

OUT-OF-POCKET EXPENDITURE FOR ASSISTED REPRODUCTIVE TECHNOLOGY RELATIVE TO WOMEN'S PERSONAL INCOME: A CROSS-SECTIONAL STUDY OF SALARIED WOMEN IN COIMBATORE, INDIA

Dr.G. Jayanthi¹, M. Kalaivani², Dharanya K³, Mr. M. Arivazhakan⁴, Elakiya A⁵

¹Assistant Professor, Department of Economics, PSG College of Arts & Science, Coimbatore

²Ph.D. Research Scholar, Department of Economics, PSG College of Arts & Science, Coimbatore

³Ph.D. Research Scholar, Department of Economics, PSG College of Arts & Science, Coimbatore

⁴Assistant Professor, Department of Economics, PSG College of Arts & Science, Coimbatore

⁵Ph.D. Research Scholar, Department of Economics, PSG College of Arts & Science, Coimbatore

ABSTRACT

Assisted Reproductive Technology (ART) in India is delivered predominantly through the private sector and is largely excluded from publicly funded insurance, so households meet its cost from their own resources. Indian cost evidence reports expenditure at the couple or household level, which cannot show what treatment costs a woman relative to her own earnings. To quantify ART-related out-of-pocket expenditure (OOPE) among salaried women as a multiple of personal income, and to describe the financing strategies used to meet it. Cross-sectional survey of 47 employed women undergoing infertility treatment in Coimbatore, Tamil Nadu, recruited purposively through fertility clinics. A structured interviewer-administered schedule captured personal monthly income, cumulative treatment expenditure, financing behaviour (asset sale, borrowing, source, amount, repayment), awareness of government schemes and treatment pathway. Income and expenditure were recorded in bands; burden was expressed as the ratio of cumulative expenditure to personal monthly income using band midpoints. In this sample, ART expenditure was large relative to women's personal income and was met substantially through asset sale and borrowing. Near-universal unawareness of existing schemes indicates that a communication gap compounds the coverage gap. Findings describe the sampled group only and are not generalizable.

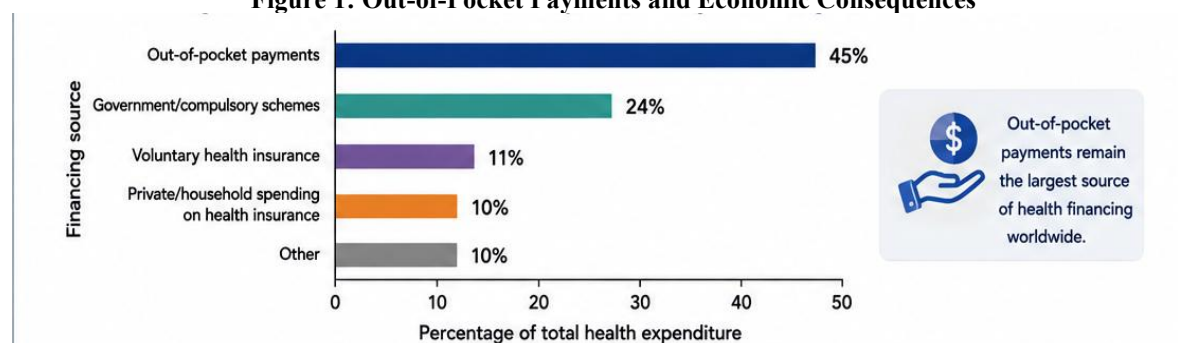
KEYWORDS. Infertility; Assisted reproductive technology; out-of-pocket expenditure; distress financing; gender; India.

1. INTRODUCTION

Infertility affects a substantial minority of couples worldwide and is recognised as a reproductive-health condition with material psychosocial and economic consequences. In India, analyses of national survey data document both the scale of the condition and its behavioral determinants. Access to treatment, however, is shaped less by clinical need than by ability to pay.

