International Journal of Community Medicine and Public Health
Vinayagam A et al. Int J Community Med Public Health. 2026 Jan;13(1):428-435
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20254457

Short Communication

An observational study towards demographic profiling to assess the health seeking behaviour of transgenders in Chittoor town, Andhra Pradesh

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Received: 04 September 2025
Revised: 22 November 2025
Accepted: 24 November 2025

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ABSTRACT

Transgenders (TGs) individuals, whose gender identity does not align with the sex assigned at birth, form less than 1% of the global population, with about 4.87 lakh in India and approximately 50,000 in Andhra Pradesh as of 2022. Existing research focuses primarily on sexual practices and HIV/STDs, leaving gaps in understanding their health problems and healthcare-seeking behaviour. Hence, this study was conducted to assess the healthcare-seeking behaviour of TG individuals. A descriptive research design with non-probability snowball sampling was adopted and data was collected through interviews with 15 TGs in Chittoor town, Andhra Pradesh, India. A self-structured questionnaire assessed their health-seeking behaviour. Data were analyzed using descriptive and inferential statistics. Among 15 TG participants, majority were residing in urban area (15, 100%), engaged in begging (14, 93%), unmarried (15, 100%) and sought health services from private hospitals (13, 87%). Most participants (11, 73%) had moderate health-seeking behaviour, while 2 (13.5%) had high and 2 (13.5%) had poor health-seeking behaviour, due to common barriers including refusal of medical care (13, 87%) and lack of health insurance (13, 87%). Chi-square test showed a statistically significant association between health-seeking behaviour and both occupation and family support during illness ($p \leq 0.05$). The study provides key insights into the health-seeking behaviour of TGs in Chittoor town. Despite moderate healthcare engagement, issues like lack of insurance, delayed care, and discrimination persist. Inclusive policies and targeted interventions are needed to improve access and quality of care.

Keywords: TGs, Health problems, Health-seeking behaviour, HIV/AIDS

INTRODUCTION

Transgender (TG) is an umbrella term for persons whose gender identity, gender expression or behaviour does not conform to that typically associated with the sex to which they were assigned at birth.[1] Gender disparities in health are a global phenomenon although at varying degrees. The situations are more critical when we focus on gender minorities like TGs, especially in culturally diversified countries like India. However, despite the significant progress represented by legal measures in acknowledging TG rights, obstacles still persist in achieving social acceptance and health equity for this community. Also, the absence of specific medical guidelines catering to the needs of TG individuals in the country jeopardises the situation further. Thus, absence of affirmative healthcare initiatives exacerbates the persistent difficulties experienced by the TG community. Research suggests that TGs often become victims of various mental health problems, such as chronic anxiety, thoughts of harming oneself, and feelings of hopelessness etc. These problems also harm their physical health and make them more vulnerable for contracting STDs, HIV, alcohol use and gender violence. Additionally, TG individuals' face challenges in their gender transition journeys, including familial rejection and engagement in sex work, further marginalizing them.[2]

TG persons and other gender minorities comprise an estimated 0.3-0.5% (25 million) of the global population as per the world health organization (WHO).[3] In India there was around 4.87 lakh TGs.[4] The TG population was estimated around 50,000 in Andhra Pradesh. A considerable number of TGs live in Chittoor district, especially in and around Tirupati (2022).[5]

TG people face discrimination in nearly every aspect of their lives. Anti-discrimination laws in most countries do not protect TG people from discrimination based on gender identity or gender expression. TG people experience high levels of discrimination in employment, housing, health care, education, legal systems, and even in their families. Discrimination affects the access to healthcare for TG people negatively. Training and education for nurses specific to TGs population issues is severely lacking.

This issue aligns with SDGs promoting inclusive healthcare (SDG 3), gender equality and protection from discrimination (SDG 5), and reducing inequalities in education, healthcare, and employment (SDG 10). It also involves strengthening legal protections and human rights for TG communities (SDG 16).

Addressing these goals is vital to improving health and social outcomes for TG individuals. Hence, the study was planned to describe the demographic profile and health-seeking behaviour of the TG population, and to find the association between demographic factors and health-seeking behaviour.

