WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 8.074
Volume 8, Issue 10, 763-777. Research Article ISSN 2277– 7105

A STUDY ON WOMEN'S HEALTH RELATED ISSUES IN A COMMUNITY

Shamseena P. M.*, Nikhila C. and Shafeena T.

Department of Pharmacy Practice, JDT Islam College of Pharmacy.

Article Received on
29 June 2019,
Revised on 19 July 2019,
Accepted on 09 July 2019
DOI: 10.20959/wjpr201910-15428

***Corresponding Author**
Shamseena P. M.
Department of Pharmacy Practice, JDT Islam College of Pharmacy.

ABSTRACT

India is one of the largest third world countries where females are considered as disadvantage sections, demographically, socially, culturally and economically. The average women suffer from protein deficiency, caused by insufficient food intake, particularly by growing children and lactating mother. Several studies have shown that the neglect of women, from their childhood, has led to poor health and higher death rates among them. This study was carried out to find out several health related issues in a female life cycle, and health status. A total 850 women participants from kudumbashree unit, and data using health questionnaire. The demographic characters of patient were collected, 88.4% are married 11.2% are widowed and 0.1% are single. 43.2% patients got high school education and around 1.7% o were illiterate. Based on the economic status 60.5% belongs to APL and 39.5% of patients belongs to BPL category, majority of the women are house wives. The socioeconomic and health status is compared 41.6% undergo irregular check up, 58.4% undergo regular checkup. 12.5% accounts cervical cancer and 18% with breast cancer. About 17% were consuming leafy vegetables. Most of female experience reproductive health problems at the age of 45-55 years, start of menopause. Income plays an important role in health care decision. Protein energy malnutrition and deficiency of micronutrients exist among women. The demographic variables like age, economic status, educational status and marital status are found to be associated with health related issues among women. Life style disorder associated with eating habits, diet, exercise etc.

KEYWORDS: Reproductive, socioeconomic status, lifestyle, health care.

INTRODUCTION

India is one of the largest third world countries where females are considered as disadvantage sections, demographically, socially, culturally and economically and India is one of the few countries where male significantly outnumber females, and the countries maternal mortality in rural area are among the world's highest, females experience more episodes of illness than male and are likely to receive medical treatment before the illness is well advanced. Disease burden per 1000 population in India is much more on women than men. The average women suffer from protein deficiency, caused by insufficient intake of food, particularly by growing children and lactating mother. The roots of the poor health situation of the population lie in the neglect of women in the society. Several studies have shown that the neglect of women, from their early childhood, including food and medical attention during illness, and burden of work, has led to poor health and higher death rates among them.[1]

In every society, the adverse health outcomes of women are visible at different stages of life cycle. At early child hood, the young children are at high risk of ill health and are more susceptible to death from their illness. In the peak reproductive years, the physical drain of pregnancy and lactation increases women's vulnerability to poor health.[1]

Kerala has attained remarkable achievements in social development despite in economic backwardness, Kerala women enjoyed relatively high status compared to the women of other states. Women's life expectancy is 76 years in Kerala compared with 61 years in India. Also a favorable female: male ratiodeath rates among them. Women from their early childhood are trained to accept pain and suffering as part of their lives. This has developed a culture of silence, which has led to women neglecting their health and not taking any treatment if they have health problem. In difference of the members of the family as well as of the society to the problems of women aggravates the consequence of the neglect.[6]

In every society, the adverse health outcomes of women are visible at different stages of life cycle. At early child hood, the young children are at high risk of ill health and are more susceptible to death from their illness. In the peak reproductive years, the physical drain of pregnancy and lactation increases women's vulnerability to poor health.[8]

Kerala women enjoyed relatively high status compared to the women of other states. Women's life expectancy is 76 years in Kerala compared with 61 years in India. Also a favorable female: male ratio. This means women's who need health care and proper treatment

much than males. Women's health concern influenced by interrelated biological, social, and cultural factors. It is generally expected that women can live longer than men it does not necessarily ensure a better quality of life. Women are more sickly and disabled than men throughout the life cycle. It has been suggested that women are particularly vulnerable, where basic maternity care is unavailable. Due to the involvement of biological factors, women are more prone to sexual exposure contracting sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV) than do men. Protein energy malnutrition and deficiency micronutrients exist among women.[6]

MATERIALS AND METHOD

Materials

- Self designed health questionnaire
- Patient counseling leaflet
- Patient informed consent form

METHODOLOGY

Study site

The study was conducted among the women's in kudumbashree units at urban area of Kozhikode corporation.

Duration of study

6 month (January 2018-June 2018).

Sample size

From statistical method about 566 patients were considered, maximum 850 women participants are involved in this study.

