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Use Of Cu-T Among Rural Women In Kashmir Valley And Their Knowledge Regarding Management And Complications Of Its Insertion As A Contraceptive Device.

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Abstract
To study the knowledge regarding prevention and management of complications of Cu-T insertion among rural women and to determine the relationship between knowledge and the selected factors (age. religion. educational qualification, occupation. type of family, income, number of children, duration of copper-t insertion) 100 rural women attending PHC's of Kashmir were investigated in the present study. It was found that majority of women (90%) were Muslims, most of the of the study subjects (78%) were house wives, more than half (54%) were in the age group of 31-40 years, (45%) belonged to nuclear family, (40%) of women were having two children ,(39%) women were in the monthly income group between Rs 10001-15000. (29%) were having 1-2 years of Cu-T insertion, (35%) women had primary education, maximum number of women with Cu-T insertion complications (12%), were having excessive vaginal discharge and minimum number of women (2%), reported nausea and vomiting and only (1%) of women's husband got hurt during sexual intercourse. Maximum subjects (70%) had inadequate knowledge regarding prevention and management of complications of Cu-T insertion. The mean of knowledge score was 20.8 (maximum score 34) and Standard deviation was found to be 6.96 depicting heterogeneity in the knowledge score of study subjects. There was a significant relationship between knowledge and educational but there was no significant relationship between knowledge and factors like age, religion, occupation, type of family, income, number of children, duration of Cu-T insertion at 0.05 levels. The study findings indicate that there is lack of knowledge among women regarding prevention and management of complications of Cu- insertion and hence there is need to educate and to give information to women regarding prevention and management of complications of Cu- insertion.

Keywords: Cu-T complications, family planning, Rural women.

INTRODUCTION

The earth is in the midst of a population explosion which threatens to exhaust the common resources upon which its inhabitants depend. India, the largest democratic republic in the world, possesses 2.4% of world's land area and supports 10% of the world's population. It is the second most populous country after China. Every year it adds 16 million people to its large base of population. According to the World Population Projections by the United Nations, it is estimated that India would have a population of 1533 million by the year 2050. Under the Eighth Five year Plan (1991-1995), achieving a slower rate of population growth was considered as one of the most important priorities facing the nation and during the Ninth Five Year Plan (1997- 2002), reduction in the population growth, mortality and achieving desired level of fertility. During the Tenth Five–Year Plan (2002-2007), the main approach of the Family Welfare Programme was: to assess the needs of reproductive and child health, meeting the unmet need for contraception, and promoting male participation in the Planned Parenthood.

Rowe (2009) reported that according to UNFPA, each pregnancy multiplies a woman's chance of dying from complications of pregnancy or childbirth. Maternal mortality rates are particularly high for young and poor women, those who have least access to contraceptive services. It is estimated that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services. Expanding access to client-centred information and services, where a range of effective contraceptive methods is offered and responsive counselling provided, reduces the number of unplanned pregnancies. These unintended pregnancies often lead to sub-optimal pregnancy care, unsafe abortions and overwhelmed mothers. As many as 50 per cent of pregnancies are unplanned, and 25 per cent are unwanted. The unwanted pregnancies are disproportionately among young, unmarried girls who often lack access to contraception. More than one quarter of pregnancies worldwide, about 52 million annually, end in abortion. Many of these procedures are clandestine, performed under unsafe conditions. About 13 per cent of maternal deaths are attributed to unsafe abortions, coupled with lack of skilled follow-up. In many developing countries, at least a third of women need contraceptive services. However, Some women do not know about modern methods, are unable to obtain or afford them, or distrust or dislike the methods that are available Single women and teenagers may be barred from obtaining

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contraceptive services other women are ambivalent about whether they want a child or are unsure about their ability to become pregnant till others live with a partner who does not approve of contraception or who wants them to become pregnant.

UNFPA is committed to closing the gap between the number of individuals who use contraceptives and those who would like to delay space or limit their families. UNFPA supports family planning services in countries around the world, usually within a broader context of reproductive health services. UNFPA supports family planning services that offer a wide selection of methods reflect high standards of medical practice are sensitive to cultural conditions provide sufficient information about proper use or possible side effects address women's other reproductive health needs imparts training for the use of various family planning devices.

Empowerment and gender equality improve the health of women and children by increasing reproductive choices, reducing child marriages and tackling discrimination and gender-based violence. Partners should look for opportunities to coordinate their advocacy and educational programs with organizations focusing on gender equality. Shared programs might include family-planning services, health education services, and systems to identify women at risk of domestic violence (UNFPA, Millennium Development Goal 3).

The UN Secretary-General's Global Strategy for Women's and Children's Health aims to prevent 33 million unwanted pregnancies between 2011 and 2015 and to save the lives of women who are at risk of dying of complications during pregnancy and childbirth, including unsafe abortion. According to the United Nations Population Fund (UNFPA, 2008). In developing countries: Every minute 146 women become pregnant who did not plan or wish it 90 women experience a pregnancy-related complication; 35 women have an unsafe abortion; 1 woman dies from a pregnancy-related cause.

