Involuntary childlessness among the middle class in Vadodara city

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Contents

Executive summary

The research focuses on experiences of involuntary childlessness among women and men and societal perceptions of the state of childlessness. A significant aspect of the research is the gendered understanding of individual experiences of childlessness. Specific reference has been made to ideas about parenthood, the importance of children, the psychosocial implications of childlessness on the self, marital relationships, family, and society, as well as the pattern of seeking treatment and the coping strategies used. The study also involves understanding the perceptions of women and men towards the process of seeking treatment, the approach of the doctors, and the type of treatment provided.

The participant group comprised: (i) women and men who were seeking treatment for infertility, either for self or spouse (n=40, 20 men and 20 women), (ii) women and men who had discontinued treatment for infertility (n=15, five men and 10 women), (iii) women and men who either had biological children or who were in the process of planning a family (n=60, 30 men and 30 women), and (iv) urologists and gynaecologists, (n=10, five men, five women).

The women and men who were seeking treatment for infertility were identified with the help of the doctors involved. A semi-structured interview schedule was used to gather the data. In-depth individual interviews were carried out after orienting the participants about the research and obtaining their informed consent, while assuring them of confidentiality. The results were analysed qualitatively.

The findings suggest that children hold an important position in Indian society. The idea of "being complete" only after having children, was commonly expressed by individuals experiencing involuntary childlessness. Societal perceptions focussed on the importance of a child in fostering cohesion among family members and strengthening the marital bond.

The implications of childlessness on the self and on marital relations were often manifested through feelings of loss, especially during the initial years of seeking treatment. Women reported feeling depressed and incomplete due to their childless state. The impact of childlessness on the marital relationship had various manifestations, such as enhanced mutual understanding and support, as well as tensions, stemming from "blaming" each other, financial difficulties related to the cost of treatment, and spousal refusal of treatment. The husband and

family were considered major sources of support in the process of seeking treatment, with the husband accompanying the wife for the treatment most of the time. Adoption emerged as one of the ways of coping, along with performing *puja*s (prayers), and visiting astrologers.

Seeking treatment for infertility was one concrete step towards resolving the problem. Views differed about the approaches adopted by the doctors. Some individuals found the doctors "sensitive" and "understanding," whereas others found the doctors' approach "mechanical." Many couples felt that the doctors were unable to give them adequate time, leaving their queries unresolved. Visiting multiple doctors was reported as a common experience. Doctors were also changed due to the type of treatment, long travelling distances, and the influence of the opinions of other people.

Treatment was discontinued largely due to reasons such as not getting results, the spouse not cooperating with the treatment, advancing age, unwillingness to undergo the treatment suggested by the doctor, and the high cost of the treatment. Most respondents reported having tried alternative forms of treatments, like ayurveda and homeopathy, along with the allopathic treatment. Many participants reported feeling tired and frustrated with the treatment when it did not yield any results. Most of them found the treatment to be painful, both physically and psychologically. Women also reported side effects. Doctors were found to use a variety of approaches with the clients, ranging from medical treatment to helping the couple accept the situation and counselling them about lifestyle changes.

Gender differences were evident in the fact that men often refused to undergo investigations, whereas women were never mentioned as having the choice to refuse. Women were usually the first among the couple to approach the doctor, and also the first to be blamed for childlessness. While discussing their feelings regarding childlessness, men more often reported the feelings of their wives rather than their own feelings. Gender differences were evident also in the various ways in which men and women coped with childlessness. Men seemed to accept their childless state better than women, maybe because their jobs occupied them, whereas the women, most of whom were not employed and generally at home, tended to dwell on their situation.

The findings reflect the links between the larger ideologies of Indian culture and individual experiences of childlessness. The necessity of counselling as part of the treatment and coping processes emerges as an important outcome of the study. This also highlights the need for a multidisciplinary approach in dealing with infertility.

Chapter 1
Introduction and review of literature

"To be mothers were women created, and to be fathers, men." [1].

The above line is from the *Manusmruti*, one of the ancient scriptures that directs and guides the code of conduct of human life in Hindu society. The most important role of the human being is that of a procreator. [1]. In most societies and religions, the ultimate aim is the perpetuation of the race. Childlessness, which contradicts the normative standards of society and cultural expectations, is generally condemned. Fertility is a universal human concern and anguish over infertility is an obvious consequence of that concern.

Millions of people all over the world are confronted with the problem of infertility. In many cultures, childlessness greatly influences the course of the lives of married couples. Yet, in India, little attention is paid to the problem of childlessness, which has a devastating impact on couples that experience it.

The present study is about the experiences and the consequences of childlessness or infertility in men and women. The study is also an effort to reveal cultural and familial beliefs about infertility and childlessness. In addition, the study places societal attitudes towards infertile men and women on a scale. Finally, the research throws light on the health services and reproductive technologies available to the childless couples and their experiences in relating to them.

The value of children in both psychosocial and economic terms cannot be overstated. Bearing and rearing children serves critical cultural functions in a hierarchical society like India. Importantly, child bearing and rearing confer otherwise unavailable power on women. However, very often, the desire to have children is veiled behind discourses such as, "It is natural for every woman to bear a child." [2]. Consequently, the distinction between the personal desire and social expectation is vague. Social pressure for couples to have children is common in many other cultures as well. For instance, in Central Africa, infertile women experience social ostracism even when the incidence of secondary infertility for women is higher than that of primary infertility. [3].

Infertility is often experienced as the inability to perform the role of a perpetuator of the human race, a role that forms a major dimension of the continuous process of enculturation. The conceptualisation of self in the process of formation of identity is enmeshed with biological givens inherited through the centuries as well as the social and cultural influences that form the individual. The ideology of certain cultures emphasises motherhood as an important and desirable part of a woman's identity, one that grants her privileges (and even reverence) thereafter. Inability to attain the status of motherhood, which is reinforced as the ultimate goal of marriage, has serious implications for the self.

In India, women are symbolised as the image of procreation. Motherhood is considered a source of power for a woman, one that determines the strength of her marital bonds. [4]. Infertility is viewed as deviance from the cultural norms rendering the woman helpless; it also provides grounds for divorce. [5]. A study in Mozambique revealed that childless persons suffer more from the community's ideology regarding childlessness than from the childless state per se. [6]. Hence, one needs to understand childlessness not only in terms of reproductive health in a physical sense, but more so as a social concern. Greil points out that "reproductive impairment is a medically diagnosed physiological characteristic of individuals whereas the socially constructed phenomenon of infertility involves a complex set of beliefs and values within a specific social structure." [3].

In most societies that are patriarchal, the woman is almost always blamed for infertility in a couple. [7]. Researches related to infertility in men are few and focused on determining the medical and aetiological factors associated with male fertility rather than the psychological implications of infertility. Although infertility is mainly perceived to be

associated with females, Gujjarappa, Apte, Garde and Nene reveal in their study on the male perspective on infertility that all men were aware that there could be "defects" in men as well. Despite this awareness, men were reluctant to go for treatment, as they feared disgrace in society. They reported that infertile men had no worth (*tuchcha*) in the society and were referred to as *namard*, or "lacking in masculinity." [8].

1.1 Infertility: demographic and clinical picture

Infertility, as we term it, is a product of biological and environmental factors. The revised definition of infertility by the WHO (cited in UNFPA) characterises primary infertility as the percentage of never-pregnant women exposed to the risk of pregnancy for at least two years without conceiving. It characterises secondary infertility as a situation in which a couple has previously conceived, but is unable to conceive subsequently, despite cohabitation and exposure to pregnancy for a period of two or more years. [9].

Worldwide, five to 10 per cent of couples are presently affected by infertility. [10].– Doctors cite the rate of infertility to be around 40 per cent due to male factors, 40 per cent due to female factors, and 20 per cent due to both. [11]. This implies that where infertility is concerned, there is no discrepancy in its prevalence rate in terms of sex differences.

Infertility results from various factors. According to S Srinivasan, in a third of the cases, the man has hormonal, mechanical or psychological problems. [12]. In women the reasons for infertility could vary from reproductive system problems related to ovulation and hormonal imbalances, blocked fallopian tubes, hostile cervical mucus, and uterine diseases.

One of the most common causes of infertility is sexually transmitted infections (STIs) and pelvic inflammatory diseases (PIDs). [13]. This implies that some aspects of infertility can be combated through behavioural changes. The WHO multi-centric study (cited in UNFPA) traced prior infection in 64 per cent of female patients experiencing infertility in Africa and 28-35 per cent in other areas of the world. [9].

Infections caused due to sexually transmitted bacteria like chlamydia trachomatis and neisseria gonorrhoea may lead to tubal obstruction or pelvic adhesions involving the fallopian tubes and ovaries. This may prevent the sperm from moving up the tubes to fertilise the ovum. Simultaneously, it obstructs the ovum from passing down the tubes, and in cases where the ovaries are infected, the process of ovulation itself may be impeded. In cases of infection, where there is no tubal obstruction, the passage of the fertilised ovum from the tube to the uterine cavity may be hampered, resulting in implantation of the ovum in the tube, causing a life-threatening condition known as ectopic pregnancy. [14].

Other external factors may affect fertility, like unhygienic obstetric practices and exposure to radiation are also known causes of infertility. [9]. Some social causes, such as poor health and nutrition for women, which can lead to repeated miscarriages and foetal wastage, are also cited. [13]. Other causes of infertility are sexual dysfunction, premature ejaculation, and genital tuberculosis. [9]. There may be cases of idiopathic infertility where no evident causes are determined. [15].

Studies about perceptions of causes of infertility reveal that most respondents among the Hmong women of Australia reported causes from the supernatural domain – a consequence of one's wrongdoings, or supernatural misfortune. [16]. None of the causes related to anatomical and physiological defects were mentioned. Consequently, couples experiencing infertility due to physiological causes seldom visited hospitals, instead spending huge amounts seeking cures from a variety of sources, including quacks, indigenous healers, and faith healers. Among the Yoruba of southwestern Nigeria, seeking alternative treatments is routine practice, regardless of the individual's level of education or occupational status. [3].

1.2 Infertility as a social construct

1.2.1 *Cultural significance of motherhood in India*

In Indian cultures the role of motherhood is inscribed in the personality of a girl child from childhood itself, either by encouraging the child to

play motherly roles of caring for younger siblings, or by only allowing her to play with dolls around the house. The reproductive role of women is highly recognised in these settings and the onset of puberty is joyously marked, accompanied by celebrations that declare the girl's fertility and announce her capability for future motherhood.

As Dube describes it, "Menstruation is likened to the process of flowering or blossoming—the necessary stage before fruit can appear." In most of these cultures, the girl is made to eat nourishing food like coconut, milk and *ghee*, and this process may continue for a few days or months, and sometimes even years, after her first menstruation. The main idea behind providing her with nourishing food is to strengthen the girl's reproductive organs and thus facilitate the process of child bearing in the near future. The girl is also restricted from doing strenuous activities or play like jumping, running or riding a bicycle, in order to protect her reproductive organs. [17].

The succeeding stage, one that further determines the initiation of the girl's role as a mother, is marriage. The ritual of marriage is seen as the pathway for the creation of offspring. "Women are created for offspring; a woman is the field and a man is the possessor of the seed." [18]. Marriage is associated with two aspects—one is the cordial relation between the husband and the wife, and the second is the blessing of children. The rites and rituals of marriage and some of the customs are also geared towards the fulfilment of these two tasks. For example, the custom of wearing green bangles during the ceremony of marriage and afterwards in many Indian cultures indicates fecundity. Thus, within marriage, the role of the woman is that of a carrier—a vehicle for the offspring of the man. [18].

Importantly, a woman's status is determined by whether or not she fulfils her responsibilities towards the family and society, through her significant role of procreation. Even the unborn child in the womb of the mother plays a role in the process of the woman finding acceptance and acquiring a higher status in the community. She is recognised as fully adult and complete in the true sense on attaining motherhood. [19,20].

According to Ghadially, cited in Vaithilingam and Murugesan, motherhood confirms a woman's status as a perpetuator of the race, granting her respect that is not extended to her as a wife. [21]. She undergoes a feeling of cultural reverence, the removal of all restrictions, receives gestures of affection from the in-laws and relatives, and experiences a sense of personal growth. The roots of such behaviour lie in the religious tradition that indicates the birth of a child, especially a male, as an essential step towards the family's salvation. There are religious texts that enforce this feeling by describing the varied sufferings of childless souls after death. [22]. As such, motherhood and womanhood are terms used simultaneously.

In a culture where so much importance is accorded to motherhood and virility, one can imagine the boundless problems that infertility is likely to cause. In case a woman is unable to conceive, she is stigmatised and rebuked by the family and society. While these women are already feeling sad and threatened, society inflicts multiple psychological tortures on them by labelling them as "incomplete" or "worthless." The following quote is a telling illustration of the predicament of a woman who is unable to bear a child: "My mother-in-law beats me and threatens to burn me alive. She also talks about marrying her son again, so that their family lineage could continue. She also instigates her son to physically harass me. What could I do if *mata* wants to punish me this way?"[9].

The plight of a childless woman is sad and she always lives in peril of being deserted or divorced. The incidence of physical violence experienced by childless women is high. In a study by Singh, Dhaliwal and Kaur, of 129 childless couples seeking treatment from a primary health centre in Raipur, Ambala district, Haryana, it was found that violence was manifested in physical forms such as physical assault and frequent quarrels; psychological forms such as taunting by the husband; and threat of second marriage by the husband. [10].

The woman may also be ill treated or burdened with domestic chores. [23]. She might even persuade her husband to remarry, just for the sake of an heir. Sayeed found that amongst childless couples with a low standard of living, the incidence of second marriages was high. She also concludes that educational attainment appeared to be an important measure of marital stability. Literate women had

higher levels of conjugal harmony compared to those who were illiterate. Apart from this, there have also been cases of severe isolation and stigmatisation of these women. [24]. In a community-based study of 332 women in Ranga Reddy district of Andhra Pradesh, Sayeed found that childless women were purposely kept away from certain ceremonies. These women hid their faces from the world and refrained from participating in social activities. [24].

1.2.2 *Fatherhood: synonymous with manhood?*

Fatherhood is now also becoming a focus of social science research. New studies point to the significance of fatherhood, but they are essentially limited to those aspects of fatherhood that come into play after the birth of a child. Research related to the cultural significance of fatherhood, and how it affects the socialisation of men, is non-existent. The terms fatherhood and manhood are considered as two distinct concepts, unlike womanhood and motherhood, which, as we have seen, are easily equated.

In patriarchal societies, contemplating the idea of infertility in men is rare. However, even men are pressurised to prove their virility. The father's blood not only contributes to the shaping of the child, but also gives the child a name, lineage and clan. [18]. Yet, society easily makes concessions for men. In the epic, *Mahabharata*, reference is made to "sowing" a substitute *bij* ("seed," implying sperm) in the *kshetra* ("field," implying womb) for obtaining progeny. The socio-historical structure of Indian society does not allow the woman to accept the fact that the problem could lie with the man.

Nevertheless, men too experience certain negative consequences of infertility, especially in the context of inter-spousal relationships. In Nene's research at KEM hospital, Pune, couples from middle class families experiencing infertility were studied, wherein 12 men reported humiliating comments, use of sarcastic language, constant arguments, and compensatory demands from their wives. [23]. Bharadwaj highlights the distinction between "stigma" and "blame." He says that women may be primarily blamed for not having children, but stigma essentially "penetrates and attaches itself to a married body." [25].

1.2.3 *Coping with infertility*

Coping mechanisms, behaviour patterns and strategies adopted by individuals to deal with the situation, and especially their feelings of control or lack of it, are important issues in the experience of infertility. Weisz, Rothbaum and Blackburn have identified two different strategies that people seem to follow to enhance feelings of control in a given context [26]:

- Primary control: involves efforts to gain control by influencing existing realities. For example, deciding to seek treatment.
- Secondary control: involves individual efforts to alter and align themselves with existing realities, leaving the realities unchanged, but exerting control over their personal and psychological impact.

  The researchers also identify four forms of secondary control:
- Predictive control, which includes attempts to anticipate events to control their impact on self. An example of this is accepting their status and anticipating consequences.
- Vicarious control, in which the individual associates with others in order to participate psychologically in the control they exert. An example of this is influencing control on others' children.
- Illusory control, which involves the individual aligning himself or herself with chance and thereby accepting his or her fate. An example of this is accepting one's childless status as ordained by destiny.
- Interpretive control, in which the individual attempts to construe existing realities to derive a sense of meaning from them. An example of this is visiting astrologers and getting horoscopes analysed.

According to Weisz, people unable to alter the existing realities apply secondary control, which provides satisfying means of coping with undesirable, unchangeable aspects of life situations. [27]. Studies have shown evidence of the expression of secondary control in Eastern cultures, the appropriate cultural context for this study. [26].

