

Original Research Article

Reproductive morbidity among married Muslim women: a community-based study in an urban slum of Mumbai, India

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ABSTRACT

Background: Reproductive morbidity is prevalent within the community; however maternal mortality remains a key indicator of maternal health. The present study examined the prevalence of reproductive morbidities with a specific emphasis on menstrual problems and RTI among married Muslim women. The paper also explored their health-seeking behavior and its association with socio-demographic and cultural determinant.

Methods: The cross-sectional study was conducted in urban slum of Mumbai, India. Three hundred married Muslim women of reproductive age (15-49) were interviewed. A structured questionnaire was used to collect the data. The data was analyzed using SPSS version 23.0.

Results: About 45% of the respondents had experienced at least one symptom of reproductive morbidity. Painful periods and white discharge were the most common symptoms. Only 43% and 47.4% respondents sought treatment for menstrual and RTIs problems respectively. Around 31% of respondents preferred home remedies for treatment, while 23% went to the government hospitals.

Conclusions: There is a high prevalence of reproductive health morbidities and low health-seeking behavior among Muslim women in the study area.

Keywords: Health-seeking behavior, Muslim women, Reproductive morbidity, Urban slum

INTRODUCTION

Addressing women's reproductive health problems is now on the global social agenda in the current century. Although reproductive morbidity occurs significantly more frequently and has a far more impact on women's lives, maternal mortality has long been the only indicator of their health.^{1,2} Reproductive health is one of the crucial components of the general health and well-being of women. It is important for women, especially during their reproductive years, as most of their reproductive health problems arise during that period.^{3,4} Maternal morbidity affects an estimated 50 million women yearly with at least 18 million women experiencing long-term and often debilitating symptoms.⁵ Reproductive ill-health

contributes to 33 % of the total disease burden in women, compared with 12.3 % in males.⁶

Reproductive morbidity includes the obstetric and gynecological conditions of ill-health related to the reproductive process during and outside the childbearing time. Gynecological morbidity includes conditions other than pregnancy-related events like menstrual disorders, reproductive tract infections, cervical cell changes, genital prolapse and other conditions like syphilis and urinary tract infections. Obstetric morbidity covers conditions during pregnancy, delivery and the postpartum period.^{7,8} In this study, reproductive morbidity refers to gynecological morbidity with special reference to menstrual problems and RTI.

There are few studies in India on women's reproductive morbidity in gynecological diseases. The available data indicate a high prevalence compared with other developing countries.⁹ Studies conducted in different part of Indian slums showed that the percentage of women complaining of gynecological problems varied from 35% cent to 58.9%.^{2,10} Around 40% of married women in India have at least one reproductive health problem related to urination or vaginal discharge.¹¹ Almost half of the women have reproductive tract infections (RTIs).^{12,13} Half of them had menstrual problems, and every tenth woman suffered from uterine prolapse.^{14,15} Available studies on this topic are based on the hospital and clinic data. Still, the number of community-based studies are limited.^{16,17} So, the results from hospitals or clinics do not reflect the magnitude of the disease burden. The hospitals' statistics are based only on biomedical causes, but information on social, economic, and demographic determinants is scanty.⁸

Women's reproductive health profile in any country closely relates to their socio-demographic background. In Indian society, the reproductive health problems of women are often neglected. There are many contributing factors to the high prevalence of reproductive morbidities such as lack of education, early marriage, working status of women, standard of living, contraceptive practices, knowledge about reproductive health problems, and menstrual hygiene practices. Conversely, stigma is attached to gynecological problems like reproductive tract infection. Misconceptions, cultural beliefs and taboos attached to gynecological problems force women to live with the morbidity silently which further affects their health-seeking behaviour.^{18,19} Married women in India are reluctant to seek treatment due to the absence of female doctors, lack of privacy, cost of treatment and low social status.²⁰

More specifically, in the Islamic culture issues related to reproductive health are considered sensitive and do not get much attention.²¹ Several studies have covered many aspects of women's reproductive health. However, few studies have focused exclusively on Muslim women. Since widespread notions regarding the religious norms over sexual behaviour exist, the area of reproductive health morbidities among Muslim women in India has been little researched. A community-based study was undertaken among married Muslim women aged 15-49 in the urban slum of Kurla (sub-urban) in Mumbai, India.

