

Reproductive healthcare seeking behaviour of women of the reproductive age group in an urban resettlement area of district Gautam Buddh Nagar in Uttar Pradesh, India

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ABSTRACT

Background: Reproductive tract infections (RTIs) and gynaecological morbidities constitute a significant proportion of morbidities in women of the reproductive age group. **Objective:** To find out the proportion of reproductive age group women in an urban resettlement colony having the symptoms of gynaecological morbidities and RTI/sexually transmitted infection (STI) and to explore the healthcare seeking behaviour of the women during such ailments. **Materials and Methods:** A community-based cross-sectional study was conducted from January to June 2023 among 317 females aged 15 to 49 years in an urban resettlement area of Gautam Buddh Nagar district in Uttar Pradesh. Statistical analysis used included descriptive statistics and Chi-square test. SPSS 23 was used for data analysis. **Results:** There was a prevalence of 65.3% of at least one self-reported symptom suggestive of RTI/STI or gynaecological morbidity among the respondents. Among the symptomatic respondents, 54.1% were found to seek treatment. Among the reasons given for not seeking treatment in any health facility, the majority (83.1%) responded 'lack of awareness that the problem needed medical treatment' and 'stigma related with the problem' to be the main reasons. **Conclusion:** The reproductive healthcare seeking behaviour was found to be inadequate, with only 54.1% of symptomatic respondents seeking treatment. Enhanced health awareness sessions can be planned in the short term, and skilled communicators within or outside of the health system in the long term may be deployed to disseminate information in the community regarding sexual and gynaecological morbidities in reproductive age group women and their timely intervention.

Keywords: Gynaecological morbidities, health seeking behaviour, reproductive age group, reproductive tract infections, urban resettlement area

Introduction

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health care is defined

as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.^[1] The reproductive health care seeking behaviour (RHSB) is culturally determined, and various socio-cultural, economic, education, physiological, and environmental factors do play a significant role and influence either directly or indirectly in shaping the RHSBs in men and women in the community.^[2]

World Health Organization (WHO) defined reproductive morbidity as consisting of three types of morbidity: obstetric,

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contraceptive, and gynaecological; gynaecological morbidity includes any condition, disease, or dysfunction of the reproductive system which is not related to pregnancy, abortion, or childbirth but may be related to sexual behaviour.^[3] Some of the gynaecological morbidity symptoms include irregular menstrual patterns, white vaginal discharge, itching of vulva, burning urination, and inguinal swelling.^[4] In developing countries, the mortality and morbidity due to reproductive tract infections/sexually transmitted infections (RTIs/STIs) are very high relative to those associated with other health problems. The consequences of RTIs which are numerous and potentially devastating include post-abortal and puerperal sepsis, ectopic pregnancy, foetal and perinatal death, cervical cancer, infertility, chronic physical pain, emotional distress, and social rejection in women. The impact of RTIs on the transmission of human immunodeficiency virus (HIV) infection and the morbidity and mortality of HIV adds substantially to the total health impact of RTIs.^[5] High prevalence of reproductive morbidity is attributed to many factors, such as child-bearing patterns,^[6] utilisation of health services,^[7] health-related behaviour,^[8] and background characteristics including the personal standard of living,^[9] community affiliation,^[9] and utilisation of social institutions.^[10,11] Many instances are preventable, yet many of them go undiagnosed and untreated because of poor access to reproductive health care services.^[12]

Rationale of the study

Most of the available studies on RTIs and gynaecological morbidities in women are based on hospital-based data and hence do not draw attention to the genuine nature of problems rampant in the community compounded by the fact that there is hesitation in reporting symptoms of RTI/STI and receiving treatment from the health centres. Also, there is insufficient information about the gynaecological morbidities and RHSB among the women living in urban resettlement colonies. Primary care providers and family physicians are usually the first accessible point in the community for these groups of patients. Assessing the reproductive health care seeking behaviour in these women will help to understand the gaps in reproductive health care services delivery in the community, thus providing key areas of improvement and in implementing need-based services.

Therefore, this study was planned to find out the prevalence of symptoms suggestive of RTI/STI and gynaecological morbidities among females aged 15–49 years (reproductive age group) and their treatment seeking behaviour in an urban resettlement area of Gautam Buddha (GB) Nagar district in Uttar Pradesh.

Objectives

1. To find out the prevalence of symptoms suggestive of RTI/STI and gynaecological morbidities in the reproductive age group women in an urban resettlement area.
2. To explore the reproductive healthcare seeking behaviour of the women during such ailments.