India's ART sector has expanded rapidly and is now regulated under the Assisted Reproductive Technology (Regulation) Act, 2021. The Act governs clinic registration, donor conditions and record-keeping; it does not address affordability, and providers have noted its practical consequences for service delivery without a corresponding change in financing. Descriptions of the Indian ART landscape emphasize that provision is concentrated in private facilities and distributed unevenly across states. The financing consequence follows directly: where care is private and insurance does not reach it, expenditure is met out of pocket.

Figure 1: Out-of-Pocket Payments and Economic Consequences



Source: World Health Organization (WHO), Global Health Expenditure Database

That places ART inside a well-characterized Indian problem. Out-of-pocket payments are the dominant mode of health financing in India, they generate catastrophic expenditure and impoverishment across disease groups and households meet them through mechanisms that carry their own costs — borrowing, and the sale of assets. This distress financing is not gender-neutral: studies of Indian hospitalization financing report systematic differences in expenditure and in financing strategy between male and female patients. Internationally, the economics of infertility care in resource-constrained settings has been reviewed systematically. Costs are high relative to income in low- and middle-income countries, and the burden falls on patients rather than on pooled funds. Cross-country policy comparison shows that infertility is frequently omitted from benefit packages even where other reproductive services are covered and cost estimates for treatment leading to a live birth vary widely across health systems. Where insurance mandates have been introduced elsewhere, they change both utilisation and treatment intensity.

Indian evidence specific to fertility care has recently strengthened. A multi-site study across five tertiary facilities estimated annual OOPE for couples seeking infertility services, reporting a median annual OOPE of ₹11,317, higher in private than public facilities, with catastrophic health expenditure — defined there as spending above 40% of annual household non-food expenditure — experienced by 59.4% of couples [24]. That study is facility-based, measures expenditure over a one-year window across diagnostic and non-IVF pathways, and uses the household as the unit of analysis.

The present study addresses a different question, and its contribution should be read as complementary rather than competing. For a salaried woman, the household is not the only relevant denominator. Her own earnings determine her financial autonomy, her exposure to asset depletion — particularly of jewellery, which in this setting is frequently her own property and her principal independent store of wealth — and her position in household decisions about whether treatment continues. No Indian study, to our knowledge, reports ART expenditure against women's personal income. Hence, the study quantified cumulative treatment expenditure as a multiple of personal monthly income among employed women in one South Indian city, and described how that expenditure was financed.

REVIEW OF LITERATURE

Widge (2005) examined the experiences of involuntarily childless Indian women and couples seeking in-vitro fertilization (IVF). The study involved 22 women/couples from clinics in New Delhi and Mumbai. The findings showed that infertility was associated with social stigma, isolation and considerable emotional and financial stress. IVF was generally pursued after other treatment options had failed, and women experienced pressure to undergo expensive assisted reproductive procedures. The study highlighted that the financial burden of ART is closely connected with the social expectations surrounding motherhood in India.

Wiersema et al. (2006) studied 118 infertile couples in southern Vietnam using questionnaires and interviews to examine the psychological, sociocultural and economic consequences of infertility. The study demonstrated that infertility affects several dimensions of couples' lives and that treatment-related difficulties can create substantial economic and social pressures.

Dyer and Patel (2012) conducted a systematic review of the economic impact of infertility on women in developing countries. The review found that infertility treatment costs were frequently borne directly by patients because of limited public financing and inadequate insurance coverage. The authors observed that infertility can produce significant economic hardship, including catastrophic expenditure and depletion of household resources.

Ezzatabadi et al. (2016) investigated infertility treatment costs and out-of-pocket payments among 216 couples receiving IVF-related care in Yazd, Iran. The study used patient interviews and medical records to estimate treatment expenditure. The evidence from this study, together with subsequent reviews, indicates that laboratory services, procedures, equipment and medicines constitute important components of ART expenditure.