Studies related to infertility have revealed that the strategies used for coping include seeking

information from and about others with a similar problem; depending on one's family for support; receiving comfort from existing children; and viewing the situation as god's will. [28].

As mentioned in the previous section, the perceived causes for infertility were often more supernatural than somatic in origin. Therefore, biomedical doctors were consulted for physical treatment, and the social and perceived spiritual causes of infertility were dealt with by going to traditional healers. This is true in many cultures, for example, among Ghanaian migrants in Amsterdam, [29], Hmong women in Australia, [16], and among Indian urban slum dwellers in Mumbai. [30].

In Mulgaonkar's study, out of the 225 childless couples interviewed, 207 couples preferred allopathic treatment as their first choice, while 13 chose religious treatment as a first option. Differences in treatment sought by men and women were the consequence of the perceived causes. It was believed that the major cause of infertility in women was supernatural, that is, caused by evil spirits, and for men, the perceived causes were medical; therefore women were sent to religious healers, while men received medical treatment. [30].

Gender differences also exist in the manner of coping with infertility. Reissman has identified several resistance strategies adopted by women such as "taking a stand in an interaction, holding one's ground by refusing to internalise a deviant label, purposefully electing to sidestep a confrontation, and finally, rejecting motherhood altogether." [15]. Davis and Dearman, in their research with women, have documented six strategies used for coping with infertility. These include staying busy; regaining control by setting a time limit on their treatment; intentionally initiating behaviour that make them feel that they were being the best; looking for hidden meaning by believing that it was god's will; giving in to feelings by crying; and sharing the burden with their husbands, caring individuals, and other women who have experienced infertility. [28].

The experiences of childless couples and the process of seeking solutions for infertility do not always correspond to the biological fact of reproductive impairment. [3]. Gender impinges upon this experience very significantly. For instance among the Nayars in South India a daughter's reproductive impairment can destroy the status and future prosperity of the entire kin group.

Men have their own ways of coping. One of the ways is to transfer the blame on to the woman. [11]. Papreen et al, in their study of a Muslim population in the urban slums of Dhaka, found that the women held themselves responsible for not having children and continued visiting faith healers, even after receiving medical evidence of their husband's infertility. Men also exhibit better coping capacities over time. [31]. Coping also depends upon an individual's investment of time, effort, and money in the process of establishing one's "fertility" and on the perceived internal and external pressure to conceive. This draws focus on the individuals concerned, their personality traits largely determining whether they are able or unable to cope.

1.2.4 *Seeking treatment*

Technological advances have helped humankind achieve the impossible. Since the birth of Louise Brown in 1978, a path of artificial reproductive technology has been opened, providing joy to childless couples. Artificial reproductive technologies are widely available at private clinics all over the country and, though expensive, are boons for many.

Berer feels that it is internal pressure in individuals, not necessarily social pressure, which keeps them motivated to sustain the effort to have children. [32]. Mulgaonkar found that for the majority (201 out of 225 women), the decision to seek treatment was their own, though family pressure and anxiety of the family members, as well as feelings of dissociation from peers, were also motivating factors. [33]. Sayeed also reported similar findings in her study, in which couples stated external pressure as well as their own impatience to have children as motivating forces to seek treatment. [24].

The type of treatment sought by the majority was allopathic. In Sayeed's study, 73 per cent of the women, and in Mulgaonkar's study 207 childless couples, chose allopathic treatment as their first choice. Other forms of treatment, such as religious treatment and ayurvedic and homoeopathic treatments tend to follow subsequently. [33,34]. At times, treatment may have been given to childless couples without proper examination or even before

considering the simpler causes of infertility, one or more of which may be the actual cause. [10]. Mulgaonkar has also revealed that only 11 per cent of the childless couples had received any information on basic reproductive anatomy, physiology, manner of occurrence of conception and timing of coitus, nor had advice on behavioural practices been given by doctors. [33].

The other issue relates to the quality of the treatment and the determination of its success. For some, success of in-vitro fertilisation would mean a confirmed pregnancy, while for others it is a healthy baby nine months later. On the one hand, publishing success rates may be informative for patients, but, on the other hand, it can be misleading. Clinics could manipulate these figures and provide treatments that are "successful" rather than providing treatments that meet the needs of the individual.

1.2.5 *Legal issues related to infertility*

Infertility is not rare in India: around three per cent of individuals are primarily infertile and eight per cent suffer secondary infertility. [11]. But the problem has not attracted the attention of the government. This is probably because most people take the ability to have a child for granted. Governments worldwide are hesitant to take the stand that infertility is a disability and, therefore, infertility treatment is not considered worthy of reimbursement. It is not viewed as something urgent, and instead is seen as a discretionary option.

However, infertility is a medical disability, which also brings about social stigmatisation and causes a lot of suffering. It may be argued that only individuals who experience infertility can truly understand the problem. On this understanding, international networks such as the International Consumer Support for Infertility (ICSI) intend to bring "patient leaders" in many countries (which recently include Bangladesh, India and Japan) to discuss common interests and concerns. The aim is to "talk it out" with people who can really empathise. The International Federation of Infertility Patients Associations (IFIPA) is another self-help group where patients find comfort in speaking to someone who really understands. [35].

There are a number of social, economic and psychological aspects of infertility, which have important legal ramifications. Dill reports one such legal issue that relates to equity of access to assisted reproductive technology (ART). The objective of the health system is to deliver health care to all those in need. However, this target is often not met due to scarcity of resources, even in some Western countries. [35].

The American Surrogacy Centre has compared legislations of various countries for ART. [36]. In South Australia, the Reproduction Technology Act requires that a couple seeking assisted conception must demonstrate that they have no outstanding criminal charges or a history of any offence that was sexual or violent in nature. De Lacy argues, "Such requirements are both ineffective in protecting the welfare of children and also unjust and extra ordinary." [35].

Surrogacy is another option for childless couples, which involves a number of legal issues. While commercial surrogacy is prohibited in many countries such as the U.K (the 1985 Act), Australia and the USA, altruistic arrangements do take place between close family, friends and/or relatives. In India, the National Guidelines for the Accreditation, Supervision and Regulation of the Assisted Reproductive Techniques (ART) states that ART clinics shall play no role in commercial surrogacy arrangements. The guidelines are liberal with regard to payments made to the surrogates and have a clause through which liability is imposed on the infertile couples to bear the medical expenses of pregnancy. [36].

The guidelines have a very different view as compared to other nations, as they sternly prohibit close members of the infertile couple's families from acting as surrogates. This could be because altruistic arrangements may be emotionally exploitative, which could be worse than the economic exploitation that takes place in commercial arrangements. Further, commercial arrangements can often be reached out of a genuine interest of the heart. Therefore, the guidelines in India seem to be the most appealing, since they provide for surrogacy arrangements that are completely free from family dynamics. [36].

Another issue relates to parental rights. The law addresses the issue of who should be the legal mother of the child—the surrogate, the genetic

mother or the commissioning parents. The measures taken by the different countries to address this issue are different. The Indian guideline has elaborately laid down laws for this sensitive issue [36]:

- It does not consider the surrogate to be the legal mother under any circumstance.
- The birth certificate shall have the name of the genetic parents. Therefore, if the commissioning parents are the genetic parents, they shall be automatically recorded as legal parents. Adoption in such circumstances is not required.
- In case the gametes have been provided by a third party then the birth certificate will have the names of the genetic parents. The infertile couples need to adopt the child to be considered the legal parents. Once the commissioning parents formally adopt the child, the surrogate and the third party donors must surrender (in writing) all parental rights with regard to the child.

1.2.6 *Support networks*

The family and other social networks could play an important role in helping infertile couples cope with feelings of guilt, worthlessness, depression and low self-esteem, which they often experience. Most studies show that the childless individuals find their spouse, family and relatives to be sources of support. Bhatti, Fikree and Khan's study reveals that the kind of support the family members provide can range from motivating the couples to seek treatment, as in Pakistan, or recommending a series of home remedies, as in Mexico, or simply by having a neutral or sympathetic attitude towards infertile women. Formal support resources such as psychosocial counselling are relied upon less in comparison with the support of family and friends, as revealed in the study in the UK. [37].

Apart from these sources, infertile couples seek support from the media, using existing written and published documentation on the emotional aspects of infertility. A study in the UK by Boivin, et al, reported that men relied more on such non-human sources of support. Even though infertility is so stigmatising, community mechanisms to support infertile couples were not reported in the studies. [37].

1.2.7 *Cultural and personal interface*

Culture is an important factor in determining the developmental outcomes for an individual. Values, beliefs, attitudes and daily life practices are all based on the cultural orientation of the individual and the patterns followed through the ages. Culture, therefore, has a prominent role as an antecedent to behaviour. [38]. Importantly, culture and personality are inextricably intertwined. This understanding is the core perspective of cultural psychology.

The eco-cultural framework proposed by Berry, Poortinga, Segall and Dasen, and cited in Lonner and Adamopoulos, is useful in understanding psychological phenomena as adaptation to specific cultural and ecological contexts. It postulates certain probabilistic relationships between ecological and the socio-cultural settings and a person's behaviour. This relationship is highly complex and interactive. [38].

The ecological context is the setting in which the human being and the physical environment interact. This physical environment constitutes the family, community and the market, which in turn influence individual behaviour. The social and the political contexts are influential variables that determine the process of socialisation that an individual undergoes throughout her or his life. Culture determines the content of socialisation and the extent of its adaptation.

The framework helps us to conclude that in different cultures there are specific individual characteristics which reflect the cultural ideology, and which, in turn, has an influence on individual actions in terms of perceptions on particular issues and the coping mechanisms adopted. The issue of infertility and its cultural construction can be further understood through the concept-mapping exercise that had been carried out in the process of developing the conceptual framework of the research.

A concept-mapping exercise is a method that integrates qualitative and quantitative methodologies and provides an opportunity to develop an understanding of a concept as perceived by a group of people representing a specific culture. [39]. This exercise was carried out to determine the understanding of infertility as perceived by a specific cultural group. Informal couple interviews were carried out with five couples from middle and upper-

middle class families with a view to understanding involuntary childlessness from the perspective of the social group. Following the interviews, a group exercise was planned wherein the group categorised the various responses into clusters, naming each cluster according to their understanding of the response.

The conceptual framework representing group ideas and the existent ideology in the sample of middle/upper-middle-class society regarding involuntary childlessness is given in Figure 1. The framework has been adapted from the conceptual framework for cross-cultural psychology proposed by Berry, Poortinga, Segall, and Dasen, cited in Lonner and Adamoupoulous. [38].

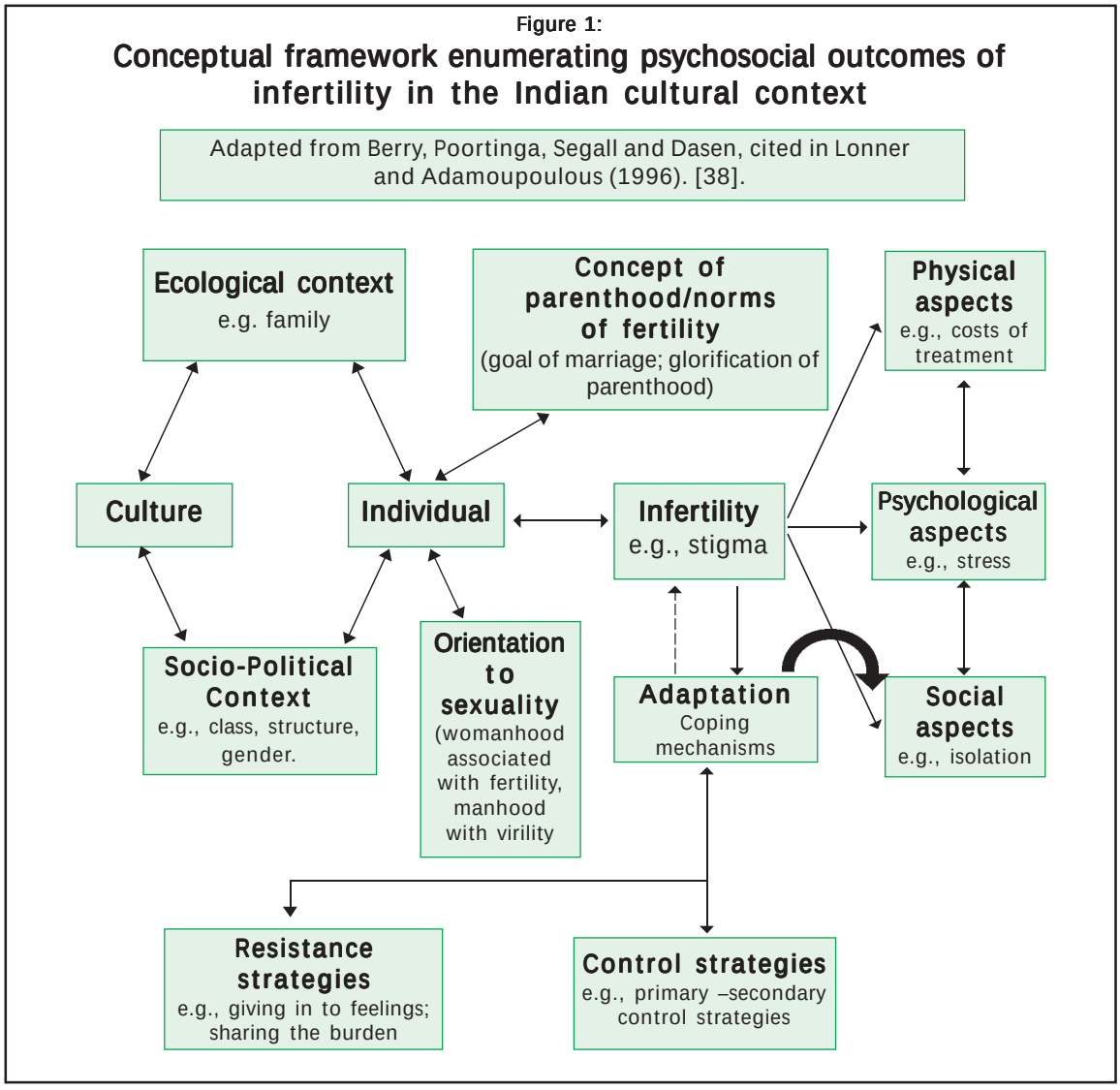
The framework describes the individual psyche as a product of the societal standards and the family's orientation to infertility. The experience of being childless contradicts the societal norm and results in physical, psychological and social stress for the individual. The impact of these on the individual can be determined by the coping strategies adopted.

The exercise of concept mapping has served the purposes of:

- enhancing an understanding of the phenomenon of childlessness from the perspective of the middle and upper-middle class of society, and,
- providing inputs in revising the interview guidelines for the present study.

Figure 1:

Conceptual framework enumerating psychosocial outcomes of infertility in the Indian cultural context



1.3 Rationale of the study

Infertility becomes a significant area of study in the contemporary situation because of the rising rates of couples experiencing involuntary childlessness. Although infertility is not rare in India, there is little social research on infertility. [15,24]. Since the Indian government is mainly concerned about overpopulation, reproductive issues and the situations of individual women remain largely hidden. Yet, research on childlessness and infertility could inform population policy by demonstrating the strength of the motherhood mandate and the stigma faced by those who cannot conceive.

The cultural motherhood mandate forces a woman to establish her fertility. The incidence of childlessness thus becomes more of a personal tragedy for a woman, reducing her status to one of a social outcast. It can create a sense of embarrassment, frustration and a feeling of personal failure for a woman. Adding to the injury is the ridicule and harassment by the family and rejection and ostracism by the society. Such familial and societal pressures have direct implications for the physical and psychological health of a woman. The man involved may also experience frustration and personal failure. He may be constantly instigated by significant others in his life to bring about a solution to the "problem," which may also affect his psychological state.

Societal perceptions of infertility differ across various sections of society, but what is prevalent across the classes is that childless couples become a "target." The experience of infertility has significant consequences on the marital life of the couple, often disrupting the bond of marriage. Thus, instead of focusing on involuntary childlessness as an individual problem, one needs to perceive it as situated within the arena of the marital relationship.

The "hi-tech" reproductive technologies marketed in India are also a cause for concern due to the expensive treatment procedures. Certain practices increase the possibility of HIV-infected semen being injected into "unaware" women. At the same time, women's bodies are used as experimental sites. [40].

This research aimed to study the perceptions of couples experiencing the problem of involuntary childlessness, their ideas about construction of parenthood, and the consequences of being childless. The study adopted an ethnographic approach, and in-depth interviews were the main method of data collection.

1.4 Research questions

1. What is the cultural concept of parenthood, both motherhood and fatherhood?
2. What are the psychosocial problems experienced by men and women facing childlessness?
3. What are the coping strategies used by women and men in dealing with childlessness?

