Knowledge of Reproductive Health among Self Help Group Women in Maharashtra

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A qualitative cross sectional study was conducted at the village level in six districts of Maharashtra to assess the knowledge, attitudes and practices of Self Help Group women regarding reproductive health. The study highlights the available knowledge and existing gaps on various reproductive health issues related to their gynaecological problems, pregnancy, delivery and post partum period, abortion, infertility, menopause, family planning, reproductive tract cancers and sexual health concerns among the SHG women.

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INTRODUCTION

The microfinance schemes of the Self Help Groups (SHGs) in India have been appreciated for their positive contribution to the economic empowerment of women. The Mahila Arthik Vikas Mahamandal (MAVIM) is the nodal agency for the Women’s Development Corporation in Maharashtra. MAVIM operates in 13,300 villages across 33 districts of rural Maharashtra. SHGs are small informal associations created for the economic benefit of its members and function on the principles of mutual help, solidarity, and joint responsibility. The group-based approach not only enables the poor to accumulate capital by way of small savings, but also helps them to get access to formal credit facilities (Shylendra, 1998). In India, most of the activities of SHGs are concentrated towards savings and credit activities (Kumar, 2006). Studies in Bangladesh also
demonstrate that participation in credit programmes can result in increased status for women within the household and in the community (Hashemi, Schuler and Riley, 1996).

Considering their outreach, these SHGs can play an important role in creating awareness on reproductive health issues by holding specific capacity-building training programmes on health and thus improve the health seeking behaviour of women. Here, the SHGs present an opportunity for initiating social action and empowerment of women through women’s participation in addressing issues affecting their health (EDA Rural Systems, 2006). SHGs are, therefore, considered to be one of the options available for women on health care delivery (Nayar, Catherine and Oliver, 2004).

Considering the scope of the SHGs, MAVIM had proposed to undertake capacity building training of the SHG members. As a prelude to this training, the researchers undertook a qualitative study with a broad objective of assessing knowledge and attitudes on reproductive health and health seeking behaviour of SHG members in Maharashtra. The specific objectives of the study were to:

- Explore the knowledge, attitudes and coping mechanisms on general health and reproductive health problems among the SHG women;
- Understand the health seeking behaviour of SHG women towards general and reproductive health; and
- Make specific recommendations on capacity building of SHG women on reproductive health.

**METHODOLOGY**

A qualitative cross sectional study was conducted at the village level in Maharashtra for a duration of three months. Each of the six districts—Thane, Kolhapur, Jalgaon, Latur, Yavatmal and Chandrapur—were randomly selected from the six administrative divisions within the state. One taluka/block was randomly chosen from each district. A random number table was used to select four villages from each block. Again, SHGs were randomly selected for conducting the focus group discussions (FGDs). Altogether twenty four FGDs (four in each district) were conducted for the study.

Necessary approval was obtained from the Ethics Committee of the National Institute for Research in Reproductive Health for conducting the study. The MAVIM District Coordinating Officers facilitated
communication with the sahayoginis in each of the selected villages and a convenient date was fixed for conducting the FGDs in the subsequent week. Two research teams, each comprising two senior investigators, were constituted. Three districts were allotted to each team. These teams were guided, supervised and monitored by the researchers. A FGD guide was formulated and translated into the local language—Marathi. The sahayoginis mobilised the SHG women in each village and also arranged a convenient place for conducting FGDs.

Ever married women in the age group of 18–44 years were selected for the study. FGDs comprising 10–15 SHG members were conducted in each village. Each FGD lasted for one and a half to two hours. Before starting the FGD, the research team explained the purpose of the study as detailed in the Participant Information Sheet. Thereafter, a written informed consent was obtained from each participant. While one team member facilitated the discussion, the others took down detailed notes. At the end of each FGD, the research team spoke to the participants and provided them with the correct information on the issues discussed, and also responded to their queries concerning reproductive health and family planning.

The Marathi transcripts were translated into English and the data interpretation was done manually. The FGD report for each of the four villages in all the talukas was compiled, and the findings of the six districts in the state were collated. The present paper describes the consolidated findings for Maharashtra.