STUDY CRITERIA

Inclusion criteria

All women participant between 18-75 year of age.

Exclusion criteria

Patients who are not willing to participate in this study.

Study procedure

Patient who are satisfying the study criteria are enrolled in the study. Informed consent is obtained from all the subjects. Patient information collected with help of a standard health questionnaire.

Statistical analysis

Data collected were entered in Microsoft excel 2010 and were keyed into the statistical package for social sciences computer version 17.0 for windows and analyzed by appropriate statistical method.

RESULT

1 Demographic distribution

11. Distribution of patient based on age

Age	frequency	Percent
18-29	132	15.5
30-39	192	22.6
40-49	266	31.3
50-59	201	23.6
>=60	59	6.9
Total	850	100

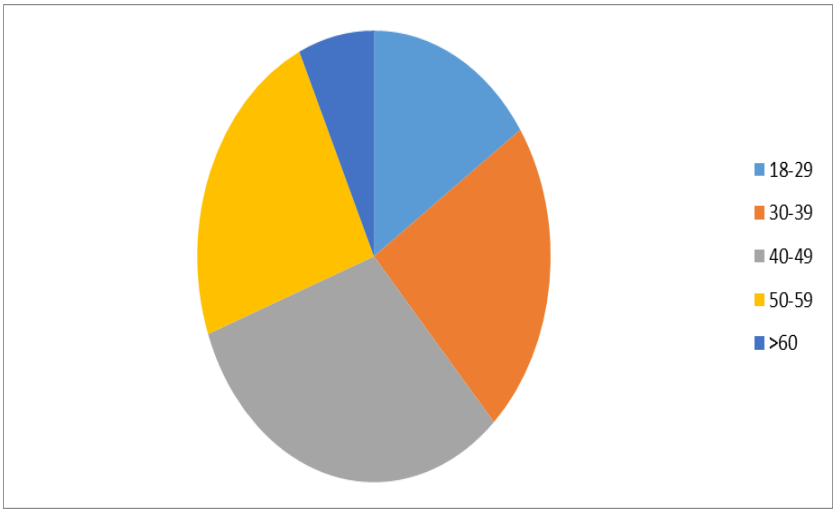


Figure 1.1: Age distribution.

1.2 Distribution of Sample According To Marital Status.

	Frequency	Percent
Married	748	88.7
Single	8	0.1
Widowed	94	11.2
Total	850	100.0

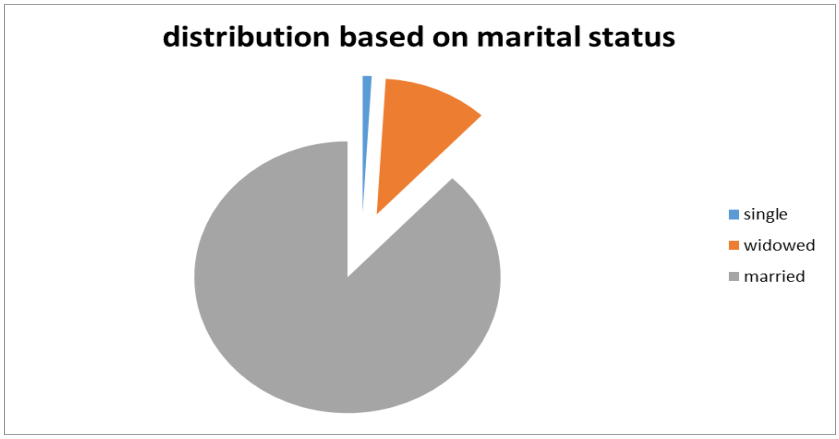


Figure 1.3: Distribution of ample based on marital status.

1.3 Distribution of sample according to educational status

Table 1.3 distribution of sample according to educational status.

	Frequency	Percent
Illiterate	15	1.7
Primary	223	26.2
High school	368	43.2
pre- degree	201	23.6
Degree and above	43	5.3
Total	850	100