Chapter 2
Research design and methodology

The design of the study was essentially descriptive with an ethnographic approach. The ethnographic approach was adopted to capture the cultural realities bearing on involuntary childlessness as construed by the participants. It was felt that the qualitative nature of the research would help cull out the nuances of infertility in terms of the lived experiences of individuals. The effort has thus been to retain verbatim responses of the participants wherever possible.

2.1 Study area

The focal group of the study comprised individuals from the urban middle/upper middle social class of Vadodara, a cosmopolitan city in the state of Gujarat, with a population of 1.5 million. The city has significant cultural variation and people of different religions have settled here. It is difficult to define the middle/upper-middle class, as it constitutes a large part of the population with a range of incomes. These families do not even share a similar lifestyle, which is, in fact, determined by the caste group to which they belong, the locality in which they reside, and their own attitudes and values. In Vadodara, the middle/upper-middle income groups are the educated majority, and most of them constitute the "service class." Each family owns at least one two-wheeler, which is either shared by the family or, in many cases, owned individually. Most of the women, irrespective of whether they are employed outside the home or not, have their own two-wheelers or at least know how to ride, thereby facilitating their mobility.

2.2 Methodology

The participant groups comprised individuals from the middle/upper middle-income group experiencing involuntary childlessness, individuals with biological children or in the process of planning a family, and practising gynaecologists and urologists.

Table 1.1 Participant groups in the study

Participant groups	Gender		Total N
	Men	Women	
Individuals representing society	30	30	60
Individuals experiencing infertility –group seeking treatment	20	20	40
Individuals experiencing infertility-group that discontinued seeking treatment	05	10	15
Doctors: urologists (3) and gynaecologists (7)	5	5	10
		Total	**125**

Men and women (not necessarily husband and wife) who were childless either due to self or spousal infertility formed the two groups. Data obtained from these interviews provided an understanding of the experience of involuntary childlessness.

The participants experiencing involuntary childlessness consisted of two groups: one group included participants who were seeking treatment for infertility and the other group constituted participants who had sought treatment for infertility earlier, but had currently discontinued the treatment, with a decision not to pursue it in the future. These two groups were selected to gain an understanding of the experience of involuntary childlessness in terms of seeking treatment and coping, and the impact on the self.

The group of individuals who had their own biological children, or were in the process of planning their family, represented societal perceptions of aspects related to childlessness, specifically to the importance of parenthood and fertility.

The health system plays a significant role in extending treatment for infertility. The attitude and approach of the medical practitioners is equally important, next only to the actual medicines. Hence, the gynaecologists and urologists were included in the study to delineate the role of the health system in infertility treatment. Private practitioners were approached as it was assumed that they cater services to the middle/upper-middle income groups.

The study participants were selected on the bases of specific criteria mainly in order to maintain the homogeneity of the group. Individuals having a family income of at least Rs. 8000 per month and education up to standard 12 were included. The participants from the group seeking treatment had been married for at least one year, whereas the group that had discontinued treatment had been married for at least eight years, to ensure that they had sought treatment at some point of time, either for their own or for their spouse's infertility.

Ten doctors (gynaecologists and urologists) running infertility clinics, or dealing with cases of infertility, were interviewed to gain a perspective on the health system's views of childlessness (in the larger socio-cultural context), and the treatment procedures. The urologists were included in the sample group, as suggested by the Ethics Committee, since men approach, or may be referred to, urologists for male dysfunctional errors.

The size of the sample varied from the earlier proposed number, based on the availability and willingness of the group to participate in the study. The criteria, too, needed to be revised due to constraints in obtaining consent of individuals to participate, as well as the timeframe of the project. The changes in criteria involved extending the range of education level from graduation and above to standard 12 and above and the duration of marriage was revised from two years to one and a half years.

2.3 Method of data collection

In-depth individual interviews were used for data collection (see Annexure 1 for the interview schedules), to elicit a holistic perspective of the perceptions and experiences related to infertility and childlessness.

The following are the main domains included in the interview schedule for the interviews with individuals experiencing involuntary childlessness:

- Meaning of parenthood
- Meaning of infertility
- Explanations for infertility
- Treatment-seeking behaviour
- Feelings regarding the process of seeking treatment, type of treatment and its expected outcome
- Feelings about and experiences with artificial reproductive technologies
- Spousal reaction/support
- Family reaction/support
- Societal reaction/support
- Coping behaviour

The schedule for the interviews for gynaecologists and urologists was based on the following aspects:

- Perception of involuntary childlessness. (Perceptions of themselves as individuals who are part of the Indian culture; and as health providers/doctors, referring to their experiences with their patients)
- Explanations for involuntary childlessness
- Psychosocial implications of involuntary childlessness and coping behaviour
- Role of new reproductive technologies
- Role of the health system

The interview schedules for interviews with individuals representing society were based on the following domains:

- Meaning of parenthood, motherhood and fatherhood
- Meaning of childlessness (involuntary) and infertility
- Gender aspects concerning infertility
- Seeking treatment
- Family attitudes and behaviour following infertility
- Effect/Impact on marital relationship
- Societal attitudes
- Alternatives available
- Coping with infertility

The schedules were prepared in English and then translated into Hindi and Gujarati, to be used according to the convenience of the participants. However, most of the participants preferred to respond in English. The schedules were pre-tested with one doctoral student from the department and one individual representing society. This was done in order to check the validity of the empirical questions. This exercise helped to finalise the interview schedule. Additionally, the project reviewer also reviewed the schedules, and suggestions for modification were obtained during the workshop on methodology organised by the Achutha Menon Centre for Health Science Studies, in June 2003 in Chennai.

2.4 Research team

The research team comprised the principal investigator, a doctoral student and two research assistants (one female and one male researcher). The major responsibility of the research assistants was to collect data and assist the principal investigator in data analysis. The female and male researchers were selected to conduct interviews with the female and male participants respectively, as it was felt that the respondents would be more comfortable sharing their views and experiences with individuals of the same sex, especially while dealing with a sensitive issue such as involuntary childlessness.

2.4.1 *Training of the research team*

Both the research assistants were from the discipline of psychology and trained in quantitative research. The nature of the present research being qualitative, it was necessary to conduct training sessions for them. The Ethics Committee that was constituted to review the ethical issues involved in the research and ensure that the researcher met with the necessary ethical considerations, also reinforced the training programme.

The first meeting of the committee revealed the concerns of the researchers in carrying out the interviews, observing the ethical considerations and handling any emotional situations that may emerge during the course of data collection. The first meeting thus formed the base for planning a workshop on "Interview as a Method of Data Collection." The workshop helped the researchers in building skills for in-depth interviews, developing an understanding of interview as a method for gathering in-depth information, equipping the researchers with skills to handle emotional situations during an interview, and enhancing their strength as interviewers. The researchers were trained to conduct interviews in a sensitive manner, keeping in mind the ethical considerations of the research and the rights of the participant. The components of training were as follows:

- Basic information about infertility
- Information about the methods of research employed by the present study
- Orientation to the ethics of research
- Sensitive data collecting techniques
- Ways of handling emotional situations during interviews
- Possible effects on study participants and how to deal with the same.

Intensive training sessions were carried out during the initial phase of the project. Weekly meetings were held to review the work on a regular basis, which helped to smoothen the process of data collection. Mock sessions were held, along with debriefing sessions, during the course of data collection.

2.4.2 *Ethical considerations*

An Ethics Committee was formulated consisting of individuals from academia and an NGO. The members were Ms. Urvi Shah, Population Research Centre and Ms. Bhavana Mehta, Lecturer, Faculty of Social Work, both from the Maharaja Sayajirao University of Baroda, representing academics, and Ms. Renu Khanna, Founder Member, SAHAJ and SARATHI (NGOs) representing non-government organisations.

Two Ethics Committee meetings were formally held through the course of the project. The first discussed the procedure of data collection and the ethical considerations during the phase of interviewing. The second meeting was held during the phase of data analysis.

The committee members were involved in the project from the initial phase of designing the methodology. They provided the staff with segments of their experience in the field in collecting data and carrying out ethically sound research.

The ethical considerations were refined and finalised in consultation with the team of researchers/ NGO representatives, who formed the Ethics Committee of the project.

- Informed consent (refer Annexure 2)
- Prior permission to record interviews
- Protection of autonomy, rights and dignity throughout the process
- Assurance of confidentiality
- Right not to answer any question
- Right to leave the research at any point of time
- Privacy at the time of data collection.

Informed consent was obtained from voluntary participants. Care was taken to respect and protect their autonomy, rights and dignity throughout the process of the research. All information and records provided by the participants were kept confidential by assigning codes for recording the data. The participants were informed that they have the right to leave the research at any point of time. During the interviews, if the participant did not feel like responding to any particular question, he or she had the right to say so. The recorded interviews were subsequently erased.

The researchers assumed complete responsibility for ensuring the protection and promotion of the interests and rights of participants while sharing or making public the available data in any form. A summary of the relevant findings was to be shared with participants who had expressed willingness to see the report.

2.4.3 *Dissemination seminar*

A dissemination seminar was organised to share the findings of the study with a group of interested professionals including gynaecologists, urologists, counsellors, and people involved in research related to women and reproductive health. The seminar also aimed to explore the possibility of setting up a network of interested persons who may be able to form a multidisciplinary support group for couples experiencing infertility.

Seminar discussions highlighted the fact that social and psychological factors are a major "cause" of infertility, in addition to medical problems. All the resource persons acknowledged the need for an integrated approach to treat infertility. It was emphasised that a number of unnecessary procedures can even aggravate the cause of infertility.

In presentations related to their current work, the resource persons Dr. Maya Hazra and Dr. Veena Mulgaonkar shared their efforts to offer integrated services, which included providing psychological counselling along with prescribing medicines. Dr. Mulgaonkar stressed the important role that communication and counselling can play in treating infertility. She emphasised the need for medicine and social sciences to form a network to build awareness about infertility and the need to advocate sensitive policy generation.

Dr. Rajni Vyas shared her work on "Unexplained Reproductive Failure and Management by Hypnotherapy." She emphasised oneness of the body-mind, contended that all diseases are psychosomatic, and that hypnosis can be used effectively to treat infertility.

Unfortunately, many doctors could not participate in the seminar due to time constraints. Hence, copies of the research findings and highlights from the seminar discussions were sent to the doctors as well as participants from NGOs and academic institutions that were unable to attend the seminar.

2.5 How the study was conducted

The study with the four different sample groups was carried out according to the procedure described below:

(i) Individuals with biological children or in the process of planning a family: The group of individuals with their own biological children was contacted through the snowball technique. Individual interviews were carried out with willing participants, at a mutually convenient time and place, which was decided beforehand. During the meeting, they were oriented with the research and consent was sought for the interview on the spot. Each interview lasted for about half an hour to 40 minutes.

(ii) Group seeking treatment: The first group of individuals who were childless was selected through practising gynaecologists. A few gynaecologists were approached and oriented with

the research. Their help was requested in seeking consent from their clients who were willing to participate in the study. Handouts describing the nature of the study, and the assurance of complete confidentiality, were given to the individuals during the initial part of the interview, along with a brochure highlighting the medical aspects of infertility (see Annexure 2). Most gynaecologists had requested their receptionists or assistants to introduce the researchers to the willing participants.

(iii) Group not seeking treatment: The second group of individuals, who were childless and had discontinued seeking treatment, was identified by the snowball method. They were verbally briefed about the study, as well as given a handout describing the nature of the study. They were assured of complete confidentiality (see Annexure 2). Written consent was obtained from each individual.

The interviews were then carried out as per the convenience of the participants, either at the clinics or at their homes. The duration of each interview was approximately half an hour to one hour. The majority of the interviews with group one were clinic-based. Initially it was proposed that two meetings would be carried out with each individual, an initial meeting for building a rapport and the next meeting for the actual interview. However, many respondents were not willing to meet for a second time. Hence, we were able to conduct only one session for each interview.

(iv) Gynaecologists and urologists: Interviews with the gynaecologists and urologists were carried out during mutually convenient times. The interviews were conducted in English, Hindi or Gujarati, as per the preference and comfort of the respondents. Interviews were tape recorded, transcribed and then translated into English, retaining the verbatim responses. Wherever the participants were hesitant about the tape recording of the interview, running notes were taken, which were later expanded.

2.6 Process of gathering data

Gathering the data was not an easy task and we had our share of problems. The first hurdle was the resistance amongst participants to agree to the interview, and their look of resentment after they had disclosed certain facts during an interview. It was difficult to assess whether this was a reaction to the interviewer, the nature of the interview, or the realisation that they had disclosed some facts which one usually would not like to share, given the sensitive topic.

There were times when the researchers were left feeling disturbed after an interview. The constant preoccupation with gathering data, listening to individual problems, understanding the complete process of seeking treatment, and empathising with the pain, led to researcher burnout. However, the meetings of the Ethics Committee and the frequent debriefing sessions within the group and with the principal investigator helped to make meaning out of the complex experience.

We could observe the doctors with their busy schedules dealing with non-compliant patients and their inhibitions regarding the treatment, and long queues of patients waiting for their turn. Such observations enabled us to understand that it was not easy for the doctors to inform their patients about the research. However, the doctors did make all the necessary arrangements to facilitate the research, such as providing the researchers with private space for the interviews, requesting their assistants to help the researchers identify the participants and, whenever possible, talking to their patients about the research. (Refer to Annexure 4 for first person accounts of the researchers).

2.7 Analysis of the data

The data were analysed qualitatively. Frequencies were calculated for the socio-demographic variables and a few other domains where this was deemed necessary.

2.7.1 *Forming analytical categories and coding the data*

Initial categories were formulated through a microanalysis. Mnemonic codes were formed, based on the initial categories, which finally lead to evolving conceptual and analytical categories that could be located in the text, to make sense of the scope and coverage of the data.

Coding was done at three levels. Open coding, which was essential to make sense of the vast

amount of data, was qualitative in nature. This helped to code the data in the initial phase, following which axial coding was done to draw specific categories and sub-categories. Selective coding was done to finally evolve categories that addressed the research questions and the objectives of the research.

2.7.2 *Establishing reliability*

Inter-coder reliability was established following the procedures outlined below:

After interviews were selected at random from each group of participants:

a. Preliminary codes were formulated based on the salient domains of the interview schedule.
b. The three researchers then coded each interview separately based on the pre-formulated coding categories.
c. The coded interviews were compared in terms of the categories and the meanings. attached to these. Discrepancies were discussed to arrive at a common understanding.
d. A final list of codes was developed.

The following steps were followed for qualitative analysis:

1. Coding each interview according to the categories. The coded responses were then transferred into matrices to view the responses of each participant on a given category together. This process helped in forming the verbatim tables (see Annexure 3).

2. Culling out patterns of responses related to the following major domains:

   - Meaning of parenthood.
   - Meaning of involuntary childlessness.
   - Explanations for involuntary childlessness.
   - Process of seeking treatment
   - Coping behaviour

Microanalysis involves careful minute observation and interpretation of data. It is necessary to generate initial categories and to suggest relationship among categories. [41].

Mnemonic codes (e.g.)

Category	Code
Importance of parenthood	Imp.Pthd.

Open coding involves breaking data into discrete parts and closely examined and compared for similarities and differences. Subsequently similar events related in meanings are grouped together under the same categories. [42].

Axial coding involves resemblance of the data. Categories are related to the sub categories to form precise and complete explanations about the phenomenon. [42].

Selective coding involves revisiting categories for integration and refinement of categories and sub-categories. [42].

Following these steps, a gender analysis framework (adapted from the gender analysis framework of the Department for International Development, Liverpool [43]) was applied to obtain an account of how gender impinges on the arena of infertility and childlessness.

2.8 Limitations of the study

The research focuses on the middle/upper-middle income groups of society. The group seeking treatment was selected from private clinics only. There may have been individuals seeking treatment from government hospitals as well, but the research did not address this aspect.

Most of the interviews were clinic-based, and there is a possibility that a few participants might have inadvertently felt pressurised to give their consent, although efforts were made to ensure privacy. The clinic-based interviews were also shorter in duration as compared to the home-based interviews, which could have been due to the nature of the setting.

The interviews were conducted in one session, which did not provide ample time to establish a proper rapport with the participants, which is necessary especially for an issue like infertility. We had sought their consent for at least two meetings, but later the participants were not willing to meet for the second session.

Most of the interviews were done in English, which was not the mother tongue of the participants. This might have had implications on their expression of feelings related to the sensitive issue of involuntary childlessness.

Chapter 3
Results and discussions

This chapter presents the perceptions of the participants in the study in the form of results and interpretations. The chapter is divided in five sections. The initial three sections represent the perspectives of the group of couples with their own biological children or in the process of planning a family, experiences of the group seeking treatment and of the group not seeking treatment, and perceptions of the medical practitioners dealing with infertility. The quantified data has been represented as frequency tables (refer Annexure 3).

