

# CHAPTER-VI

## CHAPTER – VI

### DISCUSSION AND CONCLUSION

Biological differences between the sexes give rise to differing health needs for men and women. However, biological differences are not the only determinants. Substantial evidence exists to indicate that in almost all societies, women and men have differing roles and responsibilities within the family and in society, different social realities, and unequal access to and control over resources. Differentials in health status between men and women have therefore to be understood within the context of social as well as biological differences. The sexual division of labour within the household, and labour market segregation by sex into predominantly “male” and “female” jobs, expose men and women to varying health risks. In addition, women often have multiple roles in the family and in society, as workers, mothers, and members of their communities. Social values and attitudes which defines men’s and women’s roles within the family and in the community, and norms governing acceptable behaviour for men and women, give rise to differentials in access to resources and health care. For example, son preference may influence the investment in health care of boys and girls. Because of the socialization of men and women to adhere to prevailing gender norms, their perceptions and definitions of health and ill-health are likely to vary, as is their health-seeking behaviour. Finally, gender differentials in access to and to control over resources, such as money, transport and time, and differences in men’s and women’s decision-making power within the family, affect women’s access to health services. Women may be allowed to decide on seeking medical care for their children, but may need the permission of their husbands or significant elders within the family to seek health care for themselves. Restrictions on women’s physical mobility also make it imperative for women to be accompanied to a health facility by a male family member.

A diagnostic research design has been used in the present study. The study has been carried out in four phases. In the first phase literature related to the major gynaecological diseases and various studies pertinent to the subject is reviewed. In

the second phase, a trend of the major gynaecological diseases among the women of reproductive age in Barak Valley during last eleven years is explored. In the third phase, interview schedule is developed so that each and every aspect of the study can be covered and all the objectives are met. Last phase is the main phase of the data collection. The researcher conducted interview, home visit, informal discussion, group discussion etc. to find out the relevant information.

Now the important issues which have been observed during the study are discussed below.

### *Socio-economic factors*

**Chapter-IV** shows various socio economic factors of the patients their association with the disease situation. As the present study is a comparative study between the rural and the urban patients, significance of the causative factors on the place of residence is found out. Major findings are given below:

1. If we analyze age wise distribution of the disease, we find majority of patients (64.7%) attended S.M.C.H. are in age group of 18-31 years, which means this age group is more vulnerable to gynaecological diseases. But the number of patients is more from rural area. This gives an impression that rural women in this age group are more susceptible to gynaecological diseases than their counterparts in urban area. But, the number of patients aged 32 and above attending SMCH is more in urban area. Hence, they are more vulnerable than their rural counterparts. The prevalence of gynaecological disease is more among the rural women compared to the urban women up to 31 years and the same is reverse after 31 years. If we divide the reproductive age in two equal parts, from the table it can be assumed that rural women are more vulnerable to gynaecological diseases in the first part i.e. up to 31 years and urban women are more vulnerable in the later part i.e. after 31 years.

2. From the study we get, more than two third (68%) are illiterate or less educated. It is quite understandable that women with higher educational qualification are less likely to develop gynaecological diseases as compared to the illiterate or less educated one. This can lead to a conclusion that level of education has a distinct relation with the disease situation. If we consider the rural and the urban population, illiterate population is higher in the rural area.

3. The study reveals that maximum of the patients (90.3%) are married. Married women of the reproductive age group are the high risk group for developing any gynaecological disease. This means, the sexual behaviour may have a direct relation with the probability of developing the gynaecological diseases. The trend is same in both the rural and the urban area with a slight difference in the percentage.

4. The study shows that, more than nine tenth of the families (91.3%) do not have any highly educated member in the family. Among the rural population, nine tenth of the families (90%) have no highly educated family members and among the urban population, more than nine tenth of the families (92.7%) have no highly educated family member. Thus it may be assumed that presence of highly educated members in a family have an inverse relation with the occurrence of the disease.

5. It is seen from the study that more than nine tenth of the patient (91%) under the study do not have any reading habit and less than one tenth of the patients (9%) only have reading habit and in both the rural and urban area the trend is same. Lack of reading habits is directly related to the level of awareness which affect the diseases situation.