METHODS

Study design

This study employed a descriptive research design using a non-probability snowball sampling technique to recruit TG participants for the study.

Setting

The study was conducted in Chittoor town, Andhra Pradesh, India, with a focus on TG individuals residing in and around this area. The study was conducted for the period of 3 months.

Study period

The study was conducted over a 3 months duration, from October 2023 to December 2023.

Eligibility criteria

The study included TG individuals aged 17 to 60 years residing in Chittoor town, Andhra Pradesh, who were able to understand English or Telugu and consented to participate. TG persons who were ill or unable to respond to questions, as well as those with cognitive or mental impairments, were excluded from the study.

Sources and methods of selection

Participants were recruited using a non-probability snowball sampling technique. Members of the ART staff at the ART center in GGH, Chittoor, helped to initiate contact with a group of TG individuals, who then assisted in reaching out to other TG participants. The sample consisted of 15 TGs, and the data were analyzed using descriptive and inferential statistics.

Study size

This study included 15 TGs, selected using a non-probability snowball sampling technique. The sample size was determined based on the feasibility of reaching TGs in Chittoor town, the availability of participants during the data collection period, and resource limitations. As this was a descriptive study focusing on a hard-to-reach population, a small number of participants were selected for this study to obtain basic information about their health-seeking behaviour.

Variables under study

Health-seeking behaviour of TG individuals (e.g., frequency of healthcare visits, types of healthcare sought, timing of seeking care, screening tests undergone etc.) was assessed using a tool consisting of closed-ended questions. The total scores were interpreted to categorize participants' behaviour as high, moderate, or poor health seeking behaviour. Score of more than one standard

deviation was considered as high health seeking behaviour. A score of less than one standard deviation was considered as poor health seeking behaviour: A score range between -1 to +1 standard deviation was considered as moderate health seeking behaviour.

Demographic Characteristics of TG individuals (e.g. age in years, education, occupation, monthly family income, marital status, family support etc were the predictors under study.

Having health insurance, possession of a family health card, government support in seeking healthcare, experiences of gender-based discrimination, and levels of anxiety and depression were considered potential confounders in this study. Additionally, family support and education level were also included as confounding variables.

Data sources/ measurement

The data were collected directly from participants through structured, face-to-face interviews using a self-structured questionnaire tool. The tool included both demographic variables and questions related to health-seeking behaviour of the participants. The sample consisted of 15 TGs, and the data were analyzed using descriptive and inferential statistics.

Bias

To avoid selection bias, we started with different TG people suggested by ART staff and community members to get a mix of participants. To reduce information and interviewer bias, all interviewers were trained the same way and used a tested questionnaire that was made clear and easy to follow. We reduced recall bias by asking about recent events from the past six months instead of lifetime history.

Social desirability bias was addressed by assuring participants of confidentiality and conducting interviews in private settings. Finally, we used clear rules on who could take part in the study and left out those who couldn't respond, to avoid non-response bias.

Statistical methods

The data were analyzed by using both descriptive statistics and inferential statistics to describe the demographic characteristics and health-seeking behaviour of TGs. Frequencies and percentages were calculated for categorical variables, while mean and standard deviations were used for continuous variables. To assess associations between demographic factors and health-seeking behaviour, Chi-square test was applied. Confounding factors were considered by examining demographic variables individually; however, due to the small sample size, multivariate analysis was not performed.

RESULTS

A total of 20 potential participants were initially identified for this study. Of these, 18 individuals were examined for eligibility. Following the eligibility screening, 16 were found to be eligible.

Among them, 15 participants provided informed consent and were included in this study. All 15 participants completed the face-to-face interviews and were included in the final analysis.

The reasons for non-participation includes, two participants declined to participate in this study due to personal discomfort, and one participant was excluded due to cognitive impairment and their inability to respond to interview questions.

Characteristics of study participants

Demographic variables

The study included 15 TG participants. The mean age was 35 years (±7.44), and the mean age at gender transition was 34 years (±8.70). Most participants identified as Hindu (14, 93%), and all resided in urban areas (15, 100%). The average number of working hours per day was 3.35 (±1.67), and the mean family income was ₹1,570 (±820). The average number of dependents was 2.35 (±2.05).