Table 3.1 Background details of group seeking treatment

Age group	Men	Women
20-29	05	13
30-39	14	06
40-49	01	01
Education		
Higher secondary	04	-
Graduate	14	18
Postgraduate	02	02
Income (in Rs.)		
8,000-12,000	04	04
Table 3.1 continued: 13,000-15,000	04	04
16,000-20,000	08	05
21,000-25,000	00	01
26,000 and above	04	06
Family type		
Joint	10	12
Nuclear	10	08
No. of years of marriage		
1 year- 2 years	-	01
2 years-5 years	08	12
5 years-10 years	10	05
10 years-15 years	02	02
Occupation		
Homemaker	-	15
Business	08	-
Service	12	04
Self-employed (tuitions)	-	01

Table 3.2 Background details of the group not seeking treatment		
Age group	**Men**	**Women**
20-29	-	01
30-39	02	04
40-49	01	03
50-59	02	02
Education		
Higher secondary	-	01
Graduate	03	06
Postgraduate	02	03
Income (in Rs.)		
8,000-12,000	02	02
13,000-15,000	-	02
16,000-20,000	01	02
21,000-25,000	01	01
6,000 and above	01	03
Family type		
Joint	-	03
Joint	-	03
Nuclear	05	07
No. of years of marriage		
8 years	-	01
10 years-15 years	04	07
Above 15 years	01	02
Occupation		
Homemaker	-	04
Business	02	01
Service	03	05

Section four enumerates the gendered nuances that affect individual ideologies on parenthood and the mechanisms of seeking treatment and coping. Section five profiles the treatment seeking and the coping behaviour as it emerged in the research through a few case studies. The tables that follow highlight the socio-demographic details of the study participants.

Table 3.3 Background details of individuals with biological children or planning to start a family

Age group	Men	Women
20-29	06	06
30-39	06	06
40-49	06	06
50-59	06	06
60-69	06	06
Education		
Higher secondary	04	05
Graduate	11	13
Postgraduate	15	12
Income (in Rs.)		
8,000-12,000	05	04
13,000-15,000	03	03
16,000-20,000	07	02
21,000-25,000	09	04
26,000 and above	05	17
Family type		
Joint	13	07
Nuclear	17	23

3. 1 Societal perspectives on parenthood and involuntary childlessness

This section describes the perspectives of individuals with biological children or who may be in the process of planning a family. These perspectives represent the cultural ideologies surrounding parenthood in the middle/upper-middle urban classes residing in a city. The participants represented the 20 to 70 years age group, education from higher secondary to post-graduation, income ranging from Rs. 8,000 to Rs. 25,000 and above, and belonging to joint as well as nuclear families.

This section[1] gives an idea of the set notions of parenthood in the parts of society under study and, by implication, the effects of involuntary childlessness on the self and the marital relationship. It also looks at views on seeking treatment as a coping behaviour, apart from other ways of coping, and the role of the government and private clinics in providing infertility treatment.

In Indian society, the phase of attaining parenthood holds a significant position and it is considered an inevitable stage following marriage. In India, the importance of children cannot be overstated. Empirical findings also point to the social, economical, psychological and personal value of having children. [19]. The complete process is attributed importance and is visualised as bestowing the couple, as well as the family, with joy and future happiness leading to *moksha* (salvation). Children are looked upon as the binding force that strengthens marital and familial bonds, filling the void in marriage. Apart from this, they are also a source of security for old age, which comes through in the present study as well. Therefore, the birth of a child can satisfy multiple needs such as fulfilment of conjugal desires, social expectations for family decent and the personal desire to be perceived as normal. [44].

3.1.1 *Importance of parenthood: motherhood versus fatherhood*

The participants described parenthood in different words. They talked about a child as an important being, bringing immense joy and happiness to the couple and the family, and making the family "complete." The child was important for the self, in the sense that the child provided a person with a "purpose and desire" to lead a fruitful life. The child also conferred a higher status on the couple and eased societal pressures to prove one's reproductive capacity (see Table 1 in Annexure 3). Women respondents said it was required for both women as well as men to be able to consolidate their fertility and virility, respectively.

Inclusion in religious rites and rituals too require a child as the "gate pass." Nene, Coyaji, Rao and Apte report that to attain *moksha* in Hindu culture, many rituals are required to be performed by a child, hence a child is of utmost importance. [23]. It is also believed that the soul attains salvation only on being released through the death rites performed by one's offspring. Motherhood demonstrates the woman's physical and psychological adequacy, and being producers of the next generation confers a social identity on them. [19].

Descriptions of motherhood and fatherhood were articulated more in terms of conventional roles and responsibilities. Motherhood was associated with womanhood and fatherhood with a sense of fulfilment, connoting failure for a man who is childless, while negating womanhood altogether for a woman who has not conceived. Apart from this, the father's role was viewed as that of a provider, guide and role model; and the mother was held responsible for good upbringing (see Tables 2 and 3 in Annexure 3).

- "A woman is not just biologically but also psychologically programmed to be a mother."

- "A child strengthens the bond between the husband and the wife and also binds the family members."

- "Apart from just having the desire to have a child, the couple also want the social pressure to reduce, which is also an important reason in our culture or society."

- "We need a child to meet our psychological demand, we have an innate feeling to love."

- "A child gives a sense of security to the fathers also. It's not only the mothers who think that the child will support them when they are old."

- "A child is necessary for the woman because it's the proof of her reproductive capacity. It is of a great significance. And for a man a child is a proof of his manliness."

[*1] Verbatim responses are presented in boxes.

3.1.2 *Childlessness: attitudes and impact on self*

The group expressed considerable awareness about infertility and its causes. The interviews revealed that most of the perceived causes could be attributed to the socio-demographic change of increased age at marriage, use of contraceptives to delay pregnancy, and changing lifestyles focusing on increased use of alcohol, tobacco and mobile phones. Psychological factors were also referred to, such as stress due to increasing competition in the struggle for survival. Along with this, the participants also acknowledged the gender issues related to infertility.

Society ostracises both women as well as men. They may be treated as outcasts and isolated during social gatherings. Women, especially, may not be included during auspicious ceremonies such as baby showers. "Seeing [a childless woman's] face first thing in the morning" is still considered a bad omen (see Figure 2).

Figure 2: Societal attitude towards childlessness

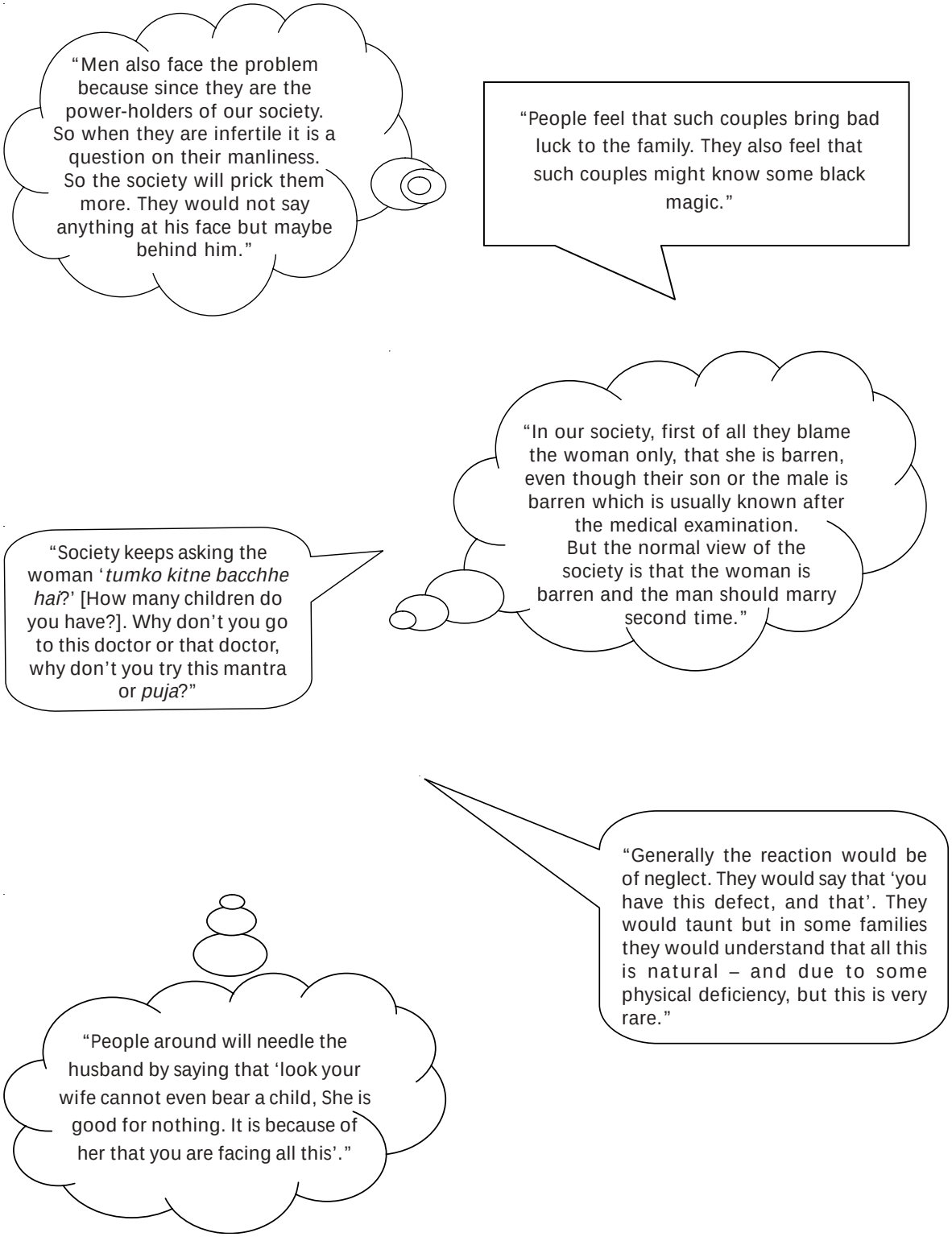
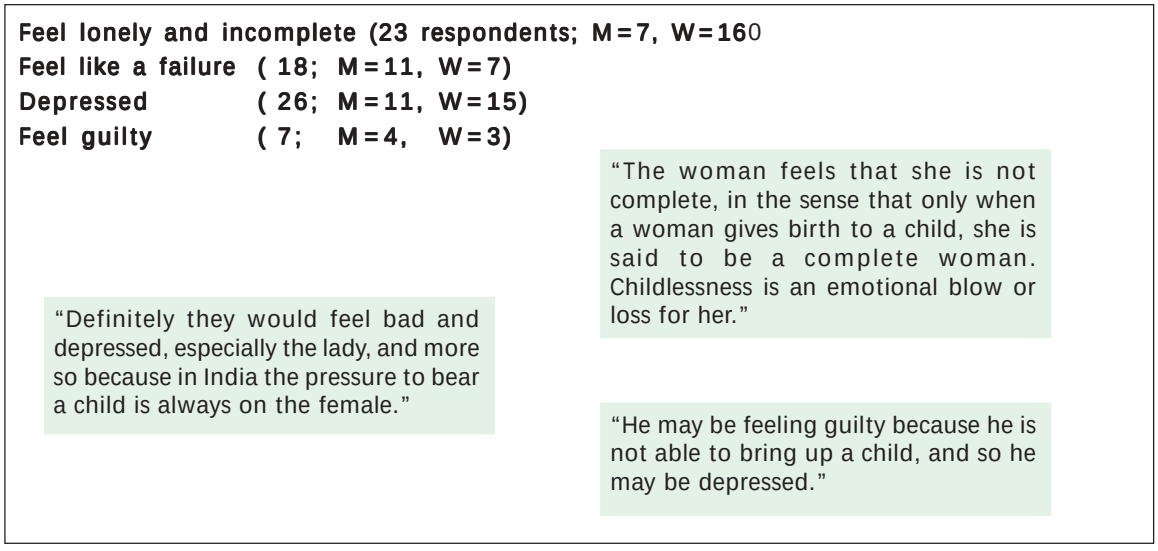


Figure 3: Feelings regarding childlessness



Women were usually subjected to direct queries. Men were saved from such questions, though they too were not spared. They were looked down upon and their "manhood" was questioned. The family, too, exhibited a biased attitude where childlessness was concerned. Women were blamed and they might even have been subjected to physical and/or verbal torture. Remarriage of the man emerged as a strong possibility, because it was important to continue the family lineage. In case the "fault" was with the man, the family found it difficult to accept this and could go to the extent of "covering up the complete issue."

Some also mentioned that the family was supportive (see Table 4, Annexure 3). This shows that in middle/upper-middle urban class society, along with awareness about infertility, people have also become more tolerant about the issue of childlessness, and the family emerges as an important institution that needs to be strengthened.

The implications of childlessness on the self were expressed mainly in terms of feelings of guilt and failure. The idea of the inability to reproduce impinged on the individual's psyche, thereby leading to depression. This was more so because in the course of marriage, attaining parenthood, especially motherhood, became of utmost importance. It was talked about as a loss for the woman, since in India, the responsibility to reproduce is perceived as being the woman's.

These feelings may also affect the marital relationship, the trouble often beginning with small tussles in the "blame game." Slowly, the couple may drift apart, as childlessness is a sensitive issue; and ultimately, it may end in a divorce. Women may degrade their husbands in front of others, or verbally torture them, if the "fault" is with the husband. The couple's sexual life also gets affected. Yet, there will be couples that support each other with no evident impact on their marital life.

The factors that may make a difference in how the issue impacts the individual were the woman's education, which may help her to understand and accept the fact better, and her employment status, as work enabled her to step out of the house and reduced the extent to which she mulled over her state of being childless.

The role of the family as an important support network was mentioned; if the family understood the problem, then the intensity of the problem reduced to quite an extent. Apart from these extrinsic factors, the focus was also on an individual's predisposed personality, which mediated the perception of the situation. If having the child were the first priority for the individual, then the impact would be greater (see Table 5, Annexure 3).

The best possible solution, suggested by many, was adoption, which required openness to the idea of adoption. The procedures of adoption,

though easy, are lengthy, and may dissuade the couple from adoption. The child's "origin," in terms of the family (heredity), and the acceptance of the adopted child in the family and society, were also a cause for concern. However, adoption definitely brings about psychological satisfaction for the couple. Other suggested ways of coping were investing financially and/or emotionally in other children, and diverting the mind by involving oneself in different activities.

Astrology also emerged as a way of coping (see Table 8, Annexure 3). It is a science that helps delineate characteristics and behaviour patterns, but it was resorted to as a tool to foresee the future. In the case of childlessness, astrology became all the more important, as it seemed to build hope, or, at times, it helped couple's to accept their childlessness.

- "Concerns about adoption? God knows if it is a legal or an illegal, or an illegitimate child, which caste it belongs to… all these concerns are there. Then it depends on what stand the couple wants to take."

3.1.3 *The health system: government versus private clinics*

The participants acknowledged the dearth of facilities for infertility treatment, making it all the more unaffordable. The government lacks the necessary infrastructure facilities. Respondents also felt that while the government was unable to provide the basic health care needs, advanced technologies for infertility treatment were beyond its reach. The government needs to address this issue on a priority basis. If treatment were accessible in terms of the physical aspects as well as the costs, then a greater number of people would benefit.

Private clinics were perceived as costly and financially accessible only to a specific part of the population. Infertility treatment limits itself to the better-off sections of society due to high costs of the artificial reproductive technologies and related drugs. It was suggested that doctors needed to be sensitive towards this issue and provide psychological support to the couples seeking infertility treatment. This was emphasised as it was felt that doctors have become more professional, which may have led them to become mechanical and money-minded. Infertility being such a delicate issue, doctors needed to cultivate skills for counselling or make provisions for client counselling. The need to provide referral services by the government and make the procedure of adoption easier was also mentioned (see Table 7, Annexure 3).

- "I think the treatments are too costly, which everyone cannot afford. I think that the government should come up with some schemes to help such couples."

Infertility, which has always been considered a "hush-hush affair," no longer seems to be a taboo subject (see Table 3.4). Though the respondents may have felt that society is still not open to this issue, through their responses they suggested increased awareness, as well as adequate information, on infertility in urban middle/upper-middle class society. This may be because of the emerging fact that even though infertility is a medical condition, the implications of being childless are more psychosocial in nature.

Table 3.4 Knowledge about infertility

Categories	M	W	Total
	N=30	n=30	n=60
Medically diagnosed causes			
Structural and functional problems in the reproductive organs (Problems with ovulation and tubal blockage, sperm count or motility, vericocelle, hormonal problems)	18	19	37
Social Causes (Late marriage, postponing conception, rituals and conventions, habits –food habits, alcohol and tobacco abuse, environmental factors, psychological factors, mobile phones)	12	7	19
Heredity	3	2	5
Side-effects of contraceptives	1		1
No response		2	2
Treatments			
Test-tube babies	7	5	12
Artificial insemination	1	8	9
Surgery and medications	7	1	8
Surrogate mothers	4	3	7
In-vitro fertilisation	4	1	5
No response	7	12	19

3.2 Experiences of involuntary childlessness: groups seeking and not seeking treatment

This section represents the experiences of the groups seeking or not seeking treatment. The socio-demographic details of the group put the age of the treatment-seeking participants in the range of 20 to 49 years, education from higher secondary to post-graduation, income ranging from Rs. 8000 to above Rs. 25,000 per month, duration of marriage between one and 15 years, representing nuclear as well as joint families, and with most of the women not employed outside the home.

