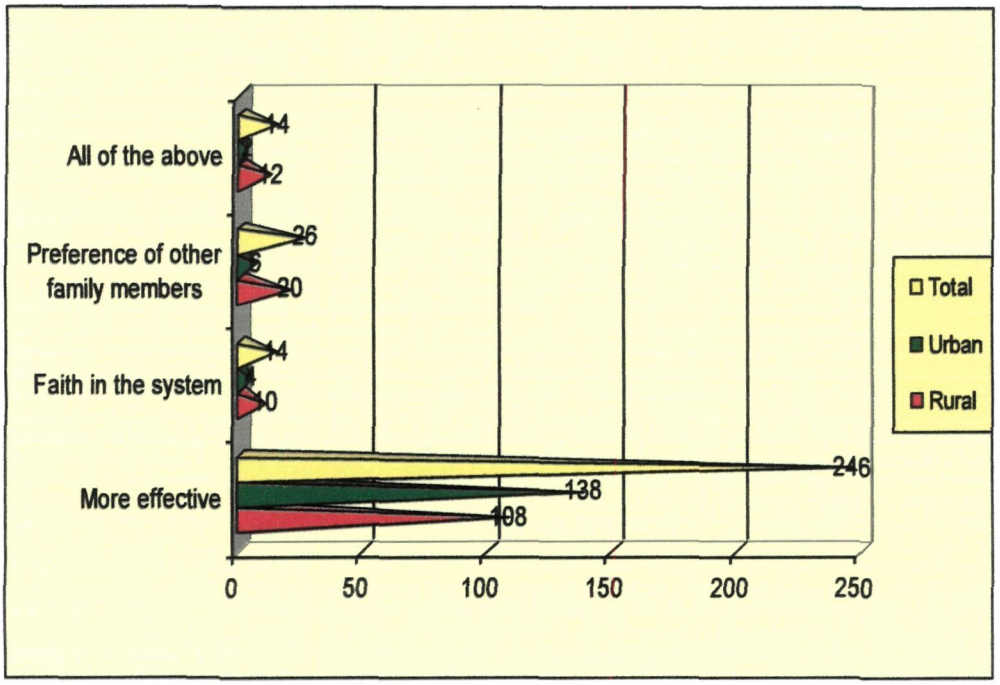


Fig.5.31 explains that more than four fifth of the respondents (82%) selected their preferred system of medicine because they think that their preferred system is more effective than the others and a little less than one tenth of the respondents (8.7%) selected their preferred system of medicine because their family members said so.

In the rural area, seven tenth of the respondents (72%) selected their preferred system of medicine because they think that their preferred system is more effective. In the urban area, a great majority of the respondents (92%) selected their preferred system of medicine because they think that their preferred system is more effective than the others.

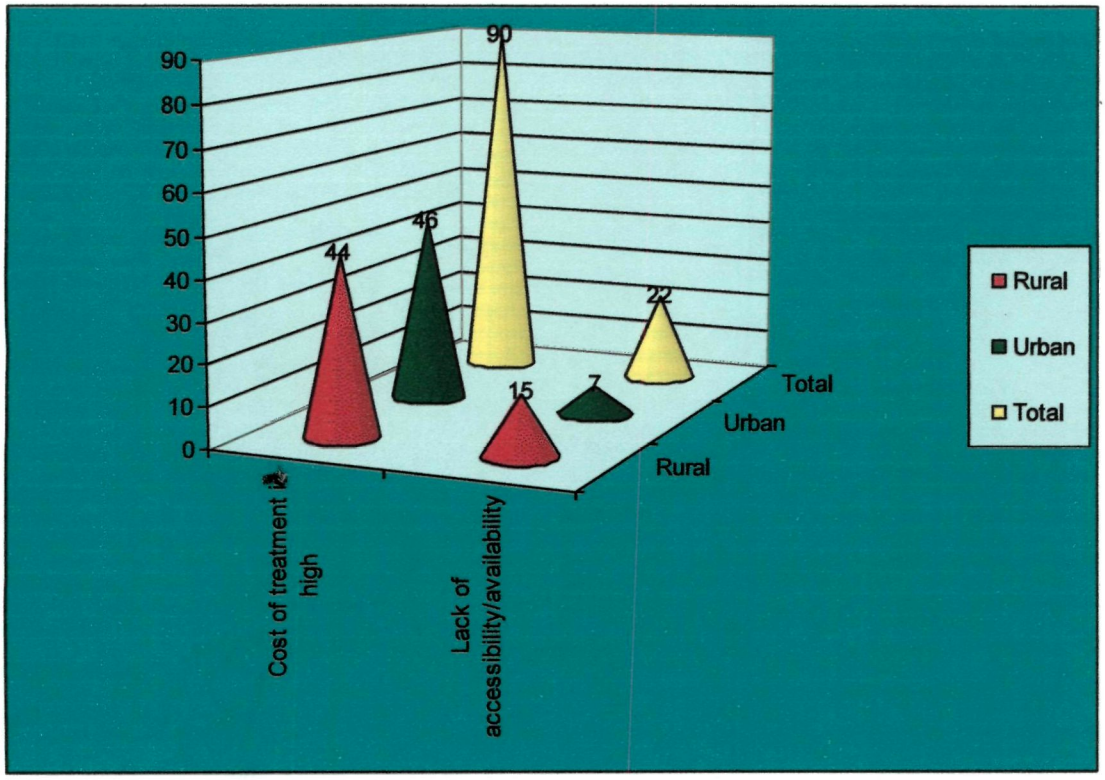
Table-5.20: System of medicine used frequently

System of medicine used frequently	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Allopathic	79(26.3%) 52.7%	95(31.7%) 63.3%	174(58%)
Homoeopathic	69(23%) 46%	53(17.7%) 35.3%	122(40.7%)
Quack	1(0.3%) 0.7%	0	1(0.3%)
Not specific	1(0.3%) 0.7%	2(0.7%) 1.3%	3(1%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.20 informs that more than half of the respondents (58%) use allopathic system frequently and more than two fifth of the patients (40.7%) use homoeopathic system frequently.

In the rural area, more than half of the respondents (52.7%) use allopathic system frequently and more than two fifth of the patients (46%) use homoeopathic system frequently. In the urban area, less than two third of the respondents (63.3%) use allopathic system frequently and more than one third (35.3%) use homoeopathic system frequently. In the urban area more number of patients are using allopathic system of medicine as compared to the rural area and in the rural area more number of patients are using homoeopathic system of medicine as compared to the rural area. Statistical significance is not much to predict the relationship between the place of residence and the system of medicine used (Pearson Chi Square value is 4.903 at p=0.179).

Fig.5.32: Reason for not using the preferred system



It is clear from fig.5.32 that the most common cause behind not using the preferred system of medicine is the treatment cost.

In the rural as well as in the urban area the most common cause behind not using the preferred system of medicine is the treatment cost.

Table-5.21: Distance from SMCH

Distance from S.M.C.H.	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Within 1 km	15(5%) 10%	0	15(5%)
1 km – 5 km	29(9.7%) 19.3%	12(4%) 8%	41(13.7%)
6 km – 10 km	10(3.3%) 6.7%	58(19.3%) 38.7%	68(22.7%)
11 km – 20 km	32(10.7%) 21.3%	67(22.3%) 44.7%	99(33%)
More than 20 km	64(21.3%) 42.7%	13(4.3%) 8.7%	77(25.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.21 shows that one third of the respondents (33%) stay at a distance of 11 to 20 kilometers from S.M.C.H. and more than one fourth (25.7%) stay at a distance of more than 20 kilometers from S.M.C.H. So we can say majority of the patients are from distant area.

In the rural area, more than two fifth of the respondents (42.7%) stay at a distance of more than 20 kilometers and more than one fifth, (21.3%) stay at a distance of 11 to 20 kilometers. So, more than three fifth of the patients (64%) are from distant area. In the urban area, more than two fifth of the respondents (44.7%) stay at a distance of 11 to 20 kilometers and more than one third (38.7%) stay at a distance of 6 to 11 kilometers.

Fig.5.33: Number of visit to the hospital

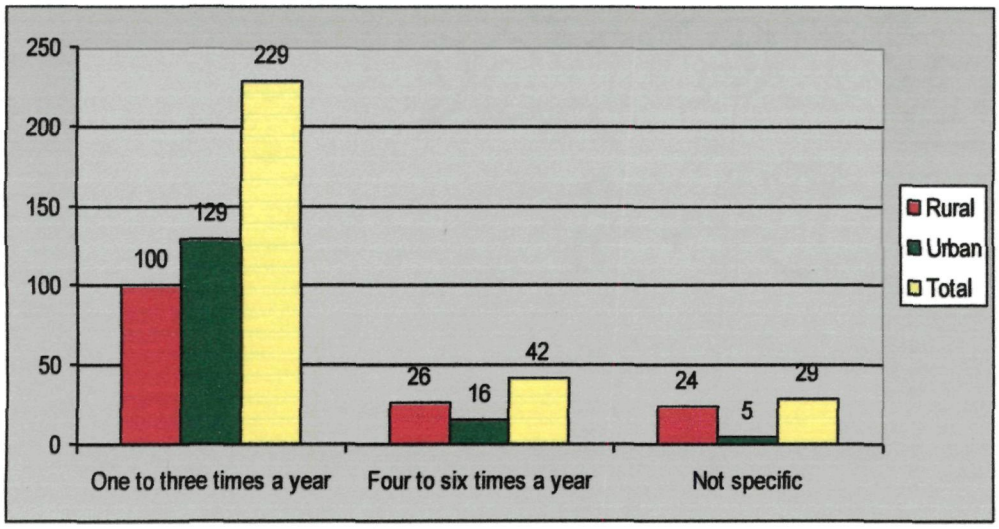


Fig.5.33 shows that more than three fourth of the patients (76.5%) visit the hospital 1 to 3 times in a year and more than one tenth (13.7%) visit 4 to 6 times in a year. This visit do not mean that the patients do not fall sick more in a year it only means that they do not come to the hospital until it gives unmanageable problem.

In the rural area, near about two third of the patients (66.7%) visit the hospital 1 to 3 times in a year and more than one tenth (16.7%) visit 4 to 6 times in a year. In the urban area, more than four fifth of the patients (86%) visit the hospital 1 to 3 times in a year and more than one tenth (10.7%) visit 4 to 6 times in a year. Statistical significance is found between the place of residence and the number of visits to the hospital in a year (Pearson Chi Square value is 19.096 at $p<0.001$ level).

Table-5.22: Type of medical treatment given

Type of medical treatment given	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Tests	1(0.3%) 0.7%	0	1(0.3%)
Medicines	84(28%) 56%	72(24%) 48%	156(52%)
Tests & medicines	53(17.7%) 35.3%	63(21%) 42%	116(38.7%)
Others	12(4%) 8%	15(5%) 10%	27(9%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.22 we see that in more than half of the cases (52%) medicines are given and in more than one third of the cases (38.7%) tests and medicines both are given.

In the rural area, in more than half of the cases (56%) medicines are given and in more than one third of the cases (35.3%) tests and medicines both are given. In the urban area, in less than half of the cases (48%) medicines are given and in more than two fifth of the cases (42%) tests and medicines both are given.

Fig.5.34: Continuation of the treatment by the patient

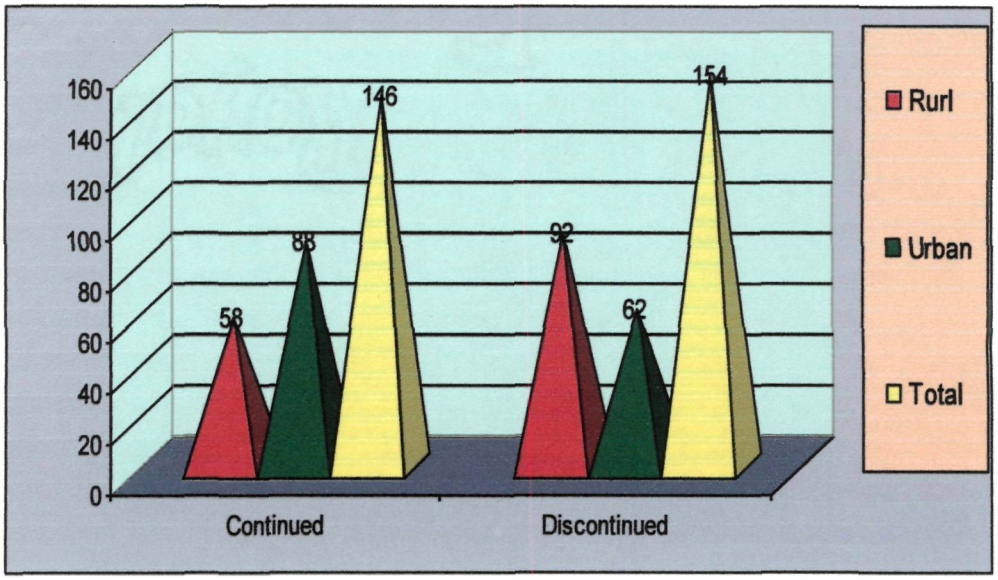


Fig.5.34 informs that more than half of the respondents (51.3%) discontinued treatment and less than half of the respondents (48.7%) continued treatment.