The main objectives of the study were to determine the prevalence of Cu-T complications among women and their knowledge regarding prevention and management of complications of Cu-T insertion and to determine the relationship between knowledge and the selected factors (age, religion. educational qualification, occupation. type of family, income, number of children, duration of copper-t insertion) The conceptual framework of the study was based on the “health belief model”. The research approach adopted for the study was the descriptive survey approach. The convenience sampling technique was used to select study subjects. The sample consisted of 100 women attending selected PHC’s of Kashmir.

The tools developed and used for data collection were structured interview schedule to obtain data as per the objectives .The reliability of structured interview schedule to assess knowledge was established by KR-20.The reliability was found to be 0.82.The reliability of structured interview schedule to determine prevalence of Cu-T complications among women and to identify the decision makers in the family in choosing family planning methods , was established by Test-Retest method and the reliability was found to be 0.86.Thus the tool was found to be reliable. For establishing validity, the tool was given to 11 experts from medical and nursing field. Data gathered were analyzed and interpreted in the light of the objectives using descriptive and inferential statistics.

Table- 1 Frequency and percentage distribution of study subjects by their demographic characteristics. n=100

S.No.	Demographic characteristics	Frequency/ percentage
1.	Age	
	Below 20 years	0
	21-30 years	38
	31-40 years	54
	Above 41 years	8
2	Religion	
	Hindu	3
	Muslim	90
	Christian	1
	Others	6
3	Education	
	No basic education [Illiterate]	20 35
	Primary	25
	Secondary	15
	Graduate	5
	Post Graduate	0
	Any other	
5	Type of family	
	Nuclear family	43
	Joint family	42
	Extended	15
6	Monthly income	
	Below Rs 5000	30
	Rs 5001-Rs10000	21
	Rs 10001-Rs 15000	39
	Above Rs 15000	10
8	Number of children	
	1	20
	2	40
	3	21
	>3	19
9	Duration of Cu-T insertion	
	6 months-1 year	25
	1 year-2 years	29
	2 years-3 years	26
	3 years-4 years	17
	4 years-5 years	3
	Above 5 years	0
10	Frequency of menstruation	
	<20 days	1
	20-23 days	6
	24-27 days	21
	28-31 days	56
	More than 31 days	16

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TABLE- 2
Frequency and Percentage Distribution of Study Subjects by Prevalence of Complications of Cu-T Insertion

n=100

Sr.No.	Complication	Yes (Frequency/ Percentage)	No (Frequency/ Percentage)
1	Irregular menstrual bleeding	7	93
2	Excessive bleeding	9	91
3	Bleeding in between menstrual cycle	5	95
4	Excessive vaginal discharge	12	88
5	Foul smelling vaginal discharge	6	94
6	Increased urinary frequency (Polyuria)	3	97
7	Pain during sexual intercourse	3	97
8	Fever with chills	5	95
9	Nausea and vomiting	2	98
10	Husband get hurt during sexual intercourse.	1	99
11	Backache -Lower area -Upper area -Pain in the whole back area	11 8 1 2	89
12	Pain abdomen -Lower abdomen -Upper abdomen -Pain in the whole abdomen.	3 2 0 1	97

Table- 3

Chi Square Showing Relationship between Age and Knowledge.

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Age <30 >30	 20 36	 18 26	0.38

X^2 (1)=3.84, at 0.05 level of significance

The data in table 11 shows that the computed chi- square value is (0.38), which is lesser than table value of 3.84 at df (1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with age of women with Cu- T insertion.

Table- 4
Chi Square Showing Relationship between Religion and Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Religion Muslim Non-Muslim	 51 5	 39 5	0.16

X^2 (1) =3.84, at 0.05 level of significance

The data in table 4 ,shows that the computed chi- square value is (0.16), which is less than table value of 3.84 at df (1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with religion of women with Cu-T insertion.

Table- 5
Chi Square Showing Relationship between Education and Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Educational qualification Illiterate Literate	 44 12	 10 34	32.21*

X^2 (1)= 3.84, at 0.05 level of significance

* -Significant at 0.05 level

The data in table 5, shows that the computed chi- square value is (32.21), which is greater than table value of 3.84 at df(1). This shows that the chi square value is significant at 0.05 level. Thus, indicating that there is significant relationship of knowledge with education of the women with Cu- T insertion.

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Table-6
Chi Square Showing Relationship between Occupation and Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Occupation Unemployed Employed	51 5	35 7	2.70

X^2 (1)=3.84, at 0.05 level of significance
The data in table 6, shows that the computed chi- square value is (2.70), which is less than table value of 3.84 at df(1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that the knowledge score have no relationship with occupation of women with Cu-T insertion.

