ABSTRACT

Objective To assess the changes in prevalence of past-year self-reported sexually transmitted infections (STIs) and its symptoms among married couples between 2006 and 2016 in India, overall and by socioeconomic status.

Design This cross-sectional study uses the two most recent waves (2005–2006 vs 2015–2016) of nationally representative health surveys in India. We examined the changes of self-reported STI and symptoms among married couples aged 15–54 by overall and by socioeconomic status. Adjusted logistic regression was used to assess the changes, accounting for covariates and the complex survey design.


Outcome measure Self-reported STI was used as a primary outcome measure.

Results In 2016, 2.5% of married women reported having had an STI in the past year, a significant increase from 1.6% in 2006 (p<0.001). The past-year self-reported STI prevalence among married men significantly increased from 0.5% in 2006 to 1.1% in 2016 (p<0.001). Adjusted results showed that the uptrend of couples’ self-reported STI was more significant among those whose husbands are currently employed and those families in middle or higher wealth quintiles. Alarmingly, among couples who reported STI or symptoms, they were less likely to seek advice or treatment in 2016 as compared with 2006 (adjusted OR=0.50, p<0.001, 95% CI=0.40 to 0.61).

Conclusion The study identifies a substantial increase in self-reported STI prevalence with a notable treatment seeking gap among married couples in India over the past decade.
unemployment. Another study, which used the data from the 1998 wave of the National Family Health Survey (NFHS) and two waves of 1998 and 2002 waves of the District Level Household Survey- Reproductive and Child Health, reported that rural women, Muslim, illiterate and whose marriage occurred at a very young age of less than 18 years old had a higher STI prevalence.

To date, there is a gap in the literature that examines the trends of STI prevalence in recent years in India, particularly among married couples over time. The available literature on STI trends in India tend to focus on high-risk groups, such as female sex workers and men who have sex with men. Existing literature that assesses STI prevalence among married couples in India only reports on one time point without time-trend epidemiological analyses. Most of the aforementioned studies have been restricted to specific regions of India; thus, the findings are not generalisable to describe the national trend of STI and not adequate to inform whether there have been differential impacts of STI trend on specific subpopulations.

This study analyses two recent waves of India’s NFHS spanning over a decade to assess self-reported STI prevalence among married couples and examine whether there are differential trends based on the married couples’ sociodemographic factors, such as education, religion, rurality and wealth. This study provides further evidence of differential patterns of self-reported STI across various demographic and socioeconomic conditions through nationally representative samples in the last decade, where there has been profound economic development and epidemiological transition in India.

**METHODS**

India NFHS is part of the Indian Demographic and Health Survey (DHS), a nationally representative household-based health surveillance system. This study used the nationally representative sample of married couples aged 15–54 from two different waves in 2005–2006 NFHS-3 (N=39,257) and 2015–2016 NFHS-4 (N=63,696). Informed consent for participation in the survey was obtained for all respondents prior to the interview. Interviewers were trained to interview the respondent alone to establish privacy—without other eligible respondents in the household. The reported rates of married couples who do not cohabitate at the time of the survey were less than 1% (female, 2006: 0.62%; female, 2016: 0.37%; male, 2006: 0.26%; male, 2016: 0.14%). The overall response rates were more than 95% for both waves of the survey.

Both NFHS-3 and NFHS-4 conducted household surveys in states and union territories of India. Both survey samples were systematically stratified in multiple stages using the primary sampling units based on the size of rural villages and urban census blocks, and the randomly selected households within each cluster were chosen for interviews. A detailed sample design is described in the NFHS report. As shown in figure 1, the datasets had 39,257 and 63,696 matched couples in a household for NFHS-3, 2006 and NFHS-4, 2016 survey wave, respectively; when both waves were combined, there were 102,953 couples identified. Then, a sample of 102,690 couples from two survey waves was analysed for self-reported STI analyses after excluding couples with unknown and missing self-reported STI status. For the multivariate analyses, a sample of 97,288 couples was analysed after excluding couples with missing covariates. After accounting for unknown and missing variables, among those with at least one self-reported STI or symptoms, we identified 50,171 husbands and 10,631 wives to analyse the outcomes for individuals seeking treatment or advice for STI or its symptoms.