The group not seeking treatment was also between 20 and 59 years of age, with all of them in the 35-plus age range (except for one woman), education from higher secondary to post graduation, income ranging from Rs. 8,000 to Rs. 25,000 and above per month, duration of marriage between eight and 15 years (and above), representing nuclear as well as joint families, and many of the women employed outside the home (see Tables 3.1 and 3.2).

3.2.1 *Importance of a child, feelings regarding childlessness and the impact on self*

"I am feeling as though I am missing something in my life."

The importance of having children was indicated through the feelings that accompany the absence of children, feelings of depression and incompleteness. Even men reported feeling incomplete; and these were the men who also reported being persistent with their treatment and changing a number of doctors. A general "bad feeling" which participants were unable to translate into words was reported. Women from joint families reported pressure from relatives who asked inquisitive questions about motherhood and asked them to

"hurry up." Details of their sexual lives and use of contraception also got discussed by relatives. The women talked about their identities being related to having a child.

Women who were employed were more open to alternatives such as adoption and donor sperm. Unemployed women preferred intra-uterine insemination, and either adoption or in-vitro fertilisation, especially those for whom finance was not a problem. One working woman, whose husband had the problem, reported being sarcastic with her husband during her moments of frustration.

Men, on the other hand, did not reveal their feelings, but instead talked of feelings of depression and tension in their wives. Here, societal orientation toward masculinity is clearly seen. Men are not allowed to verbalise their feelings, unlike women, who may cry in front of strangers to relieve themselves. Men did not talk of frustration in their life. One of the men who reported the problem of azoospermia admitted that his wife would get angry with him at times (they were still undergoing treatment), and she justified her feelings of anger. Men, too, faced verbal torture, but this may not be common.

In the group not seeking treatment, acceptance of the state of childlessness was linked to their attribution of their state to destiny. Yet, a feeling of helplessness also came through, as expressed by men. The women were more articulate in expressing their feelings when they talked of the psychological trauma and the stress of not being able to conceive, and the feelings of depression during menstruation when they again faced failure, leading to long hours of isolation and crying (see Table 11, Annexure 3). This, they reported, got aggravated at a later age when, after undergoing treatment for a long time, they still could not conceive, and their hopes started dwindling.

The importance of the support of the family was seen in the report of a woman describing how the family ostracised her and her husband, and favoured her brother-in-law and his children. She reported intense feelings of loneliness and depression and long hours of crying in isolation at a secluded place, a temple. She even shared information about how her personal and social life was disrupted because of the family's negative attitude towards the couple (see Table 14, Annexure 3).

The group seeking treatment displayed a hope of conceiving; maybe that was why they tolerated the pain of the treatment and bore the high costs, without relenting. This hope was noticeable in the sense of assurance they felt was provided by astrologers

- "For me it does not matter, but I have seen her crying many times."

- "I feel *mere saath hi aisa kyon hua, maine to kisika kuchh nahin bigada hai?*"(Why did this happen to me? I have not done any wrong to anyone.)

3.2.2 *Realising the problem*

Some participants reported seeking medical help almost immediately, with four of them seeking treatment within six months of marriage. There were also individuals who realised the need for medical help after nearly six years of their marriage. Four women who had menstrual irregularities before marriage were the ones who sought help immediately. They were the ones who reported approaching the doctor first, maybe because they anticipated problems in conceiving. The couples that did not anticipate any such problems were the ones who waited for a longer duration before approaching a doctor.

3.2.3 *The approach of doctors*

Women from the group seeking treatment reported not being given any kind of basic information about reproduction or infertility, types of treatment, success rates, costs, or the duration of treatment. Three of them were prescribed medicines on their initial visit itself, except for one woman who reported that her husband was tested before beginning with her treatment. In terms of the time input by the doctors, many women justified the doctors' not being able to give them enough time, saying that they cannot, and that it is the patients' responsibility to comply and be regular with the treatment.

Men did report being informed about a few scattered aspects regarding the medication, but they were given no detailed information. They drew comparisons between different doctors and asserted that the doctor's attitude was the main reason for either continuing with the treatment or changing doctors. Reasons for changing doctors also included having to discuss their history in front of others, not being informed by them about the problem, the doctor's insensitive behaviour, as well as the desire for a second opinion.

- "Dissatisfaction was there because response *nahin dete the*" (they did not respond well).

- "We must get proper results. For six to eight months we have taken the prescribed medications and there is no result. Money is no constraint, but if we spend money for some work, then the work should be done."

Eleven men reported having low sperm count or vericocelle. They had to seek treatment for themselves, and dissatisfaction with the treatment was the major reason for changing doctors. Men talked more of the problems with the treatment rather than their wives' issues as the major reason for doctor shopping. Thirteen of them also reported that the doctor was very sensitive and caring, discussing each and every aspect of the problem, and providing them with options (see Tables 19 and 20 Annexure 3).

Table 3.5 Number of doctors consulted

Category	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total
	M	W	M	W	
1-2 doctor	2	8			10
3-4 doctors	6	7	1	5	19
More than 5 doctors	24		4		10

Regarding the cost of treatment, women reported that their husbands insisted on continuing with the treatment, whatever the costs. Men reported the costs being their major concern. Men from joint families indicated financial support from the family, thereby easing their burden, whereas men from nuclear families with a higher income referred to the treatment as preventing them from saving any money for the future. Financial considerations emerged as one of the main reasons to discontinue the treatment for a certain period. Men also expressed their concern over their wives' treatment, but those who felt that a child was important in terms of family continuity and old age security, persuaded their wives to continue the treatment, irrespective of any problems, personal or financial.

Table 3.6 Cost of the treatment

Category	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total
	M	W	M	W	
Expensive	9	3		5	17
Affordable	6	5		2	13
Manage with help	3		4		3

In cases of male infertility, wives were found to be supportive of the treatment, and also persuaded their husbands to continue with it. The group not seeking treatment reported having spent nearly Rs. 100,000 for the treatment. They had visited different cities in search of infertility experts. They felt that they needed more from the doctors in terms of guidance and support, and even suggested counselling as part of the treatment procedure. The lack of counselling was cited as one of the main reasons for non-compliance, along with commuting problems and sheer frustration. Twenty-eight participants reported that the doctors were supportive and candid about the problem, whereas 13 participants complained about being treated mechanically (see Table 19, Annexure 3).

3.2.4 *Making decisions regarding the treatment*

Men, as well as women, reported that the woman was the first to voice concern and raise the matter of taking treatment. The decision to actually initiate the treatment was made by both the wife and husband. Men from joint families reported

discussing the issue with a brother or the father before seeking treatment, whereas women from joint families reported that their marital as well as their natal family suggested treatment if they did not conceive.

3.2.5 *Parenthood and treatment*

Women who expressed an intense desire for motherhood also expressed their wish to continue with the treatment despite the side effects and the frustration due to no results. The side effects reported were loss or gain in weight, changes in their personality, such as getting irritated with and angry over small matters, pre-menstrual cramps, dandruff and acidity. At times they reported feeling tired and wishing to discontinue the treatment (see Table 22, Annexure 3), but the hope of conceiving persisted, and they convinced themselves by saying "a few more months."

Some women were persuaded by their family to continue with the treatment. One participant's family suggested discontinuing the treatment (she did not agree). Surprisingly, she spoke of a child holding no importance for her, except for removing the boredom from her life, but felt the child was important for her husband. Women who wished to continue the treatment also expressed feelings related to the importance of a child for their husbands and the family. Two women even reported leaving their jobs in order to pursue the treatment.

3.2.6 *The marital relationship*

Marriage and parenthood are intricately linked. Children are thought to bind and strengthen the marital bond. Thus, the importance of a child for an individual is likely to influence perceptions and attitudes towards the marital relationship.

The couples reported minor conflicts between themselves, but many did not attribute the cause to childlessness. They described it as part of their marital lives. Two women stated that they verbally abused their husbands to express their grief over not being able to conceive, and over facing social inquiries due to their husbands' infertility. Some men reported asking their wives to disclose to the family that the problem was with the husband, yet the wives did not, and bore the brunt themselves. Marital conflicts were reported in instances where the husband expressed an intense desire for a child but the wife did not echo his sentiments. A big age difference between the two was an associated factor. In one such instance, a wife reported that the husband forced her to undertake treatment, which led to disputes. Women also reported disputes over financial matters related to treatment.

Men did not report any tensions or discords in their relationship because of childlessness, but they expressed dissatisfaction with their sexual life, which was being disturbed on account of having to coordinate it with the treatment procedures. They also sensed that their wives were sexually disturbed because of the concern over conception. Two men also reported coming closer to their wives because of these concerns.

- "I have a problem with my sperm count—azoospermia. *Mujhme bachha paida karne ki takat nahin hain*" (I don't have the capacity to father a child).

In the group not seeking treatment, women reported disturbances in marital life during the phase of treatment, due to non-compliance on the part of the husband in situations where male infertility was the cause. Women also talked of discord due to lack of support from the husband for the treatment, and also because the husband would not consent to adoption. They described their families as exacerbating matters by blaming the woman for the problem, by not supporting her husband, and by suggesting that the couple adopt against the husband's wishes. Some families were hesitant to agree to adoption due to discomfort with property matters. There was a feeling that the property should rightfully go to their biological grandsons.

3.2.7 *Support networks*

Both women and men rated family and friends as being their greatest supporters. Women also described spousal support, whereas none of the men talked about their wives being their source of support. However, the men did show concern over

their wives getting the family's support. Friends were described as very supportive, influencing the couples' decisions regarding the treatment. Friends also played a role in enabling the couple to initiate treatment and/or convincing one spouse to visit the doctor or to continue with the treatment.

3.2.8 *Societal and familial queries: the quest to balance the self*

Women and men from both the groups reported being subjected to societal queries. Women were posed direct questions about their motherhood, though it was not always perceived as being negative or intrusive. However, they reported other women calling them *vanjan* (infertile). They reported being isolated during certain occasions like *shrimant* (baby showers) and social gatherings like children's birthday parties. They even felt they were being treated as deviants, digressing from the norm. Men, on the other hand, reported only their wives being subjected to societal queries. Only two men reported negative comments on their masculinity, which they found to be derogatory.

Twenty-four participants said that the family was supportive. However, nine women and three men reported isolation, neglect and rude behaviour by family members, which had, in a few cases, led them to move to their own homes. Women reported the natal family to be very supportive at each stage of the treatment as well as after the treatment (see Table 14, Annexure 3).

Women who were employed, and men who were diagnosed as having the problem, reported retorting to intrusive questions, by asking people to mind their own business or simply ignoring the comments. Others reported by saying that they hadn't planned a family yet. Some informed people about the treatment without any hesitation. Some men reported their wives crying and feeling more depressed because of such queries and the family's negative attitude towards them. They reported pacifying their wives by asking them to learn to ignore such comments or talking about people less fortunate than themselves. Women, too, reported isolating themselves and withdrawing from social gatherings.

3.2.9 *Feelings regarding childlessness and coping behaviour*

Various primary and secondary control strategies identified by Weisz, Rothbaum and Blackburn are evident in the coping patterns of the participants. [26]. Seeking treatment emerged as a primary control strategy wherein the individual tried to change the existing realities. Along with this, secondary control strategies were also observed among the group, especially in individuals who had been undergoing treatment for a longer duration of time, that is, for more than a year. Participants who had just begun the treatment exhibited only the primary control strategy. This may be because when they first went to a doctor there was the hope of conceiving but it dwindled with the duration of treatment and advancing age.

The present study reveals that individuals adopt different strategies to cope with involuntary childlessness. Women reported performing *puja* (prayer), observing fasts and *badhas* (vows), visiting the temple, and seeing astrologers. Men, too, adopted such strategies, albeit to a lesser extent than women. This was particularly observed among those men who had expressed an intense desire to have a child. Nineteen men attributed their childless state to destiny, expressing their faith in god and various religious leaders. In cases where astrologers had predicted a child, men did not follow any ritual, but they did report that their wives did *puja*s and kept fasts. Two men mentioned that their families observed these rituals for them, and some reported observing such rituals themselves for the sake of the family, even though they themselves did not believe in them.

Men, who reported their wives' negative feelings towards themselves due to their state of childlessness, also described their wives' coping mechanisms. These included involving themselves in household chores, observing fasts and performing *pujas*. They also reported convincing their wives to accept the state of childlessness by citing examples of people who were being ill-treated by their own children. One man reported purchasing a computer for his wife so that she could become engaged in playing games. Two men felt that when women stay alone at home, they keep thinking of their state and feel depressed (see Table 23, Annexure 3).

Women who expressed feelings of depression and of wanting to cry a lot (see Table 11, Annexure 3) were the ones who adopted strategies such as involving themselves in activities like household chores, observing fasts, performing *puja*s. Four women reported not following any such rituals because their husbands did not believe in them. Women from nuclear families appeared to be a little more at ease; they performed *puja*s, believed in astrology, invested in others' children, and yet had left their fate to destiny.

A few women were open to adoption, but many had not even considered it as an option, because they nurtured the feeling that they would surely have a child. Cases where astrologers had predicted a child, and those women who had also conceived once, were not willing to opt for adoption, except those women who reported their husbands feeling frustrated with the treatment. These were women above 30 years of age. Men, too, expressed the desire for adopting a child, but from within the family. Nearly 15 men amongst the respondents, however, were hopeful that they would be able to have their own child.

In the group not seeking treatment, women who had expressed a strong desire to have a child revealed that they invested their feelings in dogs. Only one of them had adopted a child, and one woman reported having initiated the process of adoption in her late 30s, so as to be able to adopt a younger child. One woman, whose husband had not consented to adoption, reported visiting astrologers and quacks. She also felt that the two of them were drifting apart and the husband was veering towards his own family. She attributed this to not having children who would bind them together. Ten women from the group seeking treatment –expressed a preference for adoption, but either their husbands or their families were not in agreement.

Men from the group not seeking treatment used rationalisations. They argued that they had extra time, could go on a vacation any time of the year, and they cited examples of children not taking care of their older parents. They also invested their feelings in their relatives' children and expressed a desire to provide for these children's higher education.

- "I spend money for them (small children) like anything. When I see any child I don't hesitate to spend Rs. 50 –100. I told my wife that it would be our responsibility to educate our brother's daughter."

- "Yes we are thinking about adoption. We will wait for another year and then we will adopt a baby. Both of us now feel that its better to adopt."

The men were not in favour of adoption from outside the family, due to concerns about the child's family background. They reasoned that if there was a child in the family, then why adopt from outside? One man, however, reported a negative experience with an earlier adoption in his family.

3.3 Perceptions of medical practitioners

This section is a brief overview of the perceptions of the medical practitioners (gynaecologists and urologists) regarding the construct of involuntary childlessness in middle/ upper middle classes of the urban Indian society as well as their experiences with their patients. The group comprised 10 doctors: 7 gynaecologists (5 women and 2 men) and 3 urologists (all men).

3.3.1 *Pathways of treatment and the approach of the medical practitioners*

The interviews with the gynaecologists and urologists gave an idea of the pathways of providing treatment and the approaches used by the practitioners in providing medical help to the clients. The treatment commonly began with the clients approaching the gynaecologists, who carried out physical examinations of the woman, and simultaneously suggested a semen analysis for the husband, after taking a short history. In case of male dysfunction, the men were referred to an urologist who suggested further treatment. If there were a medical problem with the woman, the gynaecologist would carry on with the medical treatment. If, in the process of treatment, any psychogenic causes were identified, then the clients were referred to a psychiatrist (see Table 24, Annexure 3).

Throughout the course of the treatment the doctors reported that the patients also opted for religious approaches such as doing *puja*s, observing fasts, as well as pursuing alternative treatments such as ayurveda and homoeopathy, and visiting quacks. The doctors did not discourage these practices, but few of them felt that alternative treatments really helped. However, simultaneous treatment for the same person was not encouraged.

- "Ayurvedic medicines have good effects. They build up good quality sperms."

The approaches used by the doctors were varied in many aspects, from noting the patient's history to giving an explanation about infertility and the time of starting treatment, making referrals, and methods of counselling. The doctors' responses revealed that in dealing with infertility, they were often required to begin "from scratch," explaining the basics of sex and sexuality, followed by a detailed idea of the various investigations involved, and reassuring the clients to accept the line of treatment, which would be spread over a long duration of time. Explaining and reassuring were also important to "hold back the clients."

