Reproductive Morbidity among the Rural Women in Maharastra

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Introduction and literature review

The magnitude of women's reproductive health problems in India is immense. Reproductive health status of third world women as indicated by various available this indicator of maternal mortality is very alarming. The figures concerned highlight not only the enormity of the poor health status of women, but also the sharp disparity between the developing and developed countries in context. The limitation of the population control approach was recognized through experiences of women all over the world, including India. It was also recognized that women suffer silently from a large number of reproductive illness, which were termed as the silent emergency. This understanding lead to women's health researchers and activists focusing more on women's health, especially in the field of reproductive health.

Reproductive morbidity is a broad concept that encompasses health problems related to reproductive organs and functions, including and outside of childbearing. Reproductive morbidity can be broadly categorized into three subgroups: *obstetric morbidity, gynecological morbidity and contraceptive morbidity. Obstetric morbidity* refers to ill health in relation to pregnancy and childbirth. *Gynecological morbidity* includes health problems outside pregnancy such as RTIs, menstrual problems, cervical ectopic, infertility, cancers, prolepses and problems related to intercourse. *Contraceptive morbidity* includes conditions, which result from efforts to limit fertility, whether they are traditional or modern methods. Reproductive morbidity in general, is an outcome of not just biological factors but of women's poverty, powerlessness and lack of control over resources as well. Malnutrition, infection, early and repeated childbearing and high fertility also play an important role in poor maternal health conditions in India.

Also, the global emergence of sexually transmitted infections has bought attention to women's reproductive and sexual health. Women's reproductive and sexual health had for decades been a neglected area of international research (Graham and Campbel, 1999, Sen and Snow, 1994). Now, these issues feature more prominently in policy and programme development of government and non-governmental organizations (Muller et al., 1991). Concern with sexual and reproductive health gained momentum with the International Conference on Population and Development (ICPD, 1994). Programme of action articulated the need to meet the reproductive health requirements of Individuals. In the context of India, the impetus to bringing these and related issues in to the public domain began with a

community based epidemiological study of gynecological morbidity in Maharastra (Bang et al., 1989). According to WHO (1995) over one third of all healthy life lost among adults women is due to reproductive health problems. They often deal with unwanted pregnancy; suffer due to unsafe abortion, problem arising out of contraception, risk of RTI and STI including HIV infections.

Prevalence of reproductive tract infections (RTI) is detrained by number of factors. An association between pelvic inflammatory diseases (PID) women and husband extramarital sexual relation has been well documented (Ooman, 2000). Use of contraception especially, IUD, female sterilization and abortion procedures also increases risk of RTI/STI (Gittlesohn et al., 1994, Bhatia and Cleland, 1995). Also obstetric experiences of women and certain routine procedures during gynecological examination may lead to contracting RTI's. Lack of menstrual and personal hygiene is also found to be associated with RTI's. In addition, there are socio-economic and cultural determinants of RTI's studies have shown strong association between women's livelihood, work and their reproductive health (Oomen, 2000). In the study of adolescent girls in Rajasthan it is found that large proportions of girls were not aware of menstruations when they firs experienced it (Khanna and Goyal, 2005). A study conducted in Ahmednagar in Maharastra (Barua and Kurzk, 2001) shows that the married adolescent girls often went untreated in case of menstrual problem and RTI.

Generally women with self reported symptoms of reproductive morbidity do not seek treatment due to existing taboos and inhibitions regarding sexual and reproductive health. They hesitate to discuss about the reproductive problem especially, due to shame and embarrassment (Bang et. al., 1989 and Oomen, 2000). Even if they seek treatment, a majority of women seek health care from quacks or unqualified for their health. Untreated infection can not only lead to PID, ectopic pregnancy, infertility and cervical cancer but also fetal loss, health problem of new born and increased the risk of HIV infection. In addition to health consequences, women experience social consequences in terms of emotional distress related to gynecological morbidity (Mamdani, 1999).