**FINDINGS**

**Demographic Details and Activities of SHG Women**

A total of 307 women from 104 SHGs in 24 villages of the six selected districts volunteered for the FGDs. The majority of the women (55 percent) were in the age group of 26–35 years, 27 percent were in the age group of 36–45 years, while 18 percent were in the age group of 18–25 years. About one fourth of the women (24 percent) reported that they were illiterate, while a majority (65 percent) reported that they had studied up to the primary and secondary level. Only 11 percent of the women reported that they had studied up to the higher secondary level and above. The majority of the women (55 percent) reported that they resided in kuccha houses, while 45 percent reported residing in pucca houses.

The SHG women reported that they met once a month only for paying their monthly bachat gat money. No other discussions were held during
these meetings. However, the SHG women in Lakhangaon (Latur) and Borepadale (Kolhapur) stated that they had discussions about various income generating schemes, and had taken up small businesses in addition to making and selling home based handmade items in a large scale.

**Common Health Problems and Treatment Seeking Behaviour**

The SHG women reported that they and their family members experienced general health problems such as weakness and giddiness, fever, cold, cough, headache, body and joint pains. Other problems reported were acidity, stomach ache, low back pain, malaria, dysentery, urinary stone problems, blood pressure and skin problems. They generally did not seek any medical help immediately after onset of the problem. They went to a doctor only when the health problems became very severe. One SHG member from the Palghar taluka of Thane district said:

“We wait until our pain reaches beyond our tolerance limit, and only then we approach the doctors”.

Another SHG member from the Panhala taluka of Kolhapur district said:

“The PHC offers services only up to 12 noon, and it is difficult for women to reach the PHC before that time”.

Many SHG women said that they had to use ‘vashila’ (influence) to get good medical treatment in government hospitals.

**Menstruation**

The normal practice followed by these women during menstruation is to sit aside in a particular corner of the house for 3–4 days. One SHG woman said:

“Menstrual blood is bad blood and it is good that it flows out of the body.”

Some of them expressed that if a woman did not menstruate, she may put on weight and suffer health problems. It is considered unhealthy and bad if a woman does not get her periods by the age of 18 years. However, according to one SHG woman in Kolhapur district:

“Menstruation is a headache to women”.

Most SHG women in all the districts stated that:

“We try to avoid sexual relationships during menses as it is not good to have it during this period.”

Some of the SHG women from Kolhapur reported that their husbands forced them to have sex during their monthly periods, and they were unable
to negotiate with their husbands regarding this issue. Women in all the six districts reported that they maintained good personal hygiene during menstruation by using reusable homemade cotton cloths. Some SHG women from Kumtha and Lakhangaon villages in Latur district reported that they washed and dried the used cloths in one corner of the house for fear of black magic. Women belonging to the Leva Patidar Samaj did not take bath for five days during menstruation.

Reproductive Health

Awareness of Gynaecological Problems

All the SHG women reported that they were aware of gynaecological health problems such as menstrual problems and white discharge (Pandhra padar). Some of them were aware about problems like—something coming out of the vagina (“ang baher yene”) suggestive of genital prolapse.

The common menstrual problems reported by the SHG members were pain in the abdomen, lower back pain and irregular, excessive or scanty menstruation. Women from Jalgaon, Kolhapur and Chandrapur districts reported that it was common among women in the age group of 20 to 35 years to get their uterus removed in case of excessive bleeding and fibroids. Women from the Kolhapur district reported that women are unaware of the consequences of removing their uterus as the doctors do not provide them with adequate information or explanation.

Approximately 25–30 percent of the women reported to be suffering from white discharge. Among these, some had foul smelling vaginal discharge; some had curd like vaginal discharge and a few had vaginal discharge during pregnancy. Five percent (fifteen women out of the total 307 women) who participated in the FGDs reported symptoms suggestive of prolapse. Very few women were aware of involuntary urination problem; however, some SHG women in Latur, Chandrapur, Jalgaon and Yavatmal districts reported that they experienced incontinence while coughing or sneezing.

