Infertility help-seeking: Perceptions in a predominantly rural southern state

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Abstract

Purpose: As the incidence of infertility increases to a public health concern, there are a number of factors, including social and cultural ones, which influence help-seeking. An assessment of infertility perceptions in a rural southern state was conducted to gain a better understanding of how they might impact help seeking for rural dwellers from the social and cultural context. **Sample**: Phone interviews were conducted to collect data from adults, 18 years or older in a rural state.

Method: Survey research methodologies were used.

Findings: Descriptive statistics were used to analyze data. Respondents reported most often that "Doctors" should be the person sought for help with infertility and infertile persons should assume the financial responsibility for any help they seek for their infertility. **Conclusion**: The perceptions of participants in this study may have direct influence on the infertility experience of those in their environment from a social and cultural context. Advice they give and support they provide may impact those who experience infertility. Implications for

social scientist, health care providers and policy makers include focusing on nurses and doctors in primary care settings and providing enhanced reproductive support for rural citizens.

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Infertility has been defined as the inability to deliver a live birth after at least 12 months of regular unprotected intercourse (Sherrod, 2004). The emotional aspects of infertility have been well documented but what have been less documented are the aspects of infertility that impact decisions to seek help by those who suffer from infertility. Some researchers have noted the disparities in infertility help-seeking (White, McQuillan & Greil, 2006). For example, White, et al. (2006), noted that it is well established that African American couples have lower utilization of infertility services than White couples. Also, Sherrod (2004) found differences in rural and urban groups related to satisfaction with their providers when they sought help for infertility. Others, Greil, McQuillan, Benjamins, Johnson, Johnson and Heinz (2010) have found a number of factors that affect medical help-seeking such as religion. Religiosity according to Greil, McQuillan, et al. (2010) is associated with increased importance of motherhood which in turn is associated with greater help-seeking. Johnson and Johnson (2009) found that both partners contribute to the infertility help-seeking process but different factors such as intentions to get pregnant, importance of parenthood and total family income may play a role in different stages of help-seeking.

Other factors that influence help-seeking are social and cultural factors (Griel, Slauson-Blevins & McQuillan, 2010). Culture refers to shared meanings by members of social groups (Bachrach & Abeles, 2004). Significant differences in coping with infertility may be learned from one's social network and reference group (Schmidt, Christensen & Holstien, 2005). Much of that social impact is grounded in the day to day interactions and communications with those

whom comprise the environment of the infertile. These individuals may be co-workers, family members, friends, church members or even the local grocer. As infertility help seeking is likely influenced by cultural issues, perceived alternative treatments, social solutions (e.g. adoption) and ideas about who should be a parent, knowledge of the nature of these influences is critical to sufficiently provide guidance to medical professionals and policy makers in their efforts to provide relevant care (National Institute for Child Health and Human Development, 2007). Efforts to assist the infertile to deal with the emotional impact of infertility should include preparing them to deal with these interactions and communications from those in their environments. This preparation may be particularly more relevant for rural dwellers experiencing infertility because of the sense of closeness of community members that is so prevalent (Bushy, 2012). This closeness may lend an additional sense of being able to freely share opinions and attitudes with others in the community. For those who are infertile, some additional assistance may be needed to deal with this liberty from others. Key to providing that assistance is knowledge on the part of the health care provider of perceptions those in the community have regarding infertility. Therefore, the purpose of this study was to provide information related to infertility from a sample of citizens 18 years and older in a predominantly rural southern state to assist health care providers and policy makers to better formulate services and support.

Methodology

A survey design was used to assess infertility perceptions using the Capstone Poll at the Institute for Social Science Research. The Capstone Poll is based on a random survey of adult respondents, 18 years or older in Alabama. After university Institutional Review Board (IRB # EX-11-CM-083) approval, a computer using all of the three digit telephone exchanges in the state drew the random sample of households. Households were contacted using these numbers. A

respondent in the household was randomly selected by asking for the adult who had the most recent birthday. Trained, experienced personnel employed by the Capstone Poll conducted interviews.

For the purposes of this study, the Alabama Rural Health Association's (ARHA) classification of areas as "rural" or "urban" was used. Prior to June 2003, the ARHA used the White House's Office of Management and Budget (OMB) classification of counties as being urban if in Metropolitan Statistical Areas (MSAs) or rural if not in MSAs. A re-determination of counties included in MSAs announced by OMB in June 2003 resulted in several Alabama counties which must be regarded as being "rural" being included in MSAs that necessitated development of a more acceptable method for classifying counties as "rural" or "urban". The method developed and used by the ARHA includes four variables generally accepted as being characteristic of "rural" areas in a formula with each variable accounting for 25 of a possible 100 points. The higher the overall score, the more "rural" a county is considered as being. The four variables are: the percentage of total employment by public school systems, dollar value of agricultural production per square mile of land, population per square mile of land and an index to assign county scores based on population of the largest city in the county, other cities in the county, and the population of cities which are in more than one county. Using this methodology, 55(82.09%) Alabama counties are classified as "rural" and 12(17.91%) are classified as "urban" (Alabama Rural Health Association, 2012) and is therefore a predominantly rural state.