In both NFHS waves, respondents were asked if they have ever had sex and were asked whether they heard about other sexually transmitted infections. When they responded yes to those two aforementioned questions, then they were asked: During the last 12 months, have you had a disease which you got through sexual contact? This variable was coded as a primary outcome of self-reported STI for our study. Regardless of whether they have heard about STI, the women respondents were asked to identify STI symptoms through these two questions: (1) During the last 12 months, have you had a bad smelling abnormal genital discharge? (2) During the last 12 months, have you had a genital sore or ulcer? For men, they were asked: (1) During the last 12 months, have you had an abnormal discharge from your penis? (2) During the last 12 months, have you had a sore or ulcer on or near your penis? These two separate STI symptoms variables were combined and coded as a single dichotomous variable to indicate any STI symptom of a bad-smelling, abnormal discharge from the vagina/penis, a genital sore or a genital ulcer. The survey did not specify the diseases of STI diagnoses. For the analyses, the self-reported STI/STI symptom outcomes were categorised as if the respondents had reported STI and/or STI symptoms in the past year. Because STI among any partner in marriage affects the couple’s sexual health and family relationship, we followed the prior method and grouped the self-reported STI prevalence of at least one of the married couples as a single dichotomous variable to code as the primary self-reported STI outcome of a couple. Instead of individual prevalence, we used the couple STI prevalence as the primary outcome because the self-reported STI prevalence trend for husband and wife across two waves remained similar in both waves. Among those who reported any STI or symptoms, the survey asked whether they sought advice or treatment when they had STI/discharge/sore/ulcer in the past year. This paper also used married individuals’ treatment or seeking advice for STI or its symptoms as a separate outcome. We used self-reported STI status as a primary outcome in our multivariate analysis.

The year variable was coded as follows for each wave: the survey for 2016 was coded as 1, and 0 for 2006. We used covariates that wife and husband individually reported, such as age, education (college or above,
Indian National Family Health Survey (NFHS-3), 2006

109,041 households (515,507 individuals)

124,385 women aged 15-49
74,369 men aged 15-54

39,257 couples
(Married women and men who both declared that they are married to each other in their completed individual interviews.)

102,953 couples from two survey waves

102,690 couples for current self-reported STI analyses

97,288 couples for multivariate analyses

5,406 husbands with at least one self-reported STI or symptoms; 11,631 wives with at least one self-reported STI or symptoms

5,017 husbands and 10,631 wives for medical advice/treatment analyses

Indian National Family Health Survey (NFHS-4), 2016

601,509 households (2,724,122 individuals)

699,686 women aged 15-49
112,122 men aged 15-54

63,696 couples
(Married women and men who both declared that they are married to each other in their completed individual interviews.)

Figure 1 An outline of the process of sample selection from India NFHS datasets. It describes the flow diagram from datasets of two survey waves to the final sample size used for multivariate analyses. STI, sexually transmitted infections.

higher secondary, secondary, primary, illiterate), current employment status, religion (Hindu, Muslim, Christian and other), family wealth (highest, fourth, middle, second, lowest), and family residence (urban, rural). The higher secondary education group is for grades 11 and 12; the secondary education group is for grades 9 and 10; the primary education is for grades 1 to 8. The coding of these covariates was based on prior literature. The caste variable was categorised as scheduled caste, scheduled tribe, other backward class, and others (none of them). The caste system in India is a traditional method of social segregation and adverse socioeconomic and health outcomes disproportionately impact those belonging to disadvantaged caste. For the NFHS couple data set, we used sampling weights of men from both waves representing the respective population and its distribution at
the national level. All statistical analyses were performed using the SAS version 9.3 software.

Prevalence of self-reported STI and symptoms were calculated for husband, wife and couple for 2006 and 2016. Both bivariate and multivariate analyses have been conducted for this study. For this study, we used individualised socioeconomic and demographic factors as the predictor variables to assess their associations with self-reported STI. We estimated associations between individual demographic and socioeconomic characteristics and the couple’s self-reported STI status with bivariate analysis. Multiple logistic regressions with complex survey procedures were used to model predictors of a couple’s self-reported STI status. Similar approaches were also used for an individual’s treatment or seeking advice for STI. To assess the changes over time, we used the year as a categorical variable using 2006 as the reference year to assess the main effect of the time variable from 2006 to 2016. We evaluated the interaction terms of the time variable and these key covariates to determine differential changes by demographics and socioeconomic status (SES). The backward elimination procedure was used to identify significant interaction terms by removing terms from the multivariate logistic regression model with a threshold of p value greater or equal to 0.05. Statistical significance was determined by a p<0.05.

**Patient and public involvement**

No patients were involved.

**RESULTS**

The demographics of 102 953 married couples from 2006 and 2016 NFHS waves are provided in table 1. The average age for wives was 31.3 years for 2006 and 32.8 years for 2016; the average age for husbands was 36.7 years for 2006 and 37.7 for 2016. Less than half of wives were employed, whereas more than 90% of the husbands were employed in both waves. With exception to religion, there were significant differences in sociodemographics (mean age, education, employment, caste, family wealth and residence) of married women and men from 2006 to 2016. Compared to, 2006 more women had higher education in 2016; for instance, only 6% of married women reported having a college or higher education in 2006, and for 2016, about 10% of married women reported having an education at college or above (p<0.0001). Wife’s employment rate has significantly decreased over 10 years from 38% to 25% (p<0.0001). It should also be noted that similar directionality has been observed among married men: higher education has significantly increased, while employment has also significantly decreased from 97% in 2006 to 92% in 2016 (p<0.0001).

