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PREVALENCE OF OBSTETRICS MORBIDITY: A COMMUNITY- BASED STUDY AMONG EVER- MARRIED SLUM DWELLER WOMEN OF GUWAHATI CITY

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ABSTRACT

Studying the prevalence of reproductive morbidities helps in identifying the magnitude of such problems in the community. It identifies special at-risk groups to whom interventions should be directed as well as the most prevalent or serious problems. A community-based assessment also helps to identify the social context of morbidity. This paper aims at assessing the magnitude of obstetric/maternal morbidities among the ever-married slum dweller women and to identify their associated socio demographic factors.

In our study, we have attempted to assess the prevalence of obstetrics/ maternal morbidities among the ever-married slum dweller women in the age group 15 to 59 years. We have resorted to two stage sampling procedure and primary data have been collected from the female respondents who were the residents of the slums of Guwahati City and who were married and were in the age group 15-59 years.

This group of women was questioned regarding their problems related to place of delivery, problems during delivery and post partum period ranging from high BP, bleeding problem, high fever, etc, medical termination of pregnancy (MTP) and problems related to it. These morbid conditions were studied and analyzed under various socio-demographic factors like educational qualification of the respondents, their age groups and also their ages at the time of the first deliveries and the number of children ever born, so as to study their effect on the prevailing obstetric/maternal morbidity.

This study reveals that obstetric/maternal morbidity in weaker section of the population residing in the urban slums of Guwahati is perceptibly high. Though programmes have been launched on Maternal and Child Health Care yet it has been observed that there has been reluctance on the part of the slum dweller women to redress their morbid conditions either due to ignorance or due to poverty and shyness. As such, implementation of these programmes have failed to meet the objective of lowering, if not eradicate, reproductive morbidities among the low socio- economic segment of the urban female population.

KEYWORDS: Reproductive Morbidities, Community-Based Study, Obstetrics/ Maternal Morbidities, Socio- Demographic Factors, Two Stage Sampling

1. INTRODUCTION AND LITERATURE REVIEW

The role of women in the modern demographic scenario has been stated to be the ‘health providers in the family and community.’ Women health, their nutritional status, population and development are so inextricably related that any effort to effect a positive change in the latter without paying specific attention to the former would indeed be a myopic

approach. Domestic activities combined with economic burden force the women folk to compromise their time in rest, leisure and education. Moreover, the low nutritional levels owing to poverty and the traditional social set-up, greater economic pressure to earn a living and the fundamentalist attempts to control and subordinate women sexually in a number of ways, combined with multiple births and maternal depletion have placed women at considerable health risk.

Demographic studies have shown that in comparison to their male counterparts, women naturally possess greater immunity from health hazards and are biologically better protected with resistance capacity against general health problems. However, in case of Indian women, this 'gift of nature' is mostly neutralised by their low nutritional level and also by repeated pregnancies.

India has made considerable progress in the socio- economic fields as far as life expectancy, infant mortality and literacy are concerned. However, improvements in women's health have lagged behind gains in other areas. Maternal mortality rates in rural areas are among the world's highest, 40 to 50 times more as compared to developed countries. Females experience more episodes of illness and are often trapped in a cycle of ill health aggravated by child bearing and hard physical labour. Excess female mortality persists up to the age of thirty, which is a clear symptom of bias against women. Low social status of women compounded with lack of education, cultural misconception and limited access to Safe Motherhood Services are some of the causes of high maternal mortality and morbidity in the country.

Reliable data on mortality and maternal morbidity are scarce, almost non-existent. However, the limited data available reveal that there exists high morbidity among girls and women in India.

India's current picture with regard to literacy, health, and sanitation is not encouraging. India's relative rank in human development among 177 countries has risen by only two positions from 128 in 1999 to 126 in 2004 *(United Nations Development Program, 2006)*. Therefore, the National Development Council (NDC) has emphasized that attaining targets in key human development areas such as education, health, and poverty reduction is extremely important and intimately linked to economic growth objectives. A country's overall level of development affects the health status of its people. However, women are affected disproportionately more than, and in different ways from, men *(Sharma, 2002).*

Given their perception of women, Economic and Social Commission for Asia and Pacific placed on its agenda Reproductive Health as the first and foremost health care need of women. The Reproductive Health Index developed by Population Foundation of India shows that on a scale of 0 to 100, India scores 43, which shows that there is still much to be achieved on Reproductive Health Index *(Nath, 2005).*

