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Original Research Article

Healthcare-seeking and treatment experiences among women with primary infertility: a cross-sectional community study

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ABSTRACT

Background: Primary infertility affects women's emotional, family life, and may lead seeking continuous treatment. Understanding the healthcare-seeking behaviour and treatment experiences of women help identify the barriers they face. With this intention present study was undertaken to assess socio-demographic associations, recognition of infertility, healthcare access pathways, burdens of infertility care among women with primary infertility across rural and urban communities.

Methods: A community-based, cross-sectional study conducted in Dharwad district of Karnatak during 2025. Total 230 women diagnosed with primary infertility were interviewed. Data were assessed using descriptive and inferential bivariate metrics (χ^2 analysis) on SPSS software version 20.0.

Results: Socio-demographic characteristics revealed separate residential variations, with significantly high among advanced educated women (44.8% versus 28.9%; p=0.023) and specific salaried patterns observed among urban groups. Rural women presented higher tendencies of child marriage (29.8% versus 22.4%; p=0.001), within consanguineous unions (37.7% versus 19.8%; p=0.003). No significant rural-urban variation observed across treatment paths, frequency of facilities visits, or avoiding public facilities, with 85.7% women heavily dependent on private systems. More than half of the women (53.5%) discontinued treatment due to severe psychological distress (86.2%) and unaffordable medical costs (55.3%).

Conclusions: Though socio-demographic indicators vary across rural and urban residents, the real-world treatment paths, treatment dropouts, psychological and economic distress patterns remain entirely similar. Public welfare policies must integrate low-cost reproductive treatment packages and mandated psychological care and effective counselling services within facilities.

Keywords: Economic, Infertility, Infertility recognition, Psychological, Rural-urban, Type of facilities

INTRODUCTION

Infertility or childlessness is considerable public health crisis influencing individuals and couples of reproductive ages globally.[1] According to the medical definition Infertility has been outlined as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse.[2] Earlier studies estimates conducted on global burden of infertility documented that female infertility affected about 110,100,000 women during 2021, which is translating to an age-standard prevalence rate 27.64.6 per 100,000 universally.[3] The World Health Organization (WHO) report documented about 17.5% of the world adult population, approximately 1 woman among 6 experience infertility issues in their life cycle, this indicates a critical public health challenge to universal reproductive healthcare. While previous local surveys showed a peak of 16.7% but the recent data confirms that the number is steadily climbing worldwide.[4]

In India, a projected 28 million couples struggling with infertility, but still the awareness in community, access to quality reproductive treatment, and timely use of treatment profoundly inadequate across many regions.[5] A variety of etiological factors causes female infertility, including ovulatory dysfunction, tubal blockages, endocrine or hormonal imbalances, age-related fertility reduction, and associated male related abnormalities.[6] These causes greatly determine patients' health seeking behaviour, type of treatments they choose, and deep-rooted social stigma increase challenges, complicating treatment seeking pathways and care triangulation for women. The consequences of infertility extend far beyond clinical pathology, affecting deeply psychological stress and excessive economic burden on women with infertility.[7,8] In Indian social context, the motherhood is greatly tied with social status, identity, and security.[9] Accordingly, childlessness frequently concludes in marital dispute, domestic vulnerability, social isolation, and persistent anxiety, depression, or feelings of personal failure, creating an overwhelming psychological problem.[8,10] At the same time, fertility health care causes critical financial stress because majority of infertility related treatments happen in private health facilities. Based on tertiary empirical studies, reproductive health care services are mainly excluded from public insurance schemes; hence, out-of- pocket expenditure for diagnostic investigations, corrective surgeries, and advance assisted reproductive technologies (ART) require substantial private investments. For low-income and middle-income households, there complete medical bills often result in weakened family savings, assess shutting down, or severe cycles of high debt interest, leading to acute financial burden.[11] Despite this growing social and clinical burdened, comprehensive research exploring real-world infertility care pathways, healthcare utilization, and localized barriers remains limited within the Indian context.[12] Considering these critical gaps, the present study was undertaken to examine the socio-demographic characteristics, timing of infertility recognition, treatment-seeking behaviour, health facilities visited, and to understand the current status of treatment and the reasons for discontinuation among those who had stopped treatment.