Table 2 summarises the prevalence of past-year self-reported STI and any STI symptom as individually reported by married couples from 2006 and 2016 NFHS waves. Married women reported a significantly greater increase in self-reported STI from 2006 to 2016 when compared with married men. In 2016, 2.5% of married women reported having had an STI in the past year, which significantly increased from 1.6% in 2006 (p<0.001). The national prevalence of past-year self-reported STI among married men increased significantly from 0.5% in 2006 to 1.1% in 2016 (p<0.001). The prevalence of self-reported STI among married couples has significantly increased from 2.06% in 2006 to 3.55% in 2016 (p<0.001). Figure 2 shows an increase in prevalence across self-reported STI and other STI-related symptoms from 2006 to 2016 among married couples in India.

For self-reported STI symptoms (table 2), including genital sore and discharge, there was a significantly higher prevalence among husbands in 2016 compared with 2006. For married men, 6.2% reported having had any STI symptom in 2016 compared with 3.9% in 2006, a substantial increase over the period (p<0.001). Married women also reported a significantly higher prevalence of self-reported STI symptoms for genital sores from 2.3% in 2006 to 3.1% in 2016 (p<0.001). Overall, the prevalence of any self-reported STI or any symptoms in the past year experienced by married couples has significantly increased from 14.7% in 2006 to 17.4% in 2016 (p<0.001).

Table 3 summarises bivariate and multiple logistic regressions with the couple’s self-reported STI status as the primary outcome variable. In the adjusted models, married couples in 2016 were approximately 60% more likely to report having STI in the past year (adjusted OR (aOR)=1.61, p<0.001, 95% CI=1.40 to 1.85). Mutually adjusting for the individual-level and couple-level sociodemographic and SES factors, husband’s education in college or above (aOR=1.31, p<0.05, 95% CI=1.03 to 1.68), secondary (aOR=1.33, p<0.01, 95% CI=1.09 to 1.62), and primary levels (aOR=1.20, p<0.05, 95% CI=1.01 to 1.43) were significantly positively associated with the couple’s self-reported STI status, relative to those who were illiterate. Family wealth at the highest quintile (aOR=1.33, p<0.05, 95% CI=1.05 to 1.69) was significantly associated with the couple’s self-reported STI—while other lower quintiles were not significant.

Table 4 demonstrates the time trend by SES interactions in moderating the risk of self-reported STI in married couples. The husband’s employment was positively associated with the uptrend of the married couple’s report of past-year self-reported STI from 2006 to 2016 (aOR=2.02, p<0.05, 95% CI=1.13 to 3.60). Couples who were in the highest (aOR=2.60, p<0.001, 95% CI=1.72 to 3.92), fourth quintile (aOR=2.52, p<0.001, 95% CI=1.67 to 3.80) and middle quintile (aOR=1.69, p<0.01, 95% CI=1.14 to 2.52) of family wealth were significantly more likely to experience an increase from 2006 to 2016 in reporting past-year STI compared with those in the lowest quintile of family wealth.

We also examined the relationship between the socio-demographic factors and treatment or seeking advice for STI or symptoms in the past 12 months. Using the multivariate analysis, as shown in table 5, husbands with recent
### Table 1 Background characteristics of married couples, India National Family Health Survey, 2006–2016