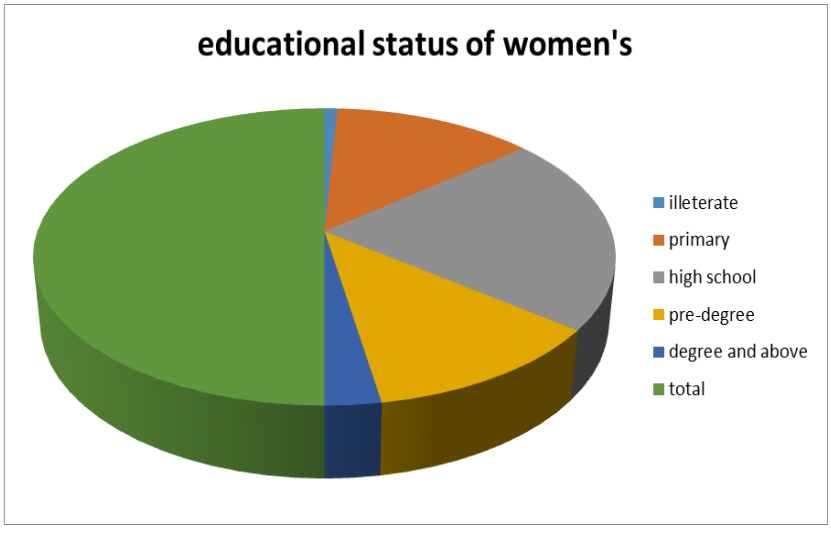


Figure: 1.3: Distribution of Sample According To Educational Status.

1.4 Distribution of according to economic status

Table 1.4 distribution of sample on the basis of economic status.

	Frequency	Percent
APL	514	60.5
BPL	336	39.5
TOTAL	850	100

Figure 1.4: Distribution of Sample According To Economic Status.

1.5 distribution of sample according to working status

Table 1.5 distribution of sample according to working status.

	Frequency	Percent
working	327	38.5%
Not Working	523	61.5%
Total	850	100.0

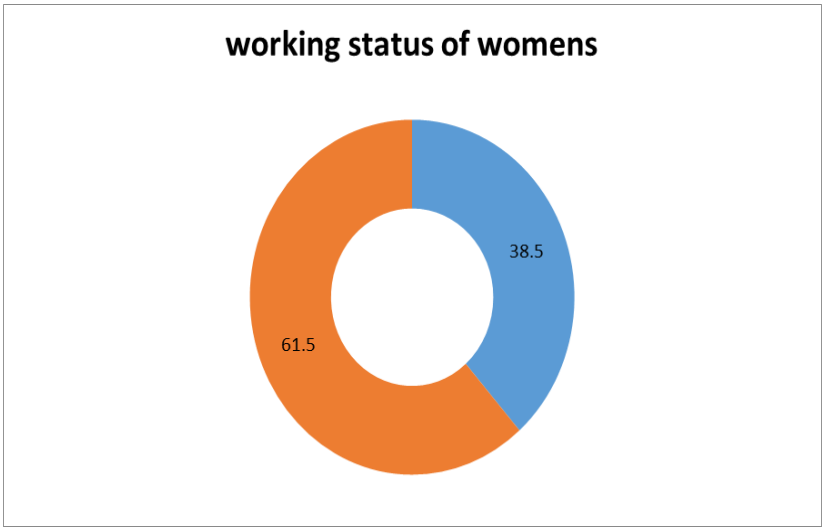


Figure 1.5: Distribution of Sample According To Working Status.

1.6 Distribution of sample socioeconomic v/s health attitude

Table 1.6: Distribution Sample Health Attitude V/S Socioeconomic Status.

	Frequency	Percent
Regular health check up	354	41.6
Irregular health checkup	496	58.4
Total	850	100.0

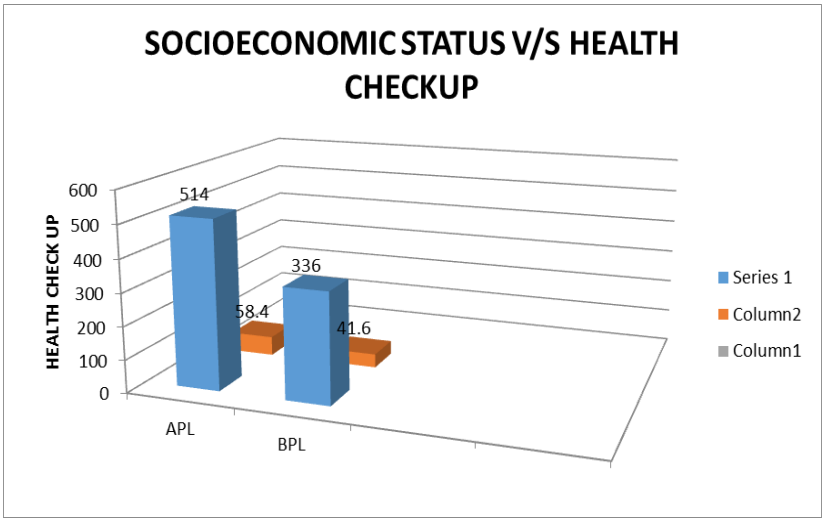


Figure 1.6: Comparison Between Socioeconomic Status V/S Health Checkup.

1.7 Distribution of vegetables and fruits with age.

Table 1.7: Distribution of vegetables and fruits with age.