The doctors decided on the time to begin the treatment after considering aspects such as the age of the woman and the duration of marriage. In some cases, the husband was not ready to undergo investigations, and the doctor had to "tactfully" convince the husband to get his semen analysed. Such an attitude on the part of the husband probably stemmed from the fear that the problem might lie with him. At times, the doctors needed to adopt a forthright manner in stating that there were no chances of conception.

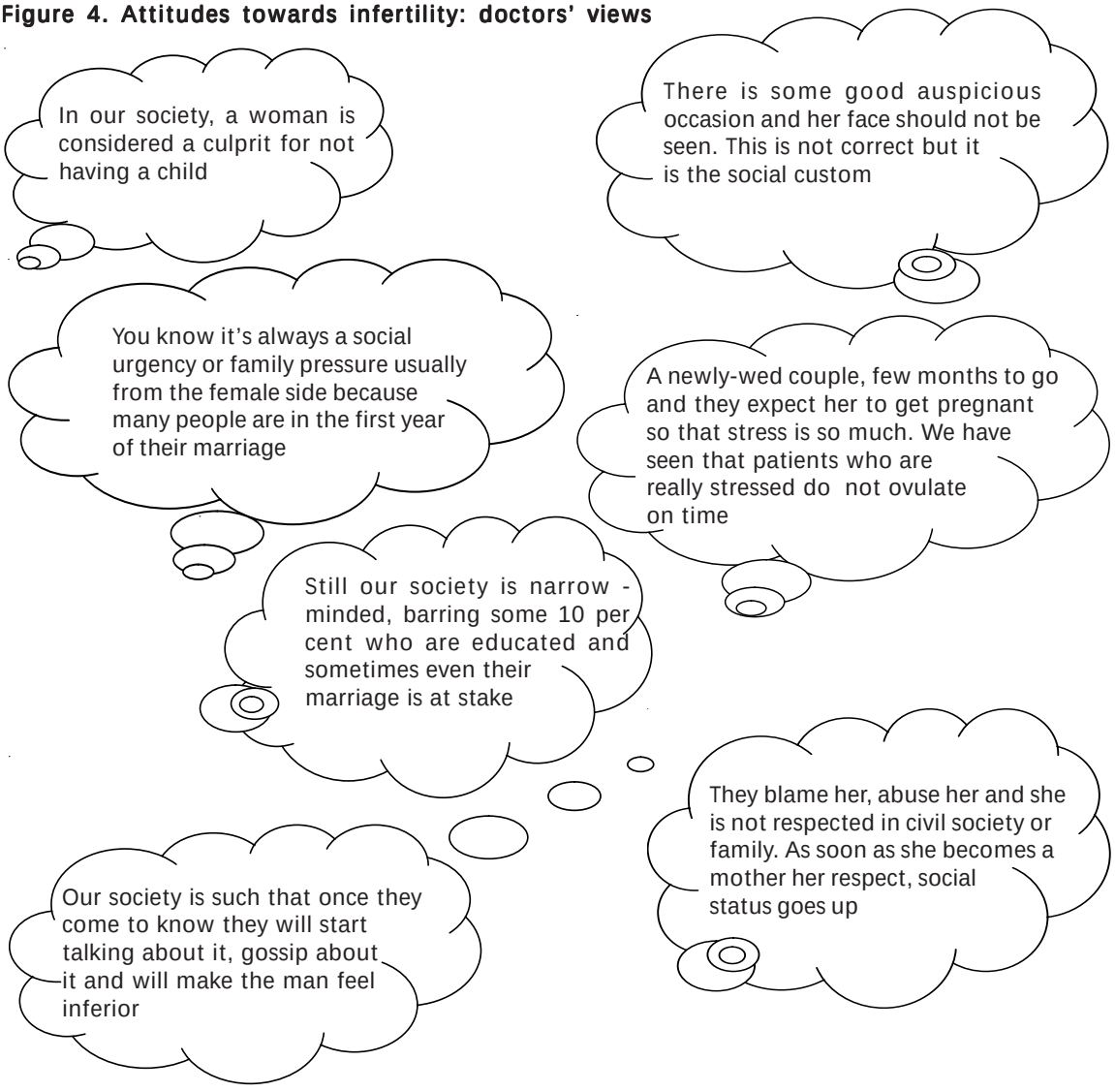
- "If you don't educate your patients, the call rate will go down."

- "See, deep down.... [the husbands] are scared that maybe the fault might lie with them and then..."

- "The woman comes to the doctor first. Sometimes there is a problem with the husband, but still the woman is always blamed."

- "Times have changed. Earlier the ladies used to be taunted by the family, hearing things like '*banjan che'* (she is infertile). This is less nowadays because of education. But in the lower strata this thing might be there."

Figure 4. Attitudes towards infertility: doctors' views



3.3.2 *Causes of infertility and its treatment*

The causes of infertility, as reported by the doctors, ranged from medical to environmental, social and psychological causes. Among these, stress and chronic illnesses emerged as the major causes reported by the doctors. The doctors also observed that there was an increase in male infertility, which was attributed to changing lifestyles and professional hazards, such as long hours of driving or riding, stress due to work, or other reasons that might lead to a disturbance in the balance of the body, thereby affecting ovulation in women and sperm production in men. At the same time, these conditions also affect the receptivity of the treatment by the body, hence aggravating the problem (see Table 25, Annexure 3).

The treatment provided ranged in accordance with the problem(s) faced, and indicated the multiple roles that the doctor was required to play. The most accepted alternative was artificial insemination and donor sperms so that the child would belong to at least one part of the couple. This might be because couples hoped to hide male infertility, and this once again draws attention to perceptions of virility and manhood and the threat to the family lineage.

The success rate of each treatment depends on the type of treatment chosen. This may be different for different persons because there are many factors that may have a simultaneous impact. It is also true that no treatment can guarantee results. The doctors

made an effort to inform their clients about the risks. The procedure of treatment was thus an intensive process and it varied from individual to individual.

"Sometimes what happens, all these processes of ovulation and sperm production and conception, all these are under direct effect of the mind. And if you are happy your body compliance is greater, receptivity of your body increases".

"The ladies today do go for artificial insemination, very few accept adoption because with artificial insemination the child at least belongs to one of them…their own child. So in this way it is much popular than adoption."

"When there is a vericocelle operation, I inform my patients that its success rate is 60-70 per cent, no treatment can give 100 per cent result."

3.3.3 *Attitudes of patients seeking treatment for infertility*

The doctors' experiences with their clients indicated underlying attitudes and ideas regarding infertility. Men usually hesitated to get investigations done due to the fear that the problem might be with them. Women were usually the first to approach the doctor, endorsing the societal perception about women being more responsible for reproduction.

The doctors felt that the family and society played a major role. Their expectations, at times, drove the couple to seek treatment much earlier than required. They also pointed to the changing social context, of a less negative attitude towards infertility, and attributed this to the increasing levels of education in the middle class. They felt that verbal abuse and ostracism were more prevalent in lower income groups where there was lack of education. According to the doctors, both the husband and the wife usually sought the treatment together, and at times the woman would come in with her mother-in-law or mother.

The urologists reported different experiences. At times men approached them alone. The urologists candidly stated that they did not force the men to bring their spouses for fear of losing the client. Women were usually asked to bring along their husbands but the same was not true for a male client. This demonstrates the gender dimension: in this case, men made decisions and were more mobile than women, which gave them easier access to treatment.

The doctors also revealed that compliance with the treatment was not very high. Clients often expected quick results, which was not possible in certain cases. Compliance also depended on the patients' ability to spend, because there is no insurance coverage for infertility treatment. However, quite a few doctors felt that if the patient was well informed about the various procedures of investigations and treatment during the initial visits, then there was higher compliance (see Table 27, Annexure 3).

3.3.4 *Self and spousal reactions towards infertility*

It was observed by the medical practitioners that if the problem was with the men, it was difficult for them to accept the fact. Women too felt depressed, not only due to the state of infertility, but also because of the invasive nature of the various investigations (see Table 29, Annexure 3). A few doctors felt that in cases of male infertility, the wives became dominant and assertive, whereas a few others felt that wives accepted the fact and supported their husbands. Surprisingly, none of the doctors mentioned the husbands' reactions to their wives' infertility (see Table 28, Annexure 3).

- "The men usually come alone and it is rarely that the spouse accompanies them. They should come as a couple, but in our society it is difficult to force them to come together. If we insist, the patient will go to another doctor."
- "Ninety five per cent of the infertile couples change doctors because they want quick results."
- "Insurance companies do not cover infertility, so the cost factor is significant."
- "I had a couple as patients a long time back. After hearing the news that the husband was azoospermic, he was so broken that he had a nervous breakdown".
- "Women are disturbed, depressed and sometimes very anxious, because they want to conceive. They get a little bit worked up because they have to undergo so many investigations."

The doctors reported that when men were told they were the source of the problem, they displayed a reluctance to accept this information, feelings of insecurity, as well as certain physiological effects. None of the doctors mentioned anything about the women's reactions to their own infertility, except for describing their problems and the strain of undergoing the various procedures of treatment. Gender differences were also evident in the fact that men refused to undergo investigations whereas women were nowhere mentioned as even having a choice. They were usually the first among the couple to approach the doctor and also the first to be blamed for childlessness.

Doctors used a variety of approaches with the clients, ranging from the medical treatment itself to helping the couple accept the treatment, to counselling about lifestyle changes. These approaches confirmed the embeddedness of the socio-cultural context in the problem of infertility.

The researchers' observations during the data collection and follow-up visits to the doctors' clinics reveal that most of the doctors were hard-pressed for time, which indicates the need for linkages with counsellors and therapists. Infertility is not a recent issue, but the very fact that a number of infertility clinics have mushroomed all over the city gives us an idea of the wider recognition of the problem and the increasing openness to treatment.

3.4 Involuntary childlessness and the intricacies of gender

The earlier sections of the report focused on the differential responses given by women and men to questions related to notions of parenthood and infertility. This section attempts to bring forth the nuances of gender at the level of cultural norms and expectations, access to and control over resources, and the bargaining positions of women and men in urban middle class culture.

Gender analysis is a way of looking at issues related to the differences in the way women and men are perceived, the opportunities they get, and the behavioural expectations from them. It seeks to recognise the ways in which perceptions of gender roles and responsibilities, and availability of resources, lead to inequalities between women and men. These differences are context-specific and certain social divisions such as class and caste guide their manifestations. All women and men may not experience these gender-related problems in the same way. [43].

The Gender Analysis Framework 1 given here describes the different expectations from women and men with reference to infertility. It delineates how gender norms, accessibility to resources, and one's bargaining position translate into how an individual views parenthood and childlessness. It also studies the impact of childlessness on the self and on marital relationships, ways of coping with infertility, treatment-seeking behaviour, and the way in which the health system deals with infertility. It is a general framework that may be applied to a homogeneous group of individuals representing the urban middle/upper-middle class culture. Framework 2 cites examples of gendered responses at the level of the self and family, community, and the health system.

3.4.1 *Importance of parenthood and feelings about childlessness*

Women are revered as a symbol of fertility, and child-bearing is their major role. Motherhood raises the status of a woman and provides her with enhanced power in the family structure. For men, it is of utmost importance to establish their virility through begetting a progeny, especially a male child, and continuing the family lineage.

Similar responses were seen in the study, where women stressed the importance of a child, essentially for achieving a sense of completeness and to strengthen the marital and familial bonds. Men's responses focussed upon continuing the family line and on the fulfilment of unattained desires. These perceptions were reflected in women's concerns to seek external help in the form of medical treatment, and the tendency to hold themselves responsible, until "proven" otherwise in medical terms. Such a pattern confirms the fact that any aspect related to the reproductive domain is associated with the woman, and it is her status that is at stake. These ideas get challenged in the course of women's education and employment, through exposure to information and knowledge about infertility.

It was also seen that men "let" the women take the blame. They reported their embarrassment

and hesitation in informing the family if the source of the problem was with them; the onus was on the woman to inform the family. Reproduction being the woman's domain, any problem with the man was not easily accepted and, in fact, it may have had negative effects on the mental health of the family. This was seen in the report by a male respondent about the shock that his family underwent on knowing of his azoospermia, despite having two grandsons from their second son. Men, too, perceived childlessness as a failure and a question about their manhood, but their feelings of insecurity were not as evident as those in women. This may be because men usually wield financial control and feel more secure, at least about material needs.

3.4.2 *Childlessness: impact on self and marital life*

Childlessness for a woman reinforced negative feelings of insecurity and incompleteness; women reported feeling depressed and crying. Fear of desertion by the husband and/or the conjugal family, and subjection to physical and verbal abuse, may also have been present. In this research, the women said the husband and the family were their major support. In keeping with cultural expectations, men did not articulate many feelings, except for feeling bad when they were diagnosed with a problem. However, women, as well as the doctors reported that men experienced a major setback, and felt depressed and shocked, when they experienced infertility, especially if the source of the problem was with them.

Another important factor may be that men had the option of remarriage. This could be countered if the problem was with the man, or if the woman was aware of her legal rights. Such instances were not revealed in this research because men and women who may have opted for remarriage were not a part of the participant groups. However, there were instances where both women and men expressed that the woman's concern with conception and preoccupation with bearing a child affected their sexual life.

Being childless in Indian society is a deviation from the norm of fertility and womanhood, and it often evokes ostracism and rebuke. Women reported feelings of isolation in a few instances. At times, both women and men reported self-imposed isolation, especially during family functions such as baby showers, with the idea that they may not be accepted.

3.4.3 *Seeking treatment and the health system*

Seeking treatment was considered the woman's responsibility, and she was the one to first approach the health system. The decision to seek treatment was mutual. The spouse, the mother-in-law or sister-in-law accompanied the woman on initial visits, but subsequent visits were usually only by the woman. The women said that having their own vehicle made it easier for them to access health care. The husbands accompanied them only when needed, or when they were able to take leave from their jobs.

Spousal consent for medical help, although important for women, was not required for men. Men approached urologists on their own, without the knowledge of their wives. Culturally, there were no restrictions on their movement, and the health system did not make it mandatory for them to bring their spouses, for fear that they may "lose the patient." Contrarily, women were expected to bring their husbands.

No informed consent procedures were reported. Women reported being examined, or prescribed medicines on the first visit, even before the examination of the husband, thereby reinforcing the prevalent notion that the problem has to be with the woman. The health system, too, is not devoid of gender bias, and, in fact, reinforces the larger societal ideology.

Women suffered from the pain of treatment in the form of needles pricking their bodies and hormones causing side effects, and men decided whether to continue or discontinue the treatment. In the face of financial problems, men convinced their wives to discontinue treatment. Yet, they were the ones who insisted on their wives undergoing treatment and tolerating the pain, in the hope of a child, without being concerned about where the money would come from. However, in instances of male infertility, women reported asking their husbands, even pleading with them, to comply with the treatment.

3.4.4 *Coping with childlessness*

Women are considered upholders of religious rituals. They are held responsible for the family's happiness in terms of continuing the family lineage. It becomes their responsibility to observe rituals for attaining parenthood, irrespective of who has the problem.

Women in this study resorted to praying and observing fasts, even after discontinuing the treatment, in the hope of a miracle, even at an advanced age. Men reported investing their feelings in other children, but only in those who were part of their family. Women expressed a willingness to adopt from outside sources, but men were more inclined to adopt from within the family, except for those who had negative experiences with family adoptions in the past. Men were also seen to assume rationalising attitudes for childlessness, whereas women were more expressive of their feelings and talked of investing emotionally, even in their pet dogs.

Although the couple (and the family) experiences the problem of infertility, its effects and experiences are largely gendered in nature. Women tend to bear the brunt more than men, at levels of the self, family, as well as the health system. The bargaining position may be tilted in favour of the women when the "fault"/"problem" lies with the husband, but only as far as the marital relationship is concerned. Little change in their status is evident in other domains.

