INTRODUCTION

In India, an ignored aspect of maternal morbidity is chronic obstetric morbidity. Information on community level chronic obstetric morbidities such as vesico-vaginal fistula/recto-vaginal fistula, uterine/vaginal prolapse, chronic pelvic inflammatory disease and secondary infertility is sparse. The major causes of these morbidities in India are early age at marriage, early age at first pregnancy along with frequent childbearing, poverty, illiteracy, deliveries conducted by untrained personnel, prolonged/difficult labor and lack of access to emergency obstetric services. In addition to physical suffering, it has social and economic consequences and may also affect marital relationship, including abandonment or rejection by the husband.

Women suffer reproductive morbidities for several years in silence. Hence, there is a need for closing the knowledge gaps with respect to perceptions, awareness, practices and treatment seeking behavior so that these problems could be addressed, particularly in the Government programs.

In the last two decades a noticeable increase has been observed in the use of Focus Group Discussions (FGDs) to gain insight into the dynamic relationship of attitudes, opinions, motivations, concerns and problems related to current and projected human activity.1 FGDs are organized to gather in-depth information and to explore a predefined topic, yet are open and flexible, thus allowing intensive exploration of opinions, feelings, attitudes and behaviors not possible through quantitative methods.2

The present study was undertaken to explore awareness, perceptions and experiences related to reproductive

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morbidities (gynecologic and obstetric); and to study the coping mechanism and treatment seeking behavior.

**Methodology**

Six Focus Group Discussions were conducted in six selected PHC areas (3-tribalm, 3-non-tribal) on the basis of systematic random sampling from the list of PHCs obtained from Nasik district in Maharashtra.

The study period was between January 2006 to December 2007. Principal Investigator of the study conducted the FGDs while the Research Investigators recorded the information. The discussion was also tape-recorded with consent from the participants. After explaining the purpose of the study to the participants, ethical consent was obtained. The discussion was carried out in a comfortable atmosphere without men around and rapport was built. Women were informed that the information collected from them would be utilized only for research purpose and that it would be kept confidential. In all the FGDs women were initially reluctant to speak but gradually participated actively in the discussion. No incentive was given for participation in the FGD. The issues explored during the FGDs were personal and menstrual hygiene, gynecological and obstetric complaints, awareness and their experiences of reproductive morbidities, perceived causes for the occurrence of these morbidities, awareness of different methods of family planning, abortion, interspousal communication and decision-making, treatment seeking behaviour and constraints in seeking services. After completion of each FGD, the women were provided with correct information on obstetric morbidities with the help of flip charts in the local language.

The discussions noted by the Research Investigators and the information obtained from the tape recorder was translated into English and transcripts were prepared. Textual and contextual analysis was done manually with the help of the prepared FGD guide.

Ten to twelve women attended each FGD. (Ever married women between 18-45 years of age). The educational status ranged from illiterate to 13th standard. The FGDs in tribal area were attended by women from Hindu Mahadeo Koli, Konkana and Bhil tribes while Marathas, Brahmins, Dhangars, Schedule caste and Muslim women participated in FGDs conducted in non-tribal areas, also included were local leaders such as Mahila Sarpanch and anganwadi workers.

The tribal women live in small pockets called “padas” which were in hilly areas and usually far away from the PHC; due to which they had difficulty in accessing services, as transportation facilities are poor. Non-tribal areas were densely populated and there were comparatively lesser accessibility problems. Women in both tribal and non-tribal areas largely represent the poor socio-economic strata. In some of the non-tribal areas women were employed in agricultural work, either of their own land or other’s land; due to proximity to urban areas some women were also engaged as labourers in small scale factories, sugar factory, vendors selling dried grapes, vegetables etc., in addition to domestic work. In some non-tribal areas women were engaged in weaving “Ghongadis” – thick bedsheets and sell them in the local market. However, in tribal areas, in addition to domestic work, most of the women were engaged as labourers in agricultural work. They did not have the basic facilities such as water for which they had to go far. In some of the Konkana and Bhil tribal families, matrilineal system is still prevailing. However, in some families there are live-in couples, due to financial problems they do not marry. They may marry later after having children, however, they have to marry before their children
merry. Women consume alcohol made from mahua flower.

**Findings**

It was noted that women in most of the communities generally got married at a very early age. Women in non-tribal areas reported the age of marriage to be around 16-17 years, however, women in tribal areas could not tell the age at which they marry, but said that usually they get married on commencement of menstruation or within three years of the onset of menstruation.

Sexual behaviour and hygiene during menstruation

Most of the women stated that they use homemade sanitary napkins made from old clothes, as they cannot afford to buy readymade sanitary napkins. Avoiding cooking and sitting out of the house during the menstrual flow days was a part of their practice of hygiene. One of the woman in a tribal PHC area said; “We don’t use sanitary napkins as we will not be able to wash it, we cannot throw it anywhere and we feel that if we use it we will have some menstrual problems.”

