Editorial

Managing Subfertility in Pakistan. What is the Difference

Shagufta Saeed Sial

Professor of Obstetrics & Gynaecology, Benazir Bhutto Hospital, Rawalpindi

Address of Correspondence: *Prof. Shagufta Saeed Sial*
Professor of Obstetrics & Gynaecology, Benazir Bhutto Hospital, Rawalpindi
Email: drshagufta8@hotmail.com

Subfertility is a worldwide problem. In a developing country like Pakistan, the management of subfertility faces various challenges which might differ in frequency, intensity and the type faced in the developed world.

The term Subfertility instead of Infertility bears a significant impact on the couple. The use of word 'infertility' is like tying the cart before the horse. The patient is labeled infertile even before the doctor interacts with the patient. The word infertility conveys 'failure' whereas 'subfertility' transmits hope! Therefore, the doctor must use the term subfertility for further communications.

The couple who fails to conceive within one year of unprotected intercourse is considered subfertile. However, on a lighter note, the 'mother in law definition' is three months only or even less. In a closely-knit family system like ours, a duration of one year is not acceptable. Therefore, it is essential to acknowledge the needs of the patient whenever she seeks advice irrespective of the duration of subfertility.

The concept of considering the patient as a 'biopsycho social model' is expressed in its sublime form in cases of subfertility. Not only the biological needs but also the psychological as well as social issues have to be addressed. Biologically the couples have to be counseled regarding various phenomenon associated with fertility. It has been observed that women consider the cyclic midcycle vaginal discharge or Mittleschmertz as abnormal. They think that primary spasmodic dysmenorrhoea is related to some disease. All sorts of fibroids irrespective of size or site are considered the cause of their problem. Presence of polycystic ovaries adds fuel to the fire. They think that removal of 'cysts' will solve their problem. Quite often, the couples are not sure about the utilization of fertile period and the optimal frequency of sexual intercourse. A lot of misconceptions surround the issues related to achievement of orgasm as an essential feature for conception. Lunenfeld and VanSteirteghem have identified three main groups of obstacles in delivering treatments to such couples i.e. accessibility, economic cost and socio-cultural factors.[1] In our case, proper patient education and counseling is also an essential component.

Apart from the biological needs, the psychological stress, an unseen menace, hovers around. ."A Mother or nothing– the agony of infertility" -by M. Fathalla, has very rightly described the concept that prevails in our society(WHO Bulletin, 2010). The issueless woman is often stigmatized, ostracized and even disinherited. The poor woman especially the one living with in-laws starts facing the ever-increasing demand for conception. This raises the anxiety level of the couple and might have a negative impact on interpersonal relationships. Generally, the whole blame is on the woman and not on her husband. The woman faces the ordeal on daily basis. She is looked down upon in the family. Her daily needs may not be properly fulfilled. She is subjected to perform all sorts of domestic chores unlike other fertile women in the family. The husband's behavior is altered, further enhancing her apprehension and anxiety. The husband's change of attitude is not only due to the influence of her family members but also due to the situation he faces at his workplace. His colleagues/fellows might also ridicule him for being incapable to procreate. This results in anxiety, anger, grief or violence.

Domestic violence is another sequel of this tragic state. This physical and psychological violence may lead to polygamy. Suicidal attempts have been reported. The couple starts avoiding the practice of intercourse as they find it to be fruitless. The situation goes from bad to worse as time passes. A time comes when the woman receives a “deadline for divorce”. Therefore, initiating the workup and even treatment earlier will be justified in such situations.

Only some pressing need compels the woman to come out of her house and seek advice. Therefore, the treating doctor must comprehend the psychosocial impact of subfertility before sending the patient back. At this stage, it will be like throwing her back into the hellfire. The doctor must find extra time to counsel the woman and her husband together. The in-laws must also be positively counseled It will ease out the woman's life at home.

Our colleagues from developed world often ask, “why do you treat subfertility in an over-populous country like yours? ”In response, I ask them the definition of ‘HEALTH’. It is a state of complete physical, mental, social and spiritual wellbeing (according to WHO) and not just absence of disease or infirmity. Being health care provider, how can you deny the treatment to those who wish to conceive, have an affordable and treatable factor, are developing ever increasing anxiety and are mentally and socially not accepted by society?

Overpopulation is a separate issue and needs to be curtailed on different lines. Failure or weaknesses in the implementation of family planning programs cannot justify taking away the rights of the couples who do not have any issue. It has been estimated that subfertility treatment in developing countries would account for less than 1% of all deliveries bearing minimal effect on the total budget.[2] Therefore, curtailing large family size needs to be emphasized. Reproductive autonomy must prevail. UN declaration of human rights 1948, the United Nations ICPD declaration Cairo 1994, FIGO declaration 2003 and World Health Assembly 2004, all support any couple’s right to procreate.[2]

According to the WHO, it is a silent population of 180 million couples facing subfertility in developing countries. In Pakistan, almost 22% couples suffer from subfertility.[3] The women development programs in developing countries do not consider infertility /subfertility as an issue because it has never been highlighted. Incidents of suicidal attempts demand it to be taken as a public health issue. Nongovernment organizations have their own preferences.

Cost of treatment makes it unaffordable for the general population. A lot of money is wasted on unnecessary investigations. Apart from few specialized centers, invasive investigations like hysterosalpingography are being done by untrained workers. Prevalence of STIs and treatment from Hakeems and Dais is quite prevalent. Unsupervised use of medicines for ovulation inductions, gonadotrophins therapy, inappropriate Intrauterine Inseminations by low-grade workers are playing havoc with patients’ lives.[4]

There is a dire need to formulate a specific plan in our set up with the aim of imparting maximum service with a minimal number of visits.[5] Specified guidelines and evaluation protocols must be implemented without wastage of time. Proper training of doctors for specific counseling, management and referrals are required. At referral centers, low-cost regimens for ART must be devised to help this suffering community.

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