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Treatment seeking pattern among infertile couple in Rural and Urban areas of Vijayapur district, Karnataka.

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ABSTRACT

Introduction: Infertility is a public health problem affecting people worldwide from all the communities due to various causes. After getting married, some couples wait for years, others seek assistance within months. With this background, we conducted this study to know the pattern of treatment seeking among infertile couples. **Objective :** To assess the treatment seeking pattern of infertile couples in rural and urban areas of Vijayapur district, Karnataka. **Methods:** A cross sectional study was conducted in the rural and urban field practice area between March 2015- February 2016. Complete enumeration of all the houses was done to list all eligible couples and those who were exposed to pregnancy and had infertility were identified. **Results:** It was found that 58% of the couples from rural area and 42% from urban area sought treatment and majority opted Allopathic medicine. Waiting for the spontaneous conception was the major reason for not seeking treatment. Around 59% of the female participants availed health care facility and among male participants it was around 41%. **Conclusion:** Infertility affects couples, rather than individual hence the burden is on the family. Among those who have consulted health care services, significant proportion of the male partners did not seek any treatment.

Key Words: Infertility, Treatment seeking pattern, Rural, Urban.

INTRODUCTION

Infertility is perceived as a problem across all cultures and societies. It varies from country to country and from cohort to cohort.^[1] Socio-cultural context is an important consideration in the meaning of and responses to infertility.^[2] Before 1994, infertility was a neglected issue in population and health policy debates. The International Conference on population and development (ICPD), called for 'Program of Action' where the goal was to achieve reproductive health for all by the year 2015. According to this, the reproductive health care includes safe delivery, prevention, appropriate treatment of infertility and abortion in accordance with national laws.^[3]

All infertile couples do not seek treatment. An estimated 51% of the couples with primary infertility and 22% with secondary infertility seek treatment. Among those seeking treatment, 85 to 90% are treated with conventional medical and surgical therapy.^[4]

Findings from DLHS 3 survey on infertility and treatment seeking pattern in India, showed that a very high proportion of women (83%) sought treatment for infertility from any source of medicine. Among them majority sought allopathic treatment. Private sector was mostly utilized among those who sought allopathic treatment. Reduced availability of infertility treatment was

mentioned to be the reason for not availing treatment in Government sector.^[5]

Couples follow religious practices, traditional practices, visit holy places and going to spiritual healers along with treatment either simultaneously or subsequently. While assisted reproductive technology centres are the first ones to be visited by some, others seek assistance from religious people or quacks.^[4]

Studies have shown that infertility causes tension among couples affecting their sexual and marital relationships. In addition to the pressure on infertile couples from relatives, friends and the community, they also suffer from stress because of the investigations, treatment procedures in addition to frustration due to treatment failure. When the cause cannot be demonstrated then specific treatment for infertility is not possible which is very difficult for the couples to accept. It may lead to seek alternate treatment. The management of infertility places a heavy financial burden on the couples.^[6]

Infertility is thus an "ice berg" phenomenon. A majority of the couples remain undiagnosed. Among them, most suffer from easily treatable conditions, yet they do not seek treatment.

MATERIAL AND METHODS

A cross sectional study was conducted at Rural and Urban Health Training Centres. The field practice areas of Department of Community Medicine of Shri B.M.Patil Medical College, Hospital and Research Centre Vijayapura from April 2015-March 2016.

Study population: Eligible couples where women are in the reproductive age group 15-49 years. **Sample size:** Complete enumeration of all the houses covered under RHTC and UHTC was done to list out all the eligible couples residing in the area. Those women at risk of pregnancy were identified so as to find out couples' with either primary or secondary infertility.

Inclusion criteria: Couples who are residents of the locality (minimum 6 months duration. Couples with inability to conceive despite cohabitation and exposure to the risk of pregnancy (in the absence of contraception) for two years or more (as per WHO Epidemiological definition) were included and considered to have primary infertility. Couples with inability to conceive despite cohabitation and exposure to risk of pregnancy (in the absence of contraception, post-partum amenorrhoea) following previous pregnancy for a period of two years or more were considered to have secondary infertility. [7]

Exclusion criteria: Among the infertile couples, those who are seriously ill, not co-operative and not willing to participate in the study were excluded from the study.

Methodology: After obtaining ethical clearance from the Institutional Ethical Committee the study was conducted in rural & urban field practice area of Shri B. M. Patil Medical College, Hospital and Research centre. Medico social workers of UHTC, Anganwadi workers and ASHA workers were involved in the study. Objectives were explained to them. The purpose and overview of the study was explained to those who were willing to participate in the study and they were assured that participation was entirely voluntary and right to withdrawal was possible at any time. It was explained to them that the information that they will be providing would be used solely for the purpose of the study. Informed consent was taken in local language.