Medical Treatment

Most of the SHG women reported that their reproductive health problems were a result of early marriages; abortions; heavy work in the fields; lack of adequate rest after delivery; eating less food; and improper diet. According to some of the SHG women:

“White discharge is due to body heat”, while for many others, “White discharge is normal, then why should we take treatment.”
However, most of the women had taken treatment from private doctors. Many women took to home made remedies such as drinking jeera water to ease their menstrual problems before approaching a doctor for treatment. Women in Lakhangaon village use lal and pandhari vasu (a local herb) for excessive bleeding and white discharge respectively; they also eat fried petals of hibiscus flowers on an empty stomach for 7-8 days as a remedy for excessive bleeding.

Some women from Yavatmal district reported to taking treatment for genital prolapse, whereas some women form Latur district reported that they had not taken any treatment.

**Support from Family Members**

The SHG members from all the six districts reported that they received full support from their in-laws and husbands for treatment. Only a few were forced to take decisions on their own for treatment. Most of the SHG members stated that women living in joint families need to consult their spouses and parents-in-laws, as they are the main decision makers.

**Reproductive Tract Infections/Sexually Transmitted Infections including HIV/AIDS**

The SHG women revealed that they were not aware of reproductive tract infections and sexually transmitted infections (RTI/STI), had never heard of ‘Gupt rog’. However, they reported suffering from related symptoms such as burning sensation during urination, itching in genital region and/or white discharge, which suggested possible RTI/STI.

With the exception of Latur district, the SHG women in all the other districts had limited knowledge of HIV/AIDS. The information gathered from them revealed many misconceptions on how HIV is caused—HIV is spread by mosquito bites and bed bugs; talking and eating with HIV infected individuals; and sharing the same room, toilets and utensils.

**Problems during Pregnancy, Delivery and Postpartum**

Medical examinations of pregnant women were regularly conducted by the Auxiliary Nurse and Midwife (ANM) working in their villages. They were given Tetanus Toxoid (TT) injections and prescribed iron and folic acid tablets. Even though the pregnant women collected iron and folic acid tablets from the clinics, many did not take them for fear of the foetus gaining weight within their wombs, which could result in caesarian section deliveries.
As reported by the women from all the six districts, most of the deliveries were undertaken in the hospitals. However, some deliveries were done at home under the supervision of the ANM or the Dai (midwife). In case of emergencies, doctors were called upon. A majority of the SHG women reported that they were not aware of the Janani Suraksha Yojana, although some of them had received some amount of the money from government hospitals.

The SHG women reported many postpartum problems such as excessive bleeding (all the districts except Jalgaon), vaginal damage and muscular spasms (Yavatmal district), stomach pain, giddiness, backache, anemia and weakness (Kumtha village in Latur district). The women from Thane and Jalgaon districts said that post delivery the newborns were first breastfed and then given sugar water and cow’s milk for two days.

Some of the SHG members reported that they had conceived during the first six months of lactation and had no knowledge of the contraceptive measures to be adopted during this period.

**Family Planning Methods**

Most of the SHG women from all the six districts were aware of oral contraceptives (Mala-D), condoms (Nirodh) and the intrauterine device Copper-T (Tambi). However, only a few of them had correct knowledge about their proper use. Some SHG women in Latur, Jalgaon and Chandrapur were aware about the dual use of condoms. A few women from all the districts, except Palghar in Thane district, were aware of the rhythm method used for spacing the birth of children. Only four of the SHG women in Lakhangaon village in Latur district stated that they were aware of the injectable contraceptive, which is effective for two to three months; they were also aware of female condoms. Only four SHG members, two from Jalgaon and two from Yavatmal, had heard about emergency contraceptive pills. All the women members participating in the FGDs knew about female and male sterilisation.