Data were analyzed using descriptive statistics. Percentages were calculated to provide summative data regarding selected demographic characteristics and respondents perceptions of factors related to the infertility experience.

Sample

The sample of 237 respondents included 42.8% who knew a couple who had problems with having children and 12.29% who themselves had problems having children. Married respondents comprised 58.74% of the sample and 19.42% each were widowed or divorced. Slightly more than half (50.65%) of the sample had been to church within the last 30 days at least once and 81% identified themselves as Protestant. Almost two-thirds (70.04%) of respondents were female with 29.96% being male. The majority (73.84%) reported themselves as White, 18.99% reported themselves African American, .84% reported their-self Native American, and 1.69% indicated "other". The U.S. Census Bureau (2010) reports that these results are somewhat consistent with the expected population in Alabama with the exception of African-Americans whom comprise 26% of the population (http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1) .

Results

Participants were asked to respond to a number of questions related to infertility. The first question asked of respondents was "What do you think is the most common medical condition that prevents people from having children?" More than half 148 (62.45%) of the 237 respondents indicated they had no idea. For those who did supply a response (n = 89), their answers reflect conditions that could be attributed to males, females, both or either. Results are reported in Table 1.

Some respondents gave more than one condition in their responses and each response was counted in the appropriate category. The "Other" category included items indicated by two (2.24%) respondents each that included STDs, abortion and "don't want any". Three (3.34%)

people each also mentioned obesity and cancer. One (1.12%) person each noted "it might be blood pressure", "handled by God", erectile dysfunction, stamina and high levels of stress.

Table 1

Medical Conditions Preventing People from Having Children

N=237	Male	Female	Both	Either	Don't Know/NA
					148
n = 89					
Low Sperm/ Mobility	11 (12.35%)				
Infertility		1 (1.12%)	27 (30.33%)	1 (1.12%)	
Sterile				6 (6.74%)	
Endometriosis		9 (10.11%)			
Ovary Issues		4 (4.49%)			
Poverty				2 (2.24%)	
Drugs/Lifestyle				3 (3.34%)	
Age				3 (3.34%)	
Other				22 (24.71%)	

When asked if they thought people who cannot have children will seek help, 76.27% said yes, 7.2% said no and 16.53% indicated they did not know. Respondents were also asked who they thought people who cannot have children might seek help from. Their responses are presented in Table 2.

Table 2

Who to Seek Help From

Type	N=168	%
Doctors	120	50.63%
Fertility Specialists	20	8.4%
OB/GYN	23	9.70%
Friends/Family	4	1.68%
Clinic	9	3.79%
Male Doctor	1	0.42%
Spiritual Advisor	1	0.42%
Adoption Agency	9	3.79%
Church/Pastor/Pray	6	2.53%

Again, some respondents had multiple responses and 93.3% of respondents provided at least one

response with only 6.7% indicating did not know or hand no response. In addition to responses in Table 2, other answers indicating who to seek help from by at least one (0.42%) respondent were social worker, professional, orphanage, and surrogate mother.

When asked if everyone should have access to health care to help them have children, 64.83% of respondents said yes, 19.92% said no and 15.25% indicated they did not know. In a follow–up question to those who responded "no" regarding what their reasons were for feeling that someone should not have access, a variety of responses were noted and categorized . These responses are reported in Table 3.

Table 3

Reasons for not Having Access to Healthcare to Have Children

Reason (n = 47)	n	%
Can't afford infertility care then can't afford children	9	19.15%
Should bear the responsibility for that care themselves	7	14.89%
Should have basic care but not specialty care like this	3	6.38%
Some people don't need to have children	11	23.40%
If it is meant to be, they would have them	2	4.25%
Too many children in the world	3	6.38%
Other	8	17.02%
Do Not Know/NA	4	8.51%

Responses in the "Other" category included "unmarried people to engage in sexual activity out of wedlock", "everyone is not going to use it effectively", "they can't take care of kids, go to social services, "mental disability", "have access, not a federal program" and "public funds should not be used for anything other than indigent people to sustain life."

