Socio-Demographic Determinants of Reproductive Tract Infection and Treatment Seeking Behaviour in Rural Indian Women

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Introduction

In developing countries, women are high risk for several reproductive health problems especially reproductive tract infection/sexual transmitted infection (RTI/STI). These problems arise primarily as a result of early marriage, high fertility, higher number of pregnancy and unsafe sex. Reproductive morbidity is an important public health issue as well as social problem. The issues of reproductive and sexual health, especially RTI/STI, have attracted attention since the International Conference on Population and Development (ICPD) held at Cairo in 1994. Many developing countries have paid more attention on reproductive health service to all the population. In India, the Reproductive and Child Health (RCH) programme that was introduced in 1997, through the network of health centers all over the nation, has addressed the matter of reproductive health directly which was largely ignored by the public health services earlier. Reproductive morbidity refers to the diseases that affect the reproductive system, although not necessarily as a consequence of reproduction. Reproductive morbidity can be classified into three categories: obstetric morbidity, gynaecological morbidity and contraceptive morbidity. This study mainly focuses on gynaecological morbidity especially RTI. Gynaecological morbidity is defined as any condition, disease or dysfunction of the reproductive system, which is not related to pregnancy, abortion or childbirth, but it may be related to sexual behaviour (WHO, 1989).

Until recently, data on prevalence of RTI and other related gynaecological morbidity were not available at the national or state level. Some nationwide surveys now provide estimate on the prevalence of RTI/STI. The National Family Health Survey-2 (NFHS-2), 1998-99, estimates the prevalence of one or more symptoms of RTI/STI as 39.2 percent in India and among those who reported an illness, 34.6 percent sought some treatment (IIPS and ORC-Macro, 2000).

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The RCH estimates that nearly thirty percent women suffer from RTI and among them 37.6 have taken treatment (IIPS, 2001). Studies conducted in India have documented high prevalence of RTI/STI such as lower abdominal pain, abnormal vaginal discharge, irregular vaginal bleeding and menstrual problems among women in the reproductive age (Bang *et al*, 1989, Bhatia *et al*, 1995). The estimates are based on either clinical examination or self reporting. Some association between prevalence of RTI and number of pregnancy and contraceptives users also observed (Joshi *et al*, 1996). A few studies are available for treatment seeking for RTI in India. Rani and Sekher (2003) studied in rural India found that 31 percent sought treatment for RTI/STI; majority of women had treatment form private sectors. Similarly, there is considerable variation in treatment seeking across different socio-economic and demographic factors prevailing in the country (Bhatia *et al* 1997; Rangaiyan and Sureender, 2000). In India, several studies reveals that high rate of reproductive wastage, number of pregnancy, and contraceptive use strongly influence on RTI/STI across the country specially difference with place of residence, so there is need to study on prevalence of RTI and treatment seeking among rural women because a large number of women are residing in rural areas. Reproductive tract infection, being a sensitive matter, rural women may be too shy to consult to a doctor. The main objective of this paper is to examine differentials in symptoms of RTI/STI and treatment seeking behaviour by selected socio-economic and demographic factors among currently married women in rural India, and also to access net effects of socio-economic and demographic factors on prevalence of RTI and treatment seeking behaviour.

Method and Materials

The present study used data from Reproductive and Child Health-Rapid Household Survey-1&2 (RCH-RHS-1&2), 1998-99, which was conducted by International Institute for Population Sciences. The Sample covered 379124 among rural currently married women in the reproductive age group of 15-44 years. The RCH survey estimated prevalence of RTI/STI by self reported symptoms; specifically, women reporting burning sensation or pain or difficulty while urination, lower abdominal pain, or any problem of vaginal discharge, during a reference period of three months prior to the survey. Further, among those who reported vaginal discharge, the type of discharge was also recorded (muccid non foul smelling, thick

curdy white, thin dirty white foul smelling, and thick grey white foul smelling). Moreover, any other symptoms accompanying discharge were also noted (ulcers, itching and ulcers, severe lower abdominal pain and fever). In the survey, women were asked whether they sought treatment for specific reproductive health problems. In order to estimate net effect of the each variable on likely to reporting symptom of RTI/STI and on the probability of seeking treatment or consultant, ***logistic regression model*** was used. The response variables considered in present study: burning sensation while urination, lower abdominal pain, any problem of vaginal discharge, any one symptom of RTI/STI and treatment seeking behaviour. The explanatory variables are: religion, caste, educational levels, type of house, age of women, age at marriage, pregnancy wastage, parity, contraceptive users, aware of RTI/STI.

Results

The present study reveals that 29.1 percent of rural women reported experience of any one symptoms of RTI/STI. Among those who reported symptoms, 34.6 percent have taken source of treatment or consultant. The burning sensation while urination is 13.7 percent, followed by lower abdominal pain (11.4 percent) and any problem of vaginal discharge (20.6 percent). Prevalence of RTI is high among women with no schooling (18.9 percent), lower age at marriage (22.9 percent), pregnancy wastage (24.0 percent) and higher age (14.6 percent). Hindu women have reported more (23.1 percent) of any RTI problems compared to other religions in rural India. Moreover, women living in kachcha houses also reported more symptoms of RTI. However, castes, contraceptive usage, parity do not show much variation on prevalence of RTI. Women who are seeking treatment for RTI also vary within different socio-economic characteristics. Women with high education (12.3 percent), high age at marriage (23.8 percent), pregnancy wastage (17.9 percent), contraceptive users (17.7 percent), and living in pucca houses (15.6 percent) have more sought treatment for RTI. But religions, castes, parity do not have much effect on treatment seeking behaviour for RTI.

The regression results reveals that women with no schooling, higher age, no pregnancy wastage and living in kachcha houses are significantly more likely to have RTI problems, whereas, highly educated women, contraceptive users, higher age at marriage, women in

higher age groups (30 years and above), and living in pucca houses are significantly more likely to take treatment for RTI in rural India. However, there are no significant effects of castes, religion, and parity on treatment seeking behaviour of rural women in the country.

The present study concludes that prevalence of RTI/STI is very high in rural areas in the country specially among women. Who has reported any symptom of RTI among those a few number of people had taken treatment from various health sectors. Socio-economic and demographic factors have significant influence on prevalence of RTI/STI and treatment seeking behaviour among rural woman. It is clear that education, age of the women and types of houses have strong effect on prevalence of RTI/STI and its treatment seeking. Therefore, it is necessary to examine further on these issues.

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