As most of these illnesses progresses to chronic state and remain with the women for the rest of their lives, the importance of early detection and management becomes evident. Until now, a matter of concern that, little is known about the prevalence of Reproductive Tract Infection (RTI's) or Sexually Transmitted Diseases (STD's) among women in developing countries such as India. A recent study of young married women aged 16-22 years in a rural community in Tamil Nadu reports a very high level of morbidity. The study shows that more then half of the women were suffering from at least one or more RTI/STDs. Clinical examination also confirmed STI/s among majority of them (Joseph et al., 2000). Kulkarni and Adhikari in a study of adolescent women in India and Nepal report relatively high rates of gynecological morbidities, especially in the settings where girls have limited excess to adequate health care (Jejeebhoy, 2000).

Need for the Study

Though there has been increasing concern over the general health and morbidity status of women in India but still much attention is required to the morbidity among women. There is

paucity of evidence base about various dimensions of reproductive morbidity. On the other side, recent efforts in different developing countries including India to study reproductive morbidity at the community level suggest a high prevalence of gynecological and obstetric morbidities. Given the common prevalence of the reproductive morbidity, it necessary to understand and identify the underlying correlates. Therefore the present study focuses upon the reproductive morbidity and identifies its demographic and socio-economic determinants in the rural Maharastra.

Objectives

The study aims at understanding the reproductive health problems among rural women of Maharashtra in the context of individual, societal and environmental factors and its programmatic implication. However the specific objectives are;

➢ To study the prevalence of reproductive morbidity, with a specific emphasis on menstrual problems and RTI/ STDs among the rural women in Maharastra.
➢ To examine the perceived severity of menstrual problems and RTI/STDs.
➢ To analyze the consultation lag and treatment seeking behaviour

Data and Methods

The basic data used in this paper has been taken from IIPS-ICMR project entitled " Psycho-social, cultural and service related factors affecting reproductive morbidity" (2002-2003), conducted by IIPS. The data is based on the randomly selected four districts (Nagpur, Thane, Jalgaon, Kolhapur) of Maharastra according to four zones (East, West, North and South) followed by selection of two primary health centres (PHCs) from each of the two districts. The research design consists of a random selection of four district of Maharastra followed by selection of two primary health centres, (PHCs) from each of the two districts. In this survey, all currently married women of reproductive age groups (15-44 years) in the selected villages were considered eligible for the study. A total of 24 villages have been selected and eligible women were included for the study. In order to identify the women currently suffering or ever suffered from reproductive morbidity, initially all women are screened. Only those women who are currently suffering are included for the psychosocial survey. Overall, the sample size includes:

Total No. Of women per village for initial screening   = 300
Total No. Of women in 24 villages for initial screening   = 7,200
Total No. Of women per village for psychosocial survey   = 90
Total No. Of women in 24 village for psychosocial survey = 2,200

In addition, a small sample (10 per cent) of women having no reproductive illness has also been taken for psychosocial survey. So out of 24 villages, a total of 288 women were selected for psychosocial survey. Hence in order to fulfill the first objective 7,200 women were selected. In the survey question is asked to the women about their perception regarding the reproductive morbidity that, "Do you think this problem or symptom as a disease?" The women who have answered 'No', another question are asked that "Is it normal for the women to have this problem/disease". Hence to capture the perceived severity among the women,

2200 women were selected with whom the psychosocial survey is carried out. Rest of the analysis is base on these women only.

If the villages are small then more subcentres and remote villages, selected randomly, are taken in order to obtain the requisite sample size for the study.

To analyze the prevalence of menstrual problem, RTI/STD and any reproductive morbidity in Maharashtra and its four districts, bivariate analysis has been carried out with the help of SPSS. Further, this prevalence is also analyzed by different background characteristics. In order to identify the effect of different independent variables on dependent variables (Menstrual problem, RTI/STD and any reproductive morbidity), three logistic regressions has been carried out separately. The dependent variables are categorized as: Menstrual problem (1 = Yes, 0 = No), RTI/STD problem (1 = Yes, 0 = No), any menstrual problem (1 = Yes, 0 = No).