However, there were certain misconceptions among them about the copper-T device. They reported that the device can slip during sexual intercourse and damage the heart and uterus; cause pinching leading to excessive bleeding; cause abortions after its removal; and also cause weight gain among women. One SHG member from Yavatmal recounted that the device had embedded in her flesh (‘masat fasli hoti’) and subsequently had to undergo an operation. Many women stated that oral pills caused giddiness and nausea.
Only a few members of the SHGs had used contraceptive methods such as oral pills, condoms and intrauterine devices. None of the SHG members had used injectable or emergency contraceptives. A majority had undergone female sterilisation. As per the information gathered from the SHG members, very few men (11) had undergone male sterilisation.

**Abortion**

Women from Thane, Latur, Chandrapur and Jalgaon districts reported that sex selective abortions were taking place. Members from Jalgaon and Yavatmal reported that some women used derivatives of the roots of some trees to abort their foetuses. Private doctors were also approached for treatment of abortion related problems.

**Infertility and its Perceived Causes**

Although there were a few women who were unable to conceive, they did not face any discrimination or ill treatment. They were treated on par with the women who had children. There was only one instance of a woman rather than the husband being blamed for childlessness from Darewadi village in Kolhapur. There were one or two instances of husbands marrying another woman from Nivade and Asurle villages of Kolhapur district; however, both wives were living together.

Couples with infertility problems generally went to private practitioners for infertility treatment as government hospitals lacked the facility. The SHG women revealed that a few couples in Kolhapur district were taking treatment from unqualified health care providers/quacks, and some couples in Jalgaon and Yavatmal districts were taking treatment from faith healers.

Undeveloped small uteruses with small openings/mouths were considered to be the cause of infertility among some women from Thane and Jalgaon. The SHG women from Lakhangaon village in Latur district considered premature ejaculation and less sperm count as causes for infertility among men. Although some of the SHG women knew that less sperm count can lead to infertility, many were unaware that men could also be infertile.

**Menopausal Problems**

The SHG women of all the six districts stated that the usual age for menopause was between 40–50 years. According to one woman in Nivade in Kolhapur district:

“When the daughter gets married, mother’s menstruation stops.”
Most of the SHG members in Kolhapur, Latur and Chandrapur identified excessive bleeding, irregular periods, backache and abdominal pain as problems related to menopause; some also attributed aggressiveness and irritation to menopause. In the words of one SHG woman in Latur district:

“There are many problems related to menopause, but the women look at it as part of life and problems go untreated and undetected.”

Cancers

Although the women knew about the existence of uterus, breast, throat, blood and mouth cancers, most were unaware of the symptoms and treatment for cancer.

Sexual Health Concerns

In Ausa taluka of Latur district, some of the SHG women had queries on issues related to sexuality such as anal sex, oral sex and age limit for men and women to have sex. In Muktainagar Taluka of Jalgaon district, one SHG member asked if one could have sexual intercourse during pregnancy.

DISCUSSION

Reproductive health of women is largely influenced by a variety of social, economic, cultural and political forces including gender inequality. Differences between sexes in the nature and timing of sexual debut, age at marriage, age at first intercourse, number and characteristics of sexual partners, and frequency of unprotected sex can result in highly differentiated sexual and reproductive health problems among them. Gender differences in access and control over key material and social resources result in inequalities not only in reproductive health and wellbeing, but also inequalities in power, knowledge and capacity to make independent sexual and reproductive decisions, in health seeking behaviour, and in the ability to pay for services. Political influences are likely to have a major impact on the distribution of reproductive health services (Ruth Dixon-Mueller, 1999).

Kerala has recorded a decadal population growth of +4.86 percent (Census 2011) as compared to the national growth rate of 17.64 percent for the same period; the decision making power enjoyed by women could be a contributory factor. As compared to other states of India, women in Kerala enjoy a higher status in society and have the freedom to access several services. Gender equity appears to have played a significant role in Kerala’s human development and significant improvement in the
reproductive health of women, as reflected by the sex-ratio of 1,084 per 1,000 males, (the highest sex ratio) as compared to the national average of 940 in the year 2011. A change in the socioeconomic conditions of the women, high literacy among women, empowerment of women, provision of health facilities and gender equity seem to have contributed to the improvement of reproductive health of the women in Kerala (Govindan, 2000). This is reflected in low infant mortality and population growth, and high level of literacy and life expectancy.