6. Majority of the families (84.7%) have only one earning member. In the rural (82%) and urban (87.3%) area also the scene is same.

7. More than one third of the respondents (38%) live in kachcha house. In the rural area, less than the half of the respondents (48%) live in kachcha house and in the urban area less than one fifth of the respondents (28%) live in kachcha house.

8. More than half of the families (55.7%) do not use any means to purify water. Among the rural population, majority of the families (62.7%) do not use any means to purify water and among the urban population, almost half of the families (48.7%) do not use any means to purify water.

#### ***Trends of major gynaecological diseases under the study***

In **Chapter – V** 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.

### ***Causes of major gynaecological diseases under the study***

**Chapter-V** encompasses almost all the aspects related to the major gynaecological diseases under the study. Trends of the major gynaecological diseases during last eleven years is found out from the records and the various causative factors of the major gynaecological diseases especially related to the life style of the patients are also found out. If we combine the causative factors of all the major gynaecological diseases which are associated with the life style we get the following factors: (a) nutritional deficiency, (b) stress, (c) infection, (d) unhygienic conditions, (e) heavy work, (f) unprotected sex or having sex with multiple partners, (g) early marriage and early coitus, (h) unsafe abortion practices, (i) delivery by unskilled persons, (j) use of IUD or oral pills etc.

The other related factors given in **Chapter – V** are described below.

### ***Types of disease occurrences among the rural and urban area.***

The study shows that leucorrhoea is found in more than one fifth of the respondents (22.3%) and is the most commonly prevailing diseases among the sample. Near about 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. Less than one fourth 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. The hard labour prevalent in the rural area may have some consequences with the prolapse patients. Vaginitis, cervicitis and PID are having one cause in common which is infection.

### ***Menstrual hygiene***

i) The study shows that more than four fifth of the respondents (85.7%) do not maintain proper hygiene during menstruation.

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 they 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.

ii) 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.

So we can conclude that poor menstrual hygiene can be a causal factor in case of the gynaecological diseases.

### ***Reproductive behaviour***

i) More than one third of the respondents (39%) have their first coitus in life in between 18 years to 22 years and a little 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.

ii) 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.

iii) 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.

iv) 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 is government hospital. More than one third cases (39%) are not applicable which means they are unmarried, widowed, separated and child less women.

In the rural area, in a little less than half of the cases (48%) place of delivery is home and in more than one fifth cases (22.7%) place of delivery is government hospital.

v) The study 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.

vi) 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 sterilization 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.



vii) Total 128 patients out of 300 samples use family planning device. Among the 128 patients in 87 cases (67.9%) patient herself use the family planning device.

In the rural area, 65 patients out of 150 samples use family planning device. Among the 65 patients in 46 cases (70.7%) patient herself uses the family planning device. In the urban area, 63 patients out of 150 samples use family planning device. Among the 63 patients in 41 cases (65%) patient herself uses the family planning device.

viii) Total 128 patients out of 300 samples use family planning device. Among the 128 patients in 44 cases (33.4%) patients face problem in using the family planning device.

In the rural area, 65 patients out of 150 samples use family planning device. Among the 65 patients in 18 cases (27.7%) patients face problem in using family planning device. In the urban area, 63 patients out of 150 samples use family planning device. Among the 63 patients in 26 cases (41.3%) patients face problem in using family planning device.

Thus, problem in using family planning device may be a cause for the gynaecological problems like cervicitis.

#### ***Patients' and their families' perception about the diseases***

i) 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%). There is a noticeable fact that no patient from the urban area thinks that cause behind their disease is evil touch or evil eye.

ii) 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.

iii) 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.

iv) 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.

#### ***Abortion related history***

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.

Out of 34 abortion cases 8 cases (23.5% of the total abortion cases) abortions are done by the quacks. Among them 6 out of 34 cases (17.6% of the total abortion cases) are from rural area.