Analysis and findings

Table-1 shows the overall scenario of reproductive morbidity among rural women in Maharastra. Nearly three fifth of women included in the survey of have reported at least one reproductive health problem. However the prevalence of any reproductive health problem varies across the districts ranging from a minimum of 40% in Jalgaon to a maximum of 80% in Nagpur. Prevalence of different types of reproductive morbidities reveal that nearly four fifth of women reporting at least one morbidity have reported suffering with RTI/STDs. On the other hand, each of delivery related problems, contraceptive related problems and menstrual related problems accounts for 26- 29 percent of reported morbidities. Even among those reported suffering with RTI/STDs the variation in the prevalence across districts reveal more or less similar pattern as observed in case of any reproductive health problem.

It's worth mentioning that prevalence of any reproductive morbidity is determined by a number of socio-economic and demographic factors influencing individual life style and behavioral traits. There fore a number of individual level factors such as age, education, age at marriage, education of husband have been considered in addition to societal and programmatic indicators. Table-2 presents the prevelance of different reproductive health problem by specific background characteristics. It is evident from the table that the symptomatic prevalence of any reproductive health problem is negatively associated with the age of the woman. Women age 35 and above are 13 percent less likely to report any reproductive health problem than women below 25 years. However there is no significant variation in the reported prevalence of RTI/STDs by age of the woman. Data shows that those women, who have educated up to primary level, are more likely to report menstrual problem as well as RTI/STDs as compared to those who have completed higher secondary. However the difference is not profound in case of reported prevalence of any reproductive health problem. The prevalence of all three morbidities clearly cuts across caste groups. It is evident from table 2 that, there is a difference of 9 percent points in the prevalence of any reproductive health problems among women belonging to SC/ST (65 percent) and OBC (56 percent). By and large a similar pattern in the differentials across the caste groups is observed even in case of prevalence of menstrual and RTI/STDs. However reported prevalence of RTI/STDs significantly cuts across Hindu and Muslims. Incase of any reproductive health problem, Muslims women (61 percent) are

reporting slightly higher than Hindu (57 percent). There is not much variation in reporting in any of three selected morbidities with respect to the health facility in the village.

Table 3 shows the prevalence of menstrual problems by specific symptoms among rural women in Maharashtra. Among the one fourth of the women suffering from any menstrual problem nearly half of them are suffering from painful periods (45 percent) followed by scanty bleeding (39 percent) delayed period (29 percent) and excessive bleeding (14 percent). Variation in the prevalence of painful periods is negatively associated with the age of the women and education, which reveals causation between reported prevalence of painful period and symptomatic prevalence of RTI/STDs (Table 4). The prevalence of painful periods clearly cuts across the caste groups, religion and types of village by availability of the health facilities. Considerably higher proportion of women in remote villages (48 percent) has reported to suffer from painful periods than their counterparts among women from sub-center villages (42 percent). The prevalence of delayed period and scanty bleeding also varies by age of the women though revealing a contrast in pattern by age of the women.

Table-3 gives an outlook about the prevalence of different menstrual problems among the rural women in Maharastra. 26 percent of women reported that they have menstrual problem and 44.8 percent of women are having painful period problem in the state. It is also found that 34.1 per cent women are suffering from any menstrual problem in Nagpur district where as 56.4 per cent women have reported problem of painful period in Jalgaon district. Painful period, scanty bleeding, delayed period are the prominent menstrual problems found in Maharastra. Considering the problems in zonal wise, Jalgaon (North zone) is the least affected and Nagpur (East zone) is the high prevalence belt in Maharastra state.