METHODS

Study design and setting

A community-based, cross-sectional study was conducted in the rural and urban areas of Dharwad district of Karnataka. The field data collection carried out from May to September 2025, focusing on women experiencing primary infertility who were currently seeking at least for 2 years or had previously sought medical intervention.

Study population and sampling

Information regarding women with infertility was obtained from front-line health workers within the selected rural and urban clusters. The sample size for the current study was outlined based on the residential prevalence of primary infertility documented in a baseline study conducted in Vijayapura district, which recorded prevalence of 7.6% in rural and 8.8% in urban areas. Using Cochran's formula n =minimum required sample, Z=standard normal deviation corresponding to the 95% confidence level (1.96). P =estimated proportion of primary infertility in the population (expressed as a decimal, based on the baseline study), 1–P=estimated proportion of the attribute absent in the population and d=Absolute margin of error or precision (0.05), the minimum needed sample size for the rural was 108 and for urban 123. To keep rural and urban groups nearly comparable for the analysis we finally interviewed 114 women from rural and 116 urban areas. A total of 230 women were interviewed in this study. This sample size was found sufficient for the Chi-square test.

Inclusion and exclusion criteria

The study included women aged 24 to 45 years with a history of primary infertility, undergoing or received fertility treatment at least for 2 years. Women diagnosed with secondary infertility, and know with severe psychiatric illnesses, cognitive impairments, and those declined to provide informed consent were excluded from the study.

Data collection

Primary data were gathered through face-to-face interviews using a structured, and pre-tested interview schedule. The tool recorded detailed information such as socio-demographic characteristics, age at marriage, recognition of infertility, pathways to treatment, types and number of health care facilities visited, utilization of public health sector, barriers perceived to be hindering health care seeking.

Data analysis

Data was cleaned, coded and entered in SPSS version 20.0 for statistical analysis. Descriptive statistics were employed using through frequencies and percentages to explain the key variables. Mutually exclusive categorical variables were compared between residential locality through Chi-square (χ^2) test, with statistical significance set at $p<0.05$. Multiple-response variables were analysed descriptively using column percentages.

RESULTS

The socio-demographic characteristics of total 230 respondents, consisting of 114 rural (49.5%) and 116 urban (50.4%) residents shows that, majority of study sample was below 29 years 104 (45.2%), with no statistically significant age difference found based on place of residences ($\chi^2=5.146$, $p=0.076$). Similarly, no significant differences were observed based on residential location in terms of religion (Hindu) or household

composition, which was mainly characterized by joint family structures 134 (58.3%). However, substantial differences were observed in women's education and socioeconomic metrics. Higher educational attainment was suggestively higher among urban women compared to rural women (44.8% versus 28.9%; χ^2=7.544, p=0.02). Women's occupation also varied drastically by residency (χ^2=15.036, p<0.001). While 145 (63.0%) of the women was outside the active workforce. Rural women were more often engaged in agricultural labour, whereas urban women were primarily engaged in salaried employment. Other variables such as husbands' education, monthly household income 111 (48.3% low-income strata) and husbands, occupation, were not statistically significant by place of residence (Table 1).

Table 1: Socio-demographic characteristics of women with primary infertility by place of residence (n=230).

