

A STUDY OF STIGMA, SELF DEVOLUTION, HOPELESSNESS AND COPING EXPERIENCE AMONG TRIBAL INFERTILE FEMALES OF JHARKHAND, INDIA

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ABSTRACT

Background: The prevalence of infertility worldwide is approximately 1 in 6 and growing as a global menace. Couples who are unable to conceive find it as a personal failure and face mental trauma and social breakdown. Religion and socioeconomic traditions in our country link womanhood to motherhood, which causes stigma in infertile couples especially females.

Aim: This study aimed to observe the socio-demographic factors and stigma scale among infertile tribal women's from Deoghar district of Jharkhand, India.

Methodology: The cross sectional study was conducted at few designated clinics at Deoghar. All the eligible couples seeking infertility treatment consenting to be a part of the study were included. A pre designed Performa was used to fill up the socio demographic profile of screened infertile couples. For observing infertility stigma scale (ISS) in female, FU et al., method was used. The present study used 22 supportive items ranked on a 5 point likert scale. The obtained result was statistically analyzed by Student's t test.

Results: Out of 175 infertile females recruited for the study, 127 gave consent for stigma study. Duration of infertility among the study group ranged between 2 to 7 years. The duration of infertility was 3.51 ± 1.45 years. Most of the females were housewife (81.48%) and 62.96% respondents belonged to joint family. The overall stigma scale was 85.44 ± 6.72 . The average value was 2.61 ± 1.23 . Out of four ISS factors, self devolution score was 2.92 ± 1.1 ; public stigma score, family stigma and social withdrawal score was 2.51 ± 1.26 , 2.05 ± 0.94 score 2.82 ± 1.32 respectively.

Conclusion: Present study showed that infertile females experience a high level of social stigma and self devolution. However, government policies and suitable public health educational, awareness programs can improve patient's cognition and help coping with pessimistic experiences and obtain improved quality of life.

KEYWORDS: Female Infertility, Stigma, Socio-demographic factor, Self devolution

INTRODUCTION (OUTLINE OF THE PROBLEM)

Increasing population and infertility are foremost intricacies for human reproduction in developing as well as developed countries. Particularly, infertility has become an ominous problem, which is not just limited to these countries, but is of worldwide occurrence. Couples are considered infertile if they do not conceive over a 12 months period of unprotected intercourse (WHO, 1999). In every society parenthood is highly accentuated duty of all. Most of the societies around the world are structured in a way in which children are essentially required for care and maintenance of older parents. So for this reason, it is mandate for everyone to have a child (Rustein & Iqbal, 2004). Motherhood has traditionally been considered as a woman's most important or sole purpose of existence. A woman who is unable to procreate a child is treated as an exile and stigmatized in several traditions. Due to the emotional stigma related to parenthood in societies, childless couples experience unconstructive consequences in terms of their status, respect and authority.

Infertile couples have to face social and psychological pressure in the form of exclusion from society and encounter social stigma that leads to segregation and psychosomatic disorders (Slade et al 2007). Both the partners are affected with infertility, although it is females who are mainly habitually blamed for the cause (Hasanpoor Azghady et al., 2109). This creates the infertile females to feel them evicted and admonish to self-confidence. In local cultural and social prospectus women's are prone to be blamed or stigmatized for being childless as compared to the men (FU et al., 2015) and this stigma prevails worldwide, either developed or developing countries (Karaca & Unsal., 2015). Many research found that infertility can be affected by several factors like age, occupation, medical problems, lifestyle factors and idiopathic factors. The present study is aimed to observe the socio-demographic factors and to explore the thoughts and experiences of stigma among selective infertile females of Deoghar district of Jharkhand, India.

MATERIALS AND METHODS OF STUDY:

A one year cross sectional study was conducted from selective infertile females of Deoghar District, Jharkhand, India. Out of 175 infertile females recruited for the study, 127 females gave consent for stigma study. The targeted study population was all married infertile couples reported at clinic for consultation and treatment. The data was collected using

a predesigned Performa via face to face interview; the questionnaire was prepared in both Hindi and English and also explained in their local language. Female interviewers had an one to one meet in a separate and comfortable room with infertile females for recording their response. To assess the perception of infertility stigma in couples, the researchers used interviewing skills to help them to express their experiences of stigma. The basic information regarding socio demographic profile including age, marital status, education, occupation, family type, causes of infertility, duration of infertility were recorded. Infertility stigma was recorded according to FU et al., method. In the present study, infertility stigma scale (ISS) was alienated into 22 item ssub-divided into four factors: public stigma (5 objects), family stigma (5 objects), self-devaluation (7 objects), and social withdrawal (5 objects). The answers towards each objects were noted on a 5-point Likert scale (1point given for strongly disagree, 2 for disagree, 3 for not sure, 4 for agree and 5 for totally agree). All objects were positively phrased. The total stigma score varied between 22 and 110, elevated score showed a higher level of infertility stigma.