Table-4 represents the prevalence of different menstrual related problems among rural women in Maharastra. More than one fourth of the rural women in Maharastra are replied at least one menstrual problem. 32 percent of women from SC/ST category have suffered from any menstrual problem, which is comparatively much higher than the women of General caste (25 percent). Data reveals that husband education has impact on the menstrual problem of women. As the education of the husband increases, the prevalence menstrual problem in the women is decreasing from 48 percent to 44 percent. Also, it is found that, prevalence of painful period, delayed period, scanty bleeding and any menstrual problem is high among the girls who effective age at marriage is more than 18 years with respect to the girls who effective age at marriage is less than 18 years.

Table-5 gives the prevalence of women having different RTI/STD problem in the Maharastra. It is found that the rural women in Maharastra have mostly affected by RTI/STDs problem among all the reproductive health problems. As an overall view, Nagpur (63.8 percent) became the high prevalence having RTI/STDs problem and Jalgaon (37 percent) became the least affected district. Among the different types of RTI/STDs problem, low backache low backache is dominated in the entire district in Maharastra. Bleeding after sexual intercourse is a problem but its prevalence is very low in Maharastra. The problem of vaginal discharge is highest around 24 percent in Nagpur district and lowest in Thane.

Table-6 shows the prevalence of different of different RTI/STDs problem by background characteristic of women. It is found that 46 percent women suffered from any RTI/STDs problem but the problem of low backache (27 percent) has drastically affected the rural women of Maharastra. Problem of vaginal discharge is more in Muslim (27.9 percent) as Hindu (17 percent) and others (18 percent). Illiterate women have suffered mostly by vaginal discharge problem but as the level of education increases the RTI/STDs problem goes down. Among the caste, 35 percent women reported the problem of low backache in SC/ST but it is less in General (25 percent). Data revels that women more then 35 years of age, low backache is a problem for them but women's between 25-35 year of age, 46 percent have reported at least any one RTI/STDs problem.

Table-7 infers about the perceived severity of menstrual problem. Among women who are of less then 25 years of age, only 22 percent have reported menstrual problem as a disease but 56 percent considered it as normal and 21 percent are not sure about it. One-fifth of women have reported menstrual problem as a disease and on the other hand, 67 percent women considered it normal for them and 12 percent women are not sure, whether it is normal or any sort of disease. Education pays a vital role and creates awareness in the women's about the different menstrual problem. About one fifth of non literate women where reported to have that menstrual problem is usually disease while little less then two-third women have the view that menstrual problem is just normal for them and 15 percent women can not say anything. Those women who are completed their primary level, secondary level and above education their perception level about menstrual problem, increases as compared to illiterates women. Among the caste, 55 percent women belong to the SC/ST category have an opinion that menstrual problem is normal for them while 33 percent women considered menstrual problem as a disease as compared to 18 percent women from general category. In case of personal hygiene, overall it is found that 18 percent to 20 percent women and their husband wash out their private parts during sexual intercourse have the opinion that "yes" -menstrual problem is a problem for them. Around 54 percent to 57 percent women have their perception that it is normal for them and 21 percent to 23 percent women reported that they are not sure about it. So, overall it gave a clear-cut view that only 20 percent women have the knowledge that menstrual problem is a disease, it is not a normal process and 80 percent of the total women population in the rural Maharastra have less knowledge about it therefore, they are at the risk of or they have greater chances to get affected by menstrual disease.

Table-8 This table gives the information about the perceived severity of RTI and STD's problem by background characteristics of women. Here, 27.7 percent of women between 25 to 35 years of age reported RTI/STDs as a problem. Along that 59 percent women have reported that menstrual problem is normal and 17 percent women have said that they are not sure about it. With regards to personal hygiene, it was observed that among women and their husband who wash their private parts, out of them about one fifth considered RTI/STDs as a problem and half of them said that it is normal rather then the disease and rest are not sure about it. Overall the trends are like that 25 percent of women only have knowledge about RTI/STDs being a disease. About 55 percent of women have considered RTI/STDs as normal but in practical these are normally the disease. Therefore it is necessary to give them more information about it also 19 percent of women have no knowledge about RTI/STDs. Hence the rural women in Maharastra are at the risk of getting RTI/STDs problem.