Sangamithra (2018) examined the cost incurred and sources of finance for infertility treatment in India. The study included 489 infertility patients and analysed the principal determinants of treatment costs using quantitative methods. The study is particularly relevant to the present research because it was conducted in India and focused directly on infertility treatment expenditure and its financing. A later systematic review identified this study as reporting particularly high ART costs in the private sector in India.

Darvishi et al. (2020) conducted a cost-benefit analysis of intrauterine insemination (IUI) and IVF in Iran. The researchers analysed treatment costs and willingness to pay using data from Kerman and Isfahan. They found that demand for IUI and IVF was sensitive to price and that economic variables strongly influenced people's willingness to pay for treatment. The study concluded that financial constraints played an important role in community preferences for advanced infertility treatments.

Njagi et al. (2023) conducted a systematic review of the financial costs of ART in low- and middle-income countries. The review found that direct medical costs of ART were often higher than average annual income, indicating serious affordability problems. In India, the cost of one ART cycle was estimated at approximately 166.4% of average annual income in the studies included in the review. The authors concluded that ART can create a substantial risk of catastrophic expenditure, particularly where financing mechanisms and insurance coverage are limited.

Amodini and Chaudhuri (2023) reviewed infertility management in India and identified high treatment costs, limited availability of ART centres, inadequate insurance coverage and social stigma as major barriers to infertility care. The authors argued that the financial burden of infertility treatment restricts access to ART for many Indian couples. They recommended stronger regulation, improved integration of infertility services and better accessibility of treatment.

OBJECTIVES OF THE STUDY

1. To study the socio-economic condition of working women undergone infertility treatment
2. To examine the factors influencing the cost and accessibility of Infertility treatment among working women.
3. To identify the economic and social burden of infertility treatment among working women.

STATEMENT OF THE PROBLEM

Infertility is often personal trauma in India, because of its social, cultural, and religious connotation. Moreover, Infertility is one of the many important health problems that people face in these countries and it is well possible than more health is gained at lower cost by attacking other health problems than infertility. Even in developed countries, low-income couples have great difficulties of access due to the high cost charged by private clinics and the lack of services offered by the public sector. Infertility treatment is costly because of the need for highly trained personnel and expensive equipment, which is often the case with the new health technology. Unfortunately, the cost of infertility treatment is more than some infertile couples are able to pay and this tends to limit access to the treatment and it will also rise mental and physical issue of infertile couple. Hence, the study focuses on Out-Of-Pocket Expenditure for Assisted Reproductive Technology relative to Women's Personal Income with emphasis on Salaried Women in Coimbatore, India.

RESEARCH METHODOLOGY

A scientific approach to research methodology is essential to evaluate the research problem systematically. Extensive primary data on the various dynamics of infertility working women collected through a suitably framed questionnaire. In addition to the responses obtained from the questionnaire, informal discussions conducted to gain deeper insights into issues related to the behaviour of infertile women in the selected clinics. Secondary data also be collected from previous studies, articles and various organizations like National Survey of Family growth, National Centre for Biotechnology Information etc.

DATA COLLECTION:

Methods of data collection

In order to investigate the research objectives, study utilizing an exploratory cum descriptive type of research design. Based on an intensive review of literature on infertility and reproductive health problems, infertility prevalence among studies in Coimbatore district women assumed to be approximately 8.43%. Based on the sample size formula at 95% confidence level, the required sample size was calculated. Considering the large population (145,733) and feasibility constraints, the sample size was minimized using appropriate precision levels and finite population correction, resulting in a final sample size of 130 respondents. The respondents undergoing infertility treatment in selected fertility clinics in Coimbatore collected using proportionate stratified random sampling. The selected fertility clinics in Coimbatore are treated as strata, and a total of 130 respondents proportionately allocated across 13 clinics, with 10 respondents selected from each clinic using random sampling methods.