In the rural area, more than three fifth of the respondents (61.3%) discontinued treatment and less than two fifth of the respondents (38.7%) continued treatment. In the urban area, less than three fourth of the respondents (58.7%) continued treatment and more than two fifth of the respondents (41.3%) discontinued treatment. Discontinuation of the treatment is more in rural area as compared to the urban area. Statistical significance is found between the place of residence and the continuation of the treatment (Pearson Chi Square value is 12.009 at $p<0.001$ level). Thus we can easily assume that discontinuation of the treatment is more in rural area i.e. rural patients are more likely to discontinue treatment as compared to urban patients.

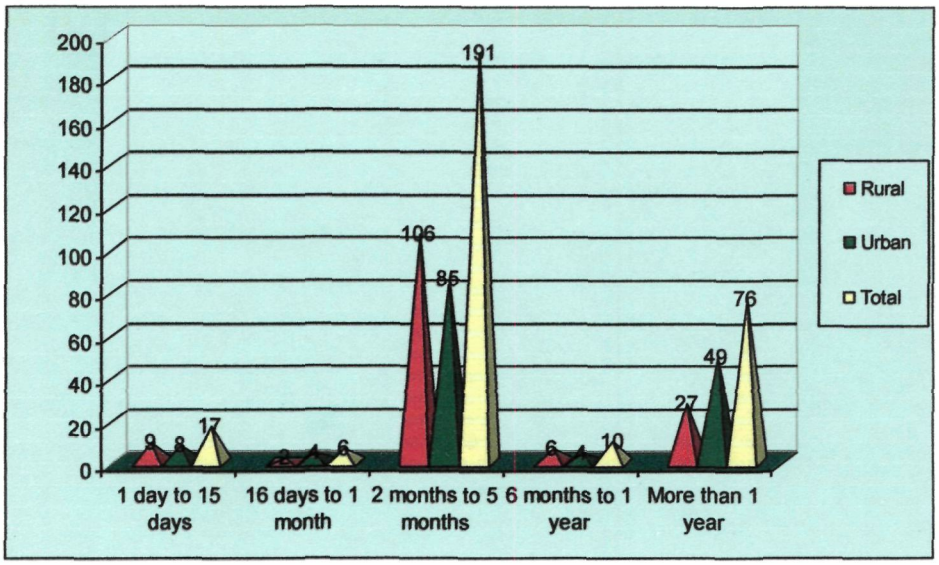
Table-5.23: Reasons for discontinuation of the treatment

Reasons for discontinuation of the treatment	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Reluctance about health matters	20(6.7%) 13.3%	10(3.3%) 6.7%	30(10%)
Cost of treatment	43(14.3%) 28.7%	28(9.3%) 18.7%	71(23.7%)
Lack of accessibility/availability	23(7.7%) 15.3%	15(5%) 10%	38(12.7%)
Fear of surgery	6(2%) 4%	9(3%) 6%	15(5%)
Not applicable	58(19.3%) 38.7%	88(29.3%) 58.7%	146(48.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is very clear from the above table cost of treatment (23.7%) is the main cause for discontinuation of the treatment and the second important cause is lack of accessibility or availability of health facilities (12.7%).

In the rural area, main cause is cost of treatment (28.7%) and the second important cause is lack of accessibility or availability of health facilities (15.3%). In the urban area, cost of treatment (18.7%) is the main cause for discontinuation of the treatment and the second important cause is lack of accessibility or availability of health facilities (10%).

Fig.5.35: Duration of illness



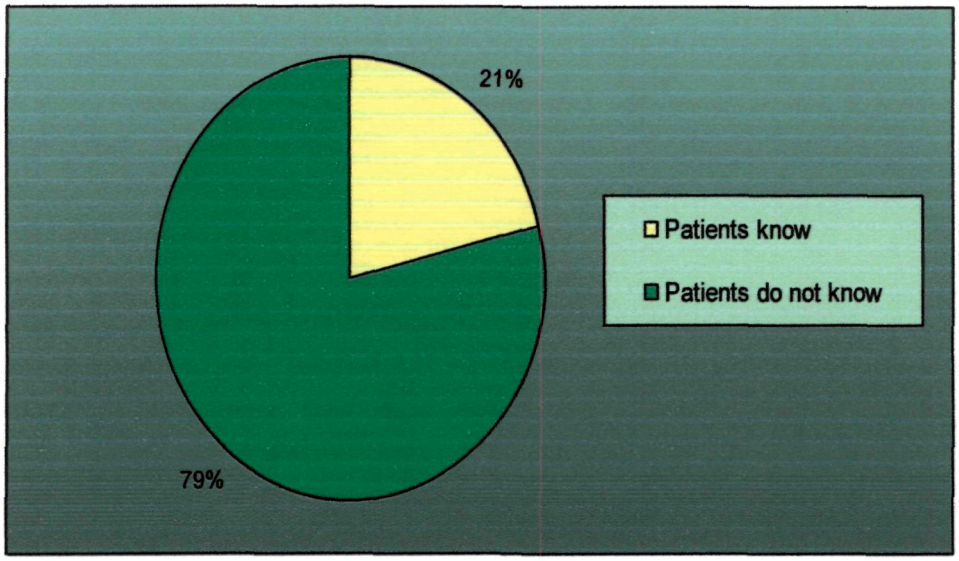
From fig.5.35 it is clear that in more than half of the cases (56.7%), the duration of suffering from disease is 2 to 3 months and in almost one fourth of the cases (25.3%), it is more than 1 year. This data is indicative of the reluctance of the patients regarding health matters which is more in case of gynaecological diseases.

In the rural area, in more than three fifth of the cases (61.3%) the duration of suffering from disease is 2 to 3 months and in less than one fifth of the cases (18%), it is more than 1 year. In the rural area, in more than half of the cases (52%) the duration of suffering from disease is 2 to 3 months and in near about one third of the cases (32.7%), it is more than 1 year.

Awareness level of the patients

Awareness level of the patients under the study are assessed to find out whether there is any consequence of low awareness level with the diseases situation. Patients were asked about various issues regarding HIV/AIDS, family planning, vaccination, water borne diseases, importance of nutrition, reason behind the child being male or female, reason behind the occurrence of any disease etc.

Fig.5.36: Knowledge of the patient about HIV/AIDS



From fig.5.36 we know that more than three fourth of the respondents (79%) have not heard anything about HIV/AIDS and less than one fourth of the patients (21.3%) have heard about HIV/AIDS. From this we can form a notion that the awareness level of the respondents about health matters is not very high.

In the rural area, more than three fourth of the respondents (79.3%) have not heard anything about HIV/AIDS and less than one fourth of the patients (20.7%) have heard about HIV/AIDS. In the urban area, more than three fourth of the respondents (78%) have not heard anything about HIV/AIDS and less than one fourth of the patients (22%) have heard about HIV/AIDS. No statistical significance is found between the place of residence and the knowledge about HIV/AIDS (Pearson Chi Square value is 0.079 at p=0.778 level). Thus it can be assessed that place of residence has no influence on the awareness of the patients about HIV/AIDS.

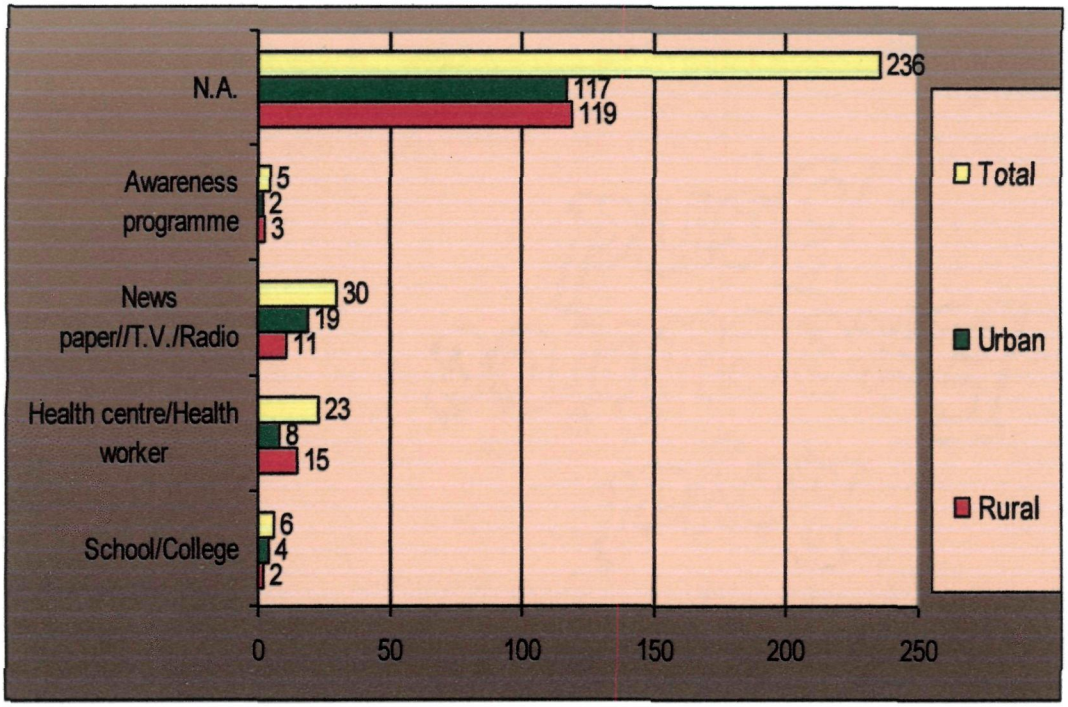
Table-5.24: Content of knowledge of the patients about HIV/AIDS

Content of knowledge of the patients about HIV/AIDS	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Only name	7(2.3%) 4.7%	8(2.7%) 5.3%	15(5%)
Causes	13(4.3%) 8.7%	22(7.3%) 14.7%	35(11.7%)
Mode of transmission	7(2.3%) 4.7%	1(0.3%) 0.7%	8(2.7%)
All of the above	4(1.3%) 2.7%	2(0.7%) 1.3%	6(2%)
Not applicable	119(39.7%) 79.3%	117(39%) 78%	236(78.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.24 shows that more than one tenth of the respondents (11.7%) know the causes of HIV/AIDS and 5 percent have heard only the name of this disease. Only hearing about a disease's name is not so useful, until a person knows the causes or mode of transmission etc. This way we can say only 16.3 percent respondents have useful information regarding HIV/AIDS out of 21.3 percent.

In the rural area, less than one tenth of the respondents (8.7%) know the causes of HIV/AIDS, 4.7 percent have heard only the name of this disease and again 4.7 percent know about the mode of transmission. In the urban area, more than one tenth of the respondents (14.7%) know the causes of HIV/AIDS and 5.3 percent have heard only the name of this disease.

Fig.5.37: Source, where from the patient came to know about HIV//AIDS



From fig.5.37 it is very clear that one tenth of the respondents (10%) heard about HIV/AIDS from newspaper/television/radio and less than one tenth of the respondents (7.7%) heard from the health centre.

In the rural area, one tenth of the respondents (10%) heard about HIV/AIDS from the health centre and less than one tenth of the patients (7.3%), from newspaper/television//radio. In the urban area, more than one tenth of the respondents (12.7%) heard about HIV/AIDS from news/television/radio and less than one tenth of the respondents (6%) heard from the health centre.

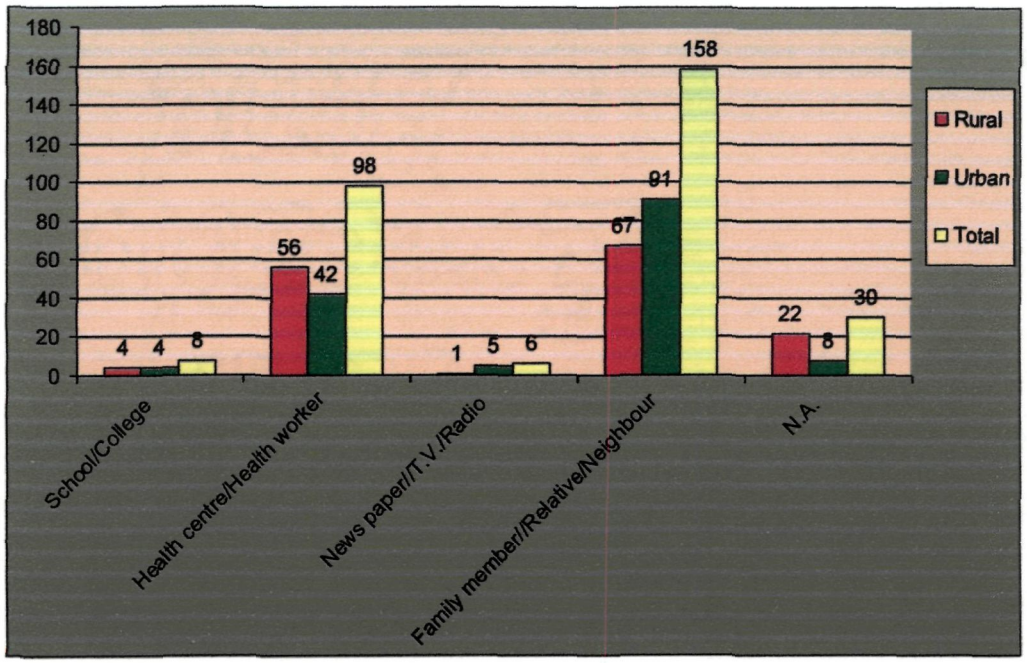
Table-5.25: Patient's knowledge about family planning

Patient's knowledge about family planning	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Know	128(42.7%) 85.3%	142(47.3%) 94.7%	270(90%)
Do not know	22(7.3%) 14.7%	8(2.7%) 5.3%	30(10%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.25 clearly portrays that nine tenth of the patients (90%) know about family planning and only one tenth of the patients (10%) do not know about family planning.