The unsafe abortions by quacks are still practiced especially in the rural area. This may be of great significance in occurrence of the gynaecological problems.

### ***Health seeking behaviour of the patient***

i) 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.

ii) 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, less 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.

iii) A 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 .

iv) 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.

v) 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.

vii) 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.

viii) More than half of the respondents (51.3%) discontinue treatment and less than half of the respondents (48.7%) continue treatment.

In the rural area, more than three fifth of the respondents (61.3%) discontinue treatment and less than two fifth of the respondents (38.7%) continue treatment. In the urban area, less than three fourth of the respondents (58.7%) continue treatment and more than two fifth of the respondents (41.3%) discontinue treatment. Discontinuation of the treatment is more in rural area as compared to the urban area.

ix) 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%).

### ***Awareness level of the patients regarding health matters***

i) 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.

ii) 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.

The most popular reason for not supporting family planning is the husband's unwillingness. 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.

iii) 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 table 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.

iv) The study 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 beliefs 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, little less than three fourth 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 more than one tenth (12.7%) do not know who is responsible for a child being male or female.

### ***Maintenance of general hygiene***

i) 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.

ii) 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 respondent (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.

iii) 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.

iv) 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.

#### ***Predominant misconceptions among the patients***

i) 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.

Various misconceptions prevalent among the sample are- a) Restriction in cooking, b) Sleeping on floor, c) Menstrual blood should not be seen by crow, d) Not to touch males, e) One should not enter into holy places and f) Avoidance of sexual activity. Menstrual blood is considered as unclean so to maintain the cleanliness various restrictions are made on the menstruating woman.

ii) Almost half of the total sample (49.7) under the study has a single belief (misconception/ wrong belief) regarding pregnancy and a little less than the half 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, near about three fifth of the respondents (57.3%) are found to have a single belief (misconception/ wrong belief) regarding pregnancy and a 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.

The predominant misconceptions about pregnancy are- a) Sex of the child depends on the process of intercourse b) One should not do any activity during eclipse, c) Sitting under the moon light will make the baby fair. d) Mother should not enter into holy places after 5 months of pregnancy, e) Not to roam hither and thither during pregnancy to avoid evil eye and evil touch, f) Mother should take less food to restrict over growth of the baby.

iii) Near about three fifth 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 a little less than one fifth of the sample (17.3%) have multiple misconceptions regarding child birth.



These misconceptions are – a) Cloths used in delivery should be burnt/buried, this helps to avoid the evil eye or evil touch and keeps the baby safe, b) 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. c) 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.

### ***Social taboos***

i) 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 a little more than one tenth of the respondents (11.3%)t 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.

ii) 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.

iii) Most of the patients (98.3%) 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.

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.

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Statistical analysis is also done and significant relationship is found among the variables like educational level, family income, awareness level, continuation of the treatment, hygiene maintenance etc. Almost all the variables are checked for the significance of rural urban divergence and is mentioned if significance is found. Considering all the discrepancies of the rural and urban patients, as a whole they suffer with the following problems:-

- a) Reluctance about health matters,
- b) Social stigma attached with the disease,
- c) Cost of treatment is high,
- d) Family members' reluctance or ignorance,
- e) Low level of health awareness,
- f) Lack of maintenance of proper hygiene,
- g) Various misconceptions regarding menstruation, pregnancy and child birth,
- h) Nutritional deficiency,
- i) Late recognition of the disease,
- j) Inactiveness of the patients in the decision making process in the family for which women have seek permission before coming to the hospital,
- k) Early marriage and child bearing practices,
- l) As compared to the disease burden there is paucity of health professional and resources etc.