Statistical analysis

Categorical variables are summarised as counts and percentages of the analysed sample ($n = 47$) with 95% Jeffreys intervals, which behave appropriately for proportions near the bounds at small n . Burden ratios are presented as a matrix over income $\times$ expenditure bands rather than as a single summary statistic, because the joint distribution of the two variables is not available.

ANALYSIS AND INTERPRETATION

TABLE: 1 SOCIO-DEMOGRAPHIC AND MARITAL CHARACTERISTICS OF RESPONDENTS

Variable	Category	n	%	95% CI
Age	25-30	17	36.2	23.6–50.4
Age	30-35	14	29.8	18.2–43.8
Age	35-40	9	19.1	9.9–32.0
Age	40-45	7	14.9	6.9–27.0
Religion	Christian	11	23.4	13.1–36.8
Religion	Hindu	36	76.6	63.2–86.9
Education	Below SSLC	2	4.3	0.9–13.0

Education	SSLC	1	2.1	0.2–9.5
Education	Higher secondary	3	6.4	1.8–16.1
Education	Degree	20	42.6	29.2–56.8
Education	PG and above	21	44.7	31.1–58.9
Occupation	Teaching	20	42.6	29.2–56.8
Occupation	Banking	8	17	8.4–29.6
Occupation	IT	10	21.3	11.5–34.5
Occupation	Medical	2	4.3	0.9–13.0
Occupation	Others	7	14.9	6.9–27.0
Income	20-30k	24	51.1	37.1–64.9
Income	31-40k	10	21.3	11.5–34.5
Income	41-50k	5	10.6	4.2–21.8
Income	Above 50k	8	17	8.4–29.6
Age of marriage	21-25	21	44.7	31.1–58.9
Age of marriage	26-30	18	38.3	25.4–52.6
Age of marriage	31-35	8	17	8.4–29.6
Type of marriage	Arranged	30	63.8	49.6–76.4
Type of marriage	Choice	17	36.2	23.6–50.4
Type of family	Nuclear	38	80.9	68.0–90.1
Type of family	Joint	9	19.1	9.9–32.0
Size of family	2 members	41	87.2	75.6–94.5
Size of family	2-4 members	6	12.8	5.5–24.4
Members	Husband	39	83	70.4–91.6
Members	Husband+MIL	5	10.6	4.2–21.8
Members	Husband+MIL+FIL	3	6.4	1.8–16.1

Source: Primary Data

Socio-Demographic and Marital Characteristics of Respondents (n = 47). Counts, percentages of n = 47, and 95% Jeffreys confidence intervals. Rows: age band; religion; educational attainment; occupation sector; personal monthly income band; age at marriage; type of marriage; type of family; household size; household composition. Table 1 presents the sociodemographic profile. Respondents were concentrated in the younger age bands (25–30 years: 17/47, 36.2%, 95% CI 23.6–50.4; 30–35 years: 14/47, 29.8%, 18.2–43.8). Educational attainment was high: 41/47 (87.2%) held a degree or postgraduate qualification. Occupations were predominantly teaching (20/47, 42.6%), information technology (10/47, 21.3%) and banking (8/47, 17.0%). Half the sample earned ₹20,000–30,000 per month (24/47, 51.1%, 37.1–64.9).

Marriages were predominantly arranged (30/47, 63.8%, 49.6–76.4) and households predominantly nuclear (38/47, 80.9%, 68.0–90.1), with 41/47 (87.2%) living in two-member households.