Out of the 1962 Houses, total of 1800 (92%) were accessed in rural area and out of 1360 houses a total of 1210(89%) were accessed in urban field practice area catering a population of 12000 and 10000 respectively. House to house survey was done covering all the participants coming under the field practice area so as to completely enumerate the eligible couples. Among them, women with primary and secondary infertility according to the definition mentioned above were considered as participants. Self-reported per capita monthly income was recorded. Modified BG Prasad's classification(June 2015) was used to assess the social class of the study subjects.

Statistical Analysis: Data were tabulated and analysed using SPSS version 16. The Results are expressed in terms of percentages and chi square test is used to test the significance of association.

RESULTS**Table 1: Socio-demographic variables**

Variables		Rural		Urban		Total
		Males	Females	Males	Females	
		Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq(%)
Age	20-29	12(23)	35(66)	10(27)	22(59.4)	79(44)
	30-39	24(45)	12(23)	15(40.5)	10(27.1)	61(34)
	40-49	14(26)	06(11)	09(24.3)	05(13.5)	34(19)
	50	03(6)	0	03(8.1)	0	6(3)
Total		53(100)	53(100)	37(100)	37(100)	180(100)
Educational status	Illiterate	22(41)	16(30)	01(2.7)	0	39(22)
	Primary school	7(13)	8(15)	10(27)	10(27)	35(19)
	High school	18(34)	15(28)	09(24.3)	12(32.4)	54(30)
	PUC/Class 12 th	3(5.6)	7(13)	09(24.3)	11(29.7)	30(17)
	Degree	3(5.6)	7(13)	08(21.6)	04(10.8)	22(12)
Total		53(100)	53(100)	37(100)	37(100)	180(100)
Occupation	Professional	6(11)	0	08(22)	0	14(8)
	Semi-skilled	8(15)	2(4)	0	05(14)	15(8)
	Skilled	19(36)	6(11)	19(51)	0	44(24)
	Un-skilled	20(38)	4(7)	10(27)	10(27)	44(24)
	Home-maker	0	41(78)	0	22(59)	63(35)
Total		53(100)	53(100)	37(100)	37(100)	180(100)

Table 2: Socio-demographic profile of the couple

Variables		Rural	Urban
		Frequency (%)	Frequency (%)
Religion	Hindu	50(94)	28(75)
	Muslim	03(06)	09(25)
Type of family	Joint	26(49)	13(35)
	Nuclear	23(43)	18(49)
	Three generation family	04(8)	06(16)
Duration of infertility	< 5 years	18(34)	17(46)
	5-9 years	19(36)	11(30)
	10-20 years	15(28)	07(19)
	>20 years	01(2)	02(5)
Socio-Economic Status	Class I	06(11)	0
	Class II	10(19)	07(19)
	Class III	23(43)	15(41)
	Class IV	09(17)	12(32)
	Class V	05(9)	03(8)
Family history of infertility	Yes	06(16)	05(14)
	No	47(89)	32(86)
History of consanguineous marriage	Yes	20(38)	10(27)
	No	33(62)	27(73)
Total		53(100)	37(100)

Tables 1 & 2 describes the socio-demographic features of the infertile couples where most of the women belonged to 20-29 years and males to 30-39 year age group. Around 22% of the study population was illiterate. Major proportion of the participants were engaged in skilled and unskilled work. In table 2, most of the couples belonged to Hindu religion both in rural (94%) & urban slums (75%). A major proportion of the study subjects belonged to joint family (49%). Most of the women belonged to Class III Socio-Economic Status according to modified B.G.Prasad classification. Around 36% of the study subjects from rural area had duration of infertility 5-9 years and 46% had duration of infertility < 5 years in urban area.

Table 3: Association between treatment seeking pattern and area of residence

Variables		Rural	Urban	Total	Chi square statistic, df, p value
		Freq(%)	Freq(%)	Freq(%)	
Availed health care facility	Yes	40(58)	29(42)	69(100)	$\chi^2=20.9$ df=1
	No	66(59)	45(41)	111(100)	p value 0.001
If Yes, which n=69	Allopathy	21(30)	23(34)	44(64)	$\chi^2=34$ df=1
	Ayurvedic, Homeopathy and Traditional healers	19(28)	6(9)	25(37)	pvalue 0.0001
If No, Why* n =111	Economic hardship	11(10)	12(11)	23(21)	$\chi^2=17.3$ df=2
	Waiting for spontaneous conception	32(29)	33(30)	65(59)	p value 0.002
	Not willing/ignorance	28(25)	08(7)	36(32)	

*multiple choices

Table 3: Unlike most of the studies done previously, this study reports that the majority(58%) of the study population seeking health care for infertility hailed from rural areas. Among those who have availed health care facility, majority visited allopathic doctors i.e., 64% (30% from rural and 34% from urban area) followed by Ayurveda doctors i.e.,18%(12% from rural and 6% from urban).

