

## HEALTH SEEKING BEHAVIOUR OF INFERTILE WOMEN IN GOMBE, NORTH EASTERN NIGERIA

<sup>1</sup>Bukar M<sup>1</sup> Audu BM, <sup>2</sup>Usman HA<sup>3</sup> Massa AA

<sup>1</sup>Departments of Obstetrics and Gynaecology, University of Maiduguri Teaching Hospital, Maiduguri, Nigeria. <sup>2</sup>Federal Medical Centre Gombe

### ABSTRACT

**Context:** Health seeking behaviour of infertile women is an area that has received scant attention in our environment.

**Objective:** To document the health seeking behaviour of infertile women in Gombe, Northeastern Nigeria.

**Study Design, Setting and Subjects:** This is a cross sectional study of infertile women seen at the gynaecological clinic of the Federal Medical Centre Gombe from January 2005 to December 2005. A total of 119 infertile women were interviewed.

**Results:** They were aged 22-40 with a mean of  $27.81 \pm 4.727$  years. The majority, 85 (71.4%) were in their second and third decades. Only 37 (31.1%) had living children. Most, 69 (58%) had post-secondary education with 32 (26.9%) being non literate. The parity ranged from 0-2 with a mean of  $0.50 \pm 0.535$ . Majority, 68 (57.1%) were Muslims while Christians made up 51 (42.9%). Almost 40% sought for care more than three years after being unable to conceive with only 27 (22.7%) being cared for by specialists. Sixty five (55%) had previously visited an orthodox health institution, while 60 (50.4%) used traditional medication. Most of the traditional healers visited were herbalists (18.5%) native doctors (16.8%) and marabout's (10.1%). Most of those childless were Muslims ( $X^2=23.615$ ,  $P=0.000$ ). The Muslims also tended to seek help later than their Christian counterparts ( $X^2=49.132$ ,  $P=0.000$ ). Health seeking behaviour is significantly influenced by education ( $X^2=2.747$ ,  $P=0.000$ ). Parity significantly influenced health seeking behaviour with the parous more likely to delay seeking help ( $X^2=71.457$ ,  $P=0.000$ ).

**Conclusion:** Delay in seeking care and patronage of traditional healers and non specialist tend to procrastinate arrival to appropriate health facility.

**Key words:** health seeking behaviour, infertility, women, Gombe

### INTRODUCTION

In some societies, fertility defines womanhood and infertility is stigmatized and socially unacceptable<sup>1,2</sup>. To be childless is a distressing experience in many parts of Africa<sup>3</sup>. These form of social pressure pushes infertile women to go to unimaginable extent to find cures to their problem<sup>4</sup>. Health seeking behaviour of infertile women is influenced by illiteracy and socioeconomic status<sup>5</sup>. Infertile women seek help from all sorts of care givers ranging from homeopaths to traditional birth attendants<sup>5</sup>. Reasons for procreation among infertile women varies from someone to carry on the family name, getting up as a parent on judgement day to preference for male children<sup>6</sup>.

Despite the fact that infertility is a common problem in Africa, the majority of infertile women have little knowledge about human

reproduction and modern treatment options<sup>7</sup>. Men's involvement in the health seeking process in some parts of Africa is reassuring<sup>8</sup> as this could lessen the psychological burden on the woman. The social pressure associated with infertility is evident in the number of health care provider shopping by the infertile woman. The psychological import of failure at provider shopping will lead to worsening of the emotional stress and sexual dysfunction<sup>9</sup>. This roller costa behaviour is unhelpful to the infertile

---

**Correspondence:** Dr Mohammed Bukar  
Department of Obstetrics and Gynaecology  
University of Maiduguri Teaching Hospital,  
PMB  
1414, Maiduguri, Borno State, Nigeria.  
E-mail: mbbukar07@yahoo.com

couple. The aim of this study therefore is to document the health seeking behaviour of infertile women in a tertiary institution in Sub-saharan Africa and recommend ways of re-setting the psyche of the infertile women as regards health seeking behaviour.