Materials and Methods

Study design

A cross-sectional study was conducted from January to June 2023 among females aged 15 to 49 years in an urban resettlement area of Gautam Buddha (GB) Nagar district in Uttar Pradesh, India.

Study area and setting

The study was conducted in an urban resettlement area of District GB Nagar that is in the catchment area under Urban Health and Training Centre (UHTC) of a Medical College located in Delhi NCR. There was a total of eight colonies within the study area, namely, Bhangel, Kunda, Rajiv, Jeetram, Salarpur, Bhatta, and Goyal colonies. The total population was 11,567 residing in 2703 households. The population in the reproductive age group was 2326.

Study participants

Inclusion criteria: Women of age 15–49 years residing in the study area for more than 6 months who gave consent to participate in the study.

Exclusion criteria: The women who were not permanent residents of the area, those who did not give consent to participate, those who had hysterectomy in the past, and those critically ill women who were unable to respond to the interview schedule were excluded from the study.

Sample size and sampling technique

For sample size calculation, we applied the formula Z^2pq/L^2 , where we had taken P as 23.3% for prevalence of symptoms of RTI/STI in women of the reproductive age group based on the data of NFHS-4 from Haryana.^[13] Considering an absolute error (L) of 5% and 95% confidence interval, the minimum sample required was 275.

To account for a non-response rate of 15%, the sample size was calculated to be 317. Systematic random sampling was used. Women in the reproductive age group who gave consent to participate in the study were selected one each from 317 households in the different colonies under UHTC selected by applying Probability Proportional to Size (PPS) to achieve the desired sample.

Ethical clearance and data collection

The study proposal was approved by the Institutional Ethics Committee. A pre-designed and pre-tested interview schedule was used for data collection. Data on socio-demographic factors that included age, gender, marital status, level of education, type of family, and socio-economic status were collected. The schedule was pre-tested among 30 reproductive age group women who were not part of our study. These questions were mainly about the study participants' demographics (age,

education, occupation, socioeconomic status, marital status etc.), contraceptive use status, symptoms suggestive of RTIs, and self-reported gynaecological morbidities. RTI symptoms were defined according to the syndromic case management guideline developed by the WHO.^[14] The symptoms included abnormal vaginal discharge accompanied by foul smell, ulcers in and around the genital region, pelvic pain not related to menstruation, burning sensation during urination, genital itching, and swelling in the groin. Provisional diagnosis of diseases of the reproductive age group women was made based on the self-reported symptoms, available prescriptions, and investigation reports with the respondents. Both acute and chronic RTIs and gynaecological morbidities were considered for our study.

Those respondents who were found to have any reproductive health problem were inquired about their health-seeking behaviour. For this study, healthseeking behaviour was defined as a sequence of remedial actions taken by the person to rectify perceived ill health.^[15] Appropriate or desired health-seeking behaviours were defined as seeking treatment and health advice through trained doctors (both allopathic and AYUSH) from public or private health facilities (government hospital, private clinic).

Statistical analysis

Data of 317 participants who responded between January and end of June 2023 were analysed using the Statistical Package for the Social Sciences version 25 (SPSS Inc., Chicago, IL) statistical software. The analyses included descriptive statistics.

Results

A total of 317 women in the reproductive age group participated in the study. The majority were in the age group of 15–34 years (66.9%). Regarding the educational status, the majority (80.1%) of women had education of a middle-school level and above. Out of all respondents, 69.1% women belonged to the socio-economic group of lower middle class and above according to modified Kuppuswamy classification updated for 2022.^[16] The married respondents comprised 79.2% of the total, 22.4% respondents had history of past abortion, and 26.2% were currently using a contraceptive method. Among the respondents, 12.6% were using condoms [Table 1].

Out of all the respondents who were asked about the presence of any symptoms of acute or chronic RTIs and gynaecological morbidities, 65.3% were found to be symptomatic. Among the symptomatic respondents, the majority (69.1%) reported the presence of dysmenorrhoea, smelly vaginal discharge, burning micturition, and menorrhagia as their symptoms [Table 2].

