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Original Article

TREATMENT SEEKING PATHWAY OF PID (PELVIC INFLAMMATORY DISEASE) PATIENTS ATTENDING GOVERNMENT HOSPITAL VADODARA, INDIA

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ABSTRACT

Context: PID is a fairly common problem among woman and usually reflects long and often neglected story of reproductive morbidity.
Aims: To study the social dimensions of health seeking behavior of PID patients reporting to Shree Sayaji General Hospital (SSGH), from the beginning of their morbidity till they reached the clinic; vocabulary used in describing the morbidity and social support available during their morbidity.
Study Settings: SSGH Vadodara, a tertiary care referral hospital in the city.
Study Design: In depth interview with multiple contacts
Methods and Material: 120 patients of PID who came to SSGH were enrolled in the study. In depth interview technique was used for data collection and up to 3 sessions were conducted with them after taking their consent.
Results: The treatment seeking pathway showed an average of three health care contacts before a patient reached SSGH. On an average, rural patients took more than 5 years while urban patients took 2 ½ years to reach SSGH with multiple contacts with other care givers prior to reaching SSGH. The most common presenting complaints were white discharge, pain in lower abdomen and backache. In 18% of patients decision for seeking treatment in SSGH was taken by the husband and in 39% of cases it was taken by patient and in 38% of cases it was taken jointly.
Conclusions: The common pattern for health seeking behaviour emerged as multiple contacts and substantial delay before a patient reached tertiary care unit hospital and rural patients took longer time to reach as compared with urban patients.

Key-words: treatment seeking, PID, Vadodara, India

INTRODUCTION

Women have the highest stake in reproduction and reproductive health due to their unique biological role and socially prescribed responsibilities. Many factors limit their choice in terms of sexual relations, reproduction. This is, because of their ignorance, illiteracy and lack of empowerment women in developing countries. Thus they have access to suboptimal services. Their socio-cultural background conditions guide them to tolerate more pain and discourage them from seeking health care. Their desire to seek help is overpowered by their fear of social disapproval or the possibility of being ridiculed.[1] In the light of women's unequal position in society, the international conference on Population and Development held at Cairo, in September 1994, endorsed a programme change from a narrow maternal and child health approach to broader women's reproductive

health approach. This change needed to be translated into policies and programmes. In India this ideological change meant moving from a target- oriented programme to improving the quality of services in women's health.[2] Several studies shows that women suffer from reproductive morbidities for a long time because of their 'culture of silence' and they believe that its not a condition for which they should seek medical help. Moreover, they are reluctant to discuss their morbidities with their husbands or health provider.[3] PID is a major public health problem associated with substantial medical problem complications like infertility, ectopic pregnancy, chronic pelvic pain and health care cost.[4-5]

OBJECTIVES

1. To study the social dimensions of health seeking behavior of P.I.D. patients reporting to. Shree Sayaji General (S.S.G) Hospital from the beginning of their morbidity till they reached the clinic and the social determinants for choosing the pathway.
2. To study the vocabulary used in describing the morbidity and its effect.
3. To study the social support available during their morbidity

METHODS

SSG hospital is regional tertiary care hospital attached to the Government Medical College, Vadodara. Approximately 100 patients a day visit the Obstetrics and Gynecology outdoor Department of which 8-10% have PID. Though the hospital is tertiary care referral unit, large number of patients also comes directly besides referral from private and government hospital due to their residential vicinity. The study received ethical clearance from institutional review board.

Enrolment: Gynaecologists, from two units of SSG hospital, who run an outdoors clinic once a week, consented to participate in the study. PID was diagnosed by the uniform criteria of lower abdominal pain, vaginal discharge and pain during vaginal examination as agreed upon jointly by the Principal Investigator and gynecologist. PID patients were then guided for the in-depth interview when they consented to be enrolled for the study to department of Preventive and Social Medicine. A postgraduate student and a research assistant trained in qualitative research methods conducted in-depth interviews after taking the written consent. Interviews were conducted in free flow style, based on pre tested semi structured research tools developed with the help of technical experts. Each interview lasted for 1 hour. Information collected in form of notes were expanded, translated in to English and then transcribed as file as soon as possible. There are some subjects that are better investigated using a qualitative approach. These tend to be complex situations like STD, RTI, adolescent issues, etc. A qualitative study involving interviews with patients, doctors, and administrative staff and observation of hospital records departments led to the development of a different conceptual model which seemed to be a closer reflection of the reality of waiting lists and therefore had the potential to provide a basis for designing a successful intervention to improve the management of patients. No amount of quantitative research based on the traditional model is likely to have had much benefit.[6]

A total 120 PID patients were enrolled for the study. They were asked the symptoms (vocabulary) that led her to come to the S.S.G. Hospital and the reasons for choosing the S.S.G. Hospital. Also the Pathway of treatment seeking before coming to the S.S.G. Hospital and the social support which was available to them during their morbidity.