Another menstrual hygiene practice was abstaining from sexual contact. One middle aged woman in non-tribal area said; “We feel it unclean to keep the relation at the time of menstrual cycle.” They indirectly communicate this to their husband by asking him to sleep on the opposite side. Few of them could not refuse, as their husband was alcoholic, while some of them said they need to keep sexual contact or else they might have quarrel.

Awareness, perceptions and experiences related to reproductive morbidities

Almost all the women were aware about the common gynecological complaints such as white discharge, excessive bleeding and irregular menstrual cycle. Most women were not aware of the symptom of prolapse, while none of them were aware of genital fistula, except a woman in one of the tribal areas, as she knew another women with this condition.

Women were asked about the common gynecological complaints experienced by them and the local terminologies used. Low backache, lower abdominal pain, white discharge (angavarun pandhare pani jane), excessive bleeding (angavarun jast jane) and irregular menstrual cycles were the most common complaints experienced by these women. Some of the women also reported blood clot (gathi padne), contamination of uterus (garbhachi pishvi ghaan hone), uterine prolapse (aang baher yene or mayang baher padne). Some of them reported knee/joint pain or itching during menses.

They associated menstrual bleeding and white discharge as a work hazard. One of the young tribal women (about 24 years old) reported, “We have this problem as we have to do laborious work in the fields and lift heavy objects.” Many women in both the tribal and non-tribal areas had this perception. Some women considered white discharge as a woman’s fate and they could not associate a reason for it. One of the women in tribal area correlated it to tailoring work done by women as she felt that it is heavy work. In one of the FGDs in non-tribal area, few women felt that vaginal discharge usually followed after an abortion i.e. “curetting” in their colloquial terms. Few women had misconception that uterine prolapse occurs only during delivery.

Awareness and practice of family planning methods and abortion

Tribal women were not aware of methods such as IUD and oral pills, however, they knew about the condom. They used the term fugera for condom. In non-tribal areas women had knowledge about these methods but very few had used it. They said “We have children in the gap of two years so there was no need of using these methods.” They expressed that use of oral pills could adversely affect their menstrual
cycle and IUD (Copper-T) may lead to heavy menstrual bleeding, hence they do not prefer using these methods. Some women were interested in using these methods but their husbands were not allowing them to do so; as illustrated by the statement of a thirty year old woman in a tribal area “You tell these things to men”. They were aware of the safe period method but they had incorrect knowledge about the days which are safe. Condoms were used basically for prevention of pregnancy, none of them was aware that it could protect against STDs and HIV/AIDS. Most of them chose sterilization after having a male child.

Women reported abortions as a common occurrence. Gender discrimination was one of the major reasons for undergoing abortion. From the discussions around several abortion cases it can be deduced that abortions are frequent and are taken very casually. There was easy access to private hospitals for undergoing abortions. However, they were not aware of the harmful effects of repeat abortions, nor of undergoing unsafe abortions at a very young age. Very few women knew that abortions can cause problems in subsequent deliveries and also increase the chances of miscarriage damage to the uterus. Some women reported to have resorted to abortion by eating papaya or certain pills for inducing abortion.

Interspousal communication and decision-making

Most of the women had no interaction with their husband related to sexual issues. They were afraid of speaking with their husband on these topics. One of the women in the tribal area said; “we want to discuss these issues with our husbands but we fear that what will he say?” Many women mentioned about lack of freedom and apathy of their husbands towards such issues and said that these issues cannot be discussed with their spouses, as they would not be willing to understand. Furthermore, they did feel the need to communicate but they could not do so, as they felt shy or were embarrassed. However, they discussed this with their female friends or relatives of the same age. Very few reported discussing contraception with their husband. Women reported that they could not take decisions themselves. In most of the cases, decisions regarding treatment seeking, spending money on household expenses or on themselves, are taken by their husband and elders in the family.

Coping mechanisms and treatment seeking behavior

When asked where they seek treatment for gynecological problems such as vaginal discharge and menstrual problems, one of the women in the tribal area reported “Generally we go to Government hospital (i.e. PHC) if there is no relief then we go to private doctor and then take injection. Sometimes we also take treatment from traditional healer, he gives herbal medicine for menstrual related problems, but we have to avoid spicy and oily food while taking such treatment from traditional healers.” They felt that the medicines provided at PHC give temporary relief and the does not “cure” the problem. In one of the tribal areas a woman said, “If we have vaginal discharge, we take home-made alcohol and we are relieved after consuming it”. In one of the tribal areas menstrual problems is being treated by “rubbing the abdomen till dirty blood comes out” and for itching in genital region, brick powder and soap is applied. In non-tribal areas, women really did not view vaginal discharge or excessive menstrual bleeding as a real problem, they sought treatment only if the problem became severe, otherwise they carried on with their daily activities unaffected.

Women stated their first choice to be PHC, but if the problem persisted they sought treatment from private practitioners. When asked about treatment seeking for these illnesses, one woman responded, “We
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feel shy to go to the doctor, we go to the ANM. But we don’t take any traditional medicine. We don’t trust it.”