Following the ICPD in 1994, and the subsequent demand for information on reproductive morbidity in developing countries, several research studies were undertaken. It became increasingly clear that finding solid evidence on reproductive morbidity presented many obstacles. The most pertinent issue was obvious: how to obtain reliable data in difficult settings. Several studies investigate various methodological approaches and the ensuing issues in collecting data in developing countries *(Bhatia and Cleland, 2000; Khanna, 2001; Koenig and Shepherd, 2001; Younis, et al, 1993).*

2. OPERATIONAL DEFINITION

Various definitions of reproductive morbidity exist and they often overlap. The most recent classification used here is cited in the newsletter of the Department of Reproductive Health and Research of the World Health Organization *(WHO, 2001).* Although the study focuses primarily on gynaecological morbidity the broader classification/concept of

reproductive morbidity is applied, as it is felt necessary to address the issue as a whole.

Reproductive morbidity refers to diseases that affect the reproductive system, although not necessarily, as a consequence of reproduction. Reproductive morbidity can be subdivided into three broad categories-

- **Obstetrics/ Maternal Morbidity**

Which covers morbidity in a women who is, or has been pregnant from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

- **Contraceptive Morbidity**

Covers conditions that result from efforts (other than abortion) to limit fertility, whether they are traditional or modern methods.

- **Gynaecological Morbidity**

Which covers any condition, disease or dysfunction of the reproductive system that is not related to pregnancy, abortion or childbirth, but may be related to sexual behaviour. Gynaecological morbidity can further be divided into Reproductive tract infections (RTI) which include Sexually transmitted infections, Endogenous infections, Latrogenic infections, Endocrine or hormonal disorders like menstrual disorders, infertility, etc. and Gynaecological cancers like cancers of the cervix, breast, endometrium, ovary, vagina, vulva and, rarely, the fallopian tube. Other gynaecological morbidity includes, among others, endometriosis, ovarian cysts, uterine fibroids and polyps, sexual dysfunction and menopausal symptoms.

3. RATIONALE OF THE STUDY AND ITS OBJECTIVES

Studying the prevalence of reproductive morbidities helps in identifying the magnitude of such problems in the community. It identifies special at-risk groups to whom interventions should be directed as well as the most prevalent or serious problems. A community-based assessment also helps to identify the social context of morbidity. This paper aims at assessing the magnitude of obstetric/maternal morbidities among the ever-married slum dweller women and to identify their associated socio demographic factors.

4. DATA

There are 25 slum pockets in the Greater Guwahati area, the total number of households in these pockets being recorded as 24,603 with a total population of 15, 6906 out of which 7,1995 are females. From these 25 slum pockets, 5 slum pockets have been selected for carrying out the survey. For our study, we have resorted to two stage sampling procedure and primary data have been collected from the female respondents who were the residents of the slums of Guwahati City and who were married and were in the age group 15-59 years.

In our study, we have attempted to assess the prevalence of obstetrics/ maternal morbidities among the ever-married slum dweller women in the age group 15 to 59 years. This group of women was questioned regarding their problems related to place of delivery, problems during delivery and post partum period ranging from high BP, bleeding problem, high fever, etc, medical termination of pregnancy (MTP) and problems related to it. These morbid conditions were studied and analyzed under various socio- demographic factors like educational qualification of the respondents, their age groups and also their ages at the time of the first deliveries and the number of children ever born, so as to study their

effect on the prevailing obstetric/maternal morbidity.

5. FINDINGS

5.1 Background Characteristics of Respondents

Table 1 presents the percentage distributions of sample women in the age group 15 – 59, social group, education and occupation. Majority of the slum dwellers (72.4%) were Muslims, 25.7% were Hindus and 1.9% belonged to other religions. Of these 91.2% belonged to the general caste, 4.6% belonged to SC category and the rest 4.3% belonged to the ST, OBC and others category. 85.5% of the respondents were not participating in work other than their household choir, which implies high level of dependency ratio in each household, as far as family income is considered.

Educational levels of the respondents and their husbands also have an important influence on the health status. A majority of 30.8% of the respondents were illiterate, 29.5% were with education High school and above. Proportion of respondents with levels below primary, primary passed (but not ME) and ME passed (but not High school) were approximately around 40%.