In the rural area, more than four fifth of the patients (85.3%) know about family planning and only less than one fifth (14.7%), do not know about family planning. In the urban area, majority of the patients (94.7%) know about family planning and only 5.3 percent do not know about family planning. This shows urban people are relatively more aware about family planning as compared to the rural people. Statistical significance is found between the place of residence and the awareness of the patients about family planning (Pearson Chi Square value is 7.259 at p=0.007 level).

Fig.5.38: Source, where from the patient came to know about family planning



It is clear from fig.5.38 that in more than half of the cases (52.7%) the respondents came to know about family planning from their family member, relative or neighbour and in near about one third of the cases (32.7%), the respondents came to know about family planning from the health centre.

In the rural area, in more than two fifth of the cases (44.7%) the respondents came to know about family planning from their family member, relative or neighbour and in more than one third of the cases (37.3%) the respondents came to know about family planning from the health centre. In the urban area, in more than three fifth of the cases (60.7%) the respondents came to know about family planning from their family member, relative or neighbour and in more than one fourth of the cases (28%) the respondents came to know about family planning from the health centre. In the rural area number of people getting family planning information from health centre is relatively more than that of urban area; though in both the area majority gather information about family planning from relatives or family members.

Table-5.26: Whether the patient support family planning or not

Whether the patient support family planning or not	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Support	86(28.7%) 57.3%	108(36%) 72%	194(64.7%)
Do not support	42(14%) 28%	34(11.3%) 22.7%	76(25.3%)
Not applicable	22(7.3%) 14.7%	8(2.7%) 5.3%	30(10%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.26 shows that less than two third of the respondents (64.7%) support family planning and more than one fourth (25.3%) do not support family planning.

In the rural area, more than half of the respondents (57.3%) support family planning and more than one fourth (28%) do not support family planning. In the urban area, less than three fourth of the respondents (72%) support family planning and more than one fifth (22.7%) do not support family planning. Statistical significance is found between the place of residence and the support of family planning (Pearson Chi Square value is 9.870 at p=0.007 level). So we can say that urban patients are more likely to support family planning as compared to the rural patients.

Fig.5.39: Reasons for supporting family planning

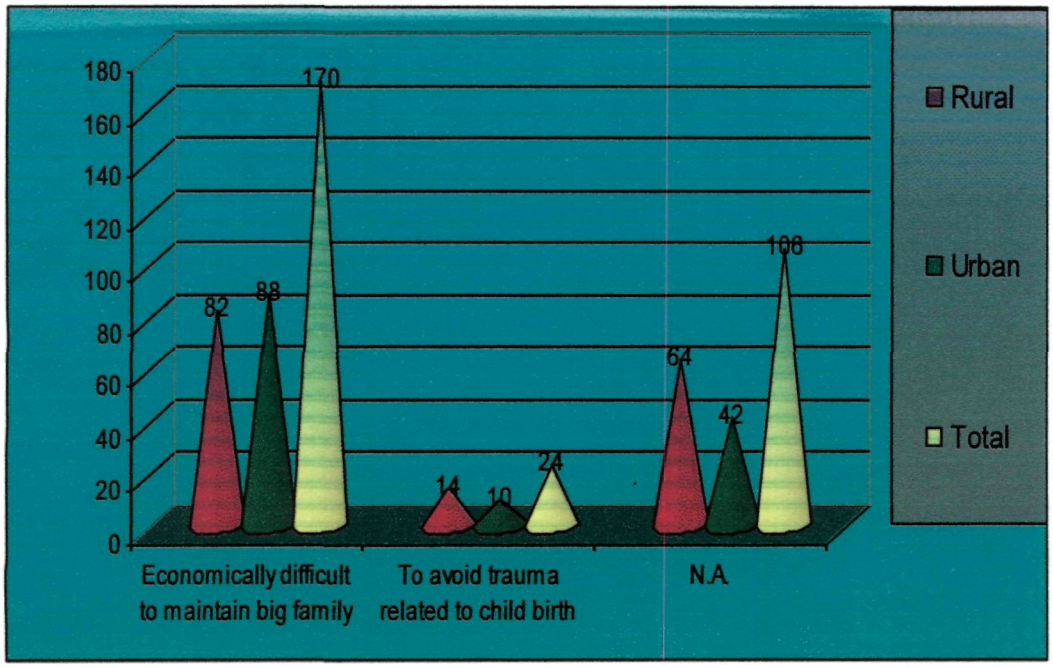
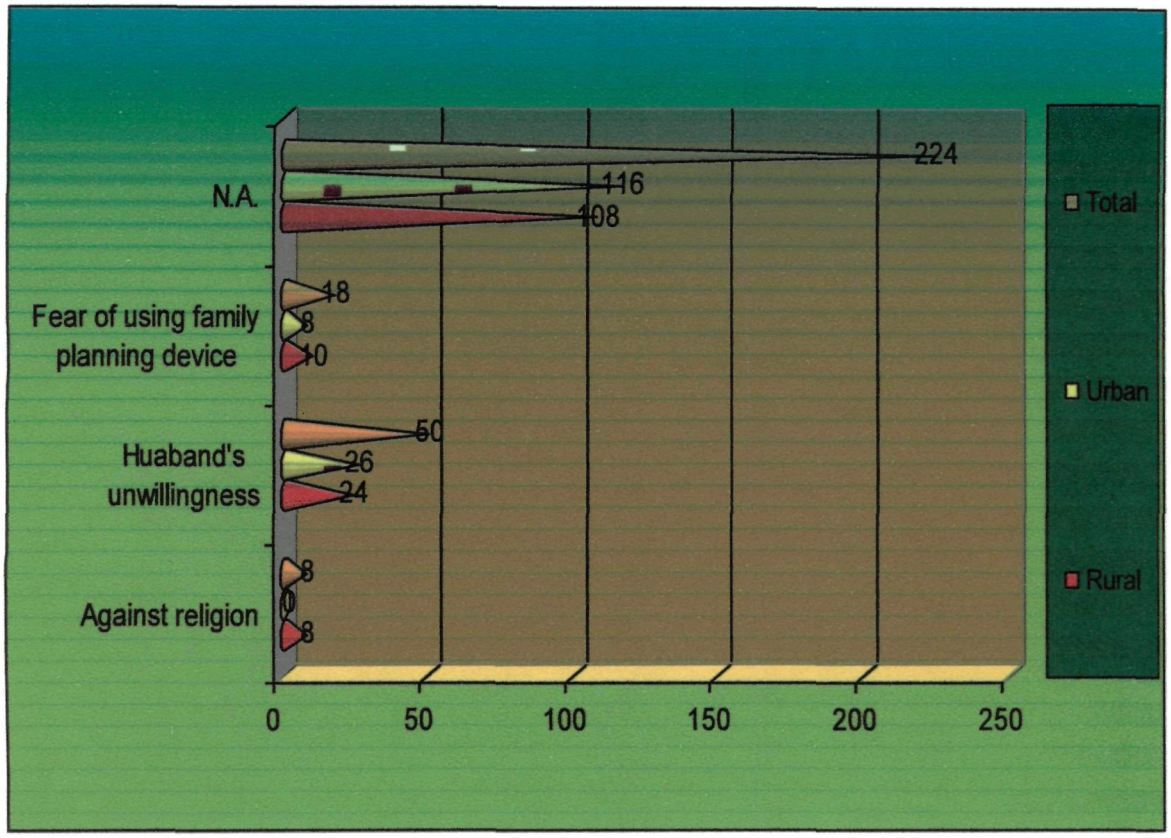


Fig.5.39 explains that more than half of the respondents (56.7%) prefer family planning because it is economically difficult to maintain a big family.

In the rural area, more than half of the respondents (54.7%) prefer family planning because it is economically difficult to maintain a big family. In the rural area, more than half of the respondents (58.7%) prefer family planning because it is economically difficult to maintain a big family.

Fig.5.40: Reasons for not supporting family planning



The above figure shows that the most popular reason for not supporting family planning is the husband's unwilling ness. This indicates that the respondents have less power to decide over their reproductive behaviour as compared to their husbands. The situation is same in both the rural and the urban areas.

Table-5.27: Patient's knowledge about vaccination

Patient's knowledge about vaccination	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Know	126(42%) 84%	144(48%) 96%	270(90%)
Does not know	24(8%) 16%	6(2%) 4%	30(10%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.27 it is clear that a large majority of the respondents (90%) know about vaccination.

In the rural area, most of the respondents (84%) know about vaccination and in the urban area, maximum of the respondents (96%) know about vaccination. The awareness level of the urban people about vaccination is little bit higher than the rural people. Statistical significance is found between the place of residence and the patients' knowledge about vaccination (Pearson Chi Square value is 12.000 at p=0.001 level).

Fig.5.41: Patients' recognition about the importance of proper nutrition in daily intake of food

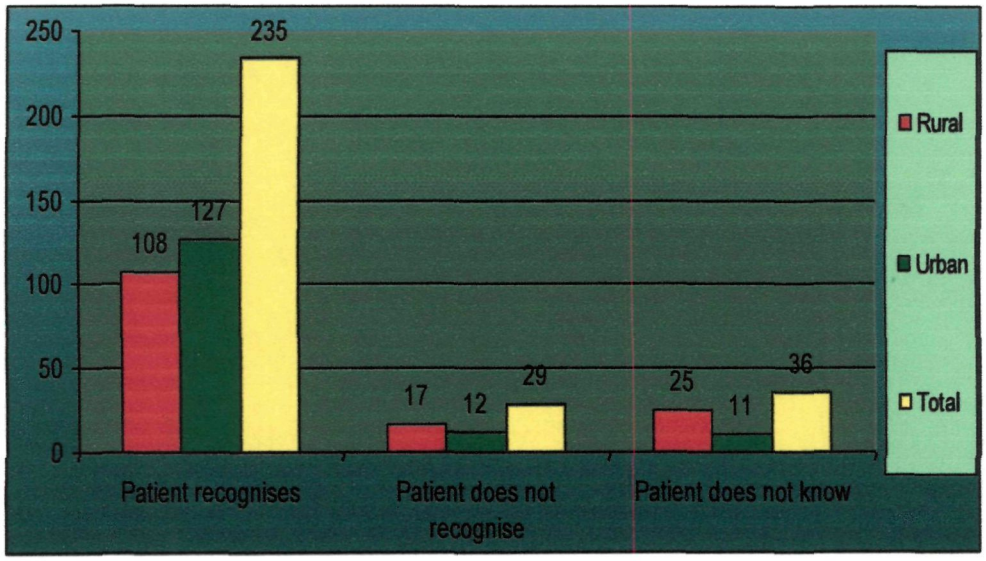


Fig.5.41 tells us that a more than three fourth of the respondents (78.3%) recognize the importance of proper nutrition in daily intake of food. Rest (21.7%) either do not know or do not recognize the importance of proper nutrition in daily intake of food.

In the rural area, more than seven tenth of the respondents (72%) recognize the importance of proper nutrition in daily intake of food and rest (28%) either do not know or do not recognize the importance of proper nutrition in daily intake of food. In the urban area, more than four fifth of the respondents (84.7%) recognize the importance of proper nutrition in daily intake of food and rest (15.3%) either do not know or do not recognize the importance of proper nutrition in daily intake of food. Though majority of the respondents recognize the importance of proper nutrition in daily intake of food as a whole, but still urban people are more aware about the nutritional needs in comparison with the rural folk.

Table-5.28: Whether the patient believe that unsafe drinking water can cause some disease or not

Whether the patient believe that unsafe drinking water can cause some disease or not	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Believe	51(17%) 34%	81(27%) 54%	132(44%)
Do not believe	5(1.7%) 3.3%	1(0.3%) 0.7%	6(2%)
Not sure	22(7.3%) 14.7%	22(7.3%) 14.7%	44(14.7%)
Do not know	72(24%) 48%	46(15.3%) 30.7%	118(39.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.28 it is clearly visible that more than two fifth of the respondents (44%) believe that unsafe drinking water can cause some disease and more than one third (39%) do not know at all that unsafe drinking water can cause some disease or not.

In the rural area, more than two fifth of the respondents (48%) do not know at all that unsafe drinking water can cause some disease or not and almost one third of the respondents (34%) believe that unsafe drinking water can cause some disease. In the urban area, more than half of the respondents (54%) believe that unsafe drinking water can cause some disease and more than one fourth (30.7%) do not know at all that unsafe drinking water can cause some disease or not. Here also rural folk are lagging behind their urban counterpart in terms of the level of awareness regarding

health matters. Statistical significance is also found between the place of residence and the patients' belief whether unsafe drinking water can cause disease or not (Pearson Chi Square value is 15.214 at p=0.002 level).