In terms of education, majority (6, 40%) completed primary education, secondary education (5, 33%), and a degree or higher education (3, 20%). All participants identified as female (15, 100%) and reported no family history of TG identity (15, 100%). Regarding occupation, (14, 93%) were engaged in begging, while (1, 7%) reported involvement in both begging and the prostitution.

Most participants owned a house (10, 67%), and (6, 40%) lived in joint families. Self-income was reported as the main source of income by (9, 60%). Similarly, majority (9,60%) were living with their families, while others stayed with peers (3, 20%), alone (2,13%), and with a Guru (1,7%) and in addition, the majority (13, 87%) of the participants had a bank account.

For healthcare access (13, 87%) visited private facilities, and (9, 60%) were highly satisfied with the health care services. Regarding family support during illness, (13, 86%) reported receiving adequate support.

No missing data were reported for any of the demographic variables.

Outcome

The outcome of interest-health-seeking behaviour-was assessed using structured, closed-ended questions.

Among 15 participants, majority were visiting doctor frequently (12, 80%) preferred getting admitted when advised, (09, 60%) feel like approaching medical health care only when they are severely ill (12, 80%) majority underwent screening test in the past 6 months (11, 73%) and experienced refusal for medical help for being a TG (13, 87%) do not have either health care insurance or the family health card (13, 86%) and undergone screening test for HIV or VDRL (12, 80%).

Main results

Unadjusted estimates and confounder adjustment

Since this was a descriptive cross-sectional study with a small sample size (n=15), only unadjusted results were presented. No advanced statistical analysis (like logistic regression) was done.

The study focused on describing the frequency and patterns of health-seeking behaviour among TG individuals.

However, descriptive analysis revealed: 80% of participants reported frequent doctor visits, 60% were willing to get hospitalized if advised, 80% reported seeking care only for severe illness and 27% reported being refused medical care due to TG identity.

No adjustments for potential confounders (e.g., income, education, occupation) were made, as the sample size was insufficient for multivariate analysis.

Category boundaries for continuous variables

The following continuous variables were categorized for descriptive analysis:

Age in years: Reported as mean±SD (35±7.44 years)

Age at gender transition: Mean±SD (34±8.70 years)

Family income: Categorized into low (<₹10,000), medium (₹10,000–20,000), high (>₹20,000) though exact boundaries were not applied due to small sample.

Working hours/day: Mean±SD (3.35±1.67 hours)

No advanced analysis or group comparisons were done because the sample size was small (n=15), however, basic subgroup observations were noted: TGs with higher education levels (secondary and above) tended to report more frequent healthcare visits.

Those living with family or in stable housing reported higher satisfaction with healthcare services. Participants with a source of income from self-employment appeared more likely to have undergone recent health screenings.

Sensitivity analyses

No formal sensitivity analysis was done. However, to reduce response bias, participants were assured of confidentiality, and all interviews were conducted privately using the same validated questionnaire.

Table 1: Description of demographic profiling to assess health seeking behaviour of TGs, (n=15).

Socio demographic characteristics	Mean±SD/ N (%)
Age in years	35±7.443
Age of changing in to TG	34±8.70
Duration of working hours	3.35±1.67
Family income per month in INR	1,570 (±820)
No. of dependents	2.35±2.05
Religion	
Hindu	14 (93)
Christian	1 (7)
Muslim	-
Residence	
Urban	15 (100)
Rural	-
Ownership of house	
Own	10 (67)
Rented	5 (33)
Type of family	
Single	1 (7)
Nuclear family	5 (33)
Joint family	6 (40)
Others	3 (20)
Occupation	
Begging	14 (93)
Begging and prostitution	1 (7)

Continued.