TABLE: 2 TREATMENT PATHWAY

Variable	Category	n	%	95% CI
Acknowledgement	Below 3 years	28	59.6	45.3–72.7
Acknowledgement	3-6 years	19	40.4	27.3–54.7
Reason	Husband	8	17	8.4–29.6
Reason	Wife	11	23.4	13.1–36.8
Reason	Both	28	59.6	45.3–72.7
Abortion	Yes	9	19.1	9.9–32.0
Abortion	No	38	80.9	68.0–90.1
Family history	Yes	3	6.4	1.8–16.1
Family history	No	44	93.6	83.9–98.2
First priority	Private clinic	41	87.2	75.6–94.5
First priority	Government hospital	2	4.3	0.9–13.0
First priority	Faith/spiritual healer	4	8.5	2.9–19.0
Doctors consulted	1	19	40.4	27.3–54.7
Doctors consulted	2	11	23.4	13.1–36.8
Doctors consulted	More than 2	17	36.2	23.6–50.4
Doctor switching	Below 6 months	1	2.1	0.2–9.5
Doctor switching	6 months-1 year	13	27.7	16.5–41.5
Doctor switching	1-2 years	22	46.8	33.1–60.9

Doctor switching	More than 2 years	11	23.4	13.1–36.8
Ineffective treatment	Yes	13	27.7	16.5–41.5
Ineffective treatment	No	34	72.3	58.5–83.5
Treatment type	ICSI	5	10.6	4.2–21.8
Treatment type	IVF	37	78.7	65.5–88.5
Treatment type	Third-party ART	1	2.1	0.2–9.5
Treatment type	Frozen embryo transfer	4	8.5	2.9–19.0
Regularity	Always	21	44.7	31.1–58.9
Regularity	Most of the time	17	36.2	23.6–50.4
Regularity	Sometimes	9	19.1	9.9–32.0
ART knowledge	Yes	22	46.8	33.1–60.9
ART knowledge	No	25	53.2	39.1–66.9

Source: Primary Data

Infertility history and treatment pathway (n = 47). Rows: interval before acknowledging a problem; attributed reason (husband / wife / both); previous abortion; family history of infertility; first provider approached; number of clinicians consulted; interval before switching clinician; experience of ineffective treatment; treatment modality; regularity of treatment; prior knowledge of ART. Counts, percentages and 95% CIs.

Table 2 presents the care pathway. A private clinic was the first provider approached by 41/47 respondents (87.2%, 75.6–94.5); 4/47 (8.5%, 2.9–19.0) first consulted a faith or spiritual healer, and 2/47 (4.3%, 0.9–13.0) a government hospital. Care was frequently discontinuous: 17/47 (36.2%, 23.6–50.4) had consulted more than two clinicians, and 33/47 (70.2%) reported switching clinician after one year or more of treatment.

IVF was the predominant modality (37/47, 78.7%, 65.5–88.5), followed by intracytoplasmic sperm injection (5/47, 10.6%), frozen embryo transfer (4/47, 8.5%) and third-party ART (1/47, 2.1%). Prior to seeking care, 25/47 (53.2%, 39.1–66.9) had no knowledge of ART.

TABLE 3. EXPENDITURE, FINANCING AND SCHEME AWARENESS

Variable	Category	n	%	95% CI
Avg expenditure	50k-1L	13	27.7	16.5–41.5
Avg expenditure	1L-1.5L	12	25.5	14.8–39.2
Avg expenditure	1.6L-2L	11	23.4	13.1–36.8
Avg expenditure	Above 2L	11	23.4	13.1–36.8
Who funded	Self	7	14.9	6.9–27.0
Who funded	Husband	13	27.7	16.5–41.5
Who funded	Parents	4	8.5	2.9–19.0
Who funded	Others	1	2.1	0.2–9.5
Who funded	Self+husband	16	34	21.8–48.2
Who funded	Husband+parents	5	10.6	4.2–21.8
Who funded	Self+husband+parents	1	2.1	0.2–9.5
Sold jewellery	Yes	16	34	21.8–48.2
Sold jewellery	No	31	66	51.8–78.2
Borrowed	Yes	22	46.8	33.1–60.9
Borrowed	No	25	53.2	39.1–66.9
Source of assistance	Maternal family	3	6.4	1.8–16.1
Source of assistance	Friends	9	19.1	9.9–32.0
Source of assistance	Bank	2	4.3	0.9–13.0
Source of assistance	Relatives	5	10.6	4.2–21.8
Source of assistance	Maternal family+friends	3	6.4	1.8–16.1
Source of assistance	Nobody	25	53.2	39.1–66.9
Amount borrowed	50k-1L	7	14.9	6.9–27.0
Amount borrowed	1L-1.5L	6	12.8	5.5–24.4