Fig.5.42: Patients' knowledge about water borne diseases

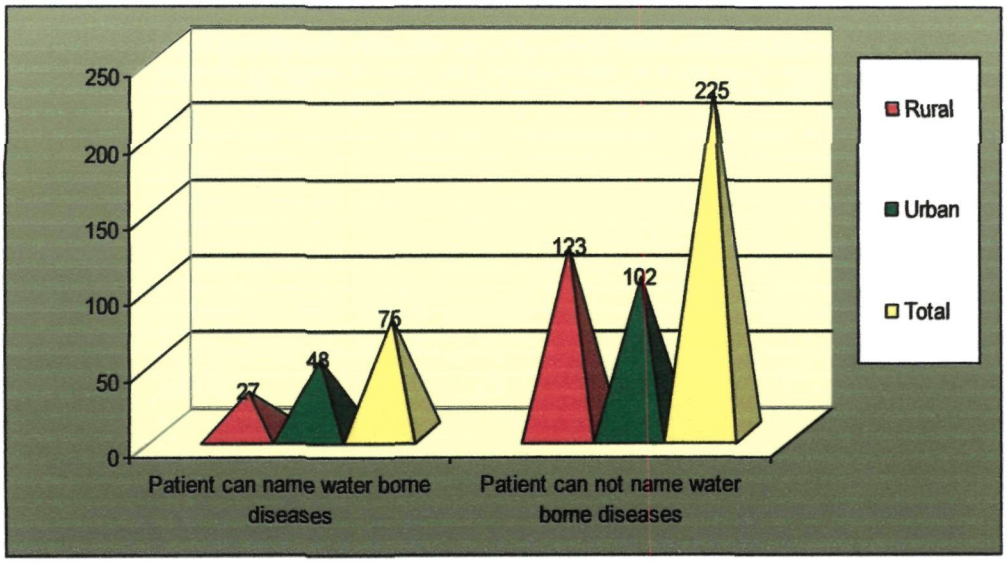


Fig.5.42 shows that only one fourth of the respondents (25%) can name some water borne disease and three fourth (75%) can not name.

In the rural area, only less than one fifth of the respondents (18%) can name some water borne disease and more than four fifth (82%) can not name. In the urban area, near about one third of the respondents (32%) can name some water borne disease and more than two third (68%) can not name. This figure also confirms that in the awareness issue rural folk are lagging behind their urban counterpart, though as a whole the awareness level is not so high. Statistical significance is found between the place of residence and the patients' knowledge about water borne diseases (Pearson Chi Square value is 7.840 at p=0.005 level).

Fig.5.43: Cause of disease/illness according to the patient

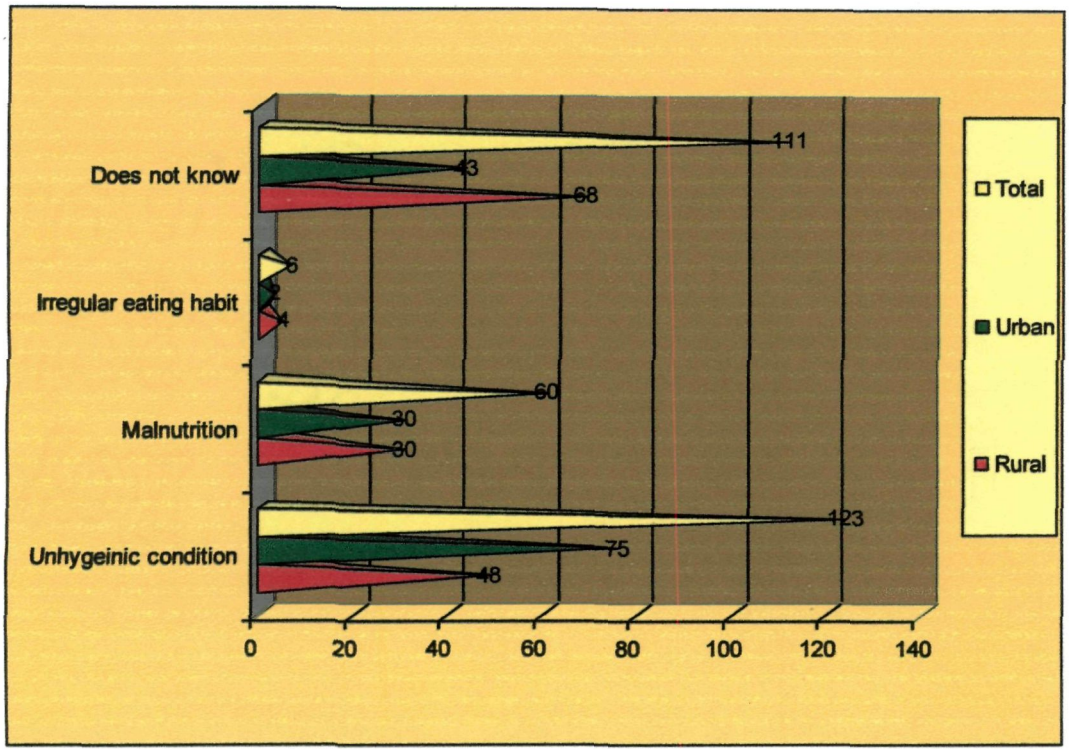


Fig.5.43 informs us that more than two fifth of the respondents (41%) believe that unhygienic condition can cause a disease or illness and more than one third (37%) do not know the cause.

In the rural area, more than two fifth of the respondents (45.3%) do not know the cause of disease and near about one third respondents (32%) believe that unhygienic condition can cause a disease or illness. In the urban area, half of the respondents (50%) believe that unhygienic condition can cause a disease or illness and more than two fifth (45.3%) do not know the cause.

Table-5.29: Reason behind a child being male or female according to the patient

Reason behind a child being male or female according to the patient	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Father(Chromosomal organization at the time of conception)	2(0.7%) 1.3%	3(1%) 2%	5(1.7%)
Mother	8(2.7%) 5.3%	0	8(2.7%)
God's gift(If the child is male)	108(36%) 72%	128(42.7%) 85.3%	236(78.7%)
Curse(If the child is female)	1(0.3%) 0.7%	0	1(0.3%)
Does not know	31(10.3%) 20.7%	19(6.3%) 12.7%	50(16.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.29 enlightens us with the important fact that more than three fourth of the patients (78.7%) under the study think that a child being male is God's gift. This shows that except 1.7 percent all of the respondents are totally ignorant about the actual cause of a child being male or female. Moreover, they are having some false believes also regarding this. Again we can conclude that majority of the respondents prefer male child cause they consider it as God's gift.

In the rural area, more than seven tenth of the patients (72%) under the study think that a child being male is God's gift and more than one fifth (20.7%) do not know who is responsible for a child being male or female. In the urban area more than four fifth of the patients (85.3%) under the study think that a child being male is

God's gift and ore than one tenth (12.7%) do not know who is responsible for a child being male or female.

General hygiene practices

Maintenance of personal hygiene is generally considered as an associated factor in various disease situations. Here the various health practices of the respondents are found out to assess whether there is any relation. Information regarding toilet hygiene, environment hygiene, use of insecticides at house, use of disinfectants etc. is asked.

Fig.5.44: Whether the patient wash hands after toilet or not

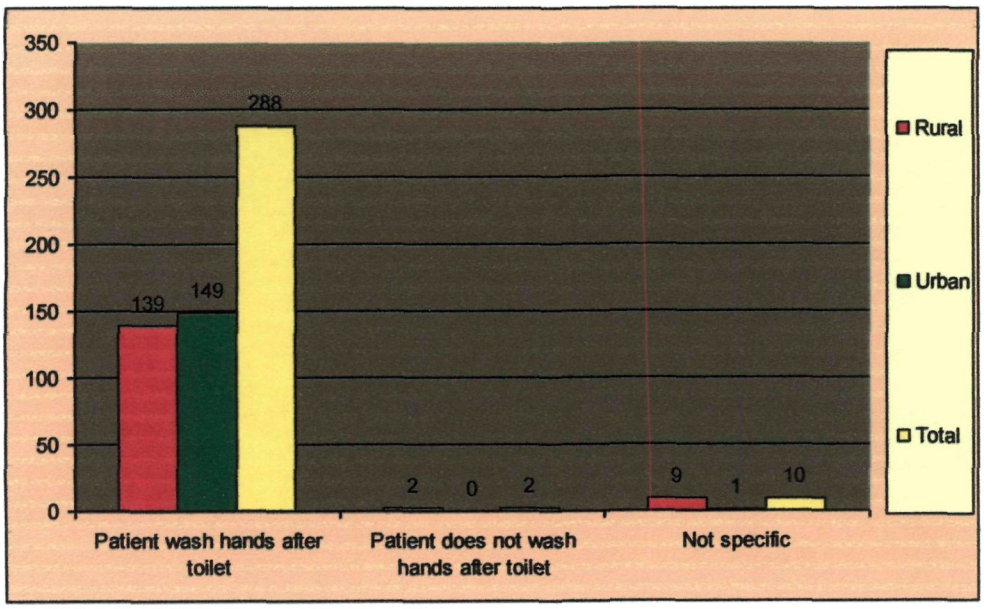


Fig.5.44 shows that most of the respondents (96%) wash hands regularly after toilet. Though they wash hands after toilet, still the use of water during toilet is always not maintained.

In the rural area, majority of the respondents (92.7%) wash hands regularly after toilet. In the urban area, all most all respondents (99.3%) wash hands regularly after toilet.

Table-5.30: Materials used for washing hands

Materials used for washing hands	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Ash	8(2.7%) 5.3%	1(0.3%) 0.7%	9(3%)
Soil	15(5%) 10%	4(1.3%) 2.7%	19(6.3%)
Soap	110(36.7%) 73.3%	139(46.3%) 92.7%	249(83%)
Only water	1(0.3%) 0.7%	0	1(0.3%)
Nothing	2(0.7%) 1.3%	0	2(0.7%)
Not specific	14(4.7%) 9.3%	6(2%) 4%	20(6.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.30 discloses that more than four fifth of the respondents (83%) wash hands with soap after toilet.

In the rural area, more than seven tenth of the respondents (73.3%) wash hands with soap after toilet and one tenth of the respondents (10%) wash hands with soil after toilet. In the urban area, most of the respondents (92.7%) wash hands with soap after toilet. Use of soap after toilet is more prevalent in the urban area as compared to the rural area. Again there is not a single case in the urban area where the patient does not wash hands after toilet.

Table-5.31: Whether the patient wash hands before taking food or not

Whether the patient wash hands before taking food or not	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Wash	45(15%) 30%	95(31.7%) 63.3%	140(46.7%)
Do not wash	66(22%) 44%	37(12.3%) 24.7%	103(34.3%)
Not specific	39(13%) 26%	18(6%) 12%	57(19%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

From table-5.31 we see clearly that more than two fifth of the respondents (46.7%) wash hands before taking food and more than one third of the respondents (34.4%) do not wash hands before taking food. Washing hands before taking food provides protection from various diseases. Here this important health habit is directly violated by quite a large number of people though not majority.

In the rural area, less than one third of the respondents (30%) wash hands before taking food and more than two fifth of the respondents (44%) do not wash hands before taking food. This means majority of the respondents from the rural area do not wash hands before taking food. In the urban area, more than three fifth of the respondents (63.3%) wash hands before taking food and almost one fourth of the respondents (24.7%) do not wash hands before taking food. From this we can conclude that respondents from the urban area are more conscious about maintaining basic health habits as compared to their counterpart in the rural area. Statistical significance is found between the place of residence and the washing of hands before taking food (Pearson Chi Square value is 33.759 at $p<0.0001$ level).

Fig.5.45: Whether the patient wash hands after taking food or not

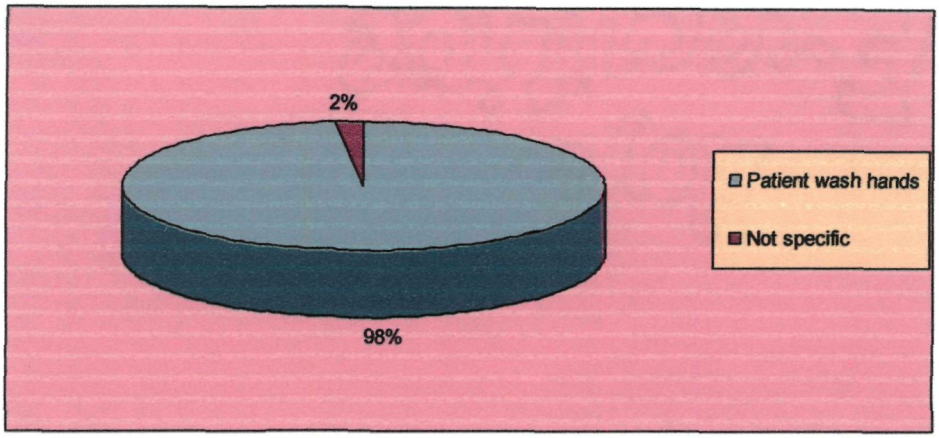


Fig.5.45 informs us that a great majority of the patients (98%) wash hands after taking food.

In the rural area, 97.3 percent patients wash hands after taking food and in the urban area, all respondents wash hands after taking food. In maintaining this general cleanliness also urban area is little more advanced.

Table-5.32: Regular exposure of bed to sunlight

Regular exposure of bed to sunlight	***Number of patients***		***Frequency (Percentage)***
	Rural	***Urban***	
Yes	106(35.3%) 70.7%	134(44.7%) 89.3%	240(80%)
No	13(4.3%) 8.7%	2(0.7%) 1.3%	15(5%)
Not specific	31(10.3%) 20.7%	14(4.7%) 9.3%	45(15%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

It is clear from table-5.32 that four fifth of the respondents (80%) expose their bed to sunlight from time to time.