## **SUBJECTS AND METHODS**

This was a cross sectional, questionnaire based study of 119 infertile women, aged 22-40 years seen during their first visit to the gynaecological clinic of the Federal Medical Centre Gombe from January 2005 to December 2005. All patients were seen at one stage or the other by the authors and questionnaires filled after verbal consent was obtained. They were asked among others about infertility, seeking of infertility treatment, place where treatments were sought for and reasons for stopping treatment. Patients who declined were excluded from the study. The research and ethics committee of the hospital approved the study. The information obtained were analyzed using SPSS version 16 (SPSS, Inc, Chicago, IL). Chi-square test was used to determine significance and a P-value <0.005 was considered significant.

## **RESULTS**

One hundred and nineteen patients complaining of inability to conceive for at least one year had questionnaires administered at their first clinic visit.

Some of the socio-demographic characteristics are shown on Table I. They were aged 22-40 with a mean of  $27.81 \pm 4.727$  years. The majority were in their second and third decade 85 (71.4%) with those aged 20-29 years constituting 43.7% of patients. Only 37 (31.1%) had living children. Most, 69 (58%) had post-secondary education with 32 (26.9%) being non literate. The parity ranged from 0-2 with a mean of  $0.50 \pm 0.535$ . Thirteen (10.9%) had previous induced abortion. Majority, 68 (57.1%), were Muslims while Christians made up 51 (42.9%).

The health seeking behaviour of infertile

women is detailed on Table II. Almost 40% sought for care more than three years after encountering the problem with only 27 (22.7%) being cared for by specialists. It was the first visit to seek for care in 46 (38.7%), of those interviewed. Sixty five (55%) had visited orthodox health institutions before and 60 (50.4%) had previously used traditional medication. Most of the traditional healers visited were herbalists (18.5%) native doctors (6.8%) and marabouts (10.1%). Majority, 43 (36.1%) stopped traditional medication because they could not achieve pregnancy while 16 (13.4%) were still using traditional medication at the time of their first clinic visit.

Table III depicts the relationship between religion and parity on health seeking behaviour of infertile women. Most of those childless were Muslims ( $X^2=23.615$ ,  $P=0.000$ ). The Muslims also tended to seek help later than their Christian counterparts ( $X^2=49.132$ ,  $P=0.000$ ). There was however no significant relationship between religion and previous traditional medication ( $X^2=5.024$ ,  $P=0.170$ ). Health seeking behaviour is significantly influenced by education ( $X^2=2.747$ ,  $P=0.000$ ). Those with lower educational status tended to patronise traditional healer's compared with their more educated peers ( $X^2=1.411$ ,  $P=0.000$ ). Parity significantly influenced health seeking behaviour with the parous women more likely to delay seeking help ( $X^2=71.457$ ,  $P=0.000$ ). There was no significant relationship between parity and number of institutions visited ( $X^2=15.627$ ,  $P=0.048$ ). Religion had no significant influence on type of traditional healers visited ( $X^2=5.024$ ,  $P=0.170$ ).

## **DISCUSSION**

Delay in seeking care among infertile women has been documented earlier by the same authors<sup>10</sup> and now re-echoed in the present study. The delay in seeking appropriate care could lead to worsening of the condition with poor outcome. Tubal factor infertility is the commonest in this environment and amenable only to surgery

which has a poor outcome<sup>11</sup> or in-vitro-fertilization and embryo transfer (IVF-ET) which is beyond the reach of the majority. This delay therefore portends a grim picture on outcome of infertility treatment in our environment. In contrast, a study from Pakistan reported that women tend to seek care for infertility early<sup>6</sup>. Consultation of appropriate health care provider was lacking as only 22.7% of infertile women consulted a specialist. This may be due to paucity of specialist gynaecologic care before 1999 when a tertiary institution was established in Gombe. Even after the establishment of specialist gynaecologic services, many cannot afford the cost and the number of gynaecologist on ground is inadequate to cater for the ever growing population of infertile women.