	Frequency	Percent
Younger	144	16.9
Older adult	286	33.6
Elderly	420	49.4
Total	850	100

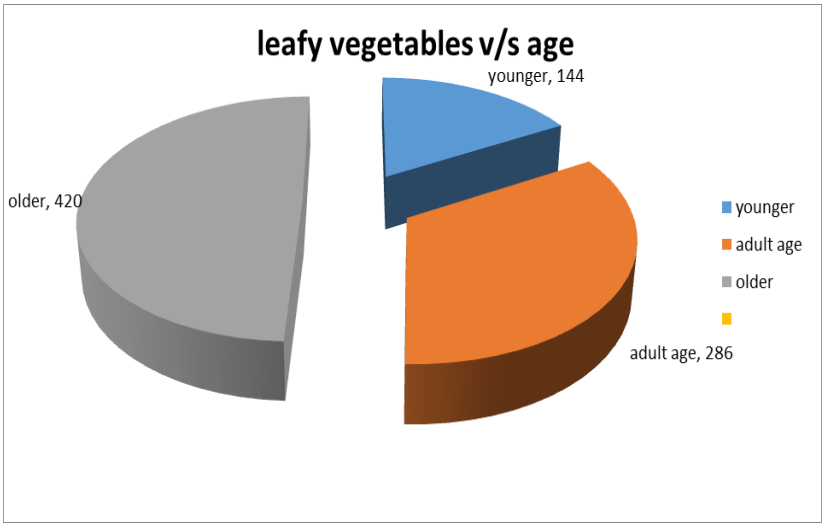


Figure 5.1.8 Comparison Between Age With Leafy Vegetables.

2.1 distribution of nutritional status with socioeconomic status.

Table 2.1: Comparison of Nutritional Status with Socioeconomic Status.

	Frequency	Percent
APL	563	66.2%
BPL	286	33.6%
TOTAL	850	100.0

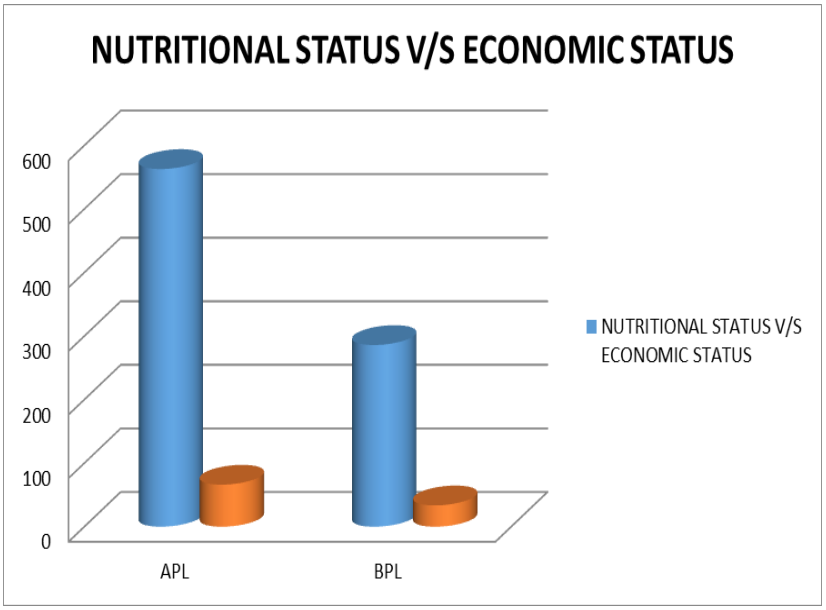


Figure 2.1: Comparison of Nutrition Status V/S Socioeconomic Status.

2.2 Distribution of Sample Depends on Age with Breast Cancer

Table 2.2 Comparison on Breast Cancer with Age.

AGE	FREQUENCY	PERCENT
18-29	9	1.05
30-39	43	5.05
40-49	96	11.2
50-59	45	5.29
>=60	2	0.31
UNREPORTED	655	77.1
TOTAL	850	100.0