Amount borrowed	1.6L-2L	3	6.4	1.8–16.1
Amount borrowed	Above 2L	3	6.4	1.8–16.1
Amount borrowed	None borrowed	28	59.6	45.3–72.7
Scheme awareness	Yes	12	25.5	14.8–39.2
Scheme awareness	No	35	74.5	60.8–85.2

Source: Primary Data

Expenditure, financing and scheme awareness (n = 47). Rows: cumulative expenditure band; funding source; asset sale; borrowing; source of borrowing; amount borrowed; repayment status; awareness of any government scheme. Counts, percentages and 95% CIs.

Table 3 presents expenditure, financing and coverage. Cumulative treatment expenditure was distributed across the four bands with 13/47 (27.7%) at ₹50,000–1,00,000, 12/47 (25.5%) at ₹1,00,000–1,50,000, 11/47 (23.4%) at ₹1,60,000–2,00,000 and 11/47 (23.4%) above ₹2,00,000 — so 22/47 (46.8%, 33.1–60.9) reported spending above ₹1.6 lakh.

Figure expresses these amounts as multiples of personal monthly income. For the modal respondent — earning ₹20,000–30,000, half the sample — expenditure in the ₹1.6–2 lakh band equals 7.2 months of her entire personal earnings, and expenditure above ₹2 lakh 9.0 months. Even in the lowest expenditure band, the same respondent's outlay corresponds to 3.0 months of personal income. Because open bands were assigned conservative midpoints, these are lower bounds.

TABLE 4. BURDEN RATIO MATRIX

Personal monthly income	50k-1L (n=13)	1L-1.5L (n=12)	1.6L-2L (n=11)	>2L (n=11)
20-30k (n=24)	3	5	7.2	9
31-40k (n=10)	2.1	3.5	5.1	6.3
41-50k (n=5)	1.6	2.7	4	4.9
>50k (n=8)	1.4	2.3	3.3	4.1

Source: Primary Data

Burden ratio matrix. Cumulative expenditure expressed as multiples of personal monthly income, at band midpoints, for each combination of income band (rows) and expenditure band (columns). Cell entries are months of personal income. Marginal counts for each band are given in the row and column headers. Note: cells report the ratio implied by the band midpoints, not observed counts of respondents in each combination, which are unavailable.

Financing did not run through insurance or public support. Sixteen of 47 respondents (34.0%, 21.8–48.2) sold jewellery or other assets, and 22/47 (46.8%, 33.1–60.9) borrowed. Of those who borrowed, the sources were predominantly informal — friends (9/47, 19.1%), relatives (5/47, 10.6%) and the maternal family (3/47, 6.4%, with a further 3/47 combining maternal family and friends) — against 2/47 (4.3%, 0.9–13.0) who borrowed from a bank. Twenty-five of 47 (53.2%, 39.1–66.9) received no financial assistance from any source. Amounts borrowed reached ₹1.5 lakh or more for 6/47 respondents (12.8%). At the time of interview 17/47 (36.2%) had repaid and 2/47 (4.3%) had not, the remainder not having borrowed.

Funding responsibility was shared or spousal in most cases: husband alone 13/47 (27.7%), self and husband jointly 16/47 (34.0%), self alone 7/47 (14.9%), with parental contribution in a further 10/47 (21.3%) across combinations. Figure 1b presents the financing pattern.

Coverage and awareness

Thirty-five of 47 respondents (74.5%, 60.8–85.2) were unaware of any government scheme relating to infertility treatment. [AUTHOR ACTION: the source table for this item prints percentages summing to 102% (26% and 76%); the corrected values from the frequencies are 25.5% and 74.5%. Verify the frequencies 12 and 35 against the response sheets.]