Ethical Issues: Patients consent was obtained and confidentiality maintained strictly. Their identity was protected as names and other means of identification were not included while expanding the notes. Home visits were avoided to maintain confidentiality

RESULTS

Patients visiting SSGH followed different pathways.(Table 1) The pathway showed an average of three health care contacts (GP, Gynaecologists, PHC) before a patient reached SSGH (excluding home remedies). Only 24 (20%) patients had come directly to SSGH, while 23% had a history of home remedies.

39% (47/120) of patients contacted a general practitioner or a traditional healer.

According to Hiraben, a 28 year woman with three children,

"As and when I get pain or fever, I get medicines from the village doctor since I cannot afford to be sick. Who will work for the family?"

Another patient, Ramilaben, says,

"Four days ago I had high grade fever so I called the doctor home. He gave me three injections and intravenous fluids for energy and cooling."

Table 1: Treatment Seeking Pathway of PID Patients coming to SSGH

Treatment path	No. of Women		
	Rural	Urban	Total
Direct	13	15	28
HR – SSGH	4	2	6
PHC – SSGH	4	1	5
GP – SSGH	11	11	22
Gy – SSGH	6	16	22
HR - GP – SSGH	3	3	6
HR - Gy – SSGH	5	4	9
HR – GP - Gy – SSGH	4	2	6
GP - Gy – SSGH	9	3	12
PHC - Gy – SSGH	2	1	3
GP - PHC – Gy – SSGH	1	0	1
Total	62	58	120

Gy = Gynecologist

Table 2: Time Lapse between Symptoms and Patients reaching SSGH

Duration (months)	No. (%) of women	
	Rural (n=49)	Urban (n=42)
<=6	7 (14.3)	12 (28.6)
7 to 12	3 (6.1)	4 (9.3)
13 to 36	11 (22.5)	14 (33.3)
37 to 60	13 (26.5)	9 (21.4)
60 +	15 (30.6)	3 (7.1)
Mean Time	61 months	31 months

50% (60/120) had contacted gynaecologists before visiting to SSGH.

Table 2 shows on an average, rural patients took more than 5 years to reach SSGH, compared to urban patients who reached SSGH in about $2^{1/2}$ years. 56% of the rural patients took more than three years to visit the hospital compared to only 28% from urban areas.

According to rural woman, who is the mother of three children,

"I am so fed up of the disease and unsuccessful treatment at various places that ultimately I decided to come here (SSGH)."

Table 3: PID Patients Presenting Complaints (n=120)

Presenting complaints	English translation	Women (%)
Sharer dhovay / Safed pani pade	White discharge	111 (92.5)
Pedhu ma dukhe / Pet ma dukhe	Pain in lower abdomen	109 (84.2)
Masik ma taklif / Masik vakhte dudhe	Menstrual problem	94 (81.0)
Kamar ma dukhe / Ked ma dukhe / Kedo tute	Backache	98 (81.6)
Chakkar ave /Ankhe andhara ave	Giddiness	57 (47.5)
Peshab ma balatara /Peshab vakhate lhay bale	Burning micturition	52 (43.4)
Tav ave	Fever	48 (40.0)
Nablai lage /Kamjori	Weakness	48 (40.0)
Sandhadukhe /Hath pag tute /Hath pag chusay	Aches & pains in joints & extremities	32 (26.7)
Sunvali jagyae cha lave /Peshab ni jagyae khanjval ave	Itching at genital areas	30 (25.0)
-	Others	82 (68.3)

Table 3 shows the presenting symptoms of patients, their relative frequency an equivalent English terms. The most common presenting complaints were white discharge, pain in lower abdomen and backache.

A 32 yr old rural woman Kanakben complained,

"There is a persistent pain in the lower abdomen. It becomes excruciatingly more when we are together (sexual act). This has been my complaint for the last ten years."

Jaliben a 42 yr old woman observed:

"During menstruation there is a severe pain in the lower part of my abdomen. When the labour work in the field increases, there is more pain. In the last five years I have never been completely alright."

Zabida a Muslim woman and mother of three children, complained:

"White discharge spoils my clothes. Now the consistency of the white discharge has thickened and smells very bad."

Table 4 shows decision makers in treatment seeking in PID patients. In 18% of patients

decision for seeking treatment in SSGH was taken by the husband and in 39% of cases it was taken by patient and in 38% of cases it was taken jointly (patient and her husband)

Table 4: Decision Makers in Treatment Seeking

Decision maker	Number of women		
	Rural (n=50)	Urban (n=48)	Total (n=98)
Patient	17	21	38 (38.8)
Husband	14	4	18 (18.4)
Joint	17	20	37 (37.8)
In laws	0	2	2 (2.1)
Others	2	1	3 (3.1)

A Muslim lady (29 yrs age) said:

"I came to my mother's house and my maternal family members were worried. So my mother brought me to the hospital. My husband does not know that I have come here."

Jaya, a patient from urban slum, said:

"When the pain was unbearable, I refused sexual relations. My husband was angry and told me to go for treatment the very next day."