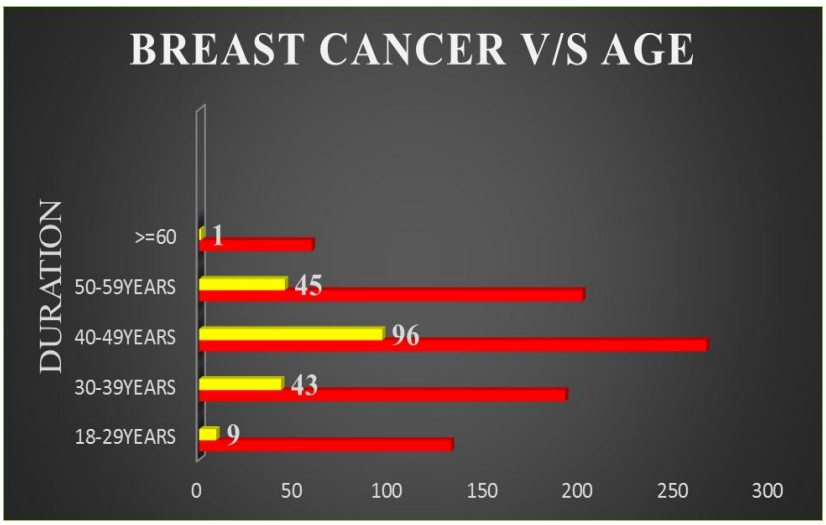


Figure 5.2.2: Comparison on Breast Cancer with Age.

2.3 Distribution Sample Across Mental/Stress Disorder with Age of Patients

Table 2.3 age wise distribution mental /depression disorder.

Age	Frequency	Percent
<40 years	18	2.11
40-49years	26	3.05
50-59years	118	13.8
60-69 years	41	4.82
>=70 years	25	2.94
Without depression	620	73.0
Total	850	100.0

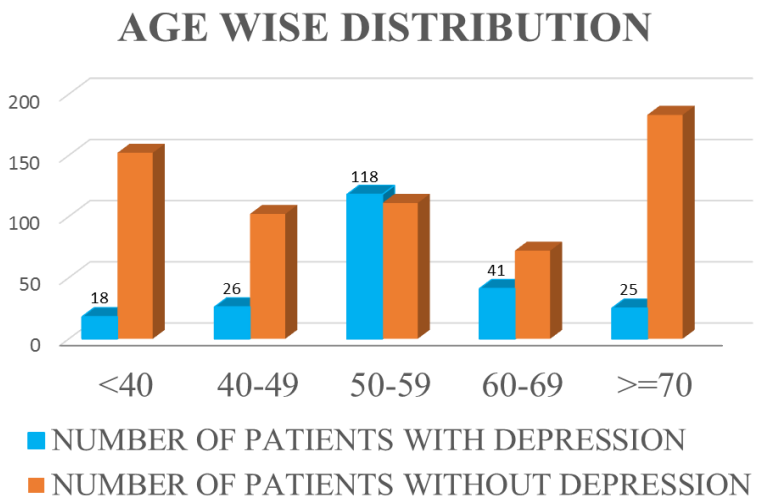


Figure 2.3: Age Wise Distribution Mental /Depression Disorder.

2.4: Distribution of Reproductive Health Problems Among Women's

	Frequency	Percent
Menopause women	379	44.5
With health problems	296	34.8
Treatment taken Total	180	21.1

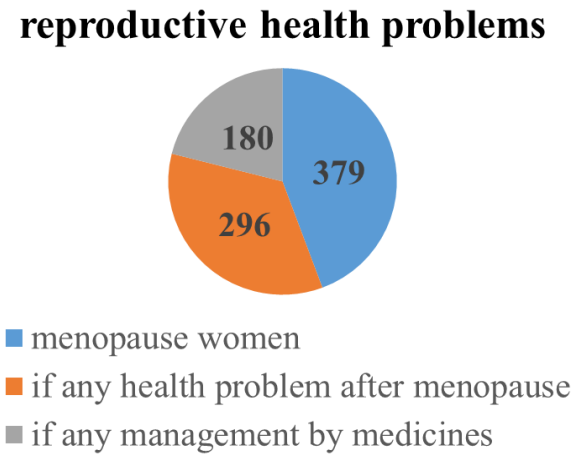


Figure 2.4: Distribution of Reproductive Health Problems Among Women's.

2.5 Distribution of sample age with reproductive health problems.

Table 2.5: Comparison of Reproductive Health Problems Corresponds To Age.

	Frequency	Percent
<=40 years	18	2.2
40-50	324	38.1
50-60	179	21.0
>60	21	2.4
without health problems	308	2.3
Total	850	100

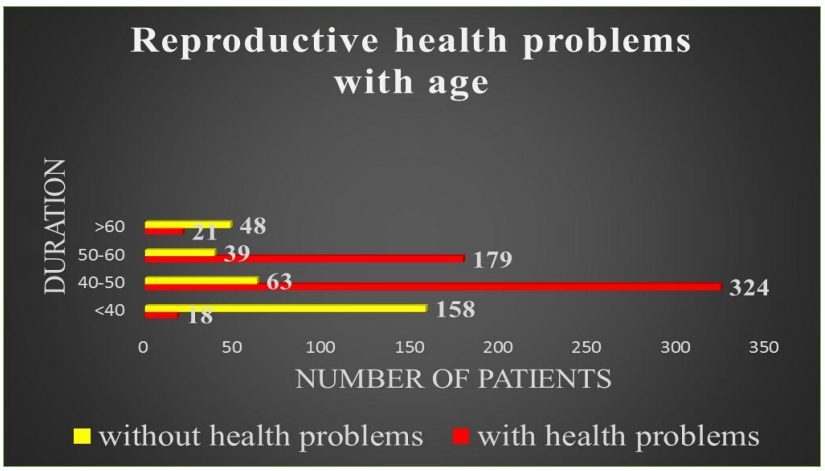


Figure 2.5: Comparison of Reproductive Health Problems Corresponds To Age.