Table 1: Percentage Distribution of Married Women in the Age Group 15 – 59 by Selected Background Characteristics

Background Characteristics	Number	Percent
I. AGE		
15 – 19	76	5.6
20 – 29	653	48.4
30 – 39	358	26.5
40 – 49	189	14.0
50 – 59	74	5.5
II. RELIGION		
Hindu	347	25.7
Muslim	977	72.4
Others	26	1.9
III. SOCIAL GROUP		
General	1231	91.1
Schedule Caste	62	4.6
Schedule Tribe	4	0.3
OBC and Others	53	4.0
IV. EDUCATION		
Illiterate	416	30.8
Not LP passed	142	10.5
LP passed	167	12.4
ME passed	227	16.8
High School passed	301	22.3
College/ University	97	7.2
V. OCCUPATION		
Gainful work	196	14.5
Others	1154	85.5
TOTAL	**1350**	**100.0**

Table 2 shows that around 58% of the respondents had their first marriage at 18 years and above and 26%, before attaining the age of 15 years. Moreover, 25% of the women delivered their first child before attaining the age of 18 years. Proportion of childless women in the age group 40 – 59 years is around 0.3%. The average number of children ever born to these women in the age group 15 – 59 years is 2.

Table 2: Percentage Distribution of Married Women in the Age Group 15 –59 by Selected Socio- Demographic Characteristics

Background Characteristics	Number	Percent
I. EDUCATION		
Illiterate	416	30.8
Not LP passed	142	10.5
LP passed	167	12.4
ME passed	227	16.8
High School passed	301	22.3
College/ University	97	7.2
II. AGE OF FIRST MARRIAGE		
Less than 15 years	348	25.8
15 – 17 years	215	15.9
18 years and above	787	58.3
III. AGE AT FIRST BIRTH		
Less than 15 years	151	11.2
15 – 17 years	179	13.3
18 years and above	840	62.2
Not yet given birth	180	13.3
IV. CHILDREN EVER BORN		
0	181	13.4
1	265	19.6
2	376	27.9
3 or more	528	39.1
TOTAL	**1350**	**100.0**

5.2 Obstetric Care and Morbidity

5.2.1 Place of Delivery

Information regarding the place of delivery, who carried out the delivery, etc., were collected from the respondents who had given birth two years prior to the survey. Apart from these, respondents who had home deliveries were asked the reasons for not being admitted to hospitals and those who had sought the assistance of untrained personals had to reply to queries for doing so.

Table 3 shows that 76% of the births took place in government hospitals, 12% in private nursing homes and the rest 12% at home. Of the respondents who had home delivery, 7% were assisted by trained midwives and the rest 4% by untrained personals.

Table 3: Percentage Distribution of Deliveries During the last Two Years According to Place of Delivery for Different Levels of Selected Background Characteristics

Background Characteristic	Place of Delivery					Total	No. of Women
	Institutional		Home				
	Government Hospital	Private Nursing Home	Conducted by Trained Midwife	Conducted by Traditional Midwife	Others (relatives, etc)		
I. AGE GROUP							
15-19	55.6	33.3	9.0	2.1	0.0	100.0	9
20-29	76.5	13.0	8.2	1.7	0.6	100.0	162
30-39	75.3	7.8	14.1	2.8	0.0	100.0	77
40-49	69.2	19.2	8.5	1.9	1.1	100.0	26
50-59	100.0	0.0	0.0	0.0	0.0	100.0	12
II. RELIGION							
Hindu	80.0	10.0	8.2	1.1	0.7	100.0	80
Muslim	73.9	13.3	5.6	4.8	2.4	100.0	203
Others	100.0	0.0	0.0	0.0	0.0	100.0	3
III. SOCIAL GROUP							
General	74.7	12.8	8.3	25	1.7	100.0	265
Schedule Caste	92.3	0.0	6.1	1.1	0.5	100.0	13
OBC and Others	87.5	12.5	0.0	0.0	0.0	100.0	8
IV. EDUCATION							
Illiterate	59.8	13.4	13.5	11.1	2.2	100.0	82
Not LP passed	79.3	20.7	0.0	0.0	0.0	100.0	29
LP passed	69.7	18.2	8.4	3.1	0.6	100.0	33
ME passed	89.3	3.6	6.0	1.1	0.0	100.0	56
High School passd	85.7	7.9	6.3	0.0	0.0	100.0	63
College/University	78.3	21.7	0.0	0.0	0.0	100.0	23
V. CHILDREN EVER BORN							
1	7.1	14.5	7.9	0.5	0.0	100.0	87
2	75.6	10.5	12.6	1.3	0.1	100.0	86
3 or more	74.3	12.4	10.4	1.8	1.1	100.0	113
TOTAL	**75.9**	**12.2**	**7.4**	**2.6**	**1.9**	**100.0**	**286**

5.2.2 Problems during Delivery and Post Partum Period

In reference to Table 4 below, out of the 77% deliveries at government hospitals, 95% were normal deliveries and the remaining 5% were caesarean cases. Of the deliveries that had taken place at nursing homes, 40% were normal deliveries and the remaining 60% caesarean deliveries.