METHODS

The community based cross-sectional study was conducted in the Kurla (sub-urban) area of Mumbai, India, from August, 2019 to December, 2019. The sample size for the study was determined based on the prevalence of mothers in Mumbai suburban who had at least four antenatal care visits. According the NFHS-4, the prevalence of at least four antenatal care visits among mothers in Mumbai suburban was 82%. The 95%

confidence interval was considered for the study. After considering the 1.25 design effects and 3.84% non-response rate final sample size was taken as 312.

Multistage sampling was used to select the blocks from the Kurla sub-urban area. Two blocks (Jarimari and Safed-Bridge) were selected based on high concentration (85%) of the Muslim population and low socio-economic status. A total of thirty-six Anganwadi centres were in the two selected blocks. Of these, twelve Anganwadi centres were chosen by using systematic random sampling. Every third Anganwadi center was selected and approached. Finally, 312 married Muslim women in the reproductive age (15-49) were selected based on purposive sampling. Twelve incomplete forms were removed, and 300 sample sizes were considered for final analysis. Information on socio-demographic variables and questions regarding reproductive morbidities in last six months was collect using a structured questionnaire.

SPSS version 23.0 was used for the data analysis. The symptoms of reproductive morbidities were divided into two categories. The first category was menstrual problems which consisted of delayed, prolonged and painful period. White discharge, burning during urination, itching in genitals and boils/ulceration in genitals are grouped under the category of any RTI problem. Descriptive analysis has been done initially. Continuous variables were represented using mean and standard deviation, and categorical variables were summarized using proportion. The chi-square analysis was done for categorical variables and tested for significance.

Inclusion criteria

Muslim women who had given birth in the last two years in the reproductive age (15-49) group were included in the present study.

Exclusion criteria

Women those who were not Muslim. Women those who were widow and unmarried. Women whose age was below 15 years and above 49 years. Women those who did not have children

Ethical considerations

The ethical committee of Tata Institute of Social Sciences, Mumbai, approved the study. The respondents have given written consent. Personal identifiers were removed before data analysis.

RESULTS

Table 1 shows the socio-demographic profile of the respondents. The mean age of the respondents was 26.3 ± 4.1 years, ranging from 18 to 38 years. About 20.7% of the respondents were married before the legal age of marriage (18 years). About 12.7% of the

respondents started childbearing at the age of 18 years. About 46.3% of the respondents had three more children. The mean years of schooling were 8.1 ± 4.1 years and among them 13% were illiterate. The mean number of pregnancies was 3.0 ± 1.5 , which ranges between 1 and 8, and 15% had more than four pregnancies. Use of the sanitary napkin as menstrual protection was higher (71%) among the respondents than cloths. Only 30% respondents mentioned that they have the freedom to go to a healthcare center. Only 46.3% respondents currently use contraceptives.

Table 1: Socio-demographic characteristics of the respondents (N=300).

Background characteristics	%	N	Mean $\pm$ SD
Respondents' age (in completed years)			
18-23	26.0	78	26.3 $\pm$ 4.1
24-27	38.0	114	
28 and above	36.0	108	
Respondents' age at marriage (in completed years)			
Below 18	20.7	62	19.9 $\pm$ 2.7
18-20	37.3	112	
21 and above	42.0	126	
Respondents' age at first delivery (in completed years)			
0-18	12.7	38	21.5 $\pm$ 2.8
19 -22	51.7	155	
23 and above	35.7	107	
Number of children			
1	22.7	68	2.4 $\pm$ 1.2
2	31.0	93	
3 and above	46.3	139	
Respondents' education (in completed years of schooling)			
Illiterate	13.0	39	8.1 $\pm$ 4.1
Primary (1-7)	26.0	78	
Secondary (8-10)	33.0	99	
Higher secondary and above (11 and above)	28.0	84	
Number of pregnancies			
1-2	51.0	153	3.0 $\pm$ 1.5
3-4	34.0	102	
Above 4	15.0	45	
Current use of contraceptives			
Yes	46.3	139	
No	53.7	161	
Types of menstrual protection			
Cloths	29.0	87	
Sanitary napkins	71.0	213	
Freedom to go to health centre			
Yes	30.3	91	
No	69.7	209	
Total	100.0	300	