Among the 207 symptomatic women who reported, 95 (45.9%) were found to have not visited any health facility, whether government or private for their treatment. Of the reasons given for not seeking treatment in any health facility, the

Table 1: Distribution of the respondents according to demographic and other characteristics (n=317)

Variable	Number (%)
Age	
15-34 years	212 (66.9)
35-44 years	88 (27.8)
45-49 years	17 (5.3)
Religion	
Hindu	275 (86.8)
Muslim	42 (13.2)
Education	
Illiterate	32 (10.1)
Just literate and primary	31 (9.8)
Middle school and above	254 (80.1)
Socioeconomic status	
Lower	9 (2.8%)
Upper lower	89 (28.1%)
Lower middle and above	219 (69.1%)
Marital status	
Married	251 (79.2%)
Separated/divorced	7 (2.2%)
Unmarried	59 (18.6%)
History of past abortion	
Yes	71 (22.4%)
No	246 (77.6%)
Current user of contraceptive method	
Yes	83 (26.2%)
No	234 (73.8%)
Type of contraceptive method used	
Condom	40 (12.6%)
Tubectomy	22 (7%)
OCP	12 (3.8%)
Cu-T	9 (2.8%)
None	234 (73.8%)
Type of absorbent material used in menses	
Old washed cloth	50 (15.8%)
Disposable sanitary pad	223 (70.3%)
Both pad and cloth	44 (13.9%)

Table 2: Distribution of respondents according to their symptoms suggestive of RTI/STI and self-reported gynaecological morbidities (n=317)

	Number (%)
Self-reported symptoms of RTI and gynaecological morbidities (n=317)	
Abnormal vaginal discharge with foul smell, burning micturition, and genital itching*	84 (26.5%)
Pelvic pain not related to menses	15 (4.7%)
Painful swelling in the groin	9 (2.8%)
Dysmenorrhoea	59 (18.7%)
Menorrhagia	19 (6%)
Inability to conceive	12 (3.8%)
Uterine fibroids	9 (2.8%)
No symptoms	110 (34.7%)

*Multiple responses

majority (83.1%) responded 'lack of awareness that the problem needed medical treatment' and 'stigma related to the health condition or disease' to be the main reasons. Among all the respondents, the majority (75.7%) however preferred the use of allopathic medicine for the treatment of any reproductive tract problems [Table 3].

Table 3: Distribution of the respondents according to their health-seeking behaviour

Response	Number (%)
(i) Preference of system of medicine for treatment of any reproductive tract problems (n=317)	
Allopathic	240 (75.7%)
AYUSH medicine	9 (2.8%)
Both allopathic and AYUSH medication	68 (21.5%)
(ii) Type of health facility used for treatment of symptoms (n=207)	
Government	30 (14.5%)
Private	64 (30.9%)
Both	18 (8.7%)
Not used any	95 (45.9%)
(ii) Reasons for not seeking treatment in a health facility for symptoms (n=95)	
Not aware that problem needed medical treatment	39 (41%)
Stigma related with the health condition/disease	40 (42.1%)
Financial constraint	16 (16.9%)

Discussion

The present study conducted among reproductive age group females in an urban resettlement area of Gautam Buddha Nagar district in Uttar Pradesh highlighted significant findings regarding their reproductive morbidity profile and health-seeking behaviour. Most of the cases of RTI/STI are untreated because they are difficult to diagnose and because competent affordable services are lacking in low-income settings. The consequences for reproductive and sexual health are extensive and include unwanted pregnancies, unsafe abortions, chronic pain syndrome, STI including HIV, and gynaecological disorders. STIs are also a leading cause of infertility in women.^[1] Primary care physicians who are properly trained in the syndromic management of STI/RTI with minimal laboratory services have a vital role to expand comprehensive reproductive and sexual health services in the community and better the quality of life.

There is also a general hesitation in reporting the symptoms of RTI/STI because of the insufficient knowledge, embarrassment, and stigma associated with it and in receiving treatment for the same from the health centres. Skilled primary health care providers can step forward by spreading awareness in the community to stop the discriminatory treatment of the patients of RTI/STI and gynaecological morbidities by their family members and neighbours.

In the present study, nearly a half (46%) of the symptomatic respondents did not seek treatment for their symptoms of RTI/STI and gynaecological morbidities. The reasons included 'a lack of awareness that problems needed medical attention' and 'stigma related with the condition'.

The current study found a prevalence of 65.3% of at least one RTI/STI symptom or gynaecological morbidity among the women of the reproductive age group. The overall prevalence in similar community-based studies conducted on textile workers of Surat, Gujarat, and urban Ludhiana, Punjab, was lower (17.0% and 17.3%, respectively) as compared to current study.^[17,18] Some international studies also share similar data with an estimated 67.6 million prevalent and 26.2 million incident STIs in the United States in 2018.^[19]

In the present study, healthcare seeking for RTI/STI symptoms and gynaecological morbidities was observed in 54.1% of the symptomatic respondents. In a study done in urban slums of Gujarat in 2008, Miteshkumar N *et al.*^[12] found a lower figure that 46% symptomatic respondents of gynaecological morbidities sought treatment from a health facility. A similar study from Dehradun, Uttarakhand, reported a higher proportion (63%) of respondents seeking care for RTI/STI symptoms.^[20] However, a study conducted in 2019 in the urban slum of district Faridabad, Haryana,^[21] found only 28.9% of the study population seeking care for RTI/STI symptoms.