Gender Analysis Framework 1: How gender impinges upon involuntary childlessness in a given culture						
	Importance of parenthood (motherhood/fatherhood)		**Perception of childlessness**		**Impact on self and marital relationships**	
	Woman	**Man**	**Woman**	**Man**	**Woman**	**Man**
Gender norms and roles	• Purpose for life • Marital happiness • Feeling of being complete • Support during old age • Is important to husband Identity and status associated with fertility	• Old age security • Brings happiness • Continuing family lineage • Proves virility Role of the provider	• Held responsible for childlessness (holds self responsible, too) • Motherhood akin to womanhood	• Threat to family continuity • Questions about masculinity and fatherhood	• Depression • Feelings of incompleteness • Fear of desertion • Engage in sexual relations for a child (as part of treatment) • Marital discord	• Hesitation in informing family in case of own infertility • Come closer to spouse • Question of manhood • Option open for remarriage
Access to and control over resources				• Can seek alternatives in the form of treatment • Has financial control		
Bargaining position	• Achievement of motherhood: status increases on producing a progeny, especially a male child		• Information about infertility • Employment status (type) • Family attitude Women have to face societal queries	• Information about infertility • Education (type)	• Problem lies with husband or both: increases bargaining position • Legal awareness • Education • Employment status • Family type	Problem with self (man): lowers bargaining position

Gender Analysis Framework 1: How gender impinges upon involuntary childlessness in a given culture						
Domains/ Issues	**Coping with childlessness/infertility**		**Seeking Treatment**		**Attitude of the health system**	
	Woman	**Man**	**Woman**	**Man**	**Woman**	**Man**
Gender norms and roles	• Responsibility for upholding cultural and religious practices (e.g., observing fasts) • Face family/ societal queries • Can share problems with other • Scope for investing feelings in other children • Seek support (family/friends) • Take up outside activities	• Cannot express emotions Stays outside home for most of the time	• First to seek treatment • First to be sent for treatment • Should and can take leave from job or discontinue (because of perceived role of only supplementing family income) • Mandatory to seek spousal consent	• Being the "breadwinner" cannot take leave from job • Is not expected to cooperate for treatment • Does not need to seek spousal consent for treatment	• Mandatory to bring in husband, but only if he is willing • More focus on women for treatment	• Can come in alone (wife may not even be called) • Sperm analysis comes in as the second step, the first step is the woman undergoing diagnostic tests • Discussions and explanations in detail
Access to and control over resources		• Wields the power of decision-making regarding treatment	• Access decreases due to restriction on movement	• No restriction on movement		• Better services: Informed choice
Bargaining position	• Problem is with the husband • Conceived at least once • Increases with employment	• Increases with financial control	• Employment (type) • Sources of information • Family type and attitude	• Increases with financial support from the family Employment (type)	• Increases with information, type of employment and socio-economic class	• Increases with information, type of employment and socio-economic class

Gender Analysis Framework 2: Gender issues and concerns: a few examples						
	Self		Family/Society		Health system	
	Woman	Men	Woman	Men	Woman	Men
How do gender norms impinge upon infertility/ childlessness	E.g., A lady is known by the fact that she has given birth to a child and presented the world with new hopes; E.g., In the beginning we did not know that he had the problem. So from within I was feeling guilty, that I am not able to have a child. For my husband it was a jolt, he went into depression for a day	E.g., How do I tell my family that I have the problem, I told my wife to disclose but she doesn't; E.g., she gets allergic reactions to the treatment sometimes. But when all compare the sorrow of being childless to the joy of having one, the treatment seems tolerable	E.g., As usual Indian culture *main ladies ko hi* they consider *na*... Everyone started like you know, check up *karwa lo*	E.g., Once when me and mydaughter (adopted) were going out, my neighbours said, she looks just like her father; E.g., My friends make fun of me because I was very romantic when I was in college		
How do gender roles affect treatment seeking	E.g., He never took it seriously, and then I realised that for him having a child is not his priority, otherwise he would have gone out of his way for the treatment	E.g., I work outstation and so I leave the house at 8 in the morning and return at around 7-8 p.m. So its very tiring to accompany my wife to the doctor;E.g., *Usko kya hai usko to chahiye hi chahiye* (what about her she simply wants a child);E.g., I have told her to go to any doctor, get herself checked, take any treatment, whatever she wants to do, she can do			E.g., Whatever I ask, the doctor answers my queries	E.g., They expect you to give a sample at their lab. But for me it just doesn't happen, so I always collect the sample at home before taking it to the lab for testing
How does environment influence infertility	E.g., I have my own vehicle so I can easily come and go for my own treatment	E.g., Excess of drinking, smoking and improper diet might have lead to my lesser sperm count				
How does access to and control over resources information influence treatment & coping	E.g., My husband is very nice. He is always afraid that something might happen to me. So he said that you wait so I stopped the treatment for eight months	E.g., I am not earning much, but I don't dare to ask for financial help from my father; my wife provides me with the finances for the treatment right now;			E.g., It was my 23rd day and ideally the injections have to begin from the 21st day, but the doctor did not know that I myself am a doctor	
How do bargaining positions of men and women influence coping	E.g., I used to scold him. *ke mere ko label lag raha hai ki* (I am being labelled), she is not able to have, and I am not telling anybody, I am being nice to you;E.g., I did conceive one. It's not that I did not conceive at all, I missed it	E.g., for a wife, husband is the only source of support, the society is irrelevant			E.g., everyone is against me, even my doctor says that if your husband doesn't want to adopt, then why should you?	

3.5 Case studies

This section contains case studies that depict emerging patterns of seeking treatment and coping mechanisms used by individuals experiencing involuntary childlessness. The case studies were constructed based on patterns that cut across different life stories. Pseudonyms have been used to maintain the confidentiality of the respondents and the doctors.

The following two cases focus on different ways of coping used by the respondents to cope with involuntary childlessness and infertility.

3.5.1 *Case study 1*

Mr. Pratik Naik, a 28-year-old businessman living in a joint family, and earning an income of Rs.20, 000 per month, got married in 1998. In the beginning, he and his wife used condoms for a year. After a year and a half of marriage they decided to have a child. However, when the couple realised that they were unable to conceive, they consulted their family members, who asked them to seek a doctor's advice. The family members also speculated about the possibility of *ratva* (or excess heat) in the woman's body.

After visiting the doctor, Ms. Naik was prescribed oral tablets that she took for six months. While the doctor conducted a few tests on Ms. Naik, he also suggested that Mr. Naik have his semen analysed. The doctor diagnosed that there was no sperm production. Mr. Naik was not convinced, so he consulted another doctor, who said the same thing. As Mr. Naik narrated it, "Dr. Daruwala explained that the sperm count was nil because of the un-descended testes. He also did a blood test and x-ray as well as sonogram to confirm."

About his feelings, Mr. Naik said, "When the doctor first told me I felt very bad. But as such I am a *bindaas* (carefree) person, and so is my wife. We thought this is all natural: *kudrati che, apne shun karvana che* (it is nature/destiny, what can we do about it)?" In terms of societal attitudes, Mr. Naik said, "*Amuk loko to abhaan hoi, amnu shu kharaab lagadvanu* (some people are ignorant, why should one feel bad about what they say).

Mr. Naik did not believe in horoscopes nor did his family members. He also stated that, unlike his wife, he was not a firm believer in god. However he said, "My wife goes to the temple every Monday and does *puja*. But I do pray in my mind that all should go well. I have also stopped eating non-vegetarian food."

Regarding artificial insemination, Mr. Naik said, "A close relative told my wife to get herself injected with sperms without telling me." Mr. Naik said that he could understand that his relative did not want him to feel hurt. He said, "If my wife would have been uneducated like my relative, then she might have done that." Mr. Naik said they did not tell his parents about artificial insemination, because, in his words, "If the secret leaks then it is fine for us, but in the future someone may tell the child something. How will the child feel?" Mr. Naik had not thought much about adoption. He said, "Because my wife does not have any problem, why not go in for artificial insemination? At least the child can be hers."

3.5.2 *Case study 2*

Suchitra Deshmukh is a graduate, married for two years. She is a housewife in a joint family. She said, "We did not use any contraceptives because my husband wanted children. He loves them. I did not want children that early because I wanted to study further. He wants me to have a child. So this is the only thing we argue about." Ms. Deshmukh had an irregular menstrual cycle prior to her marriage and her husband wanted her to undergo treatment. "After six months of our marriage, my husband talked about having children, and he insisted that I go to a doctor," she said.

The injections that she has had to take have been very painful, especially the hormone injections. She said, "They are so sticky and till it goes inside the body, it pains very much." Ms. Deshmukh has a tubal blockage and her husband was diagnosed with vericocelle, for which he underwent an operation. During the study, Ms. Deshmukh was undergoing intra-uterine insemination.

Before seeking medical treatment, Ms. Deshmukh had gone to a *vaid* (country doctor) and taken some ayurvedic medicine. However, she discontinued the treatment because of the side effects, an increase in her weight. Ms. Deshmukh is an ardent believer in religious rituals and spoke of her faith in *satsang*, "We have *satsang*. It is said that whatever you wish for over there is granted. We have also kept

a *mannat* that whenever we have a child, we will take her/him there and perform *pradakshinas*." She said that every one in the family, including her husband, had kept *badha*s.

Ms. Deshmukh had also visited a number of astrologers along with her husband and everyone had assured them that she would have a child, but that it would be late. So, she was hopeful that she would conceive. Ms. Deshmukh rationalised her state, saying, "It is God's wish. Everything is in His hands. If I am in this state, then it definitely must be for some good. I have always felt that whatever happens, happens for the best. Even if I undergo treatment, until and unless He wishes it, we won't get any positive results."

She said she had not thought about adoption since the treatment was still on. Ms. Deshmukh added, "When the doctors say that nothing else can be done, then I might think about it. I am not against it. I know my family members will not agree, not even my husband, but then I can convince them."

In this case, the cause of infertility lies with the husband. Ms. Deshmukh said, "Actually it is no problem with me. My husband is suffering from azoospermia." Marrying late, at the age of 35, she knew that for her, conception would be difficult.

But, she later also said, "I will not go for adoption. I am strongly against it. "*Woh bada hokar kaisa niklega, kya pata. Aur, kisi aur ke liye aisa kyu karneka* (How can we say what the child will turn out to be in future. Why take such a risk for someone else)?"

3.5.3 *Case study 3*[1]

Mr. Sumeet Saigal, a graduate married for five years, lives in a nuclear family. He said, "When we got married, we had not planned anything. We had not used any contraceptives like pills or tablets. We used to keep a gap of 10 days—the middle 10 days (abstaining from sex during unsafe period)."

After about one and a half years of marriage, the couple decided to have a child. Even after trying for about one and a half years, when they could not conceive, they decided to seek medical help. Mr. Saigal said, "We first went to Dr. Kiran Sen. She asked us to get some tests done. She asked me to go in for semen analysis, and tested my wife to check if the fallopian tubes were blocked, or to see if there was some problem with the ovulation."

A problem with the fallopian tube was detected and also a low sperm count. Mr. Saigal was prescribed oral medication to increase the sperm count, while Ms. Saigal underwent some more tests and a sonogram, after which medication was administered. Mr. Saigal said, "In spite of trying for six months, we did not get any results, so we went to Dr. Popat. She checked my sperm count and said that though it was low, nothing is impossible. We took medicines from her for four to five months, but nothing happened. So we stopped going to her."

Mr. and Ms. Saigal always went together for the treatment. After changing two doctors, the couple went to Dr. Gupte's clinic, where the doctor explained to them that it would take at least a few months for results to show, and it would be wise to stick to a treatment instead of changing doctors. In between, the couple also started ayurvedic treatment from a doctor who had guaranteed results. However since nothing worked out, they started consulting another doctor, Dr. Solanki, whose clinic was on the outskirts of the city, thus making travelling unfeasible. About the attitudes of the various doctors, Mr. Saigal said, "Doctors must provide adequate time to patients and not be money-minded."

Commenting on the cost of the treatment, Mr. Saigal, who works in a bank, and earns Rs. 25,000 per month, said, "In a way, the treatment is expensive. We pay around Rs. 500 to Rs. 800 per month, and now, for the IUI, we spend around Rs. 3000 per month. However, if it works out, then fine. We are earning fine and we can still earn more. After all, for whom are we earning?" Having been through all the rounds, Mr. Saigal said "I am tired of all this. I feel *have thai jai to saru* (I feel that now it will be better if we have [a child])."

In contrast to Mr. Saigal's experience, Mr. Vivek Gosar, married for seven years and living in a nuclear family, had a different story to tell. He and his wife had been trying for a child for the past four years. After three years of marriage, when the couple could not conceive, they felt the need to consult a doctor. Mr. Gosar said, "My wife got tested first. Only after knowing that everything was normal with her, I got tested." When he learned that the problem lay with him, he said he was "shocked! I really felt bad and still feel bad."

Like Mr. Saigal, Mr. Gosar also changed two or three doctors, underwent ayurvedic and homoeopathic treatments, and was "fed up" with the whole business of spending money and getting no results. However, he maintained that many doctors do understand. He had changed doctors because some did not give adequate time. He said, "It is the attitude and understanding of the doctors that matters, otherwise the treatment is the same everywhere." As far as the expenses of the treatment were concerned, Mr. Gosar found them affordable, with some financial help from his parents.

3.5.4 *Case study 4*

Ms. Anita Ahuja, a graduate and a housewife, lives in a joint family. She has been married for three years. She said they did not want to have a child immediately after marriage. However, when she did not conceive after a year, she and her husband decided to visit the gynaecologist. She had a sonogram and some tests, and her husband underwent semen analysis. Everything was normal with her husband. She said, "The sonography found some cyst formation, and for that I was given some treatment. Then I was told that there was some problem with my ova size and also that they weren't maturing."

She had been undergoing treatment for two years, and usually her husband accompanied her to the clinic. But sometimes, due to his busy schedule, he could not make it to the clinic, so she would go alone. Since she stays in a joint family, family members knew about the problem and also that the couple was undergoing treatment. But the family did not know details because she did not want to "bother them unnecessarily." Ms. Ahuja said, "My parents and in-laws know about the problem. They keep advising us … visit this doctor, take that medicine, do that treatment sincerely. They are cooperative."

Regarding the treatment process, she said, "It sometimes hurts. I have to sit with the doctors and take injections daily. Sometimes it is too frustrating to visit the doctors after every 15 or 20 days. And it becomes all the more frustrating when you don't see results".

Ms. Ahuja has changed three or four doctors in two years because, she said, "None of them used to spare time and tell us something. *Bus yeh dawai khao, woh tests karao* (take this medicine, do that test). They keep dragging things out." She added, "We would take treatment for six to nine months, but if there still would not be any changes, we would quit. We have never taken treatment in a proper way. Now that we have this doctor, we are just going to take treatment from him. Only if he says he cannot do it, will we consider another doctor, or else not." Ms. Ahuja's husband has a monthly income of Rs. 30,000. She felt that the cost of the treatment was quite affordable, it cost Rs. 800 to Rs. 1000 per month.

Twenty seven year old Shalini Mistry, a graduate staying in a nuclear family, is a housewife. She said that she had conceived earlier and during one of her pregnancy-related check-ups, the gynaecologist told her that the foetus was not developing due to some viral infection, and that it needed to be aborted. After the abortion, her doctor advised her to wait for a year. When she did not conceive even after a year, despite trying, she and her husband decided to approach a doctor.

She first underwent tests like laparoscopy, and then later her husband was asked to undergo semen analysis. The doctor informed them that one side of her fallopian tube was blocked and her husband's sperm count was low. It has been almost four years since they began treatment. Regarding her husband's sperm count she said, "The doctor says it has improved. But he has to continue with the medicines. As long as he takes it, the count is normal, but the moment he doesn't, it goes down. He is tired of having the medicines and visiting the doctor." Ms. Mistry also underwent a surgery to open the blocked tube. But in spite of doing all this, there has been no positive result.

She is satisfied with the doctor's approach and said, "My doctor gives all the needed information and time. Even when I have any queries, she answers them nicely. She is trying her level best to help me and still if things do not work, then it is my luck." However, Ms. Mistry changed four to six doctors. She said, "We were trying, and since there were no results, my husband asked me to try out with some other doctor."

She said that during the course of treatment there have been times when she had to stop the treatment: "My husband was not well and my mother-in-law passed away, so I had to stop my treatment," she said, "but no matter how much pain I have to

undergo, I will continue with the treatment because the doctors haven't given up. They are hopeful and so am I. *Mai ab tak haari nahee, mujhe pura* confidence *hai ki hoga* (I haven't lost yet, I have full confidence that it will happen)."

In the beginning, Ms. Mistry's husband would accompany her to the clinic but he does not do so now because of his busy work schedule. She said, "Sometimes I do feel depressed, that it is enough. I don't want to continue with the treatment, but then you have that hope that I have to move ahead. Many a time I feel this is the last time, now I won't go. But there is always this hope that *ho jayega* (it will happen)." Ms. Mistry added, "We have not informed our family members about anything. They just know about the problem. I feel, what is the point in discussing it with everyone. It is our problem."

3.5.5 *Case study 5*[2]

Mr. Ronak Gupta, a graduate with an income of Rs. 20,000 per month, began his story by describing his relationship with his family. He said, "I was always a rebellious child. I have been reprimanded for that, but that's okay. I was the second child, the middle one, so I was expected to do all the work. The elder brother didn't have to do anything and the younger one *to chota hai* (he is small, after all). So you can't tell him to do anything. I was threatened, kicked and booted to do the work." This discord between him and his family members had a deep psychological impact on Mr. Gupta. To date, 39-year-old Mr. Gupta shares a strained relationship with his parents.