Among all the respondents, 135 (45%) suffered at least one reproductive morbidity. Among these, 26.7% had menstrual-related problems, while 35.7% suffered from RTI-related problems (Figure 1).

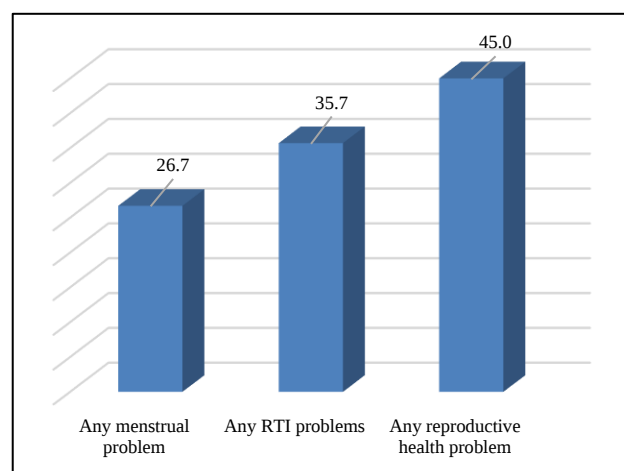


Figure 1: Types of reproductive morbidities.

Table 2: Types of menstrual symptoms and RTIs symptoms.

Background characteristic	Percentage	Number
Menstrual-related problems		
Delayed period	35.7	107
Prolonged period	41.7	125
Painful period	39.7	119
RTI-related problems		
White discharge	45.0	135
Burning during urination	43.3	130
Itching in genitals	44.7	134
Boils/ulceration in genitals	26.7	80

The present study revealed that in menstrual-related problems, a maximum (42%) of respondents had prolonged period problems, followed by a painful period (39.7%) and a delayed period (35.7%). Further, among the RTI-related issues, white discharge, burning during urination and itching genitals were the most common symptoms (Table 2).

A significant statistical association was found between age at marriage, age at first delivery, education, types of menstrual protection, freedom to health centre and reproductive health problems. The prevalence of any reproductive health problems decreased with increasing age at marriage and first delivery age. Educated respondents had fewer reproductive health problems than illiterate respondents, which was statistically significant. Further, reproductive health problems were lower among those who used sanitary napkins for menstrual protection and were free to health centers (Table 3).

Table 3: Prevalence of any reproductive health problem by background characteristics.

Background characteristics	Any reproductive health problem		Chi square value (χ^2)	P value
	N	%		
Respondent's age (in completed years)				
18-23	44	56.4	$\chi^2=16.873$	P=0.232
24-27	51	44.7		
28 and above	40	37.3		
Respondents age at marriage (in completed years)				
Below 18	41	66.1	$\chi^2=16.361$	P=0.000
18-20	50	44.6		
21 and above	44	34.9		
Respondents age at first delivery (in complete years)				
0-18	28	73.7	$\chi^2=20.469$	P=0.000
19 -22	73	47.1		
23 and above	34	31.8		
No. of children				
1	36	38.7	$\chi^2=12.698$	P=0.259
2	64	46.2		
3 and above	35	51.5		
Respondent education (in complete years of schooling)				
Illiterate	22	56.4	$\chi^2=21.456$	P=0.000
Primary (1-7)	42	53.8		
Secondary (8-10)	51	51.5		
Higher secondary and above (11 and above)	20	23.8		
No. of pregnancy				
1-2	45	44.1	$\chi^2=10.174$	P=0.217
3-4	20	44.4		
Above 4	70	45.8		
Current use of contraceptives				
Yes	56	40.3	$\chi^2=22.324$	P=0.327
No	79	49.1		
Type of menstrual protection				
Cloths	46	52.9	$\chi^2=23.069$	P=0.030
Sanitary napkins	89	41.8		
Freedom to go health centre				
Yes	33	36.3	$\chi^2=14.028$	P=0.045
No	102	48.8		
Total	135	45.0		