DISCUSSION

Women visiting SSG Hospital from urban and rural areas with limited resources generally have a higher sickness rate with lesser facilities compared to their elite counterparts. This is so primarily because of under utilization of the services with cultural barriers that they have. Tolerating pain is often an accepted norm (sometimes even a matter of pride); when they desire help, fear of social disapproval and anxieties about the medical examination act as barriers. Even when they do not want a medical check-up by a male doctor they lack the courage to state this explicitly and, as a result, avoid treatment. This reflects their low self-esteem and cultural inhibitions.

The approach that is recommended in women's holistic health care of listening to a woman's needs, perspectives, and concepts about morbidity has reminded far away from reality. Most doctors have neither the time nor the concepts and desire to listen to a woman's concept of PID, the complexities involved in their health-seeking behaviour and being sympathetic from a social perspective. However, they have been good in providing the best possible biomedical care. From the woman's needs and desire this is not sufficient.

When and where patient seek treatment has several cultural constrains and has been discussed in the foregoing. Where they go for treatment is dependent upon their area of residence, the facilities that are available nearby, their faith in different facilities, the societal approval of the treatment and response (importance) that the family members in general, and the husband, in particular, attach to the sickness. It also depends on the level the sickness of the patient and how decision-makers value the proposed places of treatment.

Often a woman initially tolerates her condition. This is followed by home remedies, which are either self tried, suggested by and elder female member of the family or other patients. If her condition worsens, they approach a local medical practitioner, who may be a traditional healer or a general practitioner. Only when her condition becomes serious they do visit to SSGH for treatment. Some patients who live in the vicinity or are in contact with people working in the hospital prefer to come directly to the hospital.

R. Mutharayyapa in his study regarding Reproductive Morbidity of Women in Karnataka has observed that fewer than half the women who reported gynaecological problems did not seek treatment and among those who sought treatment majority had gone to private health facilities.[7]

23% of patients had history of home remedies. Home remedies were quite variable and depended on women's perceptions of the disease. Since some patients perceived PID as pain in abdomen, they used an ayurvedic medicine called kayam churn, which was applied on the abdomen. Some patients thought PID was caused by heat so treatment was prescribed to counter heat like drinking a mixture of coconut water sugar and fennel water, or the juice of neem leaves, milk and black gram.39% of patients contacted general practitioner and the reasons for it were their easy availability, relatively low cost and better rapport. However treatment was sought not for relief but primarily because it interfered with their routine work. Does this reflect women's low self esteem, their low priority to health, or greater importance to their social role? 50% of patients contacted gynaecologists first before coming to SSGH. A study was carried out by

Bela Patel regarding Reproductive Health Problems of Women in Uttar Pradesh observed that majority (68 per cent) of women who sought treatment relied upon private medical practitioners in the village.[3]

As results of table 2 shows that rural patients reach later to SSGH as compared to urban patients. Reasons may be: rural patients try home remedies for a longer period and visit hospital only when the symptoms cannot be tolerated. In addition, it is more difficult for a rural patient than an urban patient to reach a hospital in the city.

Patients said they visited consultants for referral or for higher level investigations recommended by general practitioners. A general practitioner advises such visits when patients are treated without experiencing any relief or they are required to undergo investigations that are not possible at the general practitioner's level. Sometimes, because a problem persists, despite treatment, the patients decide on their own, or with the help of family members to visit a consultant.

A study done by Jasmin regarding RTI in young married women in Tamil Nadu, concluded that two-thirds of symptomatic women had not sought any treatment; the reasons cited were absence of a female provider in the nearby health care center, lack of privacy, distance from home, cost and a perception that their symptoms were normal.[8]

Another study carried out by Miteshkumar Bhandari regarding the Untreated Reproductive Morbidities among Ever Married Women of Slums of Rajkot City found that a lower sense of need, the cost of care, and societal barriers were the reasons for not seeking care.[9]

Here, Common presenting symptoms were white discharge, menstrual disturbances, pain in lower abdomen, backache, weakness, etc... Dr. G. Rangaiyan, in his study regarding gynaecological morbidity among women in South India noticed that menstrual irregularities, white discharge, backache, bodyache, fever, etc. were the symptoms reported by them.[10]

White discharge and being a woman are considered to be coexisting realities and the general tendency is to ignore the complaint. Only when white discharge starts smelling foul or is accompanied by intolerable menstrual irregularities or it hampers their routine work or sexual life disturbances then the patient seek treatment. The decision to opt for treatment at SSGH was taken either by patient herself without knowledge of husband, or by husband or jointly by them.

Similar finding was observed by Bela Patel that in many cases (nearly 16% of cases), when and where women should get treatment was dependent on their family members and not on the women suffering from problems.[3]

So there is a need to explore the possibilities of involving more nursing staff and social workers in taking care of the needs of patients adopting holistic approach to health care and make social workers and the family members of the patient their partner in providing comprehensive care to women patients.

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