As far as problems during delivery are concerned, a majority of the women (around 63%) suffered from prolonged labour pain and 21% suffered from high BP. Post partum problem is not very significant in this study as only a small fraction has complained of excessive bleeding (around 2%) and a slightly bigger proportion (around 8%) has complained of high fever.

Table 4: Percentage Distribution of Deliveries During the Last Two Years According to Place and Procedure of Delivery, Problems During Delivery and Post Partum Problems

Characteristic	Place of Delivery					Percentage of Women
	Institutional		Home			
	Government Hospital	Private Nursing Home	Conducted by Trained Midwife	Conducted by Traditional Midwife	Others (relatives, etc)	
I.Procedure						
Normal	94.9	40.0	100.0	100.0	100.0	**83.2**
Caesarian	5.1	60.0	0.0	0.0	0.0	**16.8**
TOTAL	**75.9**	**12.2**	**7.4**	**3.0**	**1.5**	**100.0**
II. Percent With Problems During Delivery:						
Prolonged labor pain	75.0	40.0	60.0	14.2	5.8	**62.5**
High BP	25.0	40.0	0.0	0.0	0.0	**20.8**
Excessive bleeding with fever	0.0	10.0	2.3	5.1	12.6	**12.5**
III. Percent With Post Partum PROBLEMS:						
Profuse bleeding	1.4	2.9	0.7	2.2	3.0	**2.1**
High fever	2.3	8.6	19.9	20.7	40.6	**8.0**
Total No. of Deliveries	**217**	**35**	**16**	**13**	**5**	

Table 5 shows the percentage distribution of deliveries at home and the reason stated by the respondents for it. The majority of the respondents (around 77%) stated availability of trained midwives as the reason for opting for home delivery. 12% were satisfied with the assistance provided by untrained dais, and the rest were of opinion that that were forced to do so either due to the prevailing social system or due to financial constraint.

Table 5: Percentage Distribution of Deliveries at Home During the Last Two Years Preceding the Survey Along with Reasons for Home Delivery for Different levels of Selected Background Characteristics

Background Characteristic	Delivery At Home		Reasons For Home Delivery			
	Percentage	Number	Family/ Social system	Availability of Trained Midwife	Traditional Midwife	Expense
I. RELIGION						
Hindu	10.0	8	0.0	62.5	25.0	12.5
Muslim	12.8	26	11.5	80.8	7.7	0.0
II. EDUCATION						
Illiterate	26.8	22	4.5	90.9	4.5	0.0
LP passed	12.1	4	0.0	50.0	50.0	0.0
ME passed	7.1	4	25.0	50.0	0.0	25.0
High School passd	6.3	4	25.0	50.0	25.0	0.0
III. CHILDREN EVER BORN						
1	8.4	7	14.3	57.1	28.6	0.0
2	14.0	12	0.0	75.0	16.7	8.3
3 or more	13.3	15	13.3	86.7	0.0	0.0
TOTAL	**11.9**	**34**	**8.8**	**76.5**	**11.8**	**2.9**

Table 6 shows that the respondents who had sought the assistance of untrained personals, 50% stated financial constraint as the reason for not taking the assistance of trained personals and the rest 50% said that they did not feel the necessity for it.

Table 6: Percentage Distribution of Deliveries at Home Conducted by Traditional Midwives During the Last Two Years Preceding the Survey Along with Reasons for Home Delivery for Different Levels of Selected Background Characteristics

Background Characteristics	Delivery At Home Attended by Traditional Midwife Reasons For Not Utilising services of Trained Personnel	
	Didn't feel the necessity	Financial Problem
I. Religion		
Hindu	100.0	0.0
Muslim	38.5	61.5
II. Education		
Illiterate	71.4	28.6
LP passed	25.0	75.0
ME passed	100.0	0.0
High School passd	33.3	66.7
College/University	0.0	100.0
III. Children Ever Born		
1	50.0	50.0
2	60.0	40.0
3 or more	40.0	60.0
TOTAL	50.0	50.0