Constraints in seeking services

Women reported that they had constraints in seeking services in tribal areas. Home delivery was preferred to institutional delivery as stated by women, “Distance to health facility and lack of transport in the village are reasons for preferring home deliveries”. Few of them were of the opinion that they do not get proper care in the health center, hence they do not prefer to go there. In non-tribal areas women reported that many women now went to the health centres for deliveries.

Discussion

It was noted that the most prevalent reproductive obstetric problems experienced by women were low backache, lower abdominal pain, white discharge, excessive bleeding, irregular menstrual cycles and uterine prolapse.

In India, several studies have been conducted to elicit information on reproductive and maternal morbidity, utilization of health services and use of fertility regulating methods. In the present study, most of the women used home made sanitary napkins made from old clothes, as they could not afford to use sanitary pads. Similar findings were noted in a study conducted by Patel et al that most of the women used washed rags as menstrual pads; only 7.6 percent used pads available in the market.

Avoiding cooking, sitting out of the house, and abstinence from sexual contact during menstruation was a part of the hygiene practices. Similar findings were observed in a study by Garg et al 2007 conducted in urban slums of Delhi in which menstruation was seen as the expulsion of dirty blood from the body, and women were considered untouchable not entering kitchen, not having sexual contact and refraining from religious practices were some of the other practices followed during menstruation.

In this context women’s bodies and bodily processes are considered shameful and defiling in most Indian cultures. Consequently, women shrink in and are segregated to their little spaces during menstruation, pregnancy and childbirth.

Majority of the women were not aware of the causative factors for the occurrence of common reproductive morbidities, in the present study. However, the local terminologies used for these complaints could be elicited in the study. For vaginal discharge, it was felt that it is a woman’s fate and that there is no reason that can be given. Patel et al reported similar findings in a study conducted in a rural area of Haryana district through interviews conducted with 230 women and two FGDs with the objective of estimating the prevalence of vaginal discharge and to explore the ethno-medical context of vaginal discharge. The respondents in their study said that vaginal discharge was the “fate of every woman and there was no need of treating it”. This shows that women perceive vaginal discharge as normal in their lives. Even if symptoms of infections are noticed by the women they are considered “normal” and a “woman’s lot” and are thus ignored. Studies underscore that symptoms of reproductive morbidities are either not considered serious, are considered self-limiting, or simply a normal consequence of marriage and childbearing and for all these reasons not severe enough to warrant attention. Thus, even when women recognize a symptom to be abnormal and causing discomfort, they often do not seek treatment readily.

In the present study, women did not know the causes for prolapse as very few were aware of this symptom. Some had misconceptions regarding prolapse that it
occurs during delivery. Elizabeth et al. in a study in Bangladesh reported that the respondents stated they had problem of prolapse in which the uterus slips down when a woman sits in a squatting position. Some young mothers said that they had not heard much about the problem because older women do not speak about it. One of the findings of this study was that if heavy weight lifting is avoided during the puerperium period, prolapse could be prevented. Generally, women were not aware of fistula and its associated symptoms. In the present study, none of the women were aware of fistula except for one woman who knew somebody with the problem.

Majority of the women in tribal areas were not aware of methods such as IUD and oral pills, however, they knew about the condom. In non-tribal areas, women had knowledge about these methods but very few had used it. Use of condoms was mostly for prevention of pregnancy, none of them was aware that it could give protection against STDs and HIV/AIDS. Mukhopadhyay et al. described the findings from three FGDs conducted to understand rural women’s perception and attitudes towards maternal (obstetric morbidity). They reveal that use of reversible methods of family planning were not popular among women because of their perceived adverse health effects and objection raised by husband and other family members.

Most of the women had no communication with their husband on sexual issues mostly because they were afraid of speaking with their husband on these topics. Women reported that they could not take decisions themselves. So, overall, it was observed that health of these women is shadowed, and problems related to gynecological/obstetric health remains a neglected issue because of various reasons.

In the present study, women gave government center/PHC as the first preference for seeking treatment in case of gynecological/obstetric problems and if there was no relief they sought treatment from private doctors. In a study conducted by Bhat conducted in West Bengal it was seen that in most cases communities prefer to visit private providers who dispense allopathic medicines. In the present study, women from tribal areas, preferred home deliveries because of distance to the health facility and lack of transportation. Few of them opined that they do not get proper care at the health center hence, they do not want to go there. Similar findings were reported by Elizabeth et al. in their study wherein none of the respondents wanted to go to the hospital for delivery, they would consider doing so only if severely ill. They felt that it had much to do with poor quality of hospital services and the difficulties of transport and finance. In the present study, women used home remedies for vaginal discharge such as application of brick powder, taking homemade alcohol etc.

**Conclusion**

The findings of the present study will fill some of the knowledge gaps in exploring perception, awareness and knowledge, practice and coping mechanism on obstetric and gynecological related issues. The study also will help in developing IEC material and messages using local terminologies, for women which would be better understood.

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REFERENCES