Table- 7
Chi Square Showing Relationship between Family Type and Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Family type Nuclear Joint Extended	24 24 8	19 18 7	0.23

$X^2(2) = 4.99$, at 0.05 level of significance
The data in Table 7 shows that the computed chi- square value is (0.23), which is lesser than table value of 4.99 at df (2). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with family type of women with Cu-T insertion.

Table- 8
Chi Square Showing Relationship between Monthly Income and Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
Monthly Income <Rs 10,000 >Rs 10,000	32 24	19 25	1.92

X^2 (1)=3.84, at 0.05 level of significance
The data in Table 8 shows that the computed chi- square value is (1.920), which is less than table value of 3.84 at df (1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with monthly income of women with Cu-T insertion.

Table- 9
Chi Square Showing Relationship between No. of children And Knowledge score

n=100

Selected Variable	Knowledge score		X^2
	Below Mean	Above Mean	
No. of children <2 >2	32 24	28 16	0.43

X^2 (1)=3.84 , at 0.05 level of significance
The data in Table 9 shows that the computed chi- square value is (0.43), which is less than table value of 3.84 at df(1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with number of children of women with Cu-T insertion.

Table- 10
Chi Square Showing Relationship between Duration of copper T insertion And Knowledge score

n=100

Selected Variable	Knowledge score Below Mean	Above Mean	X^2
Duration of copper T insertion <3 years >3 years	32 24	22 22	0.50

X^2 (1)=3.84, at 0.05 level of significance
The data in table 10 shows that the computed chi- square value is (0.50), which is less than table value of 3.84 at df (1). This shows that the chi square value is not significant at 0.05 level. Thus, indicating that knowledge score have no relationship with duration of Cu-T insertion of women.

DISCUSSION

Findings of the study are discussed in terms of objectives and theoretical bases. Women with Cu-T were having irregular menstrual bleeding. These findings were consistent with the findings of Hubacher D, et al (2009). They conducted a study on the side effects from the copper IUD to find whether they increase over time. The study showed that irregular menstrual bleeding and pain complaints

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remain unchanged. H.M Veldhuis, *et al* (2004), conducted a retrospective cohort study regarding complications and symptoms of the intrauterine device. Results of the study showed that main reasons for removal were 'menstrual problems' (irregular menses). Patai .K and Berényi .M, (2002) conducted a study on complications from the use of Cu IUD. The most common side effect of Cu IUD use was excessive bleeding. H. Salzer, *et al* (2000) carried out a retrospective study on "Intrauterine contraception with Cu-T intrauterine device''. Results showed menstrual disturbances (20.1%) necessitating removal of the device in (5.7%) women. Women with Cu-T insertion were having excessive menstrual bleeding. These findings were consistent with J.E Bradley, *et al* (2009). They conducted a retrospective study on IUD's in Bangladesh. 20% women reported excessive menstrual bleeding. In the present study, only 9% women reported excessive menstrual bleeding. Imperato F, *et al* (2002), conducted a prospective study on the role of copper releasing intrauterine device on uterine bleeding. The study also revealed menorrhagia among women using Cu-T. Patai .K and Berényi .M, (2002) conducted a study on complications from the use of IUD. The study revealed that most common side effect of IUD use was excessive bleeding. In the present study it was found that Women with Cu-T were having excessive vaginal discharges. These findings were consistent with Broso, P. R and Buffetti,G (2004), They conducted a study on uterine perforation associated with IUD insertion. They revealed that major health risks associated with IUD use were perforation of the uterus and pelvic inflammatory disease. Skajaa K, R *et al* (2002) conducted a retrospective study on "Complications caused by intrauterine contraceptive devices and found that excessive vaginal discharge (infection) occurred. In the present study women with Cu-T insertion were found to suffer pain abdomen and backache. These findings were consistent with H. Salzer, *et al* (2000), They carried out a retrospective study on "Intrauterine contraception with Cu-T intrauterine device''and reported that the most frequent complication were menstrual disturbances (20.1%), pain abdomen (9.5%), backache (10%), cervicitis (18.3%), necessitating removal of the device in 5.7%, 2%, 2.2 % and 5.1% respectively.

In the present study, the common complaint of women with Cu-T insertion was backache, vaginal discharge, pain lower abdomen and menorrhagia. These findings were consistent with Agarwal, K and Sharma, U (2004) who reported complaints of backache (54%), vaginal discharge (46%), pain lower abdomen (34%), dyspareunia (22%), menorrhagia (18%) and dysmenorrhoea (14%) in women using Cu-T.

CONCLUSION AND RECOMMENDATIONS

The study findings indicate that there is lack of knowledge among women regarding prevention and management of complications of Cu- insertion and hence there is need to educate and to give information to women regarding prevention and management of complications of Cu- insertion. Based on the study findings it is recommended that similar study may be replicated on large samples, also a comparative study may be conducted to find the knowledge of women in rural and urban settings regarding prevention and management of complications of Cu-T.

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