Around 59% of the participants were waiting for spontaneous conception (29% and 30% in rural and urban area respectively).This was the common stated reason among those who have not availed any health care facility. Non- awareness about treatment options was high among rural participants. This distribution was found to be statistically significant.(p<0.001)

Table 4. Association between socio demographic factors and treatment seeking pattern (n=69)

Variables		Availed health care facility		Chi square statistic, df, p value
		Yes (%)	No (%)	
Sex	Males	28(41)	62(56)	$\chi^2=3.97$
	Females	41(59)	49(44)	df=1
				p value 0.04
Age	20-29	17(25)	62(56)	$\chi^2=19.1$
	30-39	35(51)	26(23)	df=2
	>40	17(25)	23(21)	p value 0.001
Educational status	Illiterate	13(19)	26(23)	$\chi^2=3.64$
	Primary school	18(26)	17(15)	df=4
	High school	19(28)	35(32)	p value 0.45
	PUC	11(16)	22(20)	
	Degree	08(11)	11(10)	
Type of family	Joint	32(46)	46(41)	$\chi^2=3.21$
	Nuclear	33(48)	49(44)	df=2
	Three generation	04(6)	16(14)	p value0.20
Type of infertility	Primary	52(75)	70(63)	$\chi^2=2.95$
	Secondary	17(25)	41(37)	df=1
				p value 0.08
	Total	69(100)	111(100)	

Table 4: The above table highlights that 59% of the females have availed health care facility, and among males it was 41% and it was statistically significant. (p<0.05). Most of the couples in the age group 30-39 years availed health care facility when compared to age group 20-29 years and > 40 years and was statistically significant. (p<0.05). Educational status was not statistically associated in availing health care facility. Subjects with primary infertility availed health care facility more frequently (75%) compared to secondary infertility (25%). Statistical significance was not found with respect to type of family or type of infertility.

DISCUSSION

Our findings showed that around 38% of the study subjects sought treatment for their infertility problem among which 58% of them were rural residents and 42% were urban residents. It was observed that allopathic was the most common treatment sought by infertile couples which are consistent with the other study done by Mulgaonkar. [8] Couples also follow religious practices with such treatment, either simultaneously or subsequently.

Despite their affiliation with modern treatment, people still believe that the remedy for childlessness ultimately depends on religious methods. As a result, in addition to biomedical treatment, many couples return to or simultaneously pursue various traditional, spiritual or folk treatments.

Waiting for spontaneous conception (29% and 30% in rural and urban area respectively) was the common stated reason among those who have not availed any health care facility. Significant association was found between the area of residence and different reasons for not availing any health care services.

Most of the couples in the age group 30-39 years availed health care facility when compared to age group 20-29 years and > 40 years and was statistically significant. (p<0.05). Couples with primary infertility sought treatment more frequently which is similar to other previous study conducted by Tripathi N. [9]

In a study conducted in rural areas of Bangalore, 60% of the men and 72% of the women had sought treatment for infertility. Allopath was the most preferred treatment among the couples followed by traditional healers. 55% of the males and 68% of the females had extensive infertility investigations .Most common reason for not approaching the health care facility was economic hardship in couples with primary infertility and among secondary infertility cases, majority waited for spontaneous conception. [10]

Similarly Chabra *et al.*, reported in their hospital based study in Maharashtra that among 1000 infertile women, 53% of them were from rural area and the remaining were from urban area. [4] Our study results showed that 58% of the couples from rural area and 42% of the couples from urban area availed health care facility for infertility which is low when compared to the study conducted by Niharika Tripathi. (80% and 86% of the infertile women sought treatment from rural and urban area respectively.[11] The lesser proportion in our study may be due to the financial

constraints of the study population as our study areas are yet to be developed urban slums and rural regions. Even though males are equally responsible for the infertility status, it is the woman who usually initiates the first contact with a physician. Most of the help-seeking is undertaken by women in the form of traditional and modern biomedical health services,^[4] as was revealed in the present study as well.

The study showed that only a minority couples with infertility depend solely on medical approach as a fertility seeking behaviour. Most of them sought the spiritualists and traditional medicine besides medical option. That is, medical treatment alone is, less often used by the respondents due to reasons such as different perceptions of the causes of infertility or the lack of confidentiality at the treatment centres.^[12] This indicates that female literacy should be given prime importance.

Conclusion : Among those who have consulted health care services, a significant proportion of male partners did not seek any treatment, even though males are equally responsible for the infertility status. Even the educational status is very poor, indicating the first barrier towards motivating the couples to access health care services.

It is worth mentioning that during our study period, counselling was provided to the infertile couples along with their family members to reduce the stress and stigma in addition to lifestyle modifications and treatment seeking options.

Recommendation: Efforts to raise awareness in the population about the causes of infertility are needed, specifically to males. Facilities should be made available for early diagnosis and treatment of the same in the rural areas/urban slums. Further research needs to be undertaken involving appropriate investigations which are feasible at the primary health centre level.

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