2.6 Distribution of sample according to maternal mortality with socio economic status

	Frequency	Percent
Apl	194	22.8
Bpl	323	38.1
Without Mortality	333	39.1
Total	850	100.0

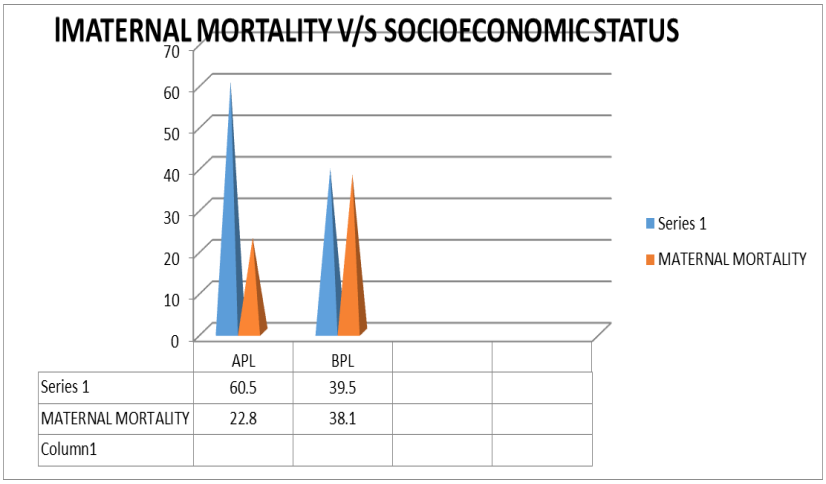
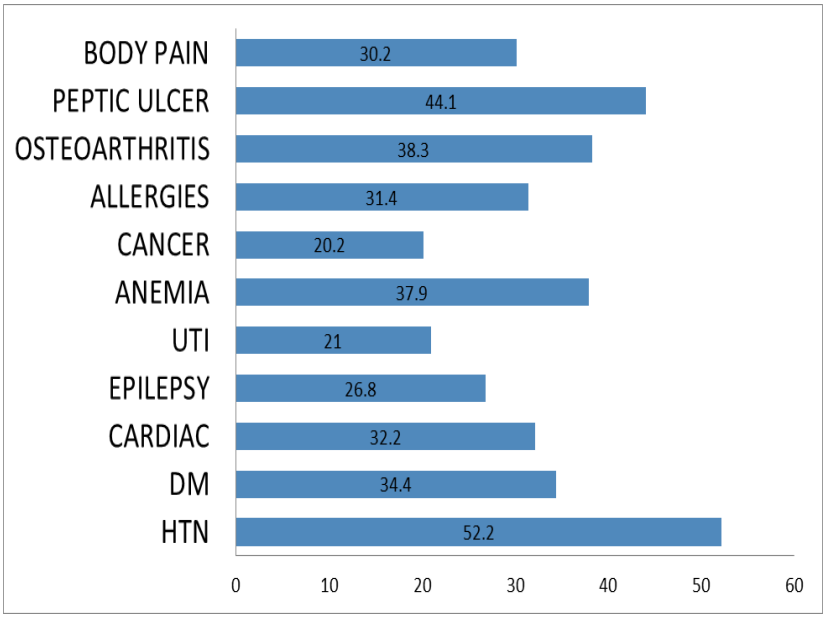


Figure 2.6: Distribution of sample according to maternal mortality with socio economic status.

2.7 Distribution of sample with age and disease.

Disordes	Frequency	Precent
Hypertension	444	52.2
Diabetes	293	34.4
Cardiac disorder	274	32.2
Epilepsy	228	26.8
UTI	179	0.19
Anemia	379	37.9
Cancer	204	20.2
Allergies	267	31.41
Osteoarthritis	326	38.3
Peptic ulcer	374	44.1
Body pain	257	30.2



2.8 Post menopausal problem in women

Table2.8 shows different menopausal symptoms.