(Any reproductive health problems include any menstrual and any RTIs related problem) [n=135 (45.0) as it includes those who had any reproductive related problems out of the total respondents of 300]. *p<0.05. **p<0.01. ***p<0.001.

Health care-seeking behavior

Respondents used institutional and non-institutional health care facilities for their reproductive morbidities. About 45.0% respondents had complained of either menstrual (26.7%) or RTI (35.7%) related problem. Among them, around 40% respondents attended health care facilities for treatment. Most respondents preferred to use home remedies to cure reproductive morbidities. Around 35% of them used home remedies to treat their menstrual problem. On the other side, almost 31% used home remedies to get relief from the problem related to RTI.

Government hospitals were used more than private hospitals for both types of morbidities. Further, almost 24% and 28% respondents who suffered from menstrual and RTI problems took treatment from traditional healers such as Bengali baba, kabir, or fakir respectively (Table 4).

Reason for not taking treatment

The primary reason, as mentioned by the respondents, for not taking any healthcare treatment for reproductive health problems was the absence of female doctors in the healthcare settings.

The reason 'shyness to explore the problem' was mentioned by 25.5% and 27% of respondents who had menstrual and RTI problems respectively. Further, 20 to 25% respondents feel 'no need to take treatment' for

reproductive morbidities. About 14-18% respondents mentioned 'fear of side effects' as a reason for not taking any treatment for reproductive morbidities (Table 4).

Table 4: Treatment seeking behavior among Muslim women for reproductive health problem.

Background characteristics	Menstrual problem		RTI problem		Any reproductive health problem	
Suffering with reproductive health problems	%	Number	%	Number	%	Number
Yes	26.7	81	35.7	108	45.0	135
No	73.3	219	64.3	192	55.0	165
Total	100.0	300	100.0	300	100.0	300
Sought treatment						
Yes	43.1	38	47.4	46	41.4	56
No	57.2	43	52.6	63	58.6	79
Total	100.0	81	100.0	108	100.0	135
Treatment sought from						
Government hospital	31.5	12	25.0	12	22.7	18
Private hospital	10.5	04	15.6	07	18.9	15
Home remedies	34.4	13	31.3	14	30.6	24
Traditional healer	23.6	09	28.1	13	27.8	22
Total	100.0	38	100.0	46	100.0	79
Reason for not seeking treatment						
No need of treatment	25.5	11	20.6	13	23.2	13
Absence of female doctors	30.6	13	38.3	24	33.9	19
Shyness to explore	25.5	11	26.9	17	30.4	17
Fear of side effect	18.2	08	14.2	09	12.5	07
Total	100.0	43	100.0	63	100.0	56

DISCUSSION

Ours was a community-based cross-sectional study carried out in an urban slum of Mumbai, India. In its menstrual problems and problems related to RTI predominantly focused on reproductive morbidity. It has shown the prevalence of reproductive morbidity based on community settings and health-seeking behaviour among Muslim women.