In the rural area, more than seven tenth of the respondents (70.7%) expose their bed to sunlight from time to time and in more than one fifth of the cases

(20.7%), they sometimes expose and sometimes do not. In the urban area, near about nine tenth of the respondents (89.3%) expose their bed to sunlight from time to time and in less than one tenth of the cases (9.3%), they sometimes expose and sometimes do not. Here also rural folk are lagging behind their urban counterpart. Statistical significance is also found between the place of residence and the regular exposure of bed to sun light (Pearson Chi Square value is 17.756 at $p<0.001$ level).

Table-5.33: Use of insecticides to sanitize the house from mosquitoes and flies

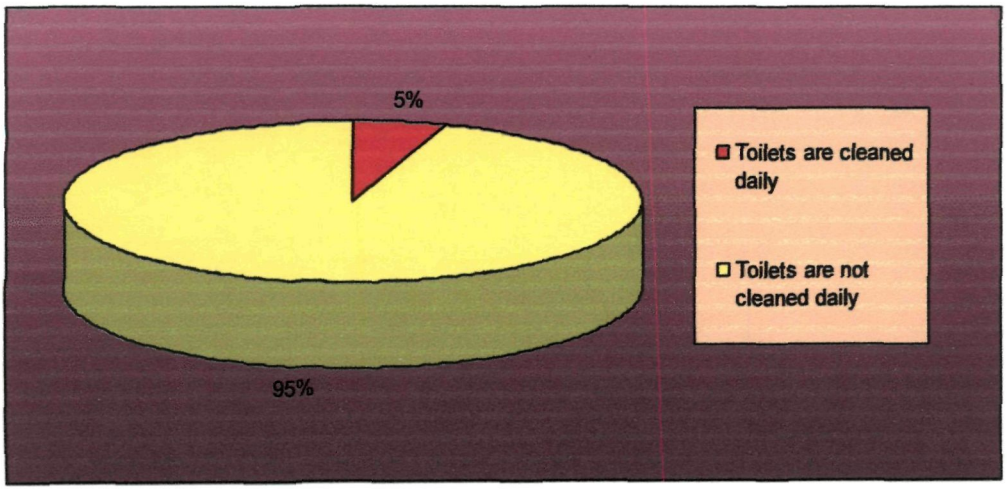
Use of insecticides to sanitize the house from mosquitoes and flies	***Number of patients***		***Frequency (Percentage)***
	Rural	***Urban***	
Use	39(13%) 26%	99(33%) 66%	138(46%)
Do not use	111(37%) 74%	51(17%) 34%	162(54%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.33 depicts that more than two fifth of the respondents (46%) use insecticides to sanitize house from mosquitoes and flies and more than half of the respondents (54%) do not use insecticides to sanitize house from mosquitoes and flies. Majority of the patients under the study do not use insecticides.

In the rural area, only near about one fourth of the respondent (26%) use insecticides to sanitize house from mosquitoes and flies and almost three fourth of the respondents (74%) do not use insecticides to sanitize house from mosquitoes and flies. In the urban area, near about two third of the respondents (66%) use insecticides to sanitize house from mosquitoes and flies and almost one third of the respondents

(34%) do not use insecticides to sanitize house from mosquitoes and flies. Here also we see respondents living in the urban area are more conscious about sanitation of their house. A high statistical significance is found between the place of residence and the sanitization of the house (Pearson Chi Square value is 48.309 at $p<0.0001$ level).

Fig.5.46: Daily cleaning of the toilets



Form fig.5.46 it is very clear that in only 5.3 percent cases the respondents clean their toilets daily and in a large majority of the cases (94.7%) the respondents do not clean their toilets daily. From using unclean toilets various gynaecological diseases may spread. The data disposed in the above table also supports the same.

In the rural area, in only 4.7 percent cases the respondents clean their toilets daily and in a big number of the cases (95.3%), the respondents do not clean their toilets daily. In the urban area, in only 6 percent cases the respondents clean their toilets daily and in majority of the cases (94%), the respondents do not clean their toilets daily. No statistical significance is found between the place of residence and the regular cleaning of toilets (Pearson Chi Square value is 0.264 at $p=0.607$ level).

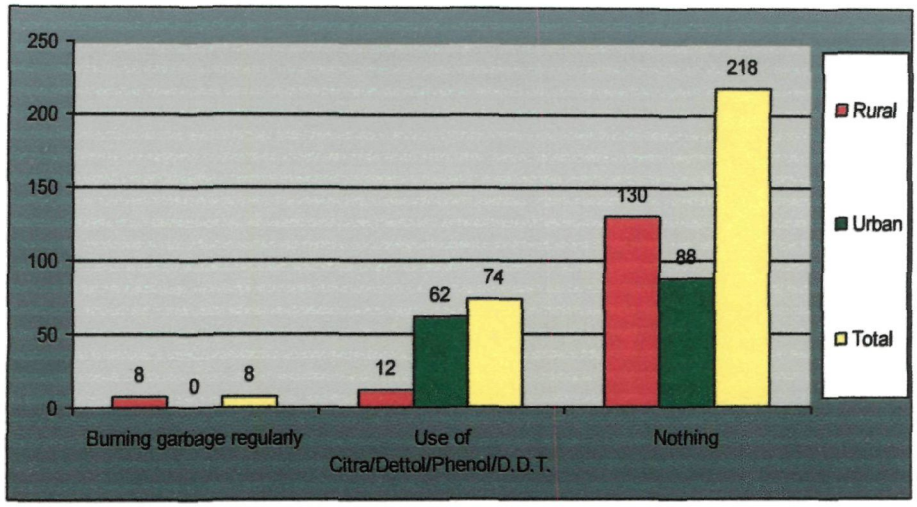
Table-5.34: Daily cleanliness of the environs

Daily cleanliness of the environs	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Environs are cleaned	150(50%) 100%	148((49.3%) 98.7%	298(99.3%)
Environs are not cleaned	0	2(0.7%) 1.3%	2(0.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.34 shows that in almost all the cases (99.3%) environs of the house are cleaned daily.

In the rural area, all the respondents clean their environs daily. In the urban area, in 98.7 percent cases environs of the house are cleaned daily and in 1.3 percent cases environs of the house are not cleaned daily. Here, the urban area is a little lagging behind the rural area in cleanliness of the environs of the house.

Fig.5.47: Any other thing done to maintain hygiene



From fig.5.47 we see that in near about three fourth of the cases (72.7%) the respondents do not use anything to maintain hygiene and in more than one fourth of the cases (27.3%) the respondents use phenol, dettol, citra , DDT etc. to maintain hygiene.

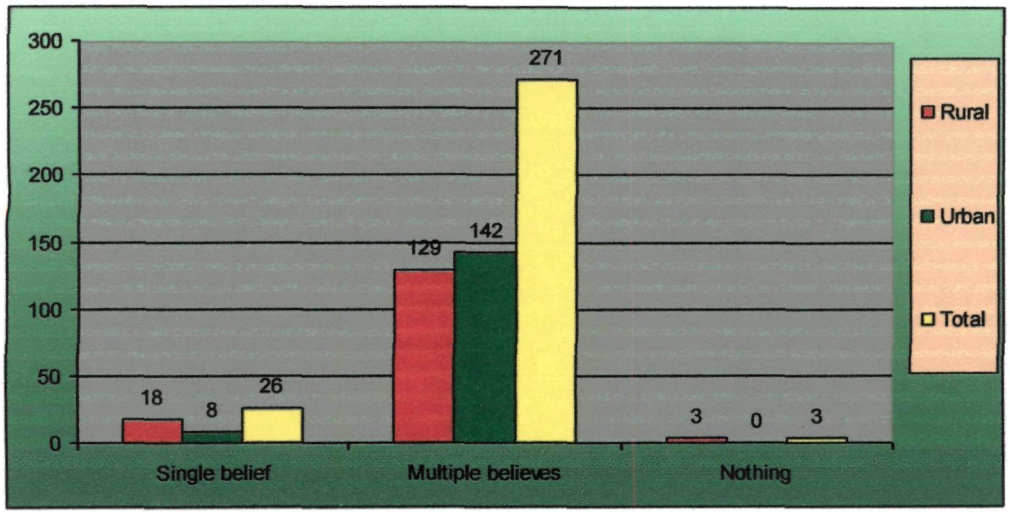
In the rural area, in more than four fifth of the cases (86.7%) the respondents do not use anything to maintain hygiene and in more than one tenth of the cases (13.3%) the respondents use phenol, dettol etc. to maintain hygiene. But burning garbage is also popular in the rural area. In the urban area, in more than half of the cases (5.7%) the respondents do not use anything to maintain hygiene and in more than one third of the cases (41.3%) the respondents use phenol, dettol etc. to maintain hygiene. A high statistical significance is found between the place of residence and use hygiene maintenance (Pearson Chi Square value is 49.876 at $p<0.0001$ level).

Predominant misconceptions regarding menstruation, pregnancy and child birth

There are various types of misconceptions related to the menstruation, pregnancy, child birth etc. among different communities. There are variations among the myths and misconceptions among communities, provinces, nations or continents, but myths and misconceptions were present at the earlier times and even till today they are

present. Here, an attempt is made to find out various misconceptions, wrong beliefs and malpractices during menstruation, pregnancy and child birth.

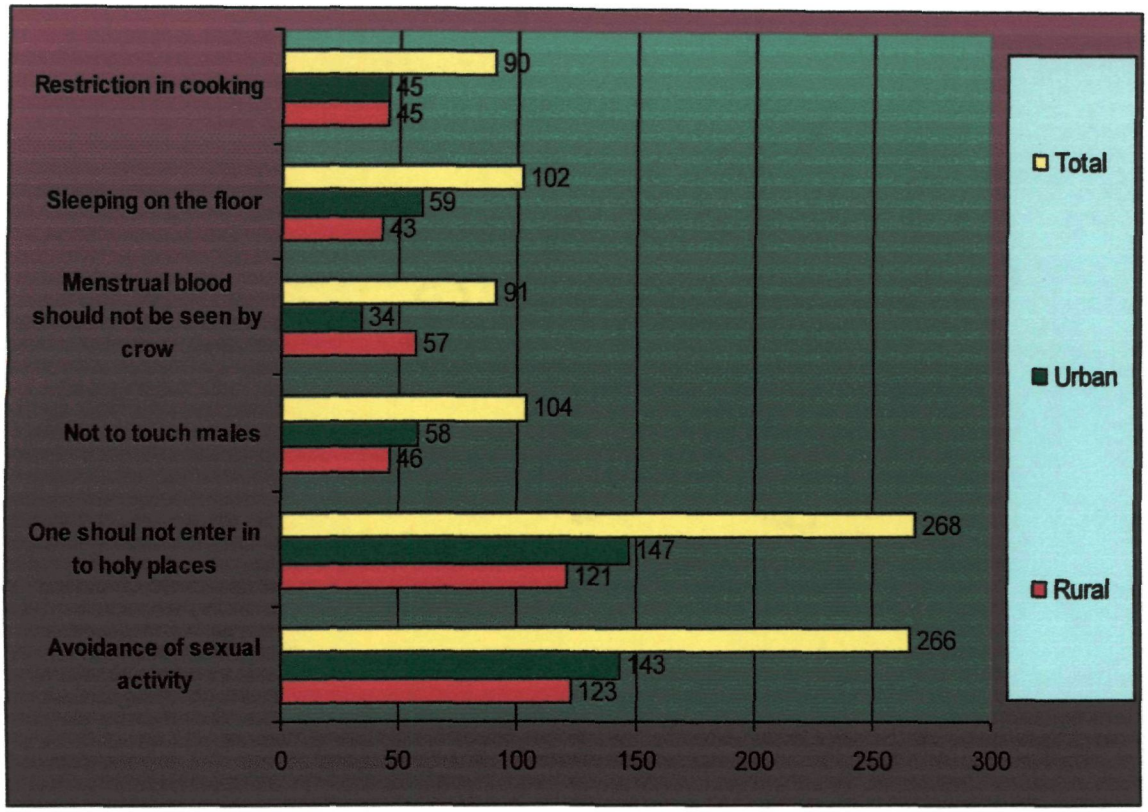
Fig.5.48: Misconceptions/wrong beliefs/malpractices regarding menstruation



As per the above fig, nearly the nine tenth of the respondents (90.3%) under the study have multiple believes (misconception/ wrong belief) regarding menstruation and nearly one tenth (8.7%) have a single belief (misconception/ wrong belief) regarding menstruation. The number of respondents having no misconception is negligible, i.e. three out of three hundred respondents.

Among the rural population, a little less than the nine tenth (86%) of the respondents under the study have multiple believes (misconception/ wrong belief) and nearly one tenth (12%) have a single belief (misconception/ wrong belief) regarding menstruation. Among the urban population, more than the nine tenth of the respondents (94.7%) under the study have multiple believes (misconception/ wrong belief) and only five percent respondents have a single belief (misconception/ wrong belief) regarding menstruation.