Progressive redistribution measures like land reforms, a wider public distribution system, welfare oriented policies with emphasis on education, implementation of a generous minimum wage, dedicated and dynamic leadership along with high levels of political participation and activism have contributed to its development. Known as “The Kerala Model”, it refers to the state’s achievement in significantly improving living conditions that are reflected in the social development indicators when compared to that of many developed countries (Franke and Chasin, 1999).

In comparison, Maharashtra, the second largest state in the country ranks fourth in the Human Development Index of the country. The female literacy is 75.4 percent, sex ratio is 925 females per 1,000 males and life expectancy for females is 71.3 percent. Though there is improvement in these indicators over the decades, bringing about improvement in women’s status and gender equity in the state will take a long time. Gender bias towards male offsprings still prevail in Maharashtra as sons are considered to be assets, while girls are a liability. It may be noted here that the Government of Maharashtra has actively tried to promote women’s economic empowerment by supporting women entrepreneurship through the introduction of micro-credit schemes.

The vision statement of MAVIM envisages to empower women by building organisations that seek to enhance women’s capacities, self-confidence, and increase employment and entrepreneurship opportunities through increasing participation of women in governance.

In order to develop SHGs as sustainable grass root institutions, training is imparted to women at various levels. These include leadership training, gender sensitisation, and the functioning of the panchayati raj institutions (PRI). Training on reproductive health issues should also be considered by MAVIM to increase awareness, knowledge, and health seeking behaviour of women. Additionally, women can use this knowledge to educate other women in the community and in turn improve their health seeking behaviour.
The findings of the present study suggest that women generally face similar problems related to menstruation and usually try home remedies out of ignorance or lack of information. Similarly, there is lack of awareness regarding RTI/STI and HIV/AIDS. Although the present study has identified many issues of immense importance concerning the reproductive health of SHG women, the study has limitations as no comparisons were made between the SHG and non-SHG women to explore whether participation in SHG could positively influence women’s health.

Mohindra, Haddad and Narayana (2008) examined the associations between female participation in a microcredit programme and women’s health in Kerala. This cross-sectional study used special survey data collected in 2003 from one Panchayat. Information was collected on women’s characteristics, health determinants (exclusion to health care, exposure to health risks, decision-making agency), and health achievements (self assessed health, markers of mental health). The study sample included 928 non-elderly poor women. The primary finding was that compared to non-participants living in a household without a SHG member, the odds of facing exclusion was significantly lower among early members, that is, those who were members for more than two years.

The findings of the present study indicate that the SHG women respondents did not seek any medical help immediately after onset of their health problems. They approached a doctor only after their health problems became very severe. Similar results were observed in a survey conducted in rural Pune in Maharashtra (Gupte, Bandewar and Pisal, 1999). The study reported that 39 percent of the women opted for self-medication as the first choice for treatment of minor illnesses. However, the study participants were non-SHG women.

Findings of the present study showed that women did not utilise government facilities, as these services were not readily available or accessible. The private doctors were, however, always available. Most of the SHG women had taken treatment for gynaecological problems. These findings are similar to a study conducted in rural Pune (Gupta, Bandewar and Pisal, 1999). Among these women, 47 percent preferred going to private doctors in Pune or Mumbai for gynaecological disorders, and 37 percent sought treatment from public health services such as the village PHC and the government hospital in Pune. The remaining 16 percent preferred traditional remedies.
Very few women participating in this study were able to make independent decisions concerning health treatment. Most women had to consult their husbands. However, findings of a study by Hashemi and Schuler (1996) in Bangladesh investigating whether women’s access to credit had any impact on their lives, irrespective of who had the managerial control, revealed very positive results. The results suggest that women’s access to credit contributes significantly to the magnitude of the economic contributions reported by women—the likelihood of an increase in asset holdings in their own names to an increase in their exercise of purchasing power; besides increasing their awareness on political and legal matters and the composite empowerment index. They also found that access to credit was also associated with higher levels of mobility, political participation, and involvement in ‘major decision-making’ processes of particular credit organisations.