5.2.3 Medical Termination of Pregnancy (MTP)

Table 7 shows that out of the 1350 women in the study only 89 have undergone MTP. 78 have undergone MTP once and the rest 11 has gone for it more than once. Majority of the MTPs are carried out at government hospitals and it is

highest among the women in the age group 20- 39

Table 7: Distribution of Women According to the No. of Times they have Undergone MTP 5 Years Preceding the Survey and the Place of Conducting MTP for Different Levels of Selected Background Characteristics

Background Characteristics	No. of times MTP Sought			Place of MTP (Percentages)	
	0 Home	1	More than once	Govt. hospital	Private Nursing
I. AGE GROUP					
15-19	75	1	0	100.0	0.0
20-29	605	43	5	79.2	20.8
30-39	330	23	5	85.7	14.3
40-49	180	9	0	100.0	0.0
50-59	71	2	1	100.0	0.0
II. RELIGION					
Hindu	329	15	3	88.9	11.1
Muslim	906	63	8	83.1	16.9
Others	23	0	0	0.0	0.0
III. SOCIAL GROUP					
General	1145	75	11	83.7	16.3
OBC and Others	49	3	0	100.0	0.0
IV. EDUCATION					
Illiterate	407	6	3	66.7	33.3
Not LP passed	121	19	2	90.5	9.5
LP passed	155	10	2	83.3	16.7
ME passed	214	12	1	76.9	23.1
High School passd	272	26	3	89.7	10.3
College/University	92	5	0	80.0	20.0
V. CHILDREN EVERBORN					
1	250	14	1	93.3	6.7
2	349	24	3	85.2	14.8
3 or more	481	40	7	80.9	19.1
TOTAL	**1261**	**78**	**11**	**75**	**14**

As far as problems following MTP are concerned, Table 8 below shows that 18% reported excessive bleeding and fever, 10% complained of only fever and 7% reported to suffer from lower abdominal pain accompanied by fever.

Table 8: Percentage Distribution of Women According to the no. of Times they have Undergone MTP 5 Years Preceding the Survey According to Post MTP Problems for Different Levels of Selected Background Characteristics

Problems following MTP	Place of MTP		Total
	Govt. Hospital	Private Nursing Home	
Excessive bleeding + Fever	68.8	31.3	18.0
Fever	77.8	22.2	10.1
Pain in the Lower Abdomen + Fever	83.3	16.7	6.7
Others	89.7	10.3	65.2
TOTAL	**84.3**	**15.7**	**100.0**

6. CONCLUSIONS

The world community, today, views health as a burning issue which needs international concern and utmost priority. The health of a country's female population has profound implications for the health education of children and the economic well-being of households as well as for women themselves. As the effects of pervasive ill health extend beyond the woman herself, it has become highly necessary to understand the roots of the vicious ill health cycle in which the female folk has been trapped and take immediate steps with pre-determined objectives so as to attain the 'good health for all' target of the World Health Organisation (WHO).

This study reveals that obstetric/maternal morbidity in weaker section of the population residing in the urban slums of Guwahati is perceptibly high. Though programmes have been launched on Maternal and Child Health Care yet it has been observed that there has been reluctance on the part of the slum dweller women to redress their morbid conditions either due to ignorance or due to poverty and shyness. As such, implementation of these programmes have failed to meet the objective of lowering, if not eradicate, obstetrics/maternal morbidities among the low socio- economic segment of the urban female population.

The women folk residing in the slums of Guwahati city are basically uneducated. Due to lack of awareness and perception of disease, most of them do not avail the facilities provided to them. It is usually seen that women belonging to the low socio- economic class are shy and consider gynaecological problems to be a part and parcel of their life. As such, at the very outset, it becomes necessary for the grass root level workers to generate awareness among this ignorant mass regarding reproductive morbidity and their consequences, if not treated on onset, and at the same time furnish information regarding the locally available facilities and schemes. Counseling on adolescent health care, MTP, RTI/ STI, prenatal, antenatal and postpartum care should be introduced.

Poverty is another very important factor for which many cases of reproductive morbidity remain unaccounted. Most of the slum dwellers live in wretched conditions. High cost of treatment retards the sufferers to seek medical assistance. Thus, Local Health Care system should provide the services to these women free of cost or at subsidized rates.

Thus, we may conclude that modification of infrastructure with skilled manpower right from the grass root level workers to the medical personnel is the need of the hour. This would help in effective utilization of the existing resources of the government undertaken health welfare projects among the weaker section of the urban population**.** Investing into women would save human folk; otherwise survival of whole generation would be at risk.

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