Fig.5.49: Kind of misconceptions



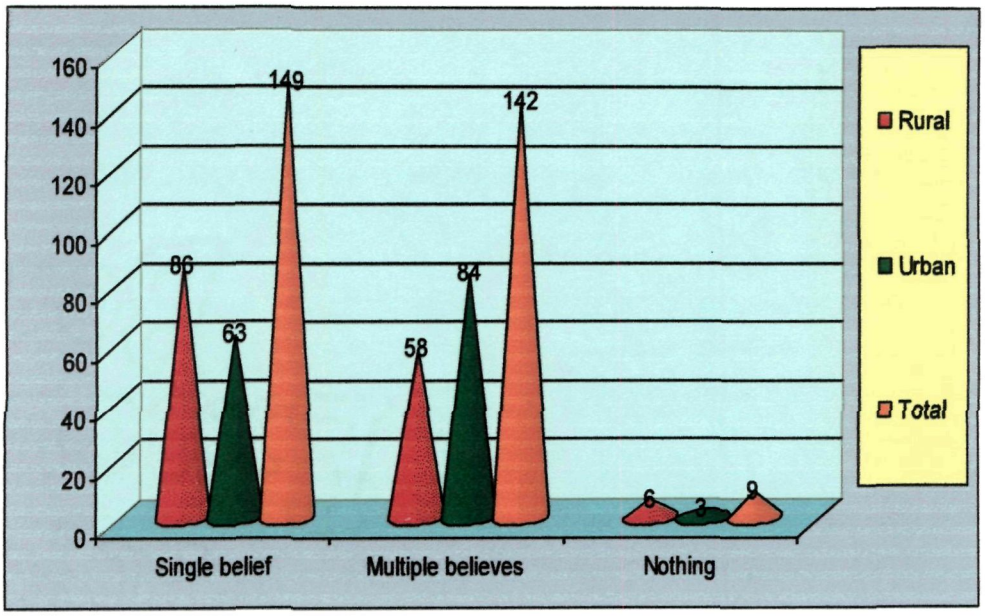
(Here the misconceptions are listed separately, so a single respondent having multiple misconceptions are listed more than one time as indicated by the misconceptions)

Various misconceptions prevalent among the sample are- i) *Restriction in cooking,* ii) *Sleeping on floor,* iii) *Menstrual blood should not be seen by crow,* iv) *Not to touch males,* v) *One should not enter into holy places* and vi) *Avoidance of sexual activity.* Menstrual blood is considered as unclean so to maintain the cleanliness various restrictions are made on the menstruating woman. Almost nine tenth of the respondents (89.3%) have the misconception that a menstruating woman should not enter in to holy places, a little less than nine tenth of the respondents (88.7%) believe that sexual activity should be avoided during the menstruation period to keep the male partner safe, more than one third of the sample (34.7%) believe that a menstruating woman should not touch males, almost one third of the sample (34%) believe a menstruating woman should sleep on floor during her menstrual period, more than three tenth of the respondents (30.3%) believe that menstrual blood should

not be seen by crow and exactly three tenth of the respondents (30%) believe that a menstruating woman should not cook or enter in to the kitchen.

In the rural area, more than four fifth of the respondents (82%) believe that sexual activity should be avoided during the menstruation period to keep the male partner safe, almost four fifth of the respondents (80.7%) believe that a menstruating woman should not enter in to holy places, more than one third (38%) believe that menstrual blood should not be seen by crow, more than three tenth of the respondents (30.6%) believe that a menstruating woman should not touch males, exactly three tenth of the respondents (30%) believe that a menstruating woman should not cook or enter in to the kitchen, more than one fourth of the respondents (28.7%) believe that a menstruating woman should sleep on floor during her menstrual period. In the urban area, maximum of the sample (98%) believe that a menstruating woman should not enter in to holy places, more than nine tenth of the sample (95.3%) believe that sexual activity should be avoided during the menstruation period to keep the male partner safe, almost two fifth of the respondents (39.3%) believe that a menstruating woman should sleep on floor during her menstrual period, more than one third of the respondents (38.7%) believe that sexual activity should be avoided during the menstruation period to keep the male partner safe, three tenth of the sample (30%) believe that a menstruating woman should not cook or enter in to the kitchen and more than one fifth of the sample (22.7%) believe that menstrual blood should not be seen by crow.

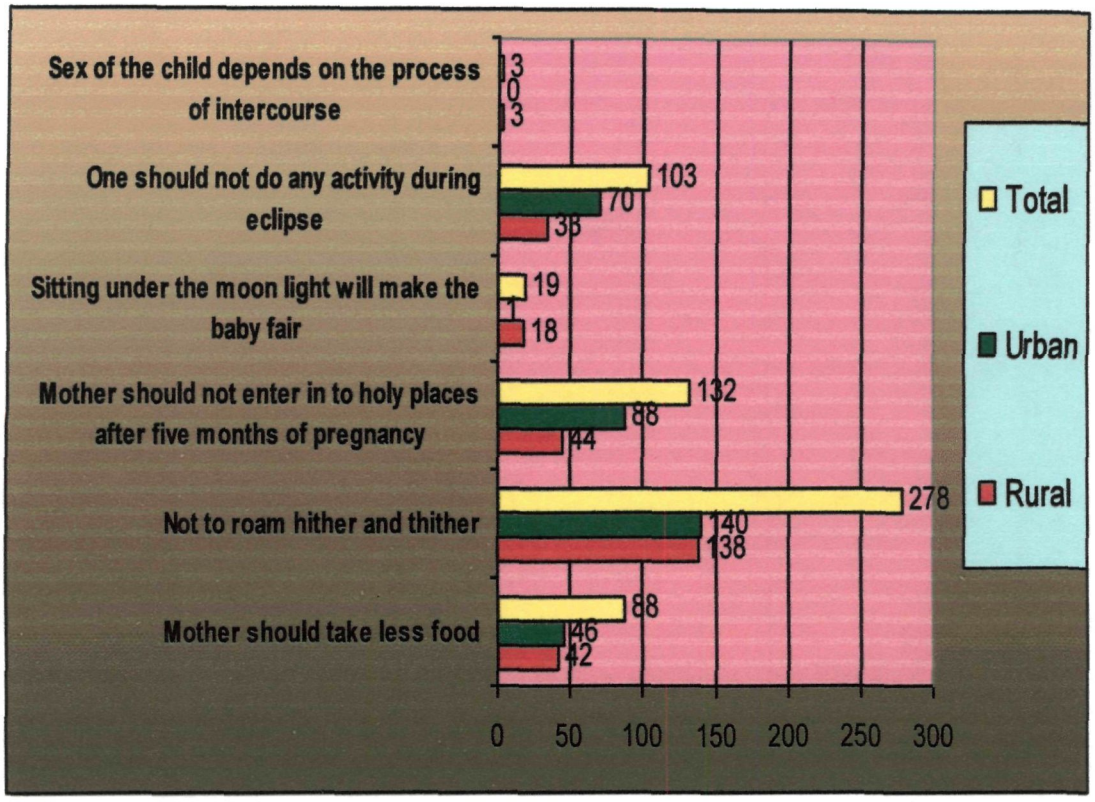
Fig.5.50: Misconceptions/wrong beliefs/malpractices regarding pregnancy



As per the above fig, almost half of the total sample (49.7) under the study has a single belief (misconception/ wrong belief) regarding pregnancy and more than two fifth of the population (47.3%) has multiple believes (misconception/ wrong belief). Only three percent of the sample size does not have any misconception regarding the pregnancy.

In the rural area, more than half of the respondents (57.3%) are found to have a single belief (misconception/ wrong belief) regarding pregnancy and more than one third of the respondents (38.7%) have multiple believes (misconception/ wrong belief). The reverse is noticed in the urban area. Nearly three fifth of the respondents (63%) are found to have a single belief (misconception/ wrong belief) regarding pregnancy and two fifth of the respondents (42%) have a single belief (misconception/ wrong belief) regarding pregnancy.

Fig.5.51: Kind of misconceptions



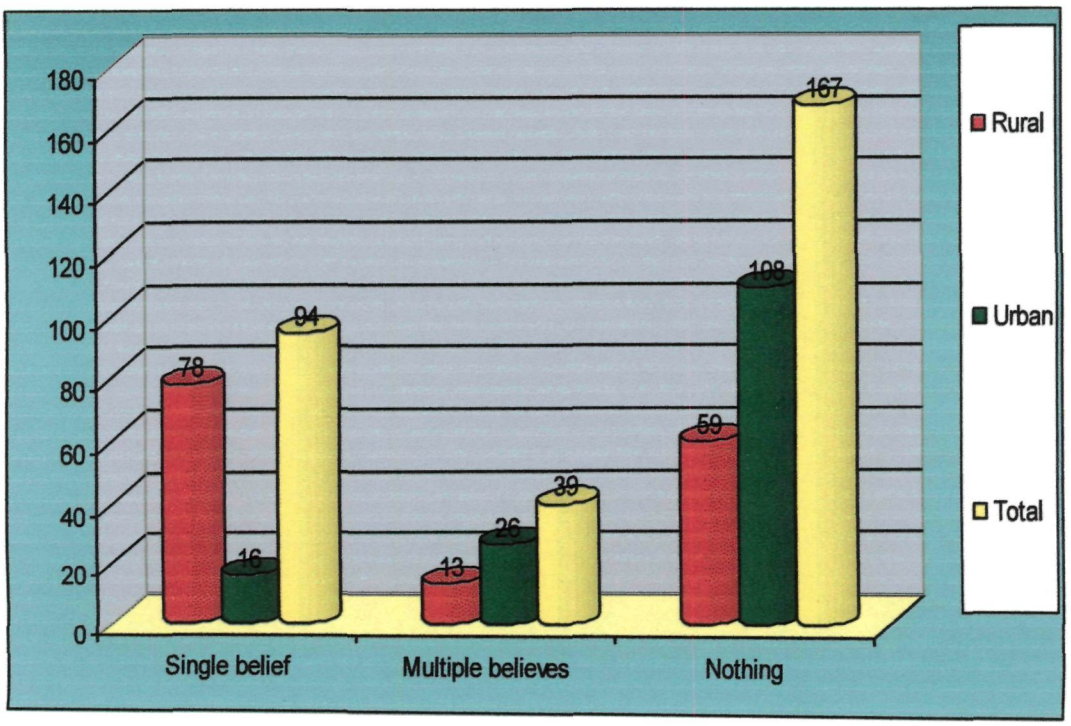
(Here the misconceptions are listed separately, so a single respondent having multiple misconceptions are listed more than one time as indicated by the misconceptions)

Here we find six different misconceptions which are- i) *Sex of the child depends on the process of intercourse* ii) *One should not do any activity during eclipse,* iii) *Sitting under the moon light will make the baby fair.* iv) *Mother should not enter into holy places after 5 months of pregnancy,* v) *Not to roam hither and thither during pregnancy to avoid evil eye and evil touch,* vi) *mother should take less food to restrict over growth of the baby.* More than nine tenth of the respondents (92.7%) believe that the pregnant woman should not roam hither and thither to avoid evil eye or evil touch, more than two fifth the respondents (44%) believe that the pregnant woman should not enter into holy places after the five moths of the pregnancy, more than one third (34.3%) believe that the pregnant woman should not do any activity during the eclipse, nearly three tenth (29.3%) believe that mother should take less food to restrict the growth of the baby, less than one tenth (6.3%)

believe that sitting under moon light will make the baby fair and only one percent believe that process of inter course will decide the sex of the child.

In the rural area, more than nine tenth of the respondents (92%) believe that the pregnant woman should not roam hither and thither to avoid evil eye or evil touch, nearly three tenth of the respondents (29.3%) believe that the pregnant woman should not enter into holy places after the five months of the pregnancy, more than one fourth of the respondents (28%) believe that the pregnant woman should take less food to restrict the growth of the baby, nearly two tenth (22%) believe that the pregnant woman should not do any activity during the eclipse, more than one tenth (12%) believe that sitting under the moon light will make the baby fair and only one percent believe that process of inter course will decide the sex of the child. In the urban area, more than nine tenth of the respondents (93.3%) believe that the pregnant woman should not roam hither and thither to avoid evil eye or evil touch, nearly three fifth of the respondents (58.7%) believe that the pregnant woman should not enter into holy places after the five months of the pregnancy, more than two fifth of the respondents (46.7%) believe that the pregnant woman should not do any activity during eclipse, almost three tenth of the respondents (30.7%) believe that mother should take less food to restrict the growth of the baby.

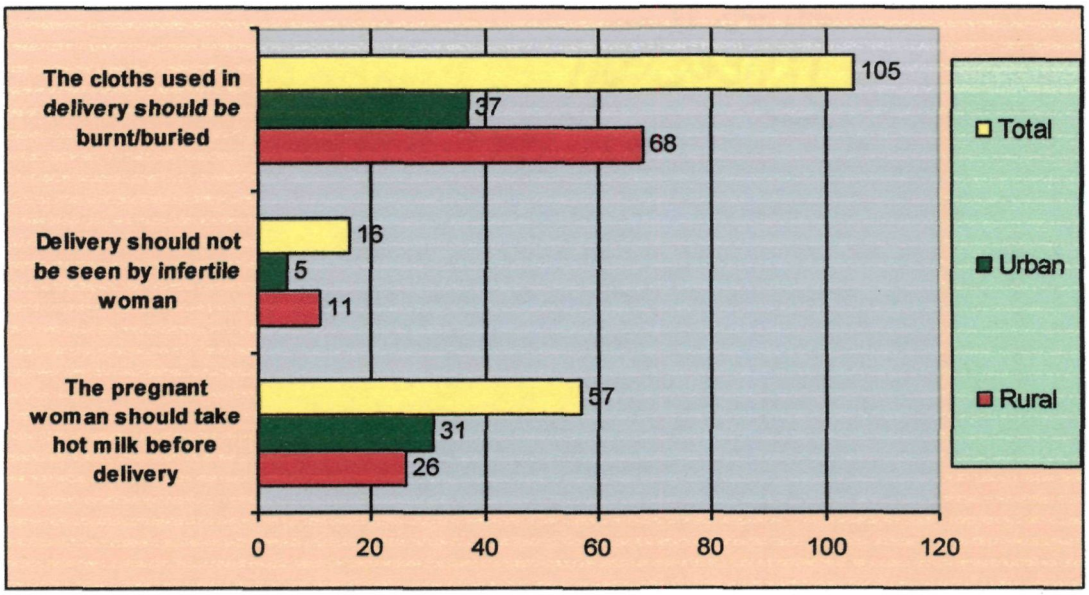
Fig.5.52: Misconceptions/wrong beliefs/malpractices regarding child birth



From the above fig, it is very clear that more than half of the respondents (55.7%) have no misconception regarding child birth. About three tenth of the sample (31.3%) have a single misconception or wrong belief and more than one tenth (13%) have multiple misconceptions regarding child birth.