	Frequency	Percent
Hot flush	221	26%
Cold flush	102	12%
Urinary urgency	91	10.7%
Painful sex	84	9.8%
Insomnia	124	14.5%
Vaginal dryness	105	12.3%
Weight gain	73	8.5%
Emotional changes	62	7.2%

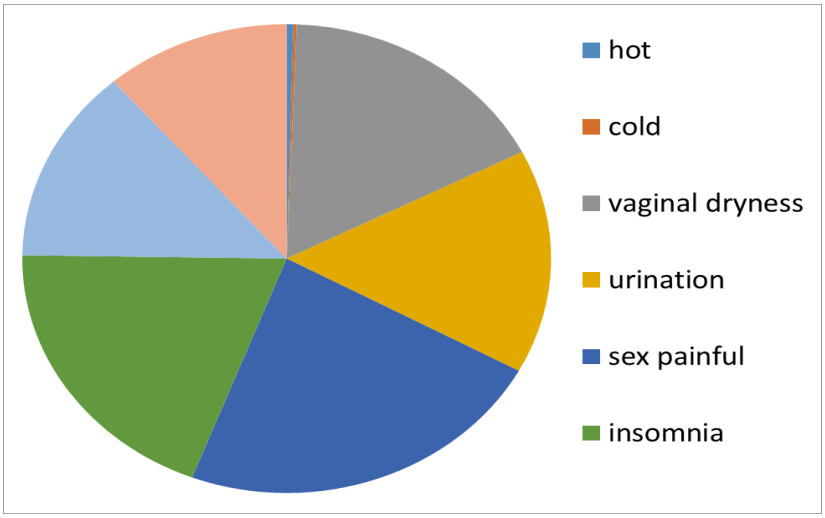


Figure 2.8: Shows Different Menopausal Symptoms.

2.9 Distribution of sample based on women health and nutrition

Table 2.9: Shows Distribution of Sample Based on Women Health and Nutrition.

	Frequency	Percent
Calcium tablet	174	20.4
Vitamin/iron tablet	185	21.7
Egg/milk	287	33.7
Cereals/fibres/vegetables/nuts	340	40
Women horlicks	182	21.4

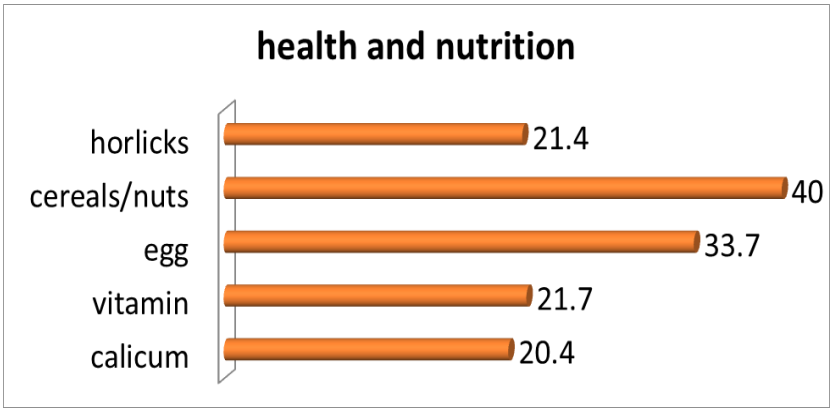


Figure 2.9 Shows Distribution of sample based on women health and nutrition.

3.1 Management of sample with different various methods

Table 3.4: Management of Sample By Using Different Modes.

	Frequency	Percent
Oral/direct	214	25.17
Verbal/leaflet	266	31.2
Visual/presentation	367	43.1
total	850	100

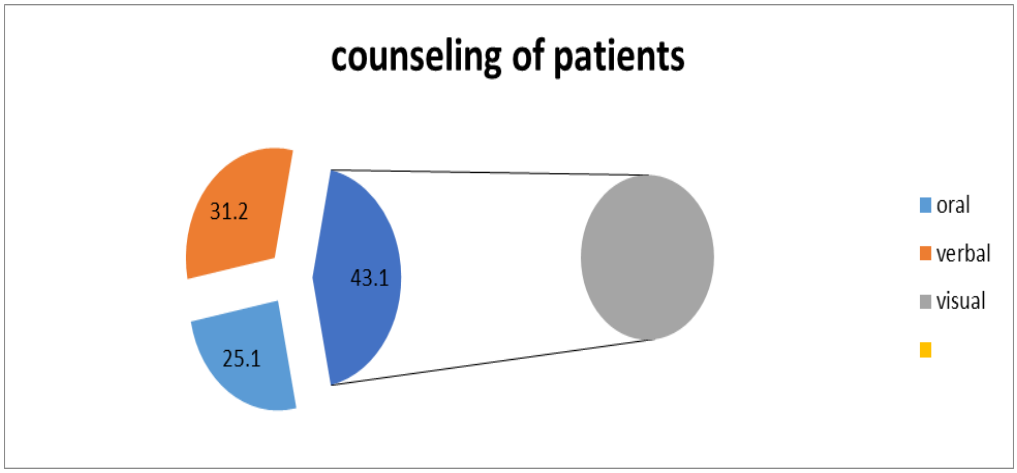


Figure 3.4: Management of Sample By Using Different Mode.