Indicators	Rural (n=114) (%)	Urban (n=116) (%)	Total (N=230) (%)	χ^2	P value
Age of respondent				5.146[a]	0.076
Less than 29	59 (51.8)	45 (38.8)	104 (45.2)		
30-34 years	27 (23.7)	42 (36.2)	69 (30.0)		
35 or more	28 (24.6)	29 (25.0)	57 (24.8)		
Religion				0.743[a]	0.39
Hindu	99 (86.8)	96 (82.8)	195 (84.8)		
Other	15 (13.2)	20 (17.2)	35 (15.2)		
Caste				2.313[a]	0.31
General	21 (18.4)	30 (25.9)	51 (22.2)		
OBC	73 (64.0)	71 (61.2)	144 (62.6)		
SC/ST	20 (17.5)	15 (12.9)	35 (15.2)		
Family type				0.918[a]	0.34
Joint family	70 (61.4)	64 (55.2)	134 (58.3)		
Nuclear family	44 (38.6)	52 (44.8)	96 (41.7)		
Women's education (highest completed)				7.544[a]	0.02*
Illiterate/Primary education	39 (34.2)	37 (31.9)	76 (33.0)		
Secondary education	42 (36.8)	27 (23.3)	69 (30.0)		
Higher education	33 (28.9)	52 (44.8)	85 (37.0)		
Husbands' education (highest completed)				4.698[a]	0.1
Illiterate/Primary education	41 (36.0)	34 (29.3)	75 (32.6)		
Secondary education	32 (28.1)	24 (20.7)	56 (24.3)		
Higher education	41 (36.0)	58 (50.0)	99 (43.0)		
Family income (per month, INR)				3.176[a]	0.2
<14,000	58 (50.9)	53 (45.7)	111 (48.3)		
15,000-29,000	34 (29.8)	29 (25.0)	63 (27.4)		
≥30,000	22 (19.3)	34 (29.3)	56 (24.3)		
Women's occupational status				15.036[a]	<0.001*
Agri/agricultural labour	27 (23.7)	12 (10.3)	39 (17.0)		
Homemaker	72 (63.2)	73 (61.9)	145 (63.0)		
Non-agricultural labour	1 (0.9)	6 (3.4)	7 (2.2)		
Salaried (govt/private)	2 (1.8)	11 (10.3)	13 (6.1)		
Self-employed/business	12 (10.5)	14 (12.9)	26 (11.7)		
Husbands' occupation status				4.865[a]	0.18
Agri/agricultural labour	39 (34.2)	26 (22.4)	65 (28.3)		
Non-agricultural labour	22 (20.2)	23 (19.0)	45 (19.6)		
Salaried (Govt/Private)	31 (26.3)	36 (31.9)	67 (29.1)		
Self-employed/Business	22 (19.3)	31 (26.7)	53 (23.0)		

Table 2 presents the marital age patterns, time of infertility recognition, and subsequent treatment trajectory by place of residence. Statistical analysis revealed a highly significant association between residential areas and age at marriage (χ^2=14.20, p=0.001). Late marriages (≥25 years) were found to be more prevalent among urban women compared to rural women 17 versus 11 (31.9% versus 11.4%). On the other hand, the proportion of rural respondents with consanguineous marriage was higher at 43 (37.7%) than urban respondents 23 (19.8%). Non-consanguineous marriages were more common among urban dwellers 93 (80.2%) than rural inhabitants 164

(62.3%). In addition, participation in religious ceremonies for conception was almost universal among rural and urban participants 218 (94.8%). No statistically significant association was observed between place of residence and participation in religious practices (χ^2=0.389, p=0.533). This demonstrating that uniform cultural behaviours exist across both rural and urban areas within the district.

Table 2: Marital history, infertility recognition and treatment trajectory by place of residence (%) (n=230).