Inclusion Criteria:

All the eligible infertile females, who gave consent for the study and were permanent residents of Deoghar District, Jharkhand State, India were included in the study.

ExclusionCriteria:

Eligible couples who are using any contraceptives, couples with active married life less than one year,couples having any serious medical illness and those who did not consent to participate for the study were excluded from the study.

Statistical Analysis:

Social demographic data were analyzed and expressed in percentages, mean and average. The results were analyzed by using Student's t test to assess the significance level of each stigma factor. Significance level (p value<0.05) was considered. Cronbach's α coefficient were calculated to evaluate the internal consistency of the scales within andbetween the four ISS factors (Wessa , 2021).

Ethical Consideration:

Ethical approval was not applicable as it was a non-experimental study.

RESULTS:

The mean age of infertile females was 23.92 ± 4.23 years. Most of the infertile females were in age group 21-25 years, whereas 22.22% females were at the age 30 to 35 yrs. The duration of infertility was 3.51 ± 1.45 years. Most of the females were housewife (81.48%) and 62.96% respondents belonged to joint family and had siblings (55.55%).The educational status of infertile female patients was as follows –11.11% primary, 25.92% having up tosecondary education, 33.33% had higher secondary education, 22.22% females were graduate, and 11.11% females were having master's degree andonly 7.40% were uneducated. Most of the infertile females reported in the study were the case of primary infertility whereas, 7.40% were of secondary infertile cases (*Table I: Sociodemographic characteristics of infertile females and their association with stigma score.

Table 1: Sociodemographic characteristics of infertile females and their association with stigma score

Variables		
Age (in years)	Percentage (%)	Stigma Score
18-21	33.33%	84.22 ± 7.59
22-25	37.07%	86.6 ± 7.51
26-30	7.4%	80 ± 2.82
30 and above	22.22%	87.16 ± 4.30
Educational status		
Primary	11.11%	85.66 ± 7.13
Secondary	25.92%	84.57 ± 8.71
Higher secondary	29.62%	88 ± 4.47
Graduation	14.81 %	82.33 ± 7.36
Masters and above	11.11%	78.33 ± 7.50
uneducated	2 7.40%	86.50 ± 6.36
Family Type		
Joint family	62.96%	87.17 ± 6.93
Nuclear family	37.03%	82 ± 5.52
Duration of Infertility		
2-3 years	59.25%	84 ± 7.07
4-7 years	40.74%	86.8 ± 5.59
Working Status		
Housewife	81.48%	84.95 ± 5.77
working	18.51%	87.6 ± 10.54
Having siblings		
Yes	55.55%	86.73 ± 7.06
NO	22.22%	83.83 ± 6.17

The total stigma scale for infertile female was 85.44 ± 6.72 . However, the 25 percentile, half and 75 percentile of stigma were 82, 86 and 90 respectively. The average score for each ISS item was 2.61 ± 1.23 . Out of four ISS factors, self-devolution score was 2.92 ± 1.19 social withdrawal score, public stigma score and family stigma score were 2.82 ± 1.32 , 2.51 ± 1.26 , 2.05 ± 0.94 , respectively. Social withdrawal is significantly higher in infertile females as compared to public stigma. The skewness was measured to be 0.46. Thus, social withdrawal was remarkably present among the respondents. The Cronbach's α coefficient represents a method for estimation of internal consistency used for Likert-type scales. The cronbach's α coefficient for total scale was calculated to be 0.76. According to internal validity, the scale was good. The duration and age of infertility was positively related to stigma scale. A critical observation is that, the longer the duration of infertility, there was an increase in stigma scores. The stigma score variation with education level is shown in Table 1. It is also observed that the stigma score of females having master's degree was significantly less as compared to those who were uneducated or primarily educated.