<table>
<thead>
<tr>
<th></th>
<th>2006 (N=39 257) % (SE)</th>
<th>2016 (N=63 696) % (SE)</th>
<th>2006 vs 2016 $\chi^2$ (or t-statistic) (p value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wife's age (mean)</strong></td>
<td>31.31 (0.06)</td>
<td>32.76 (0.05)</td>
<td>t=18.61 (t-statistic) &lt;0.0001</td>
</tr>
<tr>
<td><strong>Wife's education</strong></td>
<td></td>
<td></td>
<td>981.59 &lt;0.0001</td>
</tr>
<tr>
<td>College or above</td>
<td>6.07 (0.22)</td>
<td>10.28 (0.31)</td>
<td></td>
</tr>
<tr>
<td>Higher secondary</td>
<td>5.09 (0.16)</td>
<td>9.07 (0.19)</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>13.00 (0.27)</td>
<td>18.07 (0.28)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>28.90 (0.38)</td>
<td>31.26 (0.31)</td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>46.96 (0.51)</td>
<td>31.31 (0.32)</td>
<td></td>
</tr>
<tr>
<td><strong>Wife's employment</strong></td>
<td>37.99 (0.50)</td>
<td>25.46 (0.33)</td>
<td>459.01 &lt;0.0001</td>
</tr>
<tr>
<td><strong>Wife's religion</strong></td>
<td></td>
<td></td>
<td>0.91 0.8236</td>
</tr>
<tr>
<td>Hindu</td>
<td>82.50 (0.60)</td>
<td>82.03 (0.41)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>11.98 (0.58)</td>
<td>12.48 (0.37)</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>2.37 (0.15)</td>
<td>2.39 (0.11)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3.15 (0.19)</td>
<td>3.10 (0.16)</td>
<td></td>
</tr>
<tr>
<td><strong>Wife's caste/tribe</strong></td>
<td></td>
<td></td>
<td>101.22 &lt;0.0001</td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>19.55 (0.53)</td>
<td>20.55 (0.40)</td>
<td></td>
</tr>
<tr>
<td>Scheduled tribe</td>
<td>9.36 (0.45)</td>
<td>10.01 (0.25)</td>
<td></td>
</tr>
<tr>
<td>Other backward class</td>
<td>39.97 (0.63)</td>
<td>45.63 (0.45)</td>
<td></td>
</tr>
<tr>
<td>Others (none of them)</td>
<td>31.13 (0.60)</td>
<td>23.82 (0.41)</td>
<td></td>
</tr>
<tr>
<td><strong>Husband's age (mean)</strong></td>
<td>36.68 (0.06)</td>
<td>37.7 (0.05)</td>
<td>12.16 (t-statistic) &lt;0.0001</td>
</tr>
<tr>
<td><strong>Husband's education</strong></td>
<td></td>
<td></td>
<td>353.43 &lt;0.0001</td>
</tr>
<tr>
<td>College or above</td>
<td>11.27 (0.31)</td>
<td>14.01 (0.33)</td>
<td></td>
</tr>
<tr>
<td>Higher secondary</td>
<td>8.44 (0.22)</td>
<td>11.55 (0.24)</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>18.93 (0.30)</td>
<td>22.58 (0.30)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>36.65 (0.42)</td>
<td>34.19 (0.33)</td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>24.70 (0.44)</td>
<td>17.67 (0.25)</td>
<td></td>
</tr>
<tr>
<td><strong>Husband's employment</strong></td>
<td>96.65 (0.16)</td>
<td>92.01 (0.19)</td>
<td>301.76 &lt;0.0001</td>
</tr>
<tr>
<td><strong>Husband's religion</strong></td>
<td></td>
<td></td>
<td>1.40 0.7049</td>
</tr>
<tr>
<td>Hindu</td>
<td>82.58 (0.60)</td>
<td>82.25 (0.41)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>12.01 (0.58)</td>
<td>12.55 (0.38)</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>2.25 (0.14)</td>
<td>2.23 (0.12)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3.16 (0.19)</td>
<td>2.97 (0.15)</td>
<td></td>
</tr>
<tr>
<td><strong>Husband's caste/tribe</strong></td>
<td>19.69 (0.53)</td>
<td>20.80 (0.42)</td>
<td>79.41 &lt;0.0001</td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>9.38 (0.44)</td>
<td>9.85 (0.26)</td>
<td></td>
</tr>
<tr>
<td>Scheduled tribe</td>
<td>40.62 (0.64)</td>
<td>45.53 (0.46)</td>
<td></td>
</tr>
<tr>
<td>Others (none of them)</td>
<td>30.32 (0.60)</td>
<td>23.82 (0.42)</td>
<td></td>
</tr>
<tr>
<td><strong>Family wealth</strong></td>
<td></td>
<td></td>
<td>38.85 &lt;0.0001</td>
</tr>
<tr>
<td>Highest</td>
<td>21.48 (0.47)</td>
<td>22.51 (0.42)</td>
<td></td>
</tr>
<tr>
<td>Fourth</td>
<td>20.31 (0.39)</td>
<td>21.86 (0.33)</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>20.24 (0.38)</td>
<td>21.06 (0.28)</td>
<td></td>
</tr>
<tr>
<td>Second</td>
<td>19.52 (0.36)</td>
<td>18.78 (0.26)</td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>18.45 (0.46)</td>
<td>15.78 (0.24)</td>
<td></td>
</tr>
<tr>
<td><strong>Family residence</strong></td>
<td></td>
<td></td>
<td>39.77 &lt;0.01</td>
</tr>
<tr>
<td>Urban</td>
<td>32.54 (0.41)</td>
<td>36.01 (0.37)</td>
<td></td>
</tr>
</tbody>
</table>

Continued
self-reported STI or symptoms in 2016 were significantly less likely (aOR=0.50, p<0.001, 95% CI=0.40 to 0.62) to receive treatment or advice compared with those in 2006. Husband’s scheduled caste status was associated with less likelihood of receiving treatment or advice (aOR=0.60, p<0.05, 95% CI=0.39 to 0.91). Husbands with family wealth in the second quintile (aOR=1.35, p<0.05, 95% CI=1.05 to 1.73) compared with those in the lowest quintile were more likely to receive treatment or seek advice.