DISCUSSION

The study was carried out in women participants of kudumbashree units, urban area of Kozhikode corporation over a period of 6 months. Analyzed the patient health questionnaire to get the details (age, patient demographics, health history, maternal health, reproductive health, stress & depression and nutrition). The study also aimed to find health status of women and improve the quality of life. The quality of life of patients were assessed by using self designed health questionnaire. The collected data were analyzed using descriptive statistics like chi square test.

There were 850 female participants involved in this study between the age group 18-75 years, as they are most vulnerable group exposed to various adversities of life, and most of the study findings are similar to the result of the study conducted by Paul a bourne etal and the study conducted by k.s mohindra etal and the study of afsal Ibrahim meleis etal.

Among 850 patients most of them were aged above 50 years and the mean age was found to be 46.5 years. The age group 45-55 year is predominant for occurrence of any diseases like reproductive health problems, stress and depression. These results are similar to the study conducted by Dr. mehdi Al-alak etal and also the similar to study of afsal Ibrahim meleis etal. we can say elder age between 45-60 years is more risk of health problems.

The demographic characters of patient were collected, among the total sample, 88.4% are married, 11.2% are widowed and 0.1% are single. Based on the educational status 43.2% patients got high school education and around 1.7% of people were illiterate. Only 5.3% of patients got education degree and above. Based on the economic status of the patients they

were classified as APL (above poverty line) and BPL (below poverty line). 60.5% belongs to APL, 39.5% belongs to BPL category. Among these, working people about 38.5% but most of are working 61.5%, majority of them are house wives. This indicates that there is a lag in women approach towards their own health needs.

When the Socioeconomic and health status is compared, 41.6% of the women undergo irregular checkup, and they belong to BPL category. So, economy doesn't meet proper health needs. Depressive and mood disorder from this study was found to be in the age group of more than 50 years. This study was found to be similar when compared to a study of afsal Ibrahim meleis etal. Breast cancer and cervical cancer were seen in most of the women, 12.5% accounts for cervical cancer and 18% were breast cancer. This is similar to another study conducted by nawal m.nour etal.

According to consumption of vegetable/ fruits with age, about 17% belongs to younger age group This is because of their lack of interest in consuming leafy vegetable/fruits. Moreover, they are interested in consuming bakery/fast food items more than elder age group. The study is similar to Meredith tavener et al, based on life style, habitats, diet and stress.

The reproductive health problems is seen most of women, at the start of menopause. Menstrual disturbances occur within age of 45-55 years and they contribute about 38.1% of women, in which 11.3% were managed with medication. Others are not bothered about these kind of health problems. The was similar to another study shown with study of hedda lippus etal and the study of subrhamanyan ramachandran et al.

The maternal health, influences with socioeconomic status, under 32.3% maternal deaths reported belongs BPL category. So women's economy is doesn't meet health care to visit physician to properly, like regular check up, scanning, laboratory investigation etc and the study similar study of shramishtha basu and also similar study is ranjith kumar dohury.

The overall study have explicated lack of familial permission, non- availability of health services and financial barriers. This study to access to health care talks about barriers faced by women in accessing health services such as acknowledging the reproductive health needs of women, non availability of services and financial barriers.

CONCLUSION

Most of the people experience reproductive health problems at the age of 45-55 years

Socioecnomic disparitis among women cannot report the good health status

Income plays an important role in health care decision.

Post menopausal symptoms are seen in at age of more than 50 years among which, hot flushes are most seen.

The demographic varibles like age, economic status, educational status and mariatal status are found to be associated with health related issues among women.

Life style disorder associated with eating habits, diet, exercise etc.

The most of the depression and mental disorder influenced by income, work and familial problems.

There is arelationship between education and health approach, the uneducated or women with low economic person with irregular check up.

Breast and cervical cancer are seen women with age more then 35 years due to sedentary lifestyle.

Patients are counseled through oral, verbal, written and also visual communication.

ACKNOWLEDGEMENT

I would like to express my gratitude to my guide, Shafeena T (associate professor, department of pharmacy practice, JDT Islam college of pharmacy) for giving me critical suggestion and timely encouragement.

I am also thankfull to the kumbsree unit member for their corporation.

I am also very thankful to Dr Biju George, assistnt professor at calicut medical college for pronviding valublle direction in the statistical aspects of my work.

I would also like to thank my parents and all the members who helped in finishing my project work.