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Authors' response

We thank Shivalli for his observations on our article. The comments are related to adhering to STROBE checklist¹ while reporting cross-sectional studies. He has commented that the outcome variables should have been reported with 95% confidence intervals. The outcome variables for gynaecological morbidities are not described in our paper. For chronic obstetric morbidities in our paper, 95% confidence intervals can be calculated from the results reported in the Tables.

Of the 25 women detected with more than one reproductive morbidities, none had more than one obstetric morbidity. Nine women had more than one gynaecological morbidity while 16 had presence of one gynaecological and COM each². Regarding exploring the association of COMs with place of delivery (institutional vs. home), and mode of delivery (vaginal vs. caesarean), it should be understood that when deliveries are conducted by skilled personnel; it gives better association with the occurrence of COM, instead of the place of delivery (institutional vs. home). Even though home deliveries are reported, conduction by skilled personnel plays an important role for the occurrence of COMs. We would like to mention that the percentage of caesarean sections was only 1.3 per cent of the total deliveries reported by the women. Hence there was no point in studying this variable with the occurrence of COMs. Regarding exploring association of gynaecological morbidities, there are already many studies and abundant published literature available on this association. The authors did not wish to raise a research question which would give repetitive results. Also the focus was more on COMs on which published literature is scanty from India. This has been mentioned in the paper². Regarding association of the above mentioned variables and COM about source of health care, the authors have explored the treatment seeking by the women in case of deliveries, abortions, gynaecological and obstetric morbidities. However, it was not possible to discuss these data in the present paper.

The risk factors such as repeated births have been explored by asking the women about the number of

deliveries and mentioned in Table II². Raising apt questions such as information on postnatal exercises was not appropriate as our interaction with the health workers during the formative phase revealed that they themselves were not aware of the postnatal exercises and did not routinely provide health education to women during the postnatal visits. Hence, this aspect was not explored during the study. The authors have recommended from the findings of the study that health service system should provide education to women on Kegel exercises for prevention of prolapse.

Regarding limitations of the study, the authors agree that significant correlates of COM may not imply causality owing to the cross-sectional nature of study. However, considering the COMs such as prolapse, secondary infertility, chronic pelvic inflammatory disease (PID) and obstetric fistula, a cross-sectional study is operationally feasible. For studying causality, case-control study or interventional studies at community level will not only be difficult to conceptualize but will need a very long duration and there will be multiple confounding factors.

The authors though appreciated the comments raised, but a thorough literature search on COM especially in India would indicate that there were hardly any data available on the prevalence of these morbidities and hence this study was planned. While it is recommended to follow STROBE checklist while reporting cross-sectional studies, the applicability and the relevance should be kept in mind.

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