For the next adjusted model, wives in 2016 were significantly less likely to receive treatment or seek advice for STI and symptoms when compared to 2006 (aOR=0.88, p<0.05, 95% CI=0.78 to 0.99). Wives were more likely to receive treatment or seek advice when they had secondary (aOR=1.37, p<0.01, 95% CI=1.13 to 1.66) and primary (aOR=1.35, p<0.001, 95% CI=1.17 to 1.55) education levels compared with those who were illiterate. Wives whose husband had higher secondary (aOR=1.29, p<0.05, 95% CI=1.02 to 1.63), secondary (aOR=1.23, p<0.05, 95% CI=1.01 to 1.48) and primary (aOR=1.24, p<0.05, 95% CI=1.05 to 1.45) education level were also more likely to receive treatment or seek advice. For family wealth, wives in the highest (aOR=1.91, p<0.001, 95% CI=1.51 to 2.41), fourth (aOR=1.65, p<0.001, 95% CI=1.35 to 2.02), and middle (aOR=1.31, p<0.01, 95% CI=1.09 to 1.59) quintiles were significantly more likely to receive treatment or seek advice compared with those in lowest family wealth quintile when adjusted with other sociodemographic variables.

**DISCUSSION**

The analyses from two waves of NFHS identify a significant increase in self-reported STI prevalence among both married men and women over the past decade in India. In 2016, 2.5% of married women reported having had an STI in the past year, which significantly increased from 1.6% in 2006. Adjusted results showed that the uptrend of couples’ self-reported STI was more significant among those whose husbands are currently employed and those in middle or higher wealth quintiles. Alarmingly, among couples who reported STI or symptoms, both husband and wife were less likely to seek advice or treatment in 2016 than in 2006.

Our study uses the two latest datasets from a large nationally representative health survey to assess the relationship between self-reported STI and various sociodemographic factors in India. To the best of
our knowledge, this is the first study that describes the changes in self-reported STI prevalence among married couples in India from 2006 to 2016 and assesses whether the changes vary by sociodemographic and economic conditions. Our findings are different from the cross-sectional results of a past similar study based on a single wave of India national survey data of 1998 that showed that the rural women, Muslim and illiterate women had a higher STI prevalence.17

With the newer datasets from 2006 and 2016, our analysis revealed a new finding that married couples with currently employed husbands and with middle or higher wealth are associated with greater odds of self-reported STI. With rising disposable income due to rapid economic development in India in the past decades,31 it is possible that the availability of disposable economic resources may have increased the likelihood of risky sexual behaviours. There is evidence that in some epidemiological studies of HIV, wealthier individuals may engage in risky sexual behaviours that increase their vulnerability to infections.32 35 Other work in Uganda has found that the middle wealth quintile and disposable income posed a higher risk for STI.34 According to our findings, wives with middle or higher household wealth were more likely to seek advice or treatment for STI compared with those with lower wealth. Combining these two factors may have contributed to the higher rates of self-reported STI among wealthier groups. The imbalance of wealth among husband and wife may contribute to a shift of family dynamics that may further affect sexual health and, broadly, intimate partner relationship.

Since this study used only a limited number of sociodemographic factors in the adjusted multivariate analysis, the contextual background behind these socioeconomic indicators may need to be further examined. For example, statistical differences were observed when comparing sociodemographic factors from 2006 to 2016. While higher education has significantly increased over time for both married women and men, we observed a statistically significant decline in employment. An increase in education level can be attributed to India’s growing higher education system. India’s education system, the third-largest globally, has been growing particularly with universities, which increased 34 times from 1947 to 2014.35 Scholars attribute the increase of education level in India to the ‘Right to Education Act,’ enacted in 2009 to provide free and mandatory education for children aged 6–18.35 36 As for the statistically significant decline in employment for both married men and women in our study, it may be explained by the overall workforce trend in India during the last few decades. Existing literature shows that employment growth at the national level exploded between 1999 to 2005, but the net employment sharply declined the following years between 2005 to 2010; some scholars note that India saw ‘jobless growth’ while the national economic development was underway.37 38

Compared to 2006, more women had higher education in 2016; for instance, only 6% of married women reported having a college or higher education in 2006, and for 2016, about 10% of married women reported having an education at college or above (p<0.0001). Wife’s employment rate has significantly decreased over 10 years from 38% to 25% (p<0.0001). It should also be noted that similar directionality has been observed among married men: higher education has significantly increased, while employment has also significantly decreased from 97% in 2006 to 92% in 2016 (p<0.0001).