Indicators	Rural (n=114) (%)	Urban (n=116) (%)	Total (%)	χ^2	P value
Age at marriage				14.204[a]	0.001
Less than 18 years	34 (29.8)	26 (22.4)	60 (26.1)		
18-24 years	67 (58.8)	53 (45.7)	120 (52.2)		
≥25 years	13 (11.4)	17 (31.9)	50 (21.7)		
Consanguineous marriage				8.995[a]	0.003
Yes	43 (37.7)	23 (19.8)	66 (82.7)		
No	71 (62.3)	93 (80.2)	164 (40.4)		
Time after marriage when infertility was recognized				0.195[a]	0.907
Early (≤2 years)	59 (51.8)	57 (49.1)	116 (50.)		
Moderate (3-5 years)	43 (37.7)	47 (40.5)	90 (39.1%)		
Delayed (≥6 years)	12 (10.5)	12 (10.3)	24 (10.4)		
Participation in religious ceremonies for conception				0.389[a]	0.533
Yes	107 (93.9)	111 (95.7)	218 (94.8)		
No	7 (6.1)	5 (4.3)	12 (5.2)		
Duration of treatment-seeking				5.377[a]	0.068
2-5 years	71 (62.3)	67 (57.8)	138 (60.0)		
6-9 years	21 (18.4)	35 (30.2)	56 (24.3)		
≥10 years	22 (19.3)	14 (12.1)	36 (15.7)		
Number of hospitals visited				0.624[a]	0.732
Less than 3	35 (30.7)	36 (31.0)	71 (30.9)		
3-5	58 (50.9)	63 (54.3)	121 (52.6)		
≥6	21 (18.4)	17 (14.7)	17 (16.5)		

Note. n=230. Data are presented as percentages (%) within the columns. [a]Chi-square (χ^2) test of independence was used to compare rural and urban proportions. *p<0.05, **p<0.01).

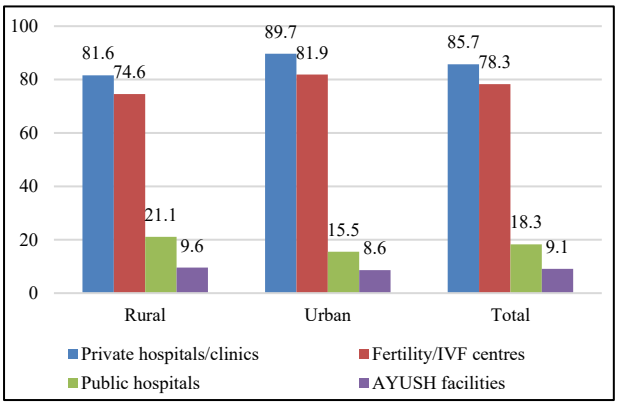


Figure 1: Type of health facilities visited for treatment.

Note: Multiple responses permitted; percentages may exceed 100%

No significant rural-urban differences were observed regarding the timing of initial infertility recognition following marriage (χ^2=0.195, p=0.907), with approximately half of the women in both settings recognized infertility within first 2 years of marriage. Similarly, the overall duration of active treatment-seeking did not differ significantly by residence (χ^2=5.377, p=0.068), although a higher proportion of urban women reported a prolonged treatment-seeking span of 6-9 years. Furthermore, the number of facilities visited exhibited no statistically significant association with place of residence ((χ^2=0.624, p=0.732). Most of the surveyed women across both rural and urban women reported visiting between three to five distinct healthcare centres, demonstrating a highly uniform pattern of healthcare utilization across the district (Table 2).

Figure 1 shows that wide majority of respondents 197 (85.7 %) sought infertility treatment from private hospitals or clinics, comparatively with higher utilization observed among urban women compared to rural women 104 versus 93 (89.7% versus 81.6%). Specialised fertility or in vitro fertilization (IVF) centres were also frequently accessed by 180 (78.3%) of the total sample, presenting more commonly among urban residents than rural residents 95 versus 85 (81.9% versus 74.6%). In contrast, less than one-fifth of the respondents 42 (18.3%) reported having ever utilized public sector health facilities for infertility care. Chi-square analysis confirmed that low utilization rate

does not vary significant across rural-urban areas (χ^2=0.281, p=0.596). Alternative medicine (AYUSH) facilities 21 (9.1%) also remained consistently low across both settings. Respondents provided multiple answers, reflecting a clear non-linear trajectory of care-seeking across more than one type of healthcare facility (Figure 1).