The preponderance of women with some formal education 87 (73.1%), with 69(58%) having had at least secondary education compares favourably with our previous study of 90% with some formal education with 41% having had post-secondary education<sup>10</sup>. Majority, 82 (68.9%) had never delivered before, while 37 (31.1%) had only delivered once. In agreement with Schmidt et al 1995<sup>12</sup>, majority of our women had no living children. In a society that places so many premiums on children like ours, the health seeking behaviour of infertile women is easily predictable. Although female infertility is socially unacceptable in our environment and threatens the security of women<sup>2,10</sup> the couple tend to pull through the difficulties together as only 2(1.7%) of our study population were divorced because of their inability to produce "the fruit of the womb"

Consultation of multiple health care providers as found in this study compares favourably with studies from Karachi<sup>5,6</sup>. Like the Karachi study, we also found that educational status has a significant relationship with health seeking behaviour with the educated more likely to seek care earlier than their non literate counterparts. Health education among the less literate could positively change their health seeking behaviour.

Our study found that those with living children, probably because of the security of having a living child tend to delay seeking for help compared with those without a living child. This finding is in consonance with that of Farley et al 2007<sup>13</sup>. A study from the United States revealed that all the infertile women studied sought for care from formal health institutions<sup>14</sup>. This sharply contrasts with our findings in which the infertile women sought for care from various sources ranging from marabouts, herbalists to native doctors all in an attempt to get pregnant. The patronage of unorthodox practitioners could be explained by the lack of/ low educational attainment of the respondents and some cultural practices that encourages consultation with herbalist and native doctors for infertility purportedly caused by witch craft and other fetish ways. Although most of the traditional healers visited are closely related to the Islamic faith, there was no significant relationship between religion and type of traditional healers visited. Similar socio-cultural peculiarities within the same environment might have overshadowed religious inclinations in the health seeking behaviour of infertile women in our study. Religious barriers are often broken when it comes to issues as sensitive and as depressive as female infertility.

In conclusion, delay in seeking care and multiple consultations are the trademarks of infertile women in Gombe, Nigeria. Education of these women on the need for early consultation of specialist care could reduce the roller coaster approach to health seeking behaviour of infertile women in Nigeria.

**Table I: Some socio-demographic characteristics of infertile women studied (n=119)**

Characteristic	Number	Percentage
<b>Age (years)</b>		
20-24	33	27.7
25-29	52	43.7
30-34	18	15.1
≥35	16	13.5
<b>Educational status</b>		
Non literate	32	26.9
Primary	6	5.0
Incomplete secondary	12	10.1
Secondary	32	26.9
Certificate/Diploma	33	27.9
Graduate	4	3.4
<b>Parity</b>		
0	62	52.1
1	55	46.2
2	2	1.7
<b>Living children</b>		
0	82	68.9
1	37	31.1
<b>Previous induced abortions</b>		
0	106	89.1
1	5	4.2
2	8	6.7

Table II: Health seeking behaviour of infertile women (n=119)

Variable	Number	Percentage
<b>1. Duration of infertility before seeking assistance (years)</b>		
1	43	36.1
2	29	24.4
3	26	21.8
4	2	1.7
≥5	19	16.0
<b>2. Previous medical assistance</b>		
None	46	38.7
After traditional medication	30	25.2
Before traditional medication	10	8.4
Medical only	33	27.7

<b>3. Type of previous medical assistance</b>		
None	54	45.4
Private practitioner	34	28.6
General practitioner	4	3.4
Specialist	27	22.7

<b>4. Previous traditional medication</b>		
None	59	49.6
After starting medical	8	6.7
Before starting medical	48	40.3
Traditional only	4	3.4

<b>5. Number of hospitals visited</b>		
0	28	23.5
1-2	63	52.9
3-4	28	23.5

<b>6. Number of traditional healers visited</b>		
0	63	53.0
1-2	36	30.2
3-4	20	16.8