Further study is warranted to ascertain associations between couples’ self-reported STI and sociodemographics after accounting for another individual, family and state covariates. Also, the decreased prevalence of seeking advice or treatment for STI from 2006 (47.8%) to 2016 (31.9%) suggests that efforts are needed to improve sexual healthcare utilisation in India. Studies in India suggest that stigma, geography, and discrimination are often barriers among high-risk groups to seek healthcare and treatment for STI.39–41

There are several limitations to our study. Although the NFHS followed a rigorous and established data collection methodology, there may be self-report bias. According to the interviewer’s manual, the survey interviewers administering the NFHS are culturally trained to build rapport, establish safe and private settings, and assure the confidentiality of the respondents.42 Despite these efforts, survey respondents may have still misreported their STI status due to the sensitive nature, cultural stigma and social undesirability associated with STI. Compared with clinical data gathered from STI laboratory tests, self-reported STI status may have been underreported or misreported.
### Table 3  Associations of married couples’ current self-reported STI status with individual demographics and socioeconomic status

<table>
<thead>
<tr>
<th>Year 2016</th>
<th>Couple’s STI to %</th>
<th>Couple’s STI (bivariate) OR (95% CI)</th>
<th>Couple’s STI (multivariate) Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>39 078.29</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife’s age</td>
<td>102 690.29</td>
<td>1.00 (0.99 to 1.01)</td>
<td>1.01 (0.99 to 1.02)</td>
</tr>
<tr>
<td>Wife’s education</td>
<td>91 798.40</td>
<td>1.56*** (1.22 to 2.00)</td>
<td>1.17 (0.87 to 1.57)</td>
</tr>
<tr>
<td>College or above</td>
<td>83 014.37</td>
<td>1.43*** (1.17 to 1.74)</td>
<td>1.13 (0.88 to 1.44)</td>
</tr>
<tr>
<td>Higher secondary</td>
<td>17 265.31</td>
<td>1.19* (1.01 to 1.40)</td>
<td>0.97 (0.80 to 1.18)</td>
</tr>
<tr>
<td>Secondary</td>
<td>31 818.27</td>
<td>1.05 (0.92 to 1.20)</td>
<td>0.91 (0.79 to 1.06)</td>
</tr>
<tr>
<td>Illiterate</td>
<td>36 124.26</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife’s employment</td>
<td>30 163.28</td>
<td>0.95 (0.84 to 1.07)</td>
<td>1.03 (0.91 to 1.17)</td>
</tr>
<tr>
<td>Wife’s religion</td>
<td>77 388.28</td>
<td>0.92 (0.70 to 1.22)</td>
<td>0.97 (0.60 to 1.58)</td>
</tr>
<tr>
<td>Hindu</td>
<td>12 905.35</td>
<td>1.13 (0.83 to 1.54)</td>
<td>1.05 (0.55 to 2.00)</td>
</tr>
<tr>
<td>Muslim</td>
<td>76 13.27</td>
<td>0.87 (0.56 to 1.34)</td>
<td>0.79 (0.33 to 1.86)</td>
</tr>
<tr>
<td>Other</td>
<td>47 373.32</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife caste/tribe</td>
<td>18 090.30</td>
<td>1.13 (0.95 to 1.34)</td>
<td>0.93 (0.65 to 1.35)</td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>16 494.26</td>
<td>1.00 (0.79 to 1.27)</td>
<td>1.06 (0.67 to 1.67)</td>
</tr>
<tr>
<td>Other backward class</td>
<td>38 957.30</td>
<td>1.15 (0.98 to 1.34)</td>
<td>1.07 (0.84 to 1.36)</td>
</tr>
<tr>
<td>Husband’s age</td>
<td>102 690.29</td>
<td>1.00 (0.99 to 1.00)</td>
<td>0.99 (0.98 to 1.01)</td>
</tr>
<tr>
<td>Husband’s education</td>
<td>13 860.37</td>
<td>1.67*** (1.34 to 2.08)</td>
<td>1.31* (1.03 to 1.68)</td>
</tr>
<tr>
<td>College or above</td>
<td>11 145.27</td>
<td>1.21 (1.00 to 1.47)</td>
<td>1.04 (0.82 to 1.31)</td>
</tr>
<tr>
<td>Higher secondary</td>
<td>22 459.34</td>
<td>1.47*** (1.23 to 1.75)</td>
<td>1.33** (1.09 to 1.62)</td>
</tr>
<tr>
<td>Secondary</td>
<td>36 050.28</td>
<td>1.25** (1.07 to 1.46)</td>
<td>1.20* (1.01 to 1.43)</td>
</tr>
<tr>
<td>Illiterate</td>
<td>19 163.23</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Husband’s employment</td>
<td>95 874.29</td>
<td>0.90 (0.72 to 1.14)</td>
<td>0.97 (0.76 to 1.24)</td>
</tr>
<tr>
<td>Husband’s religion</td>
<td>77 594.28</td>
<td>0.92 (0.69 to 1.23)</td>
<td>1.01 (0.61 to 1.66)</td>
</tr>
<tr>
<td>Hindu</td>
<td>12 901.35</td>
<td>1.14 (0.83 to 1.57)</td>
<td>1.31 (0.68 to 2.54)</td>
</tr>
<tr>
<td>Muslim</td>
<td>74 31.27</td>
<td>0.87 (0.55 to 1.37)</td>
<td>0.93 (0.38 to 2.25)</td>
</tr>
<tr>
<td>Other</td>
<td>47 564.32</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Husband caste/tribe</td>
<td>18 160.32</td>
<td>1.24* (1.05 to 1.47)</td>
<td>1.50* (1.04 to 2.15)</td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>16 489.26</td>
<td>1.01 (0.81 to 1.25)</td>
<td>1.17 (0.77 to 1.77)</td>
</tr>
<tr>
<td>Scheduled tribe</td>
<td>39 227.30</td>
<td>1.19* (1.02 to 1.38)</td>
<td>1.17 (0.92 to 1.47)</td>
</tr>
<tr>
<td>Others (none of them)</td>
<td>24 517.26</td>
<td>1.09 (0.91 to 1.30)</td>
<td>1.02 (0.85 to 1.23)</td>
</tr>
</tbody>
</table>