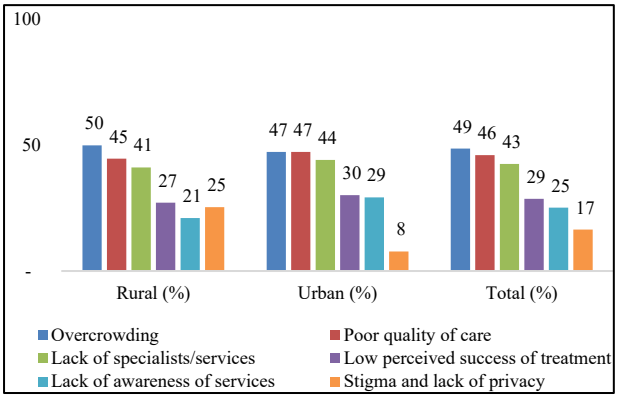


Figure 2: Perceived barriers to utilization of public health facilities for infertility care, by place of residence (%).

Note: Multiple responses permitted; percentages do not total 100%.

Overcrowding 112 (48.7%), poor quality of care 106 (46.1%), and lack of specialists or services 98 (42.6%) emerged as the most frequently reported obstacles preventing the utilization of public health facilities for infertility care. The residential stratum revealed that rural women more commonly reported overcrowding 57 (50.0%), alongside social stigma and a lack of privacy 29 (25.4%). In contrast, urban women more often highlighted a lack of awareness regarding available public services 34 (29.3%) and perceived low success of public treatments 35 (30.2%). Overall, social stigma and a lack of privacy continued the least reported barrier 38 (16.5%) but exhibited a noticeable rural-urban discrepancy (Figure 2).

Less than half of the surveyed women 107 (46.5%) were receiving infertility treatment at the time of the field survey, whereas a higher proportion 123 (53.5%) had discontinued treatment. Ongoing treatment was compliance was more commonly reported among urban women compared to their rural counterparts 59 versus 48 (50.9% versus 42.1%). Among the subset of women who had ever received primary infertility treatment, emotional or psychological distress constituted the most frequently reported challenge 106 (86.2%), closely followed by profound feeling of hopelessness due to treatment failure 95 (77.2%) and severe financial constraints 68 (55.3%). Treatment-related side effects were reported by nearly one-quarter of respondents 30 (24.4%), while a distinct lack of cooperation by the husband and his family was reported by 31 (25.2%) of women. Overall, the types of challenges remained remarkably similar across rural and urban areas, with slightly higher reporting of emotional distress among urban women and treatment related side effects among rural women (Table 3).

Table 3: Current treatment status, and difficulties in accessing treatment among women with primary infertility (n=230).

Categories	Rural (n=114)		Urban (n=116)		Total (n=230)	
Current treatment status	**N**	**%**	**N**	**%**	**N**	**%**
On treatment	48	42.1	59	50.9	107	46.5
Discontinued treatment	66	57.9	57	49.1	123	53.5
Reasons for discontinuation of treatment (n=123)						
Emotional/psychological distress	54	81.8	52	91.2	106	86.2
Hopelessness due to treatment failure	52	78.8	43	75.4	95	77.2
Financial constraints	36	54.5	32	56.1	68	55.3
Treatment-related side effects	20	30.3	10	17.5	30	24.4
Lack of cooperation by the husband/ husband family	17	25.8	14	24.6	31	25.2

Note: Multiple responses permitted; percentages do not total 100%.

DISCUSSION

The current study explored the socio-demographic characteristics, recognition time of infertility treatment pathways, and multidimensional challenges among women with primary infertility, with a special focus on rural- urban differentials in Dharwad, Karnataka. The findings indicate that while several socio-demographic variables differed significantly by place of residence, actual treatment-seeking trajectories and core infertility-related burdens were broadly uniform across both rural and urban cohorts.

