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Perspectives on Infertile Couple

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Abstract: Fertility is the essence of motherhood. A woman can be called mother when she has a child. Childlessness is a scourge on motherhood as well as on the reproductive health system. Like fertility control, infertility treatment and rehabilitation should be one of the key components of reproductive health care system. Both male and female are equally responsible for the problem of infertility. Women should not be blamed alone. The reproductive health system should take care of the reproductive health of both male and female.

Key words: Fertility, infertility, gender, motherhood, reproductive health

INTRODUCTION

World Health Organization (WHO, 1995) recognizes infertility as an illness, which has to be treated. The inability to conceive or the awareness of personal infertility can be a shattering experience for both women and men. Apart from the sadness and disappointment experienced at being unable to conceive, many spouses suffer feelings of failure and guilt towards their partners once he or she is found to be infertile (Rawland, 1995; Doyal, 1997). As most infertile women are unaware of their problems, they usually present themselves at a doctor's door when the condition is already long-lasting (Poston and Roger, 1998).

Women's natural function is assumed to be reproduction and this is seen as the central determining characteristic of their psychological and possibly even their physical being (Isiugo- Abanihe, 1994; Gupta, 2000). Many infertile women feel that feminists have not taken their problems very seriously. Satanworth (1997) wrote about infertility so that there will be more understanding and support from the women's movement for the many women with fertility problems believe that infertility is a taboo subject and an infertile woman is an embarrassment. Since a woman's status rests primarily on her success in bearing children, infertility is always believed to be the wife's fault, since the possibility that her husband may be infertile, is not considered as a major problem for the woman (World Bank, 1996).

WHO (1995) defines infertility as the inability to conceive after one year of unprotected sex. According to its estimate, in 32% of cases, the problem usually with men; in 26%, with women; in 20% with both partners and in 22% of cases, it is idiopathic. WHO's Scientific Group on the Epidemiology of Infertility categorized infertility as follows:

Primary infertility: which includes those women who have never conceived despite cohabitation and exposure to pregnancy for a period of two years. They are considered to be primarily sterile/infertile.

Secondary infertility: which accounts for the women who have previously conceived but subsequently become unable to conceive despite cohabitation and exposure to pregnancy for a period of two years.

Voluntary infertility: which incorporates the couples who are practicing contraception or have undergone sterilization operation or absence of cohabitation. These women are said to be voluntarily infertile. Involuntary childlessness predominates among the couples of the developing countries and voluntary childlessness predominates in the developed world (Poston and Rogers, 1998). In Industrialized countries, up to 25% of women with PID (Pelvic Inflammatory Diseases) become infertile and women's health experts speculate similar figures may apply today in many developing countries, where treatment is frequently delayed or simply unavailable (Easterlin and Crimmins, 1995). The estimated childlessness rate for married couples in Nigeria is 3.9%, the extent of childlessness for rural and urban couples is similar except for the younger ages.

MATERIALS AND METHODS

In this study, an attempt is made to analyze the socio-economic, physical and psychological conditions of infertile couples in the town of Jos, Nigeria. The couples who want children and are practicing unprotected sex for the last 5 years but not pregnant are considered infertile. The sample comprised 102 infertile couples randomly chosen and spreading over the city. The data

Table 1: Year of infertility of sampled couples

Duration of infertility	Number of couples	Percentage
5-10	35	34.31
11-15	40	39.22
16-20	17	16.67
21-25	6	5.88
26-30	4	3.39

Table 2: Current age-group, age at puberty and age at marriage of childless women

Categories	Numbers	Percentage
Current age-group		
21-30	45	44.12
31-40	45	44.12
41-50	12	11.76
Age-at-puberty		
10-13	3	2.94
14-17	76	74.51
17 and above	23	22.51
Age-at-marriage		
15-20	69	67.65
21-25	30	29.41
26-30	3	2.94

Table 3: Treatment of childlessness

Categories	Number	Percentage
Consultation status		
Consulted	97	95.10
Not consulted	5	4.90
Whom consulted		
Family practitioner	29	29.90
Gynaecologist	40	41.24
Traditional healers	28	28.86
Amount of money spent in Nigerian Naira		
<10, 000 thousands	34	35.05
11-25 thousands	40	41.24
26-50 thousands	16	16.49
50 thousands and above	7	7.22

was collected through a structured questionnaire administered to the women through four women investigators who are post-graduate students in demography in a Nigerian university. The sampled infertile couples according to the number of years of infertility is given in Table 1. This study was conducted during the months of January and February, 2008.

Analysis: The data on current age of childless women reveal that equally 44% of women belong to the Age group 21-30 and also the same percentage in the age group 31-40 years. A majority (74.51%) of women reached the puberty when they are in the age group 14-17. As far as age at marriage is concerned, 69% of women interviewed were married between 15-20 years of age (Table 2).