Socio demographic characteristics	Mean±SD/ N (%)
Marital status	
Married	-
Unmarried/single	15 (100)
Education in completed years	
No formal education	1 (7)
Primary education	6 (40)
Secondary education	5 (33)
Degree/and above	3 (20)
Which is the source of income	
Family	-
Self	9 (60)
Community	3 (20)
Pension	3 (20)
Other specify	-
Which gender do you currently live as in your day today life	
Male	-
Female	15 (100)
Sometimes male, sometimes female	-
History of TG people in family	
Yes	-
No	15 (100)
Details of people with whom you are living	
With family	9 (60)
With Guru	1 (7)
With other TGs	3 (20)
Single	2 (13)
With others specify	-
Do you have bank account	
Yes	13 (87)
No	2 (13)
Where do you usually seek health care	
Private	13 (87)
Government	2 (13)
Feedback on health care facilities	
Highly satisfied	9 (60)
Satisfied	6 (40)
Somewhat satisfied	-
Dissatisfied	-
Do you get enough family support while you are sick	
Yes	13 (86)
No	1 (7)
Sometimes	1 (7)

Table 2: Description of health seeking behaviour among TGs, (n=15).

Health seeking behaviour	Frequency (%)
High (>5)	2 (13.5)
Moderate (3 -5)	11 (73)
Poor (<3)	2 (13.5)

DISCUSSION

Major findings of the study

The demographic profile of TG participants in this study shows that the majority changed their gender between the ages of 28 and 42 years. This finding is comparable with the study by Turban et al, which reported that a substantial proportion (40.8%) of transgender and gender-diverse adults first realized their gender identity during adolescence or later, with a considerable delay between identity realization and disclosure.[6]

All the participants were hailing from urban part of Chittoor. This could be because the urban areas provide diverse social environment, access to supportive communities also offer more employment opportunities and legal protections against discrimination.[7]

The participants' main sources of income was begging. This finding is congruent with the studies on TGs occupational profile which reveals that even those who were educated follow traditional occupation of begging, sex work and ceremonial functions. Few studies also reveal that some of the TGs employed before had left their jobs on account of the stigma.[8] Only one participant is involved in both begging and prostitution. Engaging in sex work can be influenced by various factors, including economic circumstances, discrimination, and limited employment opportunities.[8] All the participants were unmarried, which may be attributed to the legal challenges TGs face regarding marriage. They often encounter difficulties in entering or sustaining same-sex marriages. Additionally, marriage can affect their access to employment, housing, hospital visitation rights, and insurance policies. TGs also face complications because their gender identity may differ from the sex listed on their birth certificate.[10]

Majority of the participants studied only till secondary education followed by primary education and degree. Even though the TG Persons (Protection of Rights) Rules, 2020 directs the government to facilitate the accommodation and schooling of TG, gender non-conforming and intersex children in residential government schools and universities most often Indian educational institutions are often unequipped to ensure TG students pursue their education in a safe environment. Also, institutions are unable to support TG persons who come out after their education. The other hurdles that these students also face include difficulties in changing their name and gender on official documents, a lack of accommodation, a dearth of specific committees, and no processes to facilitate a smooth and hassle-free academic and social transition and potentially bullying by the schoolmates/classmates.[11]

Most of them depend on self-income. When it comes to income this population ending up in receiving Badhai, begging or any job even if it is underpaid. Further parents, siblings and other family members also do not play any proactive role in protecting their legal rights and property inheritance etc. Due to lack of employment opportunities, the TGs tend to rely up on themselves and are compelled to engage in sex work which has high health related risk, and are exploited by clients, sometimes beaten up.[12]

Majority (12, 80%) of our study participants reported frequent visits to doctors, which suggests that TGs are paying adequate and timely attention to their health. This finding contrasts with other study findings, which highlight the challenges TG individuals face in accessing healthcare services. These challenges include a lack of physician expertise in TG health, the absence of TG-specific training in medical curricula, financial constraints, and experiences of discrimination.[14] Other research has also indicated delays in seeking both emergency and primary care among TG populations, leading to a higher prevalence of chronic illnesses, mental health conditions, and the hospital admissions.[13]

The majority of participants had undergone general health screening in the past six months. TG individuals are at an increased risk for HIV infection, making regular health screening crucial in preventing its spread. HIV self-testing (HIVST) is particularly preferred among TG women due to its confidentiality and convenience. Therefore, it is important to promote awareness about HIV screening test (HIVST) and ensure that it is easily accessible and affordable.[14]