Discussion and Conclusions

With regard to the first question, it is noteworthy that more than half of respondents did not know nor had a response for conditions that prevent people from having children. For those who are infertile and living in rural areas already with limited access to care as a normal part of rural

dwelling, so their immediate initial support and guidance may come from lay people in their environments. While 30.33% noted infertility as the medical condition for why people do not have children, there was no specific indication of what type of infertility was the reason why. It would be helpful if these individuals in the infertile person's immediate environment knew more about infertility so that their inadequate and maybe inaccurate perceptions do not add to the already emotional turmoil of those who are infertile. Therefore, there is a need for increased lay communications through various media outlets about infertility. Additionally, the equal attribution of endometriosis and low sperm count as the reason why people do not have children appears to indicate some understanding that reasons for infertility are not solely because of a problem with the man or woman but rather an experience and condition that is shared by them both equally. This perspective of cause of infertility is documented in the literature (Kolettis, 2003) and would be comforting and helpful if participants were having conversations with someone experiencing infertility. As Schmidt et al. (2005) noted, how one copes with infertility may be influenced by one's social group and the interdependence of social groups in rural communities is quite clear.

For the question related to what type of assistance those who cannot have children should seek, the indication that they seek assistance from the "doctor" by the majority of respondents is noteworthy. Because rural dwellers are reluctant to seek specialized care, they appear more willing to use a general practitioner or primary care provider for healthcare and have greater access to this type of provider (Blank, Mahmood, Fox, & Guterbock, 2002). It seems reasonable that "doctor" is the most frequently indicated source of help. The issue then for general practitioners is to be aware that they may be the provider who infertile persons are initially referred to by those in their social environments and cultural groups and that they need some

beginning understanding of infertility to provide the appropriate care (Jordon & Ferguson, 2006). OB\GYN specialists were also noted, but the limited access to specialty care in rural areas is well documented (Pierce, 2007). Another interesting response from participants was seeking adoption agency assistance. It has been suggested (Lakhvich, 2012; Sherrod, 1992) that adoption is not always an appropriate option for those who are experiencing infertility and advice to seek this type of assistance should be tempered with an understanding of where the couple is in their infertility journey especially in the early help-seeking phases. Another issue related specifically to rural dwellers is the limited availability and significant costs of help from adoption agencies.

For the question related to reasons for not having access to healthcare to have children, the most frequent response was “some people don’t need to have children”. This response is complex in terms of its implications but it does lend support to the stereotypical ideas held by some regarding ethnic groups and fertility (Greil et al., 2010) with the idea that there is too much procreation in these groups. Another item with a comparable response rate was “if they cannot afford the fertility care, then they cannot afford to have children”. This sentiment is reflective of a prevailing position in rural communities by rural dwellers that you must be self- sufficient (Bushy, 2012). It also highlights the fact that the economic challenges most rural dwellers face are relevant to those experiencing infertility and that they should be prepared to be independent or self-sufficient in their help-seeking when it comes to financial resources for infertility care. Bitler and Schmidt (2006) have noted that in some states, insurance companies are mandated to cover some infertility care costs but not all states have this requirement. However, it should be noted that rural dwellers are more likely to not have insurance or be underinsured (Bushy, 2012). None-the-less, the response by participants in this sample provides some context for help-seeking from this standpoint. As Greil, McQuillan, Shreffler, Johnson, and Salson-Blevins

(2011) concluded, individual characteristics related to help-seeking are influenced by social structural realities that from these authors' perspective are tied to responses from participants.

One final note is the clear presence of religion/religiosity in responses from participants to questions. Greil, McQuillan, et al. (2010) stated that "religion can influence the types of medical treatment perceived as appropriate" (p. 735). The strong religious influences on the sociocultural context of infertility experiences are supported by responses from participants. Blank et al. (2002) have noted the role of faith and religious personnel in rural communities. "Churches in the south are well recognized as central to the social order and character of their region. They are the strongholds of cultural and community identity and, because of congregational commitment, hold great promise for influencing the attitudes and behaviors of members." (p. 1672).

There are several methodological limitations of this survey study. One limitation is that sinlge state was used in the survey and rural residents in this state may have unique perceptions of infertility and help-seeking. Second, there may be a bias in the respondent as a consequence of the time of day that the survey was completed, e.g. during normal work time (8 a.m. to 5 p.m.). For example, 70 percent of the respondents were female and there was a slightly lower rate of African-Americans who responded.

In conclusion, the perceptions of respondents in this sample provide policy makers and healthcare providers with a context from which to develop policies for those who are experiencing infertility and particularly those in rural areas. Careful preparation of those experiencing infertility regarding what responses they might expect from those they interact and communicate with in their environment from a social and cultural perspective can assist them in navigating the experience in the most effective way.

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