In the rural area, more than half of the sample (52%) have a single misconception regarding child birth and almost two fifth of the sample (39.3%) have no misconception regarding child birth. But the scene of the urban area is slightly different. More than seven tenth of the sample size (72%) do not have any misconception regarding child birth and less than one fifth of the sample (17.3%) have multiple misconceptions regarding child birth.

Fig.5.53: Kind of misconceptions



(Here the misconceptions are listed separately, so a single respondent having multiple misconceptions are listed more than one time as indicated by the misconceptions)

If we consider the kind of misconceptions, we see there are three types of misconceptions prevalent among the sample population. These misconceptions are – i) *Cloths used in delivery should be burnt/buried*, this helps to avoid the evil eye or evil touch and keeps the baby safe, ii) *Delivery should not be seen by infertile woman,* infertile women are considered as unlucky and their presence in delivery is believed to be harmful for the pregnant woman as well as for the baby. iii) *The pregnant*

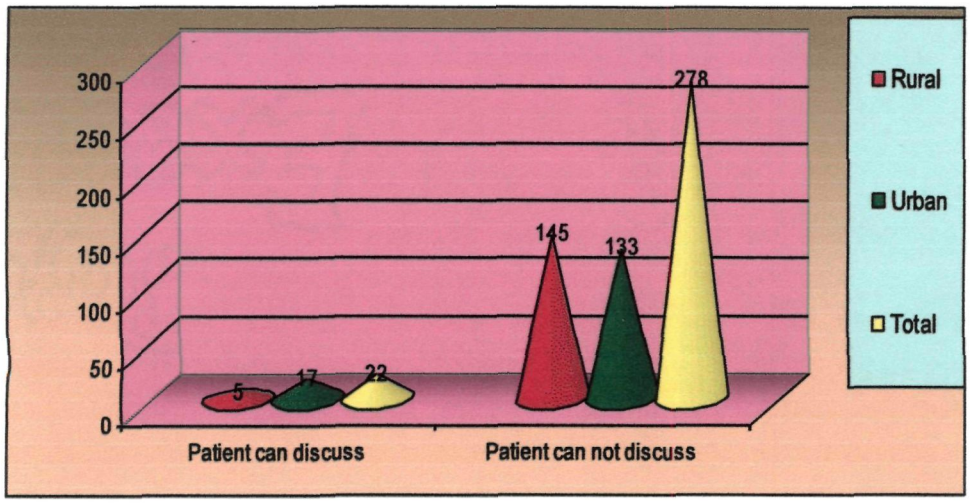
woman should take hot milk before delivery, because it is believed that the hot milk taken by the pregnant woman helps in speeding up the process of delivery. More than one third of the sample (35%) believe that the cloths used in delivery should be burnt, almost one fifth believe (19%) that the pregnant woman should take hot milk before delivery and less than one tenth (5.3%) believe that delivery should not be seen by any infertile woman.

In the rural area, more than two fifth of the sample (45.3%) believe that the cloths used in delivery should be burnt, more than one tenth (17.3%) believe that the pregnant woman should take hot milk before delivery and less than one tenth (7.3%) believe that delivery should not be seen by any infertile woman. In the urban area, almost one fourth of the sample (24.7%) believe that the cloths used in delivery should be burnt, almost one fifth (20.7%) believe that the pregnant woman should take hot milk before delivery and less than one tenth (5.3%) believe that delivery should not be seen by any infertile woman.

Social taboos associated with the disease

There are particular problems of gynaecological diseases i.e. social taboos. This is a very unique character related to the gynaecological diseases which make the diseases situation worse. Women feel shy to discuss freely about such diseases even with the family members. The respondents under the study are also asked about their inhibitions particular to the gynaecological diseases, hesitations about the physical examination and preference of female doctors over the male ones.

Fig.5.54: Whether the patient discuss the disease openly or not



It is very distinct from fig.5.54 that a large majority of the respondents (92.7%) can not discuss the disease openly and only less than one tenth of the sample (7.3%) can discuss the disease openly. This is a very unique nature of the gynaecological disease.

In the rural area, most of the respondents (96.7%) can not discuss the disease openly and only 3.3 percent can discuss the disease openly. In the urban area, also a great proportion of the respondents (88.7%) can not discuss the disease openly and more than one tenth of the respondents (11.3%) can discuss the disease openly. Again in the rural urban divergence numbers of patients who can discuss the disease openly are more in urban area as compared to rural area. This indicates towards the conservativeness more prevailing in the rural areas. Statistical significance is found, though not high, between the place of residence and the open discussion on gynaecological diseases by the patients (Pearson Chi Square value is 7.063 at p=0.008 level).

Table-5.35: Causes for which the patient can not discuss about the disease openly

Causes for which the patient can not discuss about the disease openly	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Fear	1(0.3%) 0.7%	0	1(0.3%)
Shyness	136(45.3%) 90.7%	133(44.3%) 88.7%	269(89.7%)
Fear & shyness	8(2.7%) 5.3%	0	8(2.7%)
Not applicable	5(1.7%) 3.3%	17(5.7%) 11.3%	22(7.3%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.35 gives explanation of why patient can not discuss openly about the gynaecological disease. Almost nine tenth of the patients (89.7%) feel shy to discuss about the gynaecological disease. Women feel shy to discuss about such problems which is a hindrance towards the treatment and this makes it a unique problem which is always related with the gynaecological diseases.

In the rural area, more than nine tenth of the patients (90.7%) feel shy to discuss about the gynaecological disease. In the urban area also, majority of the patients (88.7%) feel shy to discuss about the gynaecological disease. There is one noticeable fact that not a single patient in the urban area has any kind of fear regarding the gynaecological disease. Again we see that number of rural patients is more who feel shy to discuss about the gynaecological disease.

Fig.5.55: Patients' preference of female doctors to male ones to discuss about the gynaecological problems

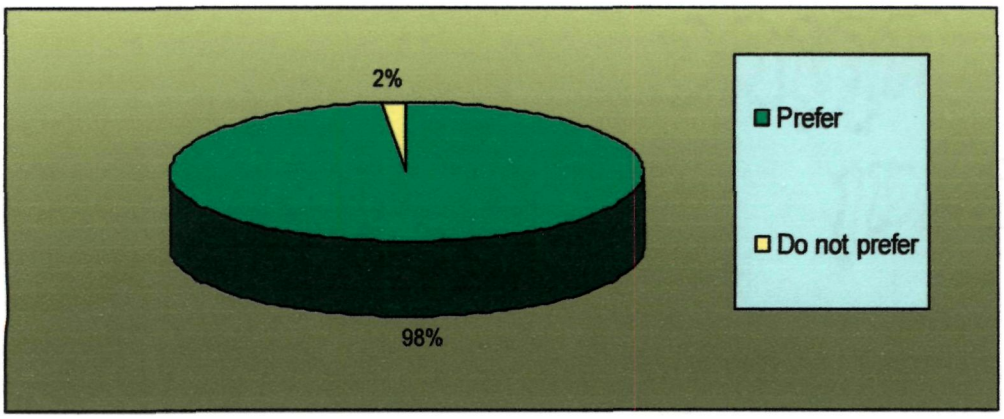


Fig.5.55 shows that most of the patients (98.3%) prefer female doctors to male ones to discuss about the gynaecological problems and only 1.7 percent patients do not prefer female doctors to male ones to discuss about the gynaecological problems.

In the rural area, a great majority of the patients (98.7%) prefer female doctors to male ones to discuss about the gynaecological problems. In the urban area also, majority of the patients (98%) prefer female doctors to male ones to discuss about the gynaecological problems.

Table-5.36: Reason for preferring female doctors

Reason for preferring female doctors	*Number of patients*		*Frequency (Percentage)*
	Rural	*Urban*	
Feels comfortable	1(0.3%) 0.7%	0	1(0.3%)
Can discuss openly	2(0.7%) 1.3%	2(0.7%) 1.3%	4(1.3%)
Does not feel shy during the check ups	4(1.3%) 2.7%	7(2.3%) 6.7%	11(3.7%)
Feels comfortable, can discuss openly, does not feel shy during the check ups	141(47%) 94%	138(46%) 92%	279(93%)
Not applicable	2(0.7%) 1.3%	3(1%) 2%	5(1.7%)
Total	150(50%) 100%	150(50%) 100%	300(100%)

Table-5.36 explains why majority of the respondents prefer female doctors to male ones to discuss about the gynaecological problems. More than nine tenth of the respondents (93%) give 3 reasons for why they prefer female doctors, these are- they feel comfortable, they can discuss openly about their problems and they do not feel shy during the check ups.

In the rural area, a great majority of the respondents (94%) give 3 reasons for why they prefer female doctors, this are- they feel comfortable, they can discuss openly about their problems and they do not feel shy during the check ups. In the urban area also, more than nine tenth of the respondents (92%) give 3 reasons for why they prefer female doctors, these are- they feel comfortable, they can discuss openly about their problems and they do not feel shy during the check ups.

Statistical analysis of some variables

Educational qualification of the patients are cross tabulated with other dependent variables like age at first coitus, patient's consent at first coitus, number of children, patient's knowledge about HIV/AIDS, patient's support to family planning, hygiene maintenance, awareness about water borne diseases, menstrual hygiene maintenance, toilet hygiene maintenance, continuation of treatment etc. Then the chi square test table is given with each cross tabulation to ascertain the significance. The educational qualification is cross tabulated family income per month to find out the significance between the economic status and the educational status. Again the family income of the patient is cross tabulated with other variables like patient's knowledge about HIV/AIDS and water borne diseases, use of insecticides and maintenance of hygiene, support to family planning and the continuation of the treatment Chi square test is given with each cross tabulation to find out the significance.

Table-5.37(1): Cross tabulation of educational qualification of the patient with age at first coitus

Educational qualification	Age at first coitus							Total
	less than 18 years	18 years-22 years	23 years-27 years	28 years-32years	33 years-37 years	38 years-42 years	not applicable	
illiterate	26	14	3	0	0	0	1	44
primary	29	27	8	1	0	1	0	66
middle	21	39	23	6	1	0	4	94
secondary	17	32	18	7	1	0	9	84
college & above	0	5	1	1	1	0	4	12
Total	93	117	53	15	3	1	18	300

Table-5.37(2): Chi-Square tests of educational qualification of the patient and age at first coitus

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	73.474	24	.000
Likelihood Ratio	70.997	24	.000
Linear-by-Linear Association	36.369	1	.000
N of Valid Cases	300		

Table-5.37(2) shows that there is a high statistical significance between the educational qualification of the patient and the age at first coitus. The age at first coitus is more likely to increase with the rise in the educational level.

Table-5.38(1): Cross tabulation of educational qualification of the patient with patient's consent at first coitus

Educational qualification of the patient	Patient's consent at first coitus			Total
	yes	no	not applicable	
illiterate	16	27	1	44
primary	39	27	0	66
middle	70	20	4	94
secondary	66	9	9	84
college & above	8	0	4	12
Total	199	83	18	300

Table-5.38(2): Chi-Square tests of educational qualification of the patient and patient's consent at first coitus

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	68.498	8	.000
Likelihood Ratio	66.392	8	.000
Linear-by-Linear Association	4.499	1	.034
N of Valid Cases	300		

Table-5.38(2) shows that there is a strong significance between the educational qualification of the patient and their consent at the first coitus. So we can say that educated women may have more right over their sexual behaviour.

Table-5.39(1): Cross tabulation of educational qualification of the patient with the number of children

Educational qualification of the patient	Number of children					Total
	nil	1 - 3	4 - 6	7 & more than 7	not applicable	
illiterate	6	20	17	0	1	44
primary	24	28	12	2	0	66
middle	44	40	6	0	4	94
secondary	22	48	3	0	11	84
college & above	4	4	0	0	4	12
Total	100	140	38	2	20	300

Table-5.39(2): Chi-Square tests of educational qualification of the patient and the number of children

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	81.292	16	.000
Likelihood Ratio	74.508	16	.000
Linear-by-Linear Association	.030	1	.863
N of Valid Cases	300		

Table-5.39(2) shows that there is a strong significance between the educational qualification of the patient and the number of children. Patients with more educational qualification are likely to have lesser number of children.