The result of logistic regression analysis of any menstrual problem, any RTI/STD problem and any reproductive problem among the rural women in Maharastra are shown in **Table-9**. This regression analysis has done to the women who are coming for the screening test and their total number is 7200. Now in the independent variable there are three regression model (Regression-1, 2 and 3).

Regression-1 = any menstrual problem (1 for Yes, 0 for NO).
Regression-2 = any RTI/STD problem (1 for Yes, 0 for NO).
Regression-3 = any reproductive health problem (1 for Yes, 0 for NO).

In regression-1, the dependent variable is menstrual problem. In this regression education of women and her husband, caste and religion have been shown significant affect on the likelihood of having menstrual problem. Age, effective age at marriage and the type of village are not shown significant relation with menstrual problem. Explain the incidence of the menstrual problem in the women; it is observed that with increase in the level of education there is decrease in the likelihood of getting menstrual problem. Among the caste group, those women who belong to OBC and SC/ST category have a higher likelihood of getting a menstrual problem compared with the General category. It is also observed that the Muslims and the other religion have a higher likelihood of having any menstrual problem.

In the second regression, having any RTI/STDs is considered as the dependent variable. Here, only education of the husband, caste and religion are significant predictors of RTI/STDs. It is observed that with secondary level education of the husband there is a lower likelihood of getting any RTI/STDs because Education increases awareness and knowledge and women are taking precaution. In case of religion, Muslim has higher likelihood of getting RTI/STDs i.e. Muslim has 1.278 times higher risk of getting RTI/STDs as compared to Hindu and other religions. Also, it is noticed that those women whose effective age at marriage is more than 18 years have 1.06 times higher risk of having RTI/STDs as those women whose effective age at marriage is less than 18 years.

In Regression-3, any reproductive problem has been taken as dependent variable. Here, current age of the woman, effective age at marriage, education of the woman and her husband, caste and religion are significant predictors of any reproductive health problem. The same trends is observed here, in case of education of her husband where it is seen that with increase in the level of the education of husband is a lower likelihood of getting any reproductive problem but the education of woman shows an opposite trend with increase in education up to primary level there is 1.383 times higher likelihood of having any reproductive health problem. In this regression, current age of woman shows an inverse relationship with having any reproductive health problem. With increase in the current age of woman, there is a lower likelihood of getting having any reproductive health problems.

Conclusion

Study on reproductive morbidity is itself a neglected area in the field of research and exploration. Also, the reproductive health and status of women in the developing countries,

like India, needs and requires a lot of attention. This study indicates that prevalence of reproductive morbidity, including menstrual problem and RTI/STD, is very common among the rural women in Maharashtra and within them district, Nagpur become the high prevalence district. The perception level of rural women's towards the reproductive morbidity is a matter of great concern and requires an immediate attention. As we know that Maharashtra ranks fourth among all the 28 states in India (Human Development Report 2001), in spite of this nearly 80 percent of women have at least one reproductive morbidity and they realize it as a normal process in their life. However some of them (nearly 20 percent) are not sure about that and remaining consider this as a disease. This will definitely become a burning issue and a matter of discussion among the policy makers. Also there is a need to develop interpersonal communication among the women in Maharashtra.