Ninety seven percent of childless women have consulted health and health related personnel for the treatment of infertility. Out of the total, 70% have consulted qualified health personnel such as a family practitioner or gynaecologist (Table 3), while the remaining 30% have consulted health related unqualified personnel such as native or traditional healers, religious

Table 4: Educational and occupational status of childless women

Categories	Number	Percentage
Educational status		
Illiterate	16	15.69
Elementary	9	8.82
High school	68	66.67
College	9	8.82
Occupational status		
Government service	3	2.94
Private sector service	2	1.96
Self-employed	1	0.98
Agriculture	0	0.00
Household activities	96	94.12

Table 5: Problem of childlessness

Categories	Number	Percentage
Whose fault		
Male spouse	40	41.24
Female spouse	53	54.64
Both/unknown	4	4.12
Problem with female		
P.I.D.	22	41.51
Congenital defect	23	43.40
Idiopathic(unexplained)	6	15.09
Problem with male		
Drug related	15	37.50
Congenital	5	12.50
Idiopathic(unexplained)	20	50.00

leaders and some of them have taken medicine prescribed by the traditional healers. Also, it was found that more than 70% have spent close to 50% of their savings and earnings on treatment.

As far as educational status of childless women is concerned, the data analyzed in Table 4 shows that only 15.69% of infertile women are illiterate and a colossal 94.12% are engaged in household activities.

Also, it is found that both males and females are more or less equally responsible for childlessness. However, women feel that they are more victimized by the in-laws and society in general. Pelvic Inflammatory Disease (PID) and congenital defects are the two major causes of infertility among women. In case of men, although in half of all cases it is idiopathic, 37-50% of infertile male are drug related (Table 5).

World Bank (2006) has remarked that infertility in women can result from reproductive tract infection (particularly, from sexually transmitted disease), unsafe abortions and complications of childbirth often related to poor hygiene. The socio-psychological conditions of childless women in a traditional society like Nigeria are not quiet healthy. They face the unhappiness of husband and in-laws. Some of them complain that the society feels sorry for them. The data analyzed in Table 6 depicts that 23% of the women feel deprived of motherhood and take it as a God's curse while 51.96% are found to be psychologically upset and depressed.

Table 6 reveals that husbands of 10.78% of infertile women have re-married and 29. 41% of women have

Table 6: Socio-psychological problems with childless women

Problems	Number	Percentage
Unhappiness of in-laws	19	18.63
Unhappiness of husband	8	7.8
Psychologically upset	53	51.96
Feeling deprived	22	21.57
Plan of action		
Adopt a child	30	29.41
Husband re- marrying	11	10.78
Leaving the situation as it is	55	53.92
Undecided	6	5.89

adopted at least a child. However, a majority (53.92) are living alone and 6% of them are still undecided of what to do.

CONCLUSION

Infertility is becoming a problem with both males and females in Nigeria. The little or no attention paid towards the heath care of the adults and adolescents and growing menace of drug use among these groups would further escalate this problem. Therefore, family life education for the adults and adolescents is an urgent need. It should be integrated into the school curriculum and be implemented inorder to have a hassle free family life.

Women are spending a lot of money for the treatment of infertility, but ironically, 30% of them are getting the services from unqualified health personnel. Moreover, those who are consulting qualified health personnel are found to be doing well when the problem is more accute.

Most of the infertile women are found to be suffering from mental and psychological pain. The husband, family members and the society need to have a healthy attitude towards them. As most of them do not want to adopt or undecided on what to do, counseling centers need to be established to make them prepare to adopt a child after age 40 or 45 years. Adoption system in the society needs to be simplified and client friendly.

The health care system existing at different levels in Nigeria and more particularly, in rural areas do not provide quality reproductive health care services. Treatment of infertility at the village level is totally lacking. Therefore, the reproductive health care system should give emphasis not only in restricting fertility but also raising fertility mong the infertile couples. The grass root health personnel need to be trained on infertility care and referrals.

Fertility is the essence of motherhood. A woman can be called "mother" when she has a child. Childlessness is a scourge on motherhood as well as on the reproductive health system. Like fertility control, infertility treatment and rehabilitation should be one of the key components of reproductive health care system. Provision of static and mobile infertility care clinic facilities through qualified and trained medical personnel should be made available in rural areas. Moreover, reproductive health care of the adolescents and treatment of sexually transmitted infections in both men and women will go a long way to fight the problem of infertility. As adolescents do not like to disclose their reproductive health problems to the parents, reproductive health camps need to be organized in the schools. Needless to say that most of the infertility cases consult the medical personnel or institutions only when the problem is at its peak and the treatment may then be too costly and cumbersome. Therefore, infertility should be made a basic aspect of family health care and education.

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