DISCUSSION:

The National Family Health Survey (NFHS-5) estimated that the Total Fertility Rate (TFR) has been declined from 2.2 children in 2015-16 to 2.0 children in 2019-21 (NFHS 5). In 1992-93 when the first round of the survey was conducted it was 3.4 children. The total fertility rate also dropped from 3.7 in 1992 -93 to 2.1 children in 2019-21 (NFHS 5). District Level Household and Facility Survey carried out in India during 2007–08 reported that, approximately, 8% of married women suffered from infertility in India and most of them were having secondary infertility (5.8%). Women's infertility rate was lowest in Meghalaya (2.5 %) and highest in West Bengal (13.9 %) (Sanjit and Pallavi, 2016). Nearly 80% of infertile women required treatment /management for infertility, however, a substantial proportion (33%) of females had access to some non-allopathic or traditional treatments, mainly due to lack of awareness or costly treatment which are unaffordable. Women in urban areas have low fertility rates as compared to rural women, there are several factors that may impact a woman's ability to conceive like ovulation problems, physical problems with the uterus, blocked fallopian tubes, uterine fibroids, polycystic ovarian syndrome (PCOD) and many more (Resolve, 2013). Many other life style factors are also involved in contributing to infertility including smoking, excess alcohol consumption, stress, poor diet, high BMI, STD's, and other health issues. Although infertility can affect women at any age, women over age of 35 are at greater risk (Resolve, 2013). According to Bahrami et al, 2007; a woman older than 35 years or more should have prompt evaluation and treatment, if not able to conceive after 6 months of failed attempts, or earlier if clinically indicated. The present study finds that most of the infertile females were in age-group of 20 to 25 years and 22.22% females were in the age-group of 30 to 35 years. The infertile females reported in this study who had a bachelors or masters and higher degree experienced less stigma score (Table 1) as compared to primary educated ones; the report of which is in accordance with the study of Donker et al.2007.

The primary infertility in Indian population, according to WHO studies varies from 3.9 to 16.8 per cent (Unisa, 1999). It is reported that, primary infertility varies from 3.7 % to 5% in Uttar Pradesh, Himachal Pradesh and Maharashtra and Andhra Pradesh (14] and 15 % in Kashmir (Zargar et al., 1997. Moreover, within the same region, it varies among different castes and tribes (Unisa, 1999, Kumar, 2007). The current study showed that most of the infertile females were the case of primary infertility and only 7.40% females were of secondary infertile.

Infertility is a social context and the pressure from society is more on women than on men. For being infertile a women have to face several type of stigma from public, family and above all, it creates self -stigma also. Social stigma referred to a situation in which infertile women or men would face discrimination from others; a different and compassionate look which was torturous to them. A study conducted by Mumtaz, et al., stated that women were more stigmatized as compared to their men and being stigmatized was more painful than being infertile for them (Mumtaz et al., 2007). Infertility stigma can bring heavy mental pressure and psychological burden to female infertility patients and affect their quality of life (Xie et al., 2023). In the present investigation, we tried to understand the stigma feeling of infertile females of Deoghar District and their sensitivity and familiarity about infertility stigma. Study showed that the perception of infertility stigma appears as verbal, communal, self as well same sex stigma. Self-stigma was practiced as distrust and increased depression. In disparity, some women used self-protective way in the form of avoidance from stigma and acceptance infertility disguised. Women's try their best to make stability between the sagacity of empowerment and stress levers. According to the study of Jansen et al., social withdrawal or social distance is one of the methods used by infertile females to manage with all type of disgrace (Jansen and Saint, 2015, Taebi et al., 2021). Our study also confirms that social withdrawal showed significantly higher value whereas, public stigma and family stigma showed significantly lower values. Current observation also gives a view regarding female stigma for infertility and could be a spur for more research allied to infertility and associated stigma factors. Our study has some limitations as no. of participants in the study was less because some women who were infertile but had not been go for medical treatments were not evaluated.

CONCLUSION (SIGNIFICANCE OF THE RESEARCH):

Infertility is a stressful life experience for both the couples. Social and personal factors strongly affect the mental health and fertility outcomes. Social and family support is very imperative to advance the reproductive performances. Hence by perceptive knowledge, suitable health educational programs can be planned to build awareness among the public regarding, treatment modalities available for infertility and to overcome social stigma. This will help to improve mental agony associated with infertility and new dimensions in their reproductive and personal life and also minimize the costly and invasive infertility treatments.

Take home message: Infertile females, particularly those of housewives from joint family experience a high level of social stigma; Socio-demographic Factor plays an important role in these stigmata. Government policies to improve patient's cognition may improve quality of life in these subjects.

Support and Funding: NIL

Conflict of Interest: NIL

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