In a cross-sectional study undertaken by Dongre and Deshmukh (2007) to compare the level of awareness about HIV/AIDS between women’s self-help group leaders and other women in the villages of the primary health centre area, the leaders of SHGs were found to have better levels of education and awareness about HIV/AIDS. This study comprised 82 leaders (the President and the Secretary) from 41 SHGs promoted by the Kasturba Rural Health Training Centre, Anji, and 98 non-SHG women from the same villages. Considering that the level of awareness on HIV/AIDS is significantly high, the leaders of SHGs could double up as potential resource persons for the delivery of health education and prevention of HIV/AIDS to other women in the villages of Anji.

The SHG women reported early marriages, abortions, heavy work in the fields, no rest after delivery, eating less food, and improper diet as some of the causes of gynaecological problems. This is reflected in a study conducted by Kulkarni and Chauhan (2009) in Nasik, Maharashtra. When asked about the reasons for heavy menstrual bleeding and white discharge: one young 24 year old woman from a tribal PHC area 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 similar perceptions. Some women considered white discharge as a woman’s fate and could not specify any reason for its occurrence. One woman belonging to a tribal area explained that these symptoms were a result of doing heavy tailoring work.

Though the SHG women were aware of the various contraceptive methods, very few of them actually used contraception in their daily lives. Many misconceptions regarding Cu-T and oral pills are still prevalent among women. A focused attention on spacing methods along with ‘Janani
Suraksha Yojana’ could bring about a change in the usage of spacing methods. Some SHG women reported getting pregnant immediately after child birth and before onset of menstruation. This calls for a more active promotion of spacing methods immediately after delivery.

A study on the impact of SHG bank linkage programmes on poverty, vulnerability and social development was conducted in five states in India—Orissa, Andhra Pradesh, Tamil Nadu, Uttar Pradesh and Maharashtra—over a duration of two periods (July 2000 and end of 2003). Women empowering activities such as adopting family planning measures, and increased participation in decision making on household issues such as improved nutrition, health and hygiene of children, were significant findings of the study (Swain, 2006).

Sex determination tests and subsequent abortions appear to be common in some of the districts covered in the present study. This is another area where the SHGs could play a very effective role by adopting income generating activities for girls.

Infertility problems are viewed without prejudice; and the reported treatment seeking behaviour among both partners is an appreciable development.

CONCLUSION

The study has highlighted the existing knowledge and gaps on various reproductive health issues among the SHG women, who are considered to be more empowered, as compared to other women in general. Significantly, there is a need for imparting knowledge to the SHG women on various aspects of reproductive health. Some suggestions are listed below:

- Causative factors, importance of seeking early treatment for prolapse and urinary incontinence, and the common indications and sequelae of undergoing hysterectomy.
- Family planning methods such as natural methods (rhythm method); knowledge regarding correct use of spacing methods (condoms, oral pills); myths and misconceptions prevailing about Copper-T; knowledge regarding indications, timing, dosage and availability of emergency contraceptive pills.
- Safe abortion, importance of the girl child and prevention of sex selective abortions.
- Signs and symptoms of reproductive tract infections and sexually transmitted infections and their causes, myths and misconceptions, dangers of self treatment and complications.
• Signs and symptoms, causes, and treatment of HIV/AIDS.
• Care during antenatal, delivery and postpartum period.
• Sensitisation on Janani Suraksha Yojna.
• Causes and treatment of male infertility.
• Information on reproductive cancers such as cervical and breast cancer.
  The importance of pap smear for the diagnosis of cervical cancer and breast self examination for early diagnosis of breast cancer.
• Sexuality and sexual health concerns among women such as oral sex, anal sex and sexual intercourse during pregnancy.

IMPLICATIONS FOR INTERVENTION

By using the KAP model, the study findings can be used to enhance knowledge on reproductive health issues among the SHG women in rural Maharashtra, who have experienced change in their own lives.

These women can take the lead to inform, educate and support other women in their neighbourhood who are ignorant and indifferent to reproductive health problems.

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REFERENCES


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