Continued
is also a possibility of recall bias due to a longer time interval for the past 12 months for STI incidence. Despite this concern, it is worth noting the large scope of the epidemiological data as it can be useful compared with smaller clinical samples.

Although our analyses use the latest available data-sets of two different time points, there is a limitation in assessing change in prevalence between only two time points. Due to the administration interval of DHS, there is a 10-year gap between the two survey

### Table 3

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Couple's STI to %</th>
<th>Couple's STI (bivariate) OR (95% CI)</th>
<th>Couple's STI (multivariate) Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>15900</td>
<td>2.49</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td><strong>Family residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>37261</td>
<td>3.21</td>
<td>1.15 (1.00 to 1.31)</td>
<td>0.94 (0.81 to 1.10)</td>
</tr>
<tr>
<td>Rural</td>
<td>65429</td>
<td>2.82</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01, ***p<0.001.
OR, Odds Ratio; Ref., Reference group for odds ratio; STI, sexually transmitted infection.

### Table 4

<table>
<thead>
<tr>
<th>Interaction terms between year and each of the following predictors</th>
<th>Couple's STI† adjusted OR (95% CI)</th>
<th>Couple's STI‡ adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wife’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>1.29 (0.68 to 2.46)</td>
<td></td>
</tr>
<tr>
<td>Higher secondary</td>
<td>1.12 (0.63 to 1.96)</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>1.82* (1.14 to 2.88)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1.36 (0.99 to 1.88)</td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>Ref.</td>
<td></td>
</tr>
<tr>
<td><strong>Wife’s employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>1.18 (0.90 to 1.56)</td>
<td></td>
</tr>
<tr>
<td><strong>Husband’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>0.95 (0.54 to 1.70)</td>
<td></td>
</tr>
<tr>
<td>Higher secondary</td>
<td>0.87 (0.51 to 1.47)</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>1.08 (0.70 to 1.66)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1.06 (0.74 to 1.52)</td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>Ref.</td>
<td></td>
</tr>
<tr>
<td><strong>Husband’s employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>1.97* (1.10 to 3.52)</td>
<td>2.02* (1.13 to 3.60)</td>
</tr>
<tr>
<td><strong>Family wealth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>2.08** (1.21 to 3.57)</td>
<td>2.60*** (1.72 to 3.92)</td>
</tr>
<tr>
<td>Fourth</td>
<td>2.07** (1.28 to 3.34)</td>
<td>2.52*** (1.67 to 3.80)</td>
</tr>
<tr>
<td>Middle</td>
<td>1.49 (0.99 to 2.25)</td>
<td>1.69** (1.14 to 2.52)</td>
</tr>
<tr>
<td>Second</td>
<td>1.27 (0.86 to 1.88)</td>
<td>1.36 (0.93 to 1.99)</td>
</tr>
<tr>
<td>Lowest</td>
<td>Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td><strong>Family residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>1.12 (0.79 to 1.59)</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>Ref.</td>
<td></td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01, ***p<0.001.
†Adjusted multivariate analysis for all predictors included in the table, including age, religion and caste.
‡Multivariate analysis for SES variables (employment, family wealth) as predictors and adjusted to all predictors included in the table, including age, religion, and caste.
STI, sexually transmitted infection.
Table 5  Associations of likelihood of married couples, who reported STI or symptoms, seeking advice or treatment when they had STI/discharge/sore/ulcer and individual demographics and socioeconomic status, 2006 and 2016