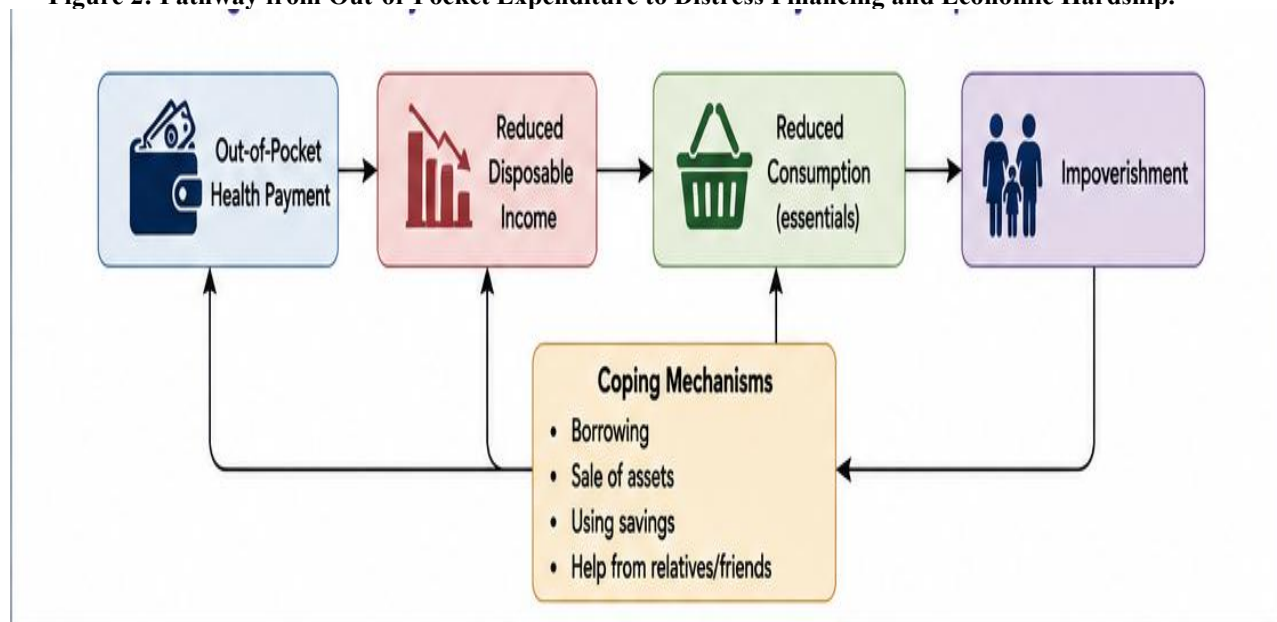
4. DISCUSSION

Among 47 salaried women receiving infertility treatment in Coimbatore, cumulative treatment expenditure was large when measured against the women's own earnings — on the order of 7.2 months of personal income for the modal respondent at the ₹1.6–2 lakh expenditure band — and was met principally through asset sale and informal borrowing rather than through insurance or public provision. Three quarters of respondents did not know of any government scheme relating to infertility, and nearly nine in ten had entered care through a private clinic.

These findings sit alongside, and should be read against, the recent multi-site Indian estimate of annual OOEPE for infertility services. The two studies measure different quantities and the difference matters for interpretation: that study reports expenditure over a single year across diagnostic, management and intrauterine insemination pathways at tertiary facilities, whereas the present sample is 79% IVF and reports cumulative spending across a treatment history. Neither figure contradicts the other, and the higher amounts here are consistent with an IVF-weighted, cumulative measure. What the present study adds is the denominator: expressing the same class of expenditure against a woman's personal income rather than against household consumption.