### ***Suggestions***

For the over all improvement of the conditions of the gynaecological patients, interventions at various levels can be done. At the policy level inclusion of sex education in the general educational curriculum, development of gender specific health services etc. can be done. Through the involvement of NGOs various health check up programmes, awareness programmes, health education etc. can be organized. For the improvement of the reproductive health of the women following aspects of a woman's life should be taken into consideration

***Education:*** Education is the most powerful weapon to fight against any social evil. Though education directly can not stop the occurrence of any disease but education can play an important role in the management of the host factors. Better education will develop better insight in to the disease situation. In case of the gynaecological diseases there are various associated factors with the disease which can be improved through proper education. Malnutrition, unhygienic condition, unprotected sex, unsafe abortion, early marriage and child bearing practices etc. play a pivotal part in case of the gynaecological diseases. An educated woman will have better knowledge about the causative factors and can fight better with the agents. Education gives information and knowledge and enables the patient to find solutions of the problem in a better way. Education facilitates better prevention, detection and management of health problems. To attain proper treatment, care and rehabilitation also education is important.

***Empowerment of women:*** Though education broaden the road towards the empowerment of women, solely education is not sufficient. Along with the education, women should be involved in the economic activities. Various income generating activities among the women will give them some sort of economic independence. Economically independent women will have more right to decide about their reproductive and health seeking behaviour.

***Changing attitudes:*** Attitudinal change is very much necessary in eradication of misconceptions as well as in developing a favourable atmosphere. Till date various types of misconceptions are prevailing in the society about menstruation, pregnancy and childbirth. Some of them are even hazardous. There is a popular

myth that a pregnant woman should take less food to restrict the size of the baby, where as a pregnant woman should take more nutrition than others. So these misconceptions can have adverse affect on the health status of the women. Again we find there is a preference of male child over a girl child which has various negative consequences. This may lead to less investment in the health and education of the women. So a favourable attitude towards the girl child should be developed among the people. Again reluctance of the patients and their family members about the health matters in general and gynaecological problems in specific should be eradicated. Attitudinal change is an utmost necessity in fighting the problem of social stigma and social taboos associated with the gynaecological diseases.

In addition to the above, there are some major suggestions which should be done, these are as follows:

- a) Health awareness of the patients and their family members so that a proper health habit develops among them, ,
- b) Women's participation in the decision making process in the family regarding regulating her reproductive and health seeking behaviour,
- c) Early recognition of the problem by the patients and their family members and detection of the disease at an early stage,
- d) Acceptance of the problems of the patients by the family members as a disease that should be given medical concern,
- e) Eradication of social stigma associated with the disease,
- f) Establishment of a separate unit under the gynaecology department for providing counseling to the patients suffering from gynaecological diseases with all infra-structural facilities.
- g) Proper nutrition of the women folk, which is most of the time neglected as to avoid the diseases related to the nutritional deficiency such as anaemia, white discharge, calcium deficiency etc.
- h) Avoidance of excess hard labour which can even cause genital prolapse,
- i) Maintenance of hygiene in general and toilet hygiene in specific to avoid the gynaecological diseases that spread from using unclean toilets such as urinary infections. Menstrual hygiene should also be maintained to avoid the vaginal and genital infections.

## **Implication for Social Work**

The key findings of the present study identified the vital need of social work practice in the hospital setting. During the study the importance of social pathology related to the gynaecological diseases are ascertained and here arises the need of social worker. Successful prevention depends upon a knowledge of causation, dynamics of transmission, identification of risk factors and risk groups, availability of early detection and treatment measures, an organization for applying these measures to appropriate persons or groups, continuous evaluation of and developments of procedure applied. In case of the gynaecological diseases women of reproductive age group who are sexually active can be considered as the high risk group. Social worker can provide counseling services to the patients, act as liaison between the doctor and the patient, can conduct group discussions through which health education, hygiene maintenance, eradication of misconceptions, taboos and stigmas can be done. Social worker can also organize awareness camps or health check up camps in collaboration with the hospital. To fight with the problem of discontinuation of treatment counseling can be given to the patients. The social pathology of the gynaecological diseases suggests that the application of the social work practice in hospital setting will be an appropriate one.

## **Conclusion**

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. Social diagnosis of the gynaecological diseases has found that there is a strong need for social work intervention. The present study also suggests that there is need for further research studies in the following areas: (a) Scenario of the Barak Valley with regard to the services for gynaecological patients in the private sector, and (b) Comparative study between the government and the private sector in the field of gynaecology.