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Table 1: Prevalence of Reproductive Health Problems in Maharashtra

Type of RH morbidity	Thane	Kolhapur	Jalgaon	Nagpur	Maharashtra
Menstrual	25.6	26.3	18.7	34.1	26.1
RTI/ STDs	38.3	45.6	36.6	63.8	46.0
Pregnancy related	9.9	21.3	9.4	17.9	14.8
Delivery related	17.4	40.3	11.1	41.1	29.2
Abortion related	0.7	0.6	0.3	1.3	0.7
Contraception related	20.1	23.2	7.6	51.3	25.8
Any reproductive health problem	50.5	62.8	40.2	80.3	58.4

Table 2: Prevalence of Different Reproductive Health Problems by Background Characteristics

Back ground characteristics	Menstrual problem	RTI/STD problem	Any RH problem
Age			
Less than 25 year	24.7	45.3	61.6
25-35	27.2	46.9	58.6
35+	25.6	44.8	53.1
Age at Marriage			
Below 18	26.0	45.4	56.3
Above 18	26.3	46.8	60.9
Education of women			
Illiterate	26.3	44.0	54.5
Up To Primary	27.8	48.7	60.0
Secondary	26.3	46.7	60.0
High School and above	21.4	44.2	61.7
Education of Husband			
Illiterate	26.7	44.6	54.9
Up to Primary	29.9	49.6	63.1
Secondary	25.4	45.7	57.9
High School and above	23.4	44.2	57.2
Caste			
General	25.0	45.6	58.3
O.B.C	24.7	43.9	55.7
S.C/S.T	31.3	51.5	64.8
Religion			
Hindu	25.4	44.9	57.3
Muslim	25.9	52.0	61.2
Other	34.9	53.8	68.0
Type of village			
PHC Village	26.5	46.3	59.7
Sub center village	26.2	45.4	58.0
Remote Village	25.7	46.3	57.5
Total	**26.1**	**46.0**	**58.4**

Table 3: Prevalence of Different Menstrual Problems in Maharashtra

Type of Menstrual Problems	Thane	Kolhapur	Jalgaon	Nagpur	Maharashtra
No period	8.2	7.8	7.1	22.0	12.4
Painful Periods	47.6	23.7	56.4	52.7	44.8
Frequent periods	7.3	23.0	7.1	14.9	13.7
Delayed Periods	35.8	27.9	26.7	25.1	28.7
Prolonged bleeding	14.9	4.7	12.8	2.9	8.0
Excessive Bleeding	17.8	13.7	17.5	10.2	14.3
Continuous Bleeding	15.6	4.2	12.8	3.6	8.3
Scanty bleeding	32.4	26.4	48.7	48.1	38.9
Inter menstrual Bleeding	7.3	0.8	5.0	5.6	4.7
Any Menstrual problem	**25.6**	**26.3**	**18.7**	**34.1**	**26.1**

Table 4: Prevalence of Different Menstrual Problems by Background Characteristics

Back ground characteristics	Painful periods	Delayed periods	Excessive bleeding	Scanty bleeding	Any menstrual problem
Age					
Less than 25 year	46.8	39.4	15.9	28.7	24.7
25-35	45.7	23.9	13.1	44.4	27.2
35+	39.2	26.2	15.2	39.0	25.6
Age at Marriage					
Below 18	43.2	27.5	15.5	36.3	26.0
Above 18	46.6	30.0	12.8	42.0	26.3
Education of women		.			
Illiterate	46.8	28.3	14.8	38.5	26.3
Up To Primary	43.7	27.0	14.7	38.4	27.8
Secondary	43.6	29.1	14.2	39.1	26.3
10 +	45.2	32.5	11.1	41.3	21.4
Education of Husband					
Illiterate	48.1	31.0	17.8	36.4	26.7
Up to Primary	45.4	24.6	14.7	39.7	29.9
Secondary	43.2	28.2	13.9	38.6	25.4
10 +	44.7	33.4	11.3	40.9	23.4
Caste					
General	32.9	28.0	15.5	31.1	25.0
O.B.C	50.4	30.9	13.2	42.5	24.7
S.C/S.T	50.4	25.6	14.7	43.0	31.3
Religion					
Hindu	45.0	30.1	13.8	39.4	25.4
Muslim	38.8	23.3	19.8	34.5	25.9
Other	46.2	20.5	14.5	37.4	34.9
Type of village					
PHC Village	44.8	28.4	13.1	39.4	26.5
Sub center village	41.8	30.5	13.6	39.1	26.2
Remote Village	47.6	27.3	16.0	38.3	25.7
Total	**44.8**	**28.7**	**14.3**	**38.9**	**26.1**