Nearly half of the respondents were <30 years of age, indicating that primary infertility is actively recognized during the early reproductive years. Although rural women generally marry earlier than urban women, no statistically significant differences in age distribution were observed between the two groups in the current study. Educational attainment was much higher among urban women, a finding highly consistent with nationwide data from the National Family Health Survey-5, which demonstrates better educational opportunities and delayed marriage among women in urban India.[13] Higher education attainment is known to directly improve reproductive

health literacy, decision-making capacity, and facilitate timely utilization of infertility services.[14]

Women's occupation structures also differed notably by residence, with agricultural labour predominating among rural women and formal salaried employment being more common among urban women. Despite these occupational differences, the monthly household income did not vary drastically, suggesting that profound financial constraints remain a universal barrier to infertility care in both settings. The aggregated cost of diagnostic investigations and sequential clinical procedures are often prohibitive, severely limiting therapeutic continuity in resource limited settings access to fertility services especially in low-resource settings.[15,16] Rural women exhibited a higher tendency for early marriages and consanguineous unions, reflecting the strong preservation of local socio-cultural practices in rural areas. Similar demographic patterns have been reported across the Indian subcontinent, where rising educational attainment and urban employment opportunities are contributing factors to delayed marriage in urban populations.[17] These results highlight the impact of social and cultural factors on reproductive health.

There was no considerable difference in the distribution of religion, caste and family type between rural and urban participants suggesting that women from different socio-cultural backgrounds are affected by infertility. Deep-rooted social stigma, family pressure, and severe psychological distress associated with infertility are almost universal, irrespective of the social groups. Earlier literature corroborates, rigid sociocultural expectations, fear of social ostracism and limited family support significantly contribute to infertility-related stress among Indian women receiving treatment.[18] Similar findings documented globally, emphasizing that infertility must be handled as a dual medical and psycho-social crisis rather than isolated clinical pathology.[15,19]

Despite socio-demographic differences, no substantial difference was observed in the total duration of infertility, time of treatment initiation, and number of healthcare facilities visited. Most women across both settings preferred private healthcare facilities, while the utilization of public health services remained critically low. This strong preference for the private sector, directly reflects the inadequate availability of specialized infertility services, perceived differences in quality of care, and limitations in rural health infrastructure.[20] This health-seeking pattern closely aligns with empirical evidence from other developing economies, where public health infrastructure greatly neglects reproductive care beyond family planning.[15] Religious practices intended to facilitate conception were reported by nearly all participants, reflecting the continuing influence of cultural and spiritual beliefs in coping with infertility.[21] These practices frequently coexist with biomedical treatment and may provide emotional support while women undergo prolonged treatment.[18]

More than half of the participants had ultimately discontinued their treatment. Within this group, actual emotional distress emerged as the most prevalent challenge, closely followed by propound hopelessness, financial burden, and treatment-related physical side effects. These findings support existing evidence that infertility imposes considerable psychological, social, and economic burdens on affected couples.[18,19] The prolonged nature of treatment, uncertainty regarding outcomes, and financial hardship often contribute to treatment discontinuation. Therefore, strengthening specialized infertility services within the public health system, enhancing the affordability of diagnostics, and integrating systematic psychological counselling into routine infertility care are essential to improve treatment adherence and overall quality of life of women battling primary infertility.

This study has certain limitations. As this study was cross-sectional, causal inferences cannot be drawn. Multiple-response measures, such as type of facilities visited, perceived barriers, and reasons for discontinuation of treatment, do not allow for inferential testing, limiting analytical depth beyond descriptive patterns. Although efforts were made to comprehensively capture women's experiences, recall bias may affect accuracy in reporting the timing of infertility recognition and treatment trajectories. The study was conducted in selected communities and may not be fully generalize to all rural or urban settings in India.

CONCLUSION

Overall, the study demonstrates that while socio-demographic differences exist between rural and urban populations, infertility-related experiences and challenges are largely similar across settings. Education, occupation, and marital patterns showed large variation, whereas treatment-seeking behaviour and psychosocial burden remain consistent. Strengthening public sector infertility services, improving accessibility, and integrating psycho-social support are essential to address the unmet needs of infertile couples in both rural and urban India.

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