<b>7. Types of traditional healers visited</b>		
Church	2	1.7
Marabout	12	10.1
Native doctor	20	16.8
Herbalist	22	18.5
None	63	52.9

**8. Reasons for stopping traditional medication**

Still on	16	13.4
No reason	20	16.8

Table III: Relationship between religion and parity on health seeking behaviour

Variable	Number			Total
<b>Religion</b>	<b>NO of living children</b>			<b>Total</b>
	<b>0</b>	<b>1</b>		
Christian	23	28		51
Muslim	59	9		68
<b>Total</b>	<b>82</b>	<b>37</b>		<b>119</b>
	<b>X<sup>2</sup>=23.615, P=0.000</b>			
<b>Parity</b>	<b>NO. of institutions visited</b>			<b>Total</b>
	<b>0</b>	<b>1-2</b>	<b>3-4</b>	
0	16	32	14	62
1	12	31	12	55
2	0	0	2	2
<b>Total</b>	<b>28</b>	<b>63</b>	<b>28</b>	<b>119</b>
	<b>X<sup>2</sup>=15.627, P=0.048</b>			

## REFERENCES

1. Inhorn M C. Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. *Soc Sci Med* 2003; 56 (9): 1837-51
2. Widge A. Seeking conception: experience of urban Indian women with in vitro fertilisation. *Patient Educ Couns*. 2005; 59(3): 226-33
3. Dyer SJ, Abraham N, Mokoena NE, Lombard CJ, Van der Spuy ZM. Psychological distress among women suffering from couple infertility in South Africa: a quantitative assessment. *Hum Reprod* 2005; 20(7): 1938-43
4. Anate M, Akeredolu O. Surgical management of female infertility: The Ilorin experience. *Nigeria Medical Practitioner*. 1996;32:39-42
5. Sami N, Ali TS. Health seeking behaviour of couples with secondary infertility. *J Coll Physicians Surg Pak*. 2006; 16(4): 261-4
6. Bhatti LI, Fikree FF, Khan A. The quest of infertile women in squatter settlements of Karachi, Pakistan: a qualitative study. *Soc Sci Med* 1999 49(5):637-49
7. Dyer SJ, Abraham N, Hoffman M, Van der Spuy ZM. Infertility in South Africa: women's reproductive health knowledge and treatment-seeking behaviour for involuntary childlessness. *Hum Reprod* 2002; 17(6): 1657-62
8. Dyer SJ, Abraham N, Mokoena NE, Van der Spuy ZM. 'You are a man because you have children': experiences, reproductive health knowledge and treatment-seeking behaviour among men suffering from couple infertility in South Africa. *Hum Reprod* 2004; 19(4):960-7
9. Nelson CJ, Shindel AW, Naughton CK, Ohebshalom M, Mulhal JP. Prevalence and predictors of sexual problems, relationship stress, and depression in female partners of infertile couples. *J Sex Med* 2008; 5(8): 1907
10. Audu BM, Massa AA, Bukar M, El-Nafaty AU, and Sa'ad ST. Prevalence of utero-tubal infertility. *Journal of obstetrics and gynaecology*. 2009; 29(4): 326-328
11. Bukar M, Audu BM, Yahaya UR, and Dawha YM. Outcome of tubal macrosurgery in Gombe, North-eastern Nigeria. *Journal of obstetrics and gynaecology*. 2009; 29(6):536-538
12. Schmidt L, Munster K, Helm P. Infertility and the seeking of infertility treatment in a representative population. *Br J Obstet Gynaecol*. 1995; 102(12): 978-84
13. Farley OSJ, Webb NJ. Utilization of infertility services: how much does money matter? *Health Serv Res*. 2007; 42(3): 971-89
14. Stephen EH, Chandra A. Use of infertility services in the United States. *Fam Plann Perspect*. 2000; 32(3): 132-7