Further, the majority study participants reported experiencing refusal of medical help which draws attention towards the specific need to determine the current status of anti-TG discrimination in the health care system and whether health care providers are receiving adequate training in TG medicine with a recommendation to determine potential solutions to address the gaps (including training for knowledge gaps and policy shifts for financial gaps) along with mechanisms to validate such solutions. Failure to understand the TG patient experiences also can be reason for health care providers as discriminatory by the patients and lack of adequate training in TG healthcare issues will make health care providers to perceive being TG as deviant.[15]

Majority participants do not possess healthcare insurance /family health card which indicates low health seeking behaviour. But all TGs who holds a TG certificate issued by the National Portal are well covered by government of India initiative under Ayushman Bharat PM-JAY," with a specific package (Sex reassignment surgery (SRS) and treatment). Apart from sex-reassignment surgeries, the customized package will include hormonal therapies and laser ablation surgery in any AB PM-JAY empanelled hospitals across the country. Under the same scheme TGs are also eligible for a ₹5 lakh insurance coverage.

Considerable no. of participants stated that they tried getting help from government. Support for marginalized individuals for livelihood and enterprise (SMILE) is another government initiative providing welfare measures to the TG community along with those involved in the act of begging. This scheme covers composite medical care Scholarships for TGs students and housing named Garima Greh to provide shelter to TGs. The scheme will give the necessary legal protection, social security and a promise to a secured life to the targeted group. The Ministry has allocated Rs. 365 crores for the scheme for five years from 2021-22 to 2025-26.[16]

Majority had moderate health seeking behaviour (11, 73%) while others had high and poor health seeking behaviour in equal ratio. The study participants also reported, the cost of healthcare as a major barrier to seeking health care which often leads to delays in health care seeking and opting for low-cost options like medicines from pharmacists for interim relief. This lowers the direct cost for common illness but increases the cost in the case of chronic illness. The indirect cost of both common and chronic illness (recorded as the cumulative of wages lost on account of illness) was also on the higher side, which indicates that delayed treatment seeking may result in an increase in duration of illness leading to loss of wages. Therefore, the downside of delayed treatment seeking is the heightened burden of disease.[17]

A statistically significant association was found between health-seeking behaviour and certain demographic characteristics, specifically occupation and the level of family support received during illness. The majority were engaged in begging, while a few reported involvements in both begging and prostitution.

A significant proportion of respondents in this study were engaged in occupations such as begging and prostitution. Most were aware of the very fact that their occupation poses a challenge and vulnerability towards exploitation and risk for conditions like Sexually transmitted diseases. The analysis also revealed that the majority of respondents exhibited moderate health-seeking behaviour. This may explain the significant association observed between occupation and health-seeking behaviour among TG individuals.[18]

Another demographic characteristic that was found to have a significant association with the health-seeking behaviour of the study participants is family support. Family support has a consistently positive influence and fosters self-confidence in individuals. As noted in previous research, family support shapes values, perceptions, and access to information, all of which contribute to the development of health-seeking behaviour. Support in the form of basic needs, financial assistance, and transportation can also mitigate psychological barriers and encourage timely healthcare utilization.[19]

CONCLUSION

Based on the responses, it is evident that the majority of TGs exhibit moderate health-seeking behaviour, which is significantly associated with their occupation and the level of family support during illness. A large number reported being refused medical care due to their TG identity. These findings highlight the lack of adequate support from healthcare providers in promoting health-seeking behaviour. Therefore, sensitizing both the public and healthcare personnel to TG-specific issues, as well as educating TGs on the importance of timely healthcare, is imperative.

ACKNOWLEDGEMENTS

Authors would like to thank to medical superintendent, apollo institute of medical sciences and research, district headquarters hospital, Chittoor, Andhra Pradesh.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee Apollo Institute of Medical Sciences and Research Ref: No.UG/38/IEC/AIMSR/2023

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Cite this article as: Vinayagam A, Natarajan B, Koni K, Tarugu J, Ramapuram P, Elumalai MA. An observational study towards demographic profiling to assess the health seeking behaviour of transgenders in Chittoor town, Andhra Pradesh. Int J Community Med Public Health 2026;13:428-35.