Table-5.40(1): Cross tabulation of educational qualification of the patient with patient's knowledge about HIV/AIDS

Educational qualification of the patient	Patient's knowledge about HIV/AIDS		Total
	yes	no	
illiterate	1	43	44
primary	3	63	66
middle	14	80	94
secondary	34	50	84
college & above	12	0	12
Total	64	236	300

Table-5.40(2): Chi-Square tests of educational qualification of the patient and patient's knowledge about HIV/AIDS

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	85.524	4	.000
Likelihood Ratio	84.547	4	.000
Linear-by-Linear Association	60.940	1	.000
N of Valid Cases	300		

Table-5.40(2) shows that there is a strong significance between the educational qualification of the patients knowledge about HIV/AIDS. Educated women are more likely to have awareness about HIV/AIDS.

Table-5.41(1): Cross tabulation of educational qualification of the patient with patient's support to family planning

Educational qualification of the patient	Patient's support to family planning			Total
	yes	no	not applicable	
Illiterate	15	13	16	44
Primary	30	31	5	66
middle	67	21	6	94
secondary	71	10	3	84
college & above	11	1	0	12
Total	194	76	30	300

Table-5.41(2): Chi-Square tests of educational qualification of the patient and patient's knowledge about HIV/AIDS

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	74.294	8	.000
Likelihood Ratio	65.024	8	.000
Linear-by-Linear Association	51.964	1	.000
N of Valid Cases	300		

From table-5.41(2) it is very clear that there is a strong significance between the educational qualification of the patient and patient's support to the family planning. With the increase in the level of education patient's support to family planning increases. Patients with more educational qualification are more likely to support family planning.

Table-5.42(1): Cross tabulation of educational qualification of the patient with the habit of washing hands daily before taking food

Educational qualification of the patient	Habit of washing hands daily before taking food			Total
	yes	no	not specific	
illiterate	5	31	8	44
primary	11	36	19	66
middle	54	21	19	94
secondary	62	14	8	84
college & above	8	1	3	12
Total	140	103	57	300

Table-5.42(2): Chi-Square tests of educational qualification of the patient and the habit of washing hands daily before taking food

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	87.235	8	.000
Likelihood Ratio	93.039	8	.000
Linear-by-Linear Association	31.376	1	.000
N of Valid Cases	300		

Table-5.42(2) shows a strong significance between the educational qualification of the patients and their usual habit of washing hands before taking food. Patients with higher educational qualification are more likely to wash hands before taking food as compared to the less educated one.

Table-5.43(1): Cross tabulation of educational qualification of the patient with the use of insecticides by the patient

Educational qualification of the patient	Use of insecticides by the patient		Total
	yes	no	
illiterate	2	42	44
primary	9	57	66
middle	59	35	94
secondary	57	27	84
college & above	11	1	12
Total	138	162	300

Table-5.43(2): Chi-Square tests of educational qualification of the patient and the use of insecticides by the patient

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	95.137	4	.000
Likelihood Ratio	108.624	4	.000
Linear-by-Linear Association	77.841	1	.000
N of Valid Cases	300		

Table-5.43(2) shows a strong significance between the educational qualification of the patients and their habit of using insecticides. Patients with higher educational qualification are more likely to use insecticides as compared to the less educated one.

Table-5.44(1): Cross tabulation of educational qualification of the patient with the daily cleaning of toilets

Educational qualification of the patient	Daily cleaning of toilets		Total
	yes	no	
illiterate	0	44	44
primary	0	66	66
middle	4	90	94
secondary	7	77	84
college & above	5	7	12
Total	16	284	300

Table-5.44(2): Chi-Square tests of educational qualification of the patient and the daily cleaning of toilets

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.287	4	.000
Likelihood Ratio	27.357	4	.000
Linear-by-Linear Association	21.317	1	.000
N of Valid Cases	300		

Table-5.44(2) shows a strong significance between the educational qualification of the patients and their habit of using insecticides. Patients with higher educational qualification are more likely to clean toilets regularly as compared to the less educated one.

Table-5.45(1): Cross tabulation of educational qualification of the patient with the maintenance of hygiene

Educational qualification of the patient	Maintenance of hygiene			Total
	nothing	burning garbage regularly	citra/dettol/phenol/D.D.T.	
illiterate	44	0	0	44
primary	61	3	2	66
middle	65	1	28	94
secondary	46	3	35	84
college & above	2	1	9	12
Total	218	8	74	300

Table-5.45(2): Chi-Square tests of educational qualification of the patient and the maintenance of hygiene

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	68.314	8	.000
Likelihood Ratio	83.356	8	.000
Linear-by-Linear Association	56.631	1	.000
N of Valid Cases	300		

Table-5.45(2) shows a strong significance between the educational qualification of the patients and the maintenance of hygiene. Patients with higher educational qualification are more likely to use different thing for maintaining hygiene as compared to the less educated one.

Table-5.46(1): Cross tabulation of educational qualification of the patient with patient's knowledge about the water borne diseases

Educational qualification of the patient	Patient's knowledge about the water borne diseases		Total
	yes	no	
illiterate	0	44	44
primary	1	65	66
middle	23	71	94
secondary	40	44	84
college & above	11	1	12
Total	75	225	300

Table-5.46(2): Chi-Square tests of educational qualification of the patient and patient's knowledge about the water borne diseases

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	85.460	4	.000
Likelihood Ratio	99.289	4	.000
Linear-by-Linear Association	70.225	1	.000
N of Valid Cases	300		

Table-5.46(2) shows a strong significance between the educational qualification of the patients and patient's knowledge about the water borne diseases. Patients with higher educational qualification are more likely to know about the water borne diseases as compared to the less educated one.

Table-5.47(1): Cross tabulation of educational qualification of the patient with frequency of changing pads/cloths per day

Educational qualification of the patient	Frequency of changing pads/cloths per day						Total
	Less than one time a day	One time a day	Two times a day	Three times a day	More than three times a day	not applicable	
illiterate	4	9	25	3	1	2	44
primary	1	9	47	2	5	2	66
middle	4	15	67	5	3	0	94
secondary	1	9	60	12	1	1	84
college & above	0	0	6	4	1	1	12
Total	10	42	205	26	11	6	300

Table-5.47(2): Chi-Square tests of educational qualification of the patient and frequency of changing pads/cloths per day

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.279	20	.006
Likelihood Ratio	37.545	20	.010
Linear-by-Linear Association	4.647	1	.031
N of Valid Cases	300		

Table-5.47(2) shows significance between the educational qualification of the patients and the frequency of changing pads/cloths per day. Patients with higher educational qualification change pads/cloths more frequently during menstruation as compared to the less educated one.

Table-5.48(1): Cross tabulation of educational qualification of the patient with continuation of the treatment

Educational qualification of the patient	Continuation of the treatment		Total
	yes	no	
illiterate	21	23	44
primary	55	11	66
middle	86	8	94
secondary	82	2	84
college & above	12	0	12
Total	256	44	300

Table-5.48(2): Chi-Square tests of educational qualification of the patient and continuation of the treatment

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	64.969	4	.000
Likelihood Ratio	56.127	4	.000
Linear-by-Linear Association	55.671	1	.000
N of Valid Cases	300		

Table-5.48(2) shows a strong significance between the educational qualification of the patients and the continuation of the treatment. Patients with higher educational qualification are more likely to continue treatment as compared to the less educated one.

Table-5.49(1): Cross tabulation of educational qualification of the patient with family income of the patient per month (approximately)

Educational qualification of the patient	Family income per month (approximately)				Total
	Rs 1000 - Rs 3000	Rs 3001 - Rs 5000	Rs 5001 - Rs 10000	above Rs 10000	
illiterate	2	30	10	2	44
primary	2	35	24	5	66
middle	3	20	48	23	94
secondary	1	11	31	41	84
college & above	0	0	0	12	12
Total	8	96	113	83	300

Table-5.49(2): Chi-Square tests of educational qualification of the patient and family income of the patient per month

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	111.834	12	.000
Likelihood Ratio	114.586	12	.000
Linear-by-Linear Association	78.790	1	.000
N of Valid Cases	300		

Table-5.49(2) shows a very strong significance between the educational qualification of the patients and the family income of the patient per month. Patients with higher educational qualification have more family income as compared to the less educated one or it can be assumed that patients having more family income are more likely to get higher education.

Table-5.50(1): Cross tabulation of the family income of the patient with patient's knowledge about HIV/AIDS

Family income per month (approximately)	Patient's knowledge about HIV/AIDS		Total
	yes	no	
Rs 1000 - Rs 3000	0	8	8
RS 3001 - Rs 5000	4	92	96
Rs 5001 - Rs 10000	26	87	113
above Rs 10000	34	49	83
Total	64	236	300

Table-5.50(2): Chi-Square tests of the family income of the patient and patient's knowledge about HIV/AIDS

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	38.275	3	.000
Likelihood Ratio	43.511	3	.000
Linear-by-Linear Association	37.353	1	.000
N of Valid Cases	300		

Table-5.50(2) shows a strong significance between the family income of the patients and the knowledge about HIV/AIDS. Patients with higher family income are more likely to have awareness about HIV/AIDS as compared to the less income group.

Table-5.51(1): Cross tabulation of the family income of the patient with patient's support to family planning

Family income per month (approximately)	Patient's support to family planning			Total
	yes	no	not applicable	
Rs 1000 - Rs 3000	2	1	5	8
RS 3001 - Rs 5000	44	34	18	96
Rs 5001 - Rs 10000	78	30	5	113
above Rs 10000	70	11	2	83
Total	194	76	30	300

Table-5.51(2): Chi-Square tests of the family income of the patient with patient's support to family planning

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	59.425	6	.000
Likelihood Ratio	50.304	6	.000
Linear-by-Linear Association	43.585	1	.000
N of Valid Cases	300		

From table-5.51(2) it is very clear that there is a strong significance between the family income of the patient and patient's support to the family planning. With the increase in the income level patient's support to family planning increases. Patients having more family income are more likely to support family planning.

Table-5.52(1): Cross tabulation of the family income of the patient with the use of insecticide

Family income per month (approximately)	Use of insecticide		Total
	yes	no	
Rs 1000 - Rs 3000	1	7	8
RS 3001 - Rs 5000	12	84	96
Rs 5001 - Rs 10000	54	59	113
Above Rs 10000	71	12	83
Total	138	162	300

Table-5.52(2): Chi-Square tests of the family income of the patient and the use of insecticide

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	99.377	3	.000
Likelihood Ratio	110.579	3	.000
Linear-by-Linear Association	95.352	1	.000
N of Valid Cases	300		

Table-5.52(2) shows a very strong significance between the family income of the patients and their habit of using insecticides. Patients with higher family income are more likely to use insecticides as compared to those having lower family income.

Table-5.53(1): Cross tabulation of the family income of the patient with the maintenance of hygiene

Family income per month (approximately)	Any other thing done to maintain hygiene			Total
	nothing	burning garbage regularly	citra/dettol/phenol/D.D.T.	
Rs 1000 - Rs 3000	8	0	0	8
RS 3001 - Rs 5000	91	3	2	96
Rs 5001 - Rs 10000	85	3	25	113
Above Rs 10000	34	2	47	83
Total	218	8	74	300

Table-5.53(2): Chi-Square tests of the family income of the patient and the maintenance of hygiene

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	75.669	6	.000
Likelihood Ratio	83.691	6	.000
Linear-by-Linear Association	69.801	1	.000
N of Valid Cases	300		

Table-5.53(2) shows a strong significance between the family income of the patients and the maintenance of hygiene. Patients with higher family income are more likely to use different thing for maintaining hygiene as compared to those having less family income.

Table-5.54(1): Cross tabulation of family income of the patient with patient's knowledge about the water borne diseases

Family income per month (approximately)	Patient's knowledge about the water borne diseases		Total
	yes	no	
Rs 1000 - Rs 3000	0	8	8
RS 3001 - Rs 5000	3	93	96
Rs 5001 - Rs 10000	24	89	113
Above Rs 10000	48	35	83
Total	75	225	300

Table-5.54(2): Chi-Square tests of family income of the patient and patient's knowledge about the water borne diseases

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	75.734	3	.000
Likelihood Ratio	80.818	3	.000
Linear-by-Linear Association	69.702	1	.000
N of Valid Cases	300		

Table-5.54(2) shows a strong significance between the family income of the patients and patient's knowledge about the water borne diseases. Patients with higher family income are more likely to know about the water borne diseases as compared to those having lower family income.

Table-5.55(1): Cross tabulation of family income of the patient with continuation of the treatment

Family income per month (approximately)	Continuation of the treatment		Total
	yes	no	
Rs 1000 - Rs 3000	5	3	8
RS 3001 - Rs 5000	70	26	96
Rs 5001 - Rs 10000	101	12	113
Above Rs 10000	80	3	83
Total	256	44	300

Table-5.55(2): Chi-Square tests of family income of the patient and continuation of the treatment

Statistical tests	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	24.738	3	.000
Likelihood Ratio	25.091	3	.000
Linear-by-Linear Association	23.424	1	.000
N of Valid Cases	300		

Table-5.55(2) shows a strong significance between the family income of the patients and the continuation of the treatment. Patients with higher family income are more likely to continue treatment as compared to those having less family income. In general also, it is easy for the higher income group to bear the treatment cost as compared to the lower income group.

After analyzing the trends, causes, social pathology, health seeking behaviour, related issues and treatment facilities it is seen that there are multiple factors associated with the disease situation which are again inter related. Social taboo is also a unique character related with the gynaecological diseases. Women should be given proper health education regarding the menstrual and sexual behaviour and the stigma attached with the gynaecological diseases or the hesitation which a patient feels while discussing about the sexual matters should be eradicated.