The financing pattern places infertility care within the Indian distress-financing literature rather than outside it. Borrowing and asset sale are the mechanisms documented for hospitalisation, delivery and maternity care in India, and they appear here at comparable prominence. The gendered dimension deserves emphasis. Evidence on Indian hospitalisation financing shows that expenditure and financing strategy differ by patient sex [15,16]. In this sample the asset most commonly liquidated was jewellery, which in the South Indian context is typically held by the woman and functions as her independent reserve. Its sale is therefore not a neutral financing choice but a transfer of the woman's own capital into treatment, with consequences for her economic position that a household-level accounting does not record.

Figure 2: Pathway from Out-of-Pocket Expenditure to Distress Financing and Economic Hardship.



Source: Leive & Xu, 2008

The coverage findings identify two distinct policy failures. The first is the exclusion of infertility from pooled financing, which is common across low- and middle-income settings and documented in comparative policy analysis. The second is informational: whatever provision exists was unknown to three quarters of this sample. The second failure is considerably cheaper to remedy than the first, and remedying it is a precondition for the first to have any effect. That 87% of respondents began in the private sector, and that half had not heard of ART before seeking care, suggests entry into the treatment pathway is mediated by private provision rather than by public information.

4.1 Implications for research and policy

For research, the priority is measurement: exact expenditure amounts with cycle counts, a household consumption denominator alongside the personal-income one, and insurance status, which together would permit both Catastrophic Health Expenditure estimation on the standard definition and a comparison of personal against household burden. For policy, the pairing of near-total private entry with near-total unawareness of public provision suggested that information about entitlements, delivered at the point where women first seek care, is a low-cost intervention that does not wait on the larger question of whether ART enters the benefit package.

4.2 Limitations of the Study

These are substantial and constrain the claims that can be made.

The sample is 47 women recruited purposively in a single city; it is not representative of any wider population, and no inference beyond the sampled group is offered. At this size a proportion near 50% carries a 95% interval spanning roughly ± 14 percentage points, which is why every estimate above is reported with its interval.

Recruitment through fertility clinics reaches only women who accessed and could sustain treatment. Those deterred by cost, or who discontinued, are absent by construction. This selection biases the burden estimate downward, and the direction of that bias should be borne in mind.

Income and expenditure were recorded in bands, so all burden ratios are midpoint approximations rather than measured quantities. Expenditure was self-reported without verification against receipts, and the number of treatment cycles was not recorded — so expenditure cannot be normalized per cycle, and a woman reporting a high amount after four cycles is not distinguished from one reporting the same amount after one. Household income and insurance status were not captured, precluding both a household-level burden measure and any analysis of the role of insurance. Indirect costs — lost earnings, travel, accompanying persons' time — were not monetized.

The design is cross-sectional, so no sequence or causal direction can be established between expenditure, financing behaviour and any outcome.

5. CONCLUSION

In this purposively sampled group of 47 salaried women in Coimbatore, the cost of infertility treatment was large relative to their own incomes and was met largely by liquidating personal assets and borrowing informally, with most respondents unaware of any public scheme. Measuring the burden against women's personal earnings, rather than household aggregates, makes visible a cost that falls specifically on them.

The study on “Out-of-Pocket Expenditure for Assisted Reproductive Technology Relative to Women’s Personal Income: A Cross-Sectional Study of Salaried Women in Coimbatore, India” highlighted the significant financial burden associated with infertility treatment. ART procedures such as IVF and ICSI involve substantial expenses for consultation, investigations, medicines, laboratory procedures and repeated treatment cycles. For salaried women, these expenses can consume a considerable proportion of their personal income and may affect their savings, household financial security and ability to continue treatment.

The study emphasized that ART affordability should not be assessed only by the total treatment cost but also in relation to women's individual earning capacity. Understanding this relationship is important for identifying the extent of financial burden faced by salaried women. The findings can provide useful evidence for improving insurance coverage, financial assistance programmes and affordable ART services. Overall, the study contributes to understanding the economic dimension of infertility treatment among salaried women in Coimbatore and highlighted the need for more accessible and financially sustainable ART services.

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