Among the symptomatic respondents of RTI/STI and gynaecological morbidities, the most frequently reported symptom (40.6%) was 'abnormal vaginal discharge with foul smell along with burning micturition and genital itching'. The community-based study of Phrasisombath *et al.* from Lao, Vientiane,^[22] and other studies^[17,21] conducted in India reported that vaginal discharge was the most common symptom. Though the majority of literature in this domain belongs to hospital-based studies, abnormal vaginal discharge remains the most common symptom reported.^[21-25]

In the present study, among the symptomatic respondents, there were 12 (5.8%) self-reported cases of infertility and 9 (4.3%) self-reported cases of uterine fibroids. In a study conducted by Garg *et al.* in a Delhi slum,^[5] where most of the migrants were from Uttar Pradesh and Bihar, among the self-reported cases of gynaecological morbidities, there were 8% cases of infertility, which is higher than the current study. Our study however did not report any other cases of gynaecological morbidities like uterine prolapse and genital ulcers.

The majority of RTI symptoms were reported in women who were middle-school-educated and above as compared to illiterate women. A study from urban Haryana reported similar findings in women who were educated intermediate and above in comparison to illiterate women.^[21] Alike were the findings from a study conducted in urban Ludhiana.^[18] This may be due to the fact that more educated women were more likely to be aware and alert to report their symptoms as compared to the illiterate ones.

In the current study, out of the 112 (54.1%) who sought treatment for symptoms of RTI and gynaecological morbidities in any health facility, 57.1% went to a private health facility and 16.1% went to both government and private health facilities, thus making private health facility the most chosen facility for the treatment of their symptoms. This could be accounted for by the fact that there were 9 (4.34%) self-reported cases of uterine fibroids; 12 (5.8%) were self-reported cases of infertility. So, the cases might have reported to a private health facility because of the sensitive nature of their health problems and/or expectation of better treatment.

In a study done by Ray *et al.* in Delhi, treatment seeking behaviour was found to be 50% in the urban women for symptoms of RTI/STI.^[26] Hence, the present study was comparable to the above study.

The strength of the present study

The strength of the present study is its community-based design in the selected urban resettlement area. It assessed the prevalence of both symptoms suggestive of RTI/STI and self-reported gynaecological morbidities among the marginalized women in the reproductive age group.

Limitations of the study

Since it was a cross-sectional study, there was no follow-up done on the women who were seeking treatment for their reproductive tract morbidities and infections or were motivated to seek the treatment through our study. There were no laboratory investigation tests done on women complaining of STI/RTI symptoms to know the exact prevalence of the disease as the self-reported morbidity alone was not specific to measure the exact burden of reproductive tract diseases and infections in the community.

Conclusion

The present study found a prevalence of 65.3% of at least one symptom suggestive of RTI/STI or a self-reported gynaecological morbidity among the women of the reproductive age group. However, only 54.1% women sought treatment out of all the symptomatic respondents; the reasons cited for not seeking treatment were 'unaware that condition needed medical attention' and 'stigma associated with the condition'. It is therefore beneficial to increase awareness regarding timely and adequate treatment of the symptoms suggestive of RTI/STI and gynaecological morbidities among the women from marginalized sections. Consequently, there is a need of enhanced health awareness sessions for the women in the short term and skilled communicators within or outside of the health system in the long term who can dispel the stigma associated with sexual/ reproductive diseases and simultaneously disseminate correct information in the community regarding when and where to seek timely treatment for their symptoms.

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Key messages

The study explored the prevalence of symptoms of hidden reproductive tract infections (RTIs) and self-reported gynaecological diseases in women in an urban resettlement area and found that insufficient knowledge and stigma related to RTI and gynaecological morbidities prevent these women from seeking timely medical intervention which can lead to further health complications and degradation in their quality of life and sexual relationships. Promoting health education among the women in the area regarding timely medical treatment for symptoms of RTI and gynaecological morbidities and deployment of skilled communicators to dispel the stigma and simultaneously provide correct information regarding where to avail the services is the need of the hour.

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Conflicts of interest

There are no conflicts of interest.

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