Table 5: Prevalence of Different RTI/STI Problems in Maharashtra

Type of RTI/STDs problems	Thane	Kolhapur	Jalgaon	Nagpur	Maharashtra
Vaginal discharge	15.0	16.7	17.1	24.0	18.2
Itching over vulva.	4.7	5.1	2.0	10.3	5.4
Pain in lower Abdomen	9.3	13.2	6.6	18.0	11.6
Low backache	21.5	27.2	19.6	45.2	27.9
Boils, warts and ulcers.	1.0	1.7	0.3	3.6	1.6
Pain during sexual intercourse	1.7	1.3	0.5	6.5	2.4
Bleeding after sexual intercourse	0.1	0.3	0.1	0.4	0.2
Swelling in the groin	0.3	1.0	0.7	2.4	1.1
Frequent painful passage of urine.	2.7	4.7	1.7	7.1	4.0
Any RTI/STDs problem	**38.3**	**45.6**	**36.6**	**63.8**	**46.0**

Table 6: Prevalence of different RTI/STDs Problems by Background Characteristics

Back ground Characteristics	Vaginal discharge	Pain in lower abdomen	Low backache	Any RTI problem
Age				
Less than 25 Year	18.0	12.2	25.7	45.3
25-35	19.7	11.2	27.8	46.9
35+	14.5	11.7	31.5	44.8
Age at Marriage				
Below 18	18.5	11.9	26.8	45.4
Above 18	17.9	11.3	29.2	46.8
Education of women				
Illiterate	19.0	11.3	26.5	44.0
Up To Primary	18.7	12.1	31.8	48.7
Secondary	17.9	11.8	27.7	46.7
High School and above	15.6	10.8	26.5	44.2
Education of Husband				
Illiterate	19.4	11.6	26.5	44.6
Up to Primary	19.1	13.7	32.0	49.6
Secondary	18.3	10.7	27.2	45.7
High School and above	16.0	11.6	26.4	44.2
Caste				
General	19.5	11.2	25.9	45.6
O.B.C	16.8	10.9	26.3	43.9
S.C/S.T	19.2	14.4	35.2	51.5
Religion				
Hindu	17.5	11.5	27.3	44.9
Muslim	27.9	10.2	27.2	52.0
Other	18.4	13.8	36.0	53.8
Type of village				
PHC Village	17.7	10.7	27.9	46.3
Sub center village	18.2	11.4	26.2	45.4
Remote Village	18.1	12.7	29.5	46.3
Total	**18.2**	**11.6**	**27.9**	**46.0**

Table 7: Perceived severity of menstrual problem by background characteristics

Back ground characteristics	Severe problem	Normal	Can't sure
Age			
Less than 25 Year	22.2	56.1	21.7
25-35	27.3	53.2	19.5
35+	20.0	67.6	12.4
Age at Marriage			
Below 18	25.6	55.4	19.0
Above 18	23.0	58.1	18.9
Education of women			
Illiterate	21.6	62.9	15.5
Up To Primary	25.2	55.1	19.7
Secondary	25.0	56.5	18.5
High School and above	25.5	48.9	25.5
Education of Husband			
Illiterate	28.9	55.6	15.6
Up to Primary	24.0	52.7	23.4
Secondary	24.1	58.9	17.0
High School and above	24.2	57.5	18.3
Caste			
General	18.3	60.4	21.3
O.B.C	24.8	54.5	20.6
S.C/S.T	33.6	55.5	10.9
Religion			
Hindu	24.3	56.8	18.8
Muslim	27.8	52.8	19.4
Other	22.5	57.5	20.0
Type of village			
PHC Village	22.6	54.7	22.6
Sub center village	25.3	61.3	13.4
Remote Village	25.4	53.2	21.4
Women wash their private parts after intercourse.	18.2	60.0	21.8
Women wash their private parts before and after intercourse.	19.1	62.7	18.3
Husband washes their private parts after intercourse.	17.9	60.0	22.1
Husband washes their private parts before and after intercourse.	18.7	62.6	18.7
Total	**24.5**	**56.3**	**19.1**