<table>
<thead>
<tr>
<th>Husband’s treatment or seeking advice for STI and symptoms (multivariate) Adjusted OR (95% CI)</th>
<th>Wife’s treatment or seeking advice for STI and symptoms (multivariate) Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2016</td>
<td>0.50***</td>
</tr>
<tr>
<td>2006 Ref.</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife’s age</td>
<td>1.02</td>
</tr>
<tr>
<td>Wife’s education</td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>1.33</td>
</tr>
<tr>
<td>Higher secondary</td>
<td>1.31</td>
</tr>
<tr>
<td>Secondary</td>
<td>1.09</td>
</tr>
<tr>
<td>Primary</td>
<td>0.92</td>
</tr>
<tr>
<td>Illiterate</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife’s employment</td>
<td>0.99</td>
</tr>
<tr>
<td>Wife’s religion</td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>1.14</td>
</tr>
<tr>
<td>Muslim</td>
<td>1.50</td>
</tr>
<tr>
<td>Christian</td>
<td>0.42</td>
</tr>
<tr>
<td>Other</td>
<td>Ref.</td>
</tr>
<tr>
<td>Wife caste/tribe</td>
<td></td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>1.85**</td>
</tr>
<tr>
<td>Scheduled tribe</td>
<td>1.51</td>
</tr>
<tr>
<td>Other backward class</td>
<td>1.12</td>
</tr>
<tr>
<td>Others (none of them)</td>
<td>Ref.</td>
</tr>
<tr>
<td>Husband’s age</td>
<td>0.99</td>
</tr>
<tr>
<td>Husband’s education</td>
<td></td>
</tr>
<tr>
<td>College or above</td>
<td>1.00</td>
</tr>
<tr>
<td>Higher secondary</td>
<td>0.87</td>
</tr>
<tr>
<td>Secondary</td>
<td>1.04</td>
</tr>
<tr>
<td>Primary</td>
<td>1.00</td>
</tr>
<tr>
<td>Illiterate</td>
<td>Ref.</td>
</tr>
<tr>
<td>Husband’s employment</td>
<td>1.04</td>
</tr>
<tr>
<td>Husband’s religion</td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>0.81</td>
</tr>
<tr>
<td>Muslim</td>
<td>1.12</td>
</tr>
<tr>
<td>Christian</td>
<td>1.38</td>
</tr>
<tr>
<td>Other</td>
<td>Ref.</td>
</tr>
<tr>
<td>Husband caste/tribe</td>
<td></td>
</tr>
<tr>
<td>Scheduled caste</td>
<td>0.60*</td>
</tr>
<tr>
<td>Scheduled tribe</td>
<td>0.69</td>
</tr>
<tr>
<td>Other backward class</td>
<td>0.77</td>
</tr>
<tr>
<td>Others (none of them)</td>
<td>Ref.</td>
</tr>
<tr>
<td>Family wealth</td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>1.22</td>
</tr>
<tr>
<td>Fourth</td>
<td>1.18</td>
</tr>
<tr>
<td>Middle</td>
<td>1.20</td>
</tr>
<tr>
<td>Second</td>
<td>1.35*</td>
</tr>
</tbody>
</table>

Continued
waves. The gap between these two survey periods may introduce an additional source of bias that can affect the association. The cross-sectional design is limited to causal inference. Because the current investigation focuses on demographic and socioeconomic conditions, additional residual confounding may be due to unobserved factors.

Evaluating the relationship of sociodemographic determinants and self-reported STI rates among married couples can be valuable for programmatic and policy decisions for community-based clinical care to improve sexual health outcomes for married individuals. The prevention and intervention models for sexual health in communities in India should consider the multitude of social factors that may put certain groups of individuals at greater risk for STI infections than others.

Contributors JC performed the analyses, interpreted the results and led the writing. ZX conceived of the study and supervised all aspects of the study. DB and MA contributed significantly to the interpretation of findings and review of the article. All authors reviewed the manuscript and approve of its contents.

Funding This study was supported by the National Institute of Allergy and Infectious Diseases (grant F33AI042853) and an award from the Frederick S. Pardee Center for the Study of the Longer-Range Future at Boston University (PI: ZX).

Disclaimer The funding organisations had no role in the design and conduct of the study; in the collection, analysis, and interpretation of the data; or in the article's preparation, review, or approval.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Because we used secondary, publicly available data sources without personal identifiers, this study is exempted from institutional Review Board's review and approval.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available in a public, open access repository. Datasets for the analyses were obtained from the Demographic and Health Survey (DHS) and are freely available online at the DHS website.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

REFERENCES

Table 5 Continued

<table>
<thead>
<tr>
<th>Family residence</th>
<th>Husband’s treatment or seeking advice for STI and symptoms (multivariate) Adjusted OR (95% CI)</th>
<th>Wife’s treatment or seeking advice for STI and symptoms (multivariate) Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>Ref.</td>
<td>(0.92 to 1.44)</td>
</tr>
<tr>
<td>Urban</td>
<td>1.15</td>
<td>Ref.</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Odds ratios adjusted for all variables included in the table. *p<0.05, **p<0.01, ***p<0.001.

STI, sexually transmitted infection.

Open access

BMJ Open: first published as 10.1136/bmjopen-2021-049049 on 20 October 2021. Downloaded from http://bmjopen.bmj.com/ on September 17, 2023 by guest. Protected by copyright.