This study found that 45% of the respondents had at least one reproductive morbidity. Similar studies were reported elsewhere in India where the magnitude of reproductive morbidities ranged from 33% to 92%.²² Comparable findings were obtained in the study carried out among married rural women in Karnataka.²³ Surveys carried out in other developing countries like Karachi, Pakistan found the same findings, i.e., around 55% of women reported having at least one reproductive morbidity.²⁴ In our study, the most common reproductive morbidities were RTI (35.7%) and menstrual problems (26.7%). Comparable results were observed in the study conducted in urban slums of Baroda, India, where the most common reproductive health problems were menstrual (21-32%) and RTI (27%).²⁵ Likewise, similar findings were found in the review of the seven urban and rural studies; the prevalence of menstrual disorders was 33-65% and that of

RTI 13-57%.²⁶ Another two studies carried out in an urban slum of Mumbai found similar findings about the prevalence of reproductive morbidities.^{27,28} In the present study, the most commonly diagnosed symptoms among the problems related to RTIs were "white discharge" (45%) and "itching in the genitals" (44.7%). Similar findings were corroborated by studies conducted in the Tirupati slum (Andhra) and Himachal Pradesh.^{29,30}

The high prevalence of such diseases among Muslim women may be due to illiteracy, early age at marriage and lack of freedom to go to health centers. The percentage of reproductive morbidities was higher among illiterate women than educated women, and it was statistically significant. Similar findings were found in the study in Agra and Kolkata.^{31,32}

In this study, women who married before the legal age (18 years) had a high prevalence of RTI symptoms. A similar finding was found in the study conducted in Shimla city. Early age marriage (>18) was found to be significantly related to reproductive morbidities.³³ Socio-cultural background of Muslim women can be attributed to the early age of marriage. A higher percentage of women using clothes for menstrual protection (44.8%) suffered from RTI-related problems than those using sanitary napkins. Comparable findings were found in the

study conducted in 2001 where there was a direct correlation between menstrual hygiene and reproductive morbidities.³⁴ At the time of the first delivery, respondents who were younger (up to 18 years) had more reproductive morbidities than respondents having a first child after 18 years. A statistically significant association between the age of first delivery and reproductive morbidities was found. A similar finding was noted in a cross-sectional study in Karnataka.³⁵

This study shows poor health-seeking behaviour for reproductive morbidity as only 43% respondents sought treatment for menstrual problems, while 47% respondents took treatment for problems of RTIs. This prevalence is lower than seen in similar findings in Kargil where 77.3% of symptomatic women did not seek treatment for reproductive morbidities.³⁶ Studies done in Tamil Nadu and Calcutta also showed poor health-seeking behaviour.^{37,38}

A majority of the respondents used home remedies to cure reproductive morbidities. Similar findings were recorded in the study by Srivastava et al. In Mevat (North India), around 67% of Muslim women adopted home remedies like Multani mitti (fuller's earth) and leaves of neem tree (*Melia azadirachta*) to cure reproductive morbidities.¹⁹ However, the visits to government hospitals were more than to the private hospitals. Our findings are in contrast with the study carried out in Rajkot, where women preferred private hospitals.³⁹ Common reasons for not seeking treatment were shyness, a perception that there was no need to take treatment and the absence of female doctors. The results of this study corroborate those of studies carried out in India and other countries.⁴⁰

The chances of under reporting cannot be rule out about gynecological morbidities among respondents due to silence associated with the issue of reproductive health.

CONCLUSION

The study revealed a high prevalence of reproductive morbidities among married Muslim women in the urban slum of Mumbai. About 45% of respondents had at least one symptom of reproductive morbidity in the last six months. Painful periods and white discharge were the most common symptoms. Respondents' age at marriage, age at first delivery, respondents' education, type of menstrual protection, and freedom to go health center had a significant association with reproductive morbidities. Poor treatment-seeking behaviour was found among the respondents for reproductive morbidities. Most respondents preferred home remedies to treat reproductive morbidities, while the absence of female doctors was the more common reason for not seeking treatment. To promote morbidity-free healthy life, there is a need to create awareness about reproductive morbidities and provide health care education. Female religious leaders, ASHA, and Anganwadi workers need to be

trained to create awareness and provide information about healthcare facilities.

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