Table 8: Perceived Severity of RTI/STD Problem by Background Characteristics

Back ground characteristics	Severe	Normal	Cant sure
Age			
Less than 25 Year	22.6	59.6	17.8
25-35	27.7	52.6	19.6
35+	23.5	58.2	18.2
Age at Marriage			
Below 18	27.3	54.7	18.1
Above 18	23.5	56.6	19.9
Education of women			
Illiterate	24.8	54.1	21.1
Up To Primary	25.7	54.4	19.1
Secondary	25.5	57.2	17.3
High School and above	26.3	53.5	20.2
Education of Husband			
Illiterate	33.8	46.2	20.0
Up to Primary	30.5	52.7	16.9
Secondary	23.2	60.0	16.8
High School and above	23.0	51.0	26.0
Caste			
General	20.5	56.3	23.2
O.B.C	26.2	58.1	15.6
S.C/S.T	33.3	48.5	18.1
Religion			
Hindu	25.7	56.1	18.3
Muslim	26.7	50.0	23.3
Other	23.5	56.5	20.0
Type of village			
PHC Village	25.4	51.8	22.8
Sub center village	25.6	57.6	16.8
Remote Village	25.7	56.7	17.6
Personal hygiene			
Women wash their private parts after intercourse.	20.9	57.2	21.9
Women wash their private parts before and after intercourse.	19.7	56.7	23.6
Husband washes their private parts after intercourse.	21.6	56.2	22.1
Husband washes their private parts before and after intercourse.	20.4	56.7	22.9
Total	**25.6**	**55.6**	**18.9**

Table 9: Treatment Seeking Behavior

Back ground characteristics	Menstrual problem	RTI/STD problem
Sought treatment	**41.5**	**48.8**
Within a week	1.9	1.1
With in a month	6.7	16.9
1 – 12 months	16.5	17.4
After 12 months	16.4	13.4
Shared problem with		
Husband	82.4	84.3
In-laws	11.2	8.1
Friend/neighbor	4.0	4.6
Local health provider	0.8	0.2
Qualified doctor	2.4	1.6
Unqualified doctor	1.6	1.4
Others	8.4	5.8
Treatment sought from		
Home remedy	2.0	3.8
Self medication	0.8	2.2
Non-allopathic	4.4	4.2
Faith healing	42.4	34.7
Allopathic	63.2	67.5
Others	0.8	0.4
Total	**602**	**1017**

Table 10. Result of Logistic Regression Analysis of Menstrual Problem, any RTI/ STI Problem and any Reproductive Problem

Background Characteristics	Menstrual Problem	RTI/ STD	Any reproductive problem
Age			
Less than 25 Year			
25-35	1.012	0.993	0.733*
35+	0.917	0.929	0.819*
Effective age at marriage			
Below 18 year			
Above 18 year	1.062	1.058	1.137**
Education of women			
Illiterate			
Up to primary	0.846	1.100	1.383*
Secondary	0.767**	0.909	1.111
High school and above	0.779**	0.933	1.091
Education of husband			
Illiterate			
Up to primary	0.823	0.893	0.819**
Secondary	0.731*	0.776**	0.622*
High school and above	0.905	0.926	0.853**
Caste			
General			
OBC	1.274*	1.282*	1.277*
SC/ ST	1.276*	1.303*	1.401*
Religion			
Hindu			
Muslim	1.462*	1.278*	1.361*
Other	1.392**	0.943	1.186
Type of village			
PHC Village			
Sub Center Village	0.900	0.974	0.905
Remote Village	0.915	0.993	0.941

* 1% significance level, ** 5% significance le