Mr. Gupta recalls had an inter-caste love marriage, without the consent of his family members. Now a businessman, Mr. Gupta was in the civil services during the initial three or four years of his marriage. During that period, Mr. Gupta and his wife, Anjali, had to live separately for months. Even when they were together for short periods of 15-20 days, they couldn't spend time together. Mr. Gupta explained, "Generally, when she came to the field, I was busy with the operational duty, and when I came for a vacation, I had to spend a lot of time with my family members against Anjali's wishes, and mine." Since Anjali was also working she did not initially feel the urge to have a child. But after two years of marriage, Mr. Gupta heard from his wife that she was pregnant. Though it was unplanned, they were really thrilled. Mr. Gupta said, "We were so excited that we took the bike and went all the way to *darshan* (pray). We didn't know, there was no one to advise us." After a fortnight or so, Mr. Gupta heard from his wife that she had a miscarriage. At that time they did not take it seriously, but after some time Anjali certainly wanted to conceive. When even after trying hard she couldn't conceive, they decided to visit the doctor.

The check-up found that everything was normal with his wife, but Mr. Gupta had a low sperm count. Mr. Gupta recounted that his days in civil service were strenuous and exhausting. He feels that the life style at his work place— the vigorous exercises, the kind of food, and his addiction to alcohol, could be responsible for his lowered sperm count. Initially, Mr. Gupta's father was not ready to accept that there was a problem with his son. Later he began to give him advice on treatment and diet

After a 15-day course the doctor told Mr. Gupta to discontinue the treatment, saying that everything was normal. Since the treatment did not bring any positive results, Mr. Gupta consulted another doctor. The doctor suggested that Mr. Gupta should get operated for vericocelle. Mr. Gupta doubted the doctor's ability and got himself operated by another doctor. After the operation, the doctor said that there was some other problem.

Mr. Gupta said that before allopathic treatment, they had also tried homoeopathy and ayurvedic treatments. They had also been to the *bhuva* (traditional healers), and Anjali also did a lot of *puja*. Describing the various treatments, he said, "Here the doctors are not competent, they are interested only in money. *Bhuva se kuch khas itna farak nahee pada* (visiting the traditional healer made no difference). *Bas koi paisa dene wala aa jai* (they are also after money)." Mr. Gupta felt all this was tiring and a waste of time, energy and money.

Meanwhile, the couple had also been considering adoption. Family members suggested that they should adopt his brother's child. However, Mr. Gupta was against this because he was not on good terms with his sister-in-law. He also felt insecure about what would happen if, at some point in time, they claimed the child back. They decided to adopt a child through an adoption agency.

Mr. Gupta's only concern was that his parents were uncooperative and would not accept the adopted child. However, the couple went ahead and adopted a child. Mr. Gupta was satisfied with the services provided by the agency and also the follow-up after the adoption. He said, "They are of tremendous help. It's nice to know that they care. Before letting the parents adopt, they ensure that there is some similarity of the child's complexion and certain facial features with the parents." One problem that they faced during adoption was the birth certificate of the child, which they managed after a long ordeal.

Talking about the attitude of his family members, relatives, friends and society in general, Mr. Gupta said, "In the beginning, my parents accepted, but I feel it was half-heartedly. They would go and tell people that Manoj is an adopted child." He said that none of their friends openly commented on this matter. However, they were afraid to cuddle or touch the child, they were worried about the origins of the child in terms of caste. But society at large regards the adoption as a great deed. Mr. Gupta said, "People come and tell us that you have done something godly, you have done society a favour. But I tell them that Manoj has done us a favour by coming into our lives. He has changed our lives."

Chapter 4
Conclusion

A child is important everywhere, irrespective of which culture or society we consider. A child is considered to be important mainly because it brings happiness to the family and advances the family lineage. The child strengthens the bond between husband and wife.

The conceptual framework of this research, which was derived from existing literature and the concept mapping exercise, guided us in conceptualising and formulating the research questions and the methodology. The framework addresses the individual as a part of the larger culture, which shapes the individual's ideology. Thus, the individual's orientation towards various concepts of parenthood and sexuality in terms of femininity and masculinity are formed through the process of socialisation, which itself is shaped by different social norms.

In India, a woman gets her identity through a child; this is based on the belief that a woman is incomplete without child and that she does not have an identity of her own. The power, respect, and position that she gets in the family, and also in society, depend upon her reproductive capacity. The nuances of motherhood are instilled into the girl child from a very young age through the process of socialisation. She is expected to take care of her younger siblings, making motherhood appear important to her. However, if she fails to bear a child of her own, she faces the brunt not only of society, but also of her family. She is criticised, taunted and not allowed to attend auspicious functions. For a man, a child is proof of his virility and manhood. India is a patrilineal society, where men are the actors in continuing the family, so male infertility can have serious repercussions on the psyche of the man.

The participants in this research echoed similar views. Men and women both felt that a child was necessary because it gave purpose to their lives. The utmost significance of a child for a sense of self, for a smooth marital relationship, and to enhance status in the family, was evident in the finding that women from the group not seeking treatment, who were in their mid-40s and 50s, still hoped for this miracle. Almost all women, irrespective of age, employment or education, shared this feeling.

The desire to be a mother may be within the woman; but stronger than her desires are the pressures on her to bear child—pressures from society, family and also from the self. In Indian society, especially in the middle/upper-middle classes, women are dependent upon men for financial security. The child also helps them achieve a sense of security in old age.

Childlessness impacts both men and women. Both feel bad about their childless state. But childlessness affects the woman more, leaving her with feelings of loneliness and insecurity, often pushing her towards depression. Although men feel upset about their state, they do not report or express their feelings much; they are supposed to be the strong ones and cultural norms do not allow them to openly express their emotions.

Since children are seen as strengthening the bond between husband and wife, childlessness can have a huge impact on the marital relationship. In this study, factors such as the education level of the couple, the extent of understanding between them, whether the woman was employed or not, and their personal views about the importance of a child, determined the nature and extent of the impact of childlessness on the marriage.

The couple dealt with the problem of infertility primarily by visiting doctors; usually a gynaecologist. Some simultaneously tried ayurvedic and homoeopathic medicines, and some tried homemade remedies. There is great pressure on a childless couple to produce children, because of which they try every possible option to combat infertility. This, once again, reiterates the importance of a child in our culture and our society.

As this study showed, reproduction and related problems were generally perceived as domains that belong solely to the woman. She was the one taken for the treatment either by her husband or by her mother-in-law, even if the husband had the problem. It was her responsibility to seek treatment.

She had to bear all the pain related to the treatment. The decision to begin or discontinue the treatment did not depend upon her, but upon her husband and family.

On the other hand, men would visit an urologist with or without the knowledge of their wife and family members, thereby confirming the fact that male infertility is not acceptable in Indian society. Men were not under pressure to seek treatment or continue with their treatment. Often their responsibility was restricted to accompanying their spouses and providing them with the finances for the treatment. Most of the time men decided which doctor to consult, how much money to spend on the treatment and when to discontinue the treatment. However, if the woman was employed, she played a role in such decisions.

Coping with infertility begins when couples actively start seeking treatment for infertility, which is a form of primary coping. Secondary coping strategies such as performing *puja*, visiting astrologers, and investing emotions in other children were also simultaneously adopted by the couples in this study. Women in India have the responsibility for ensuring the family's happiness, so it was the duty of the women interviewed to perform *puja* and fasts. Indian men usually do not engage in such activities, except if the problem lies with them, or if insisted upon by the family. Women respondents found it more difficult to accept and cope with their childless state. The men accepted their state better. This could be explained by the fact that society more often questions the woman about childlessness.

Adoption emerged as a significant way of coping with infertility, which indicates its increasing acceptance in society. Such a trend enables couples to cope better with the fact that they cannot have a biological child. However, adoption is seen as the last resort that the couple would opt for, in case all other methods fail.

People suffering from infertility in this study pinned all their hopes on doctors. So whenever they did not get results they were disappointed and frustrated, not only with the doctor, but also with the treatment. Doctors did try to reach out to many patients who required their help. They were pressed for time and unable to spare adequate time for their patients. Doctors agreed that the treatments for infertility are so costly that people cannot afford them; they also acknowledged that none of these costly treatments guaranteed 100 per cent success. The doctors felt that infertility is rising because of the stress individuals face daily and also due to their style of living. These factors need serious attention.

Thus, infertility involves more than just physical causes. Psychological factors, such as stress, are not the only cause, but also the consequence of infertility, as unveiled by this research. More than focussing on the cause, it is necessary to view the individual as a whole. Just targeting the physical cause does not necessarily ensure that the individual will conceive. Psychological and social factors also need to be dealt with simultaneously.

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Annexure 1

1. 1 Interview schedule for individuals with biological children or planning a family

The following interview schedule was prepared with a view to understanding the perceptions of men and women from middle and upper-middle income groups regarding childlessness. The interview schedule served as a reference during the interviews. No specific sequence of questions was followed; it depended on the mode of conversation.

The interview began with a brief overview of the research and the participants were oriented to the ethical dimensions that were to be taken care of by the researcher. Informed consent was sought from each participant. The interviews were tape recorded with the consent of the respondents. In case they did not prefer recording, the investigator took running notes, which were expanded immediately after the interview.

1.1.1 Criteria for selection

The participants in the interviews were men and women who were married (irrespective of whether they had children or not), and with a family income of more than Rs. 8000 per month. The participants were selected from different cohort groups (age cohorts— 20 to 70 years).

1.1.2 Background information

Self	**Spouse**
Name:	Name:
Age:	Age:
Education:	Education:
Occupation:	Occupation:
Address:	
Contact numbers:	
Years of marriage:	
Type of family:	
Family composition:	
Mother tongue:	
Religion:	
Day and date of the interview:	
Time:	
Place:	

1.1.3 Importance of parenthood

- What is your idea of parenthood?
- How would you distinguish motherhood and fatherhood?

- What is the importance of a child for an individual (man/woman)?
- What is the importance of a child for the family? (probe for natal and marital family and individual members within the family)
- Do you feel that having one's own child makes any difference to a person (man/woman) or the family?
- Would a child affect one's status within the family or society? Would it be different for a man and a woman?
- What is the importance of a child in Indian society (for a man and a woman)?

1.1.4 Perceptions regarding childlessness

- What do you understand by the term childlessness (infertility)?
- What, according to you, is the difference between a couple who has a child and a couple who is childless? (probe for individual man/woman)
- What do you feel is the general cause for childlessness (infertility)?
- In your opinion, whom does the problem usually lie with?
- Can anyone be blamed for childlessness? If yes, who and why? If no, why?
- What do you feel would be the experience of childlessness (for a man and a woman separately)? (probe if the woman is infertile/man is infertile)
- What are the alternatives to childlessness?

1.1.5 Societal attitudes towards childlessness

- What is society's attitude towards childlessness?
- How do you feel does society look at childless couples? Why?
- How does it look at a childless woman and a childless man?

1.1.6 Family attitudes towards childlessness

- How would the family react to childlessness (natal and marital)?
- What would be the family's attitude in case of the woman's infertility?
- What would be the family's attitude in case of the man's infertility?
- What kind of role can the family (natal/marital) play in helping the couple (man/woman) cope with childlessness?

1.1.7 Coping with childlessness

- What do you think should childless couples do to combat childlessness?
- Who should decide what to do?
- What is the family's role in such a situation?
- Are there any alternatives to childlessness?
- If yes, what are these and what do you feel about them?
- Do you feel that childless individuals/couples need some support? What kind (family, external, professional, etc.)?

1.1.8 Impact on self and marital relations

- How does childlessness affect an individual?
- Will it be different for a man and a woman?
- What implications does childlessness have on marital relations?
- In case the problem lies with the woman what would be the situation in their marital life?
- In case the problem lies with the man what would be the situation in their marital life?

1.1.9 Role of the health system

- What is the role of the health system in dealing with infertility (male and female)?
- Are you aware of treatments for infertility?
- Are you aware of the assisted/new reproductive technologies? What do you feel about this?
- What do you feel about the treatment given by doctors for infertility (to men and women separately)?

1. 2 Interview schedule for women and men: group seeking treatment (group A)

The following interview schedule was prepared with a view to understanding the perceptions of women and men who are childless and who are consulting a gynaecologist/urologist for the same, either on their own, or with their spouse. The schedule served as a reference during the interviews. No specific sequence of questions was followed; it depended on the mode of conversation.

1.2.1 Criteria for selection

The sample for the interviews constituted women and men who were childless and married for at least one year and with a family income of more than Rs. 8000 a month.

1.2.2 Background information

Self	**Spouse**
Name:	Name:
Age:	Age:
Education:	Education:
Occupation:	Occupation:
Address: Contact numbers:	
Years of marriage:	
Type of family:	
Family composition:	
Mother tongue:	
Religion:	
Day and date of the interview:	
Time:	
Place:	

1.2.3 Importance of parenthood

- What is your idea of parenthood?
- What is the importance of a child for an individual?
- What is the importance of a child for you and your spouse?
- Do you feel that having one's own child makes any difference to a person or the family?

- Would a child affect one's status within the family or society?
- How do you feel society looks at childless couples? Why?
- What according to you is the difference between a couple who has a child and a couple who is childless?

1.2.4 Realising the problem

- Who amongst the two of you realised that there was some problem?
- What did you do next? Whom did you consult?
- If you consulted a gynaecologist, why and when did you feel the need to consult the gynaecologist? Who decided?
- Before consulting the gynaecologist did you perceive there was a problem? What did you think about it? Who did you think was the problem with?
- Did you talk to anyone else about it (someone in the family or an outsider or a friend)?
- When and how did you realise that you are unable to conceive?
- When and how did you come to know that you or your spouse has a problem?
- If the woman has a problem: What was your reaction on learning that you had a problem? What was your husband's reaction?
- If the man has a problem: what was your reaction on learning that you had some problem? What was your wife's reaction?

1.2.5 Treatment-seeking behaviour

- What kind of treatment did you first try (allopathic, homeopathic, ayurvedic, home remedies, etc.)?
- What did the treatment-givers advise you to do?
- Who amongst the two of you was the first one to go in for treatment? Why?
- What are the tests that you/your spouse undertook to confirm infertility?
- What kind of treatment has the doctor suggested? What is the duration of treatment?
- What are the chances of success of the present treatment?
- What are the approximate costs to be incurred for the treatment? How much have you spent on the treatment to date? What do you feel about it?
- Who was the first amongst the two of you to go in for clinical examination? Who suggested it?
- Who accompanies you/your spouse to the clinic for the treatment?
- What do you feel about the treatment you are undergoing? What do you think about the doctor's approach and inputs? Do you feel the doctor is able to give you enough time?
- Have you been to any other doctor? How many? Why did you change the doctor?
- Have you heard about the assisted/new reproductive technologies? Are you planning to use/or are you currently using any of these? What do you feel about it?

1.2.6 Feelings regarding the treatment

- How did you feel when you were/your spouse was undergoing the tests?
- What was your spouse's reaction during this phase?
- What do you feel about the treatment you are undergoing (any kind of mental stress or pressure because of maintaining routines, etc.)?

1.2.7 Beliefs associated with childlessness

- Apart from the treatment sought, what other things are you doing to solve the problem (for example, observing some fast or doing some *puja*)?
- Is anyone else in your family or outside doing something of this kind for you?

1.2.8 Perceptions regarding childlessness

- What, according to you, is the reason for your/your spouse's problem?
- What, according to the gynaecologist, is the cause of the present condition?
- How would you define infertility?
- How do you think others perceive this? Why?
- Who is your major support during this phase of your life (husband/wife, friend, parents, etc.)?
- Do you feel the need for any external support (e.g. a counsellor)?

1.2.9 Family as a support network

- Who are the members of your family?
- Do your family members know that you are consulting a gynaecologist/ urologist?
- What do they feel about it? What was their reaction when they first heard about it?
- Are you experiencing any problems with the family because of this specific problem? If yes, what kind of problems and what could be the reason for it?
- Do they know whom the problem lies with?
- If the problem is with the woman: what was their reaction on knowing about your problem?
- If the problem is with the man: what was their reaction on knowing about your problem?
- If the couple has not disclosed who the problem lies with, then why not?
- Who does the family feel has the problem? What do they say?
- If no, then do you anticipate any problems in the near future? What kind of problems and why?
- What kind of family support do you require?
- Do you feel that your family is supporting you at each and every stage of the treatment? How?
- Do you feel that they will always support you?

1.2.10 Marital problems faced as a consequence of childlessness

- Have you faced/experienced any problems with your spouse because of childlessness?
- Have you ever had any difference of opinion regarding the treatment? What kind and how do you resolve it?
- If the problem is with the husband, is he regular with his treatment?
- If no/yes, then why and what does he/ the wife feel about it?
- If the problem is with the wife, is she regular with her (the respondent) treatment? Yes/no, what does the husband feel about it?

1.2.11 Alternatives to childlessness and coping mechanisms

- Did you think of any alternative to having a biological child?
- Have you decided till when you would like to continue the treatment?
- Have you ever considered adoption? If yes, how seriously have you thought about it?
- How do you think that your family will react to the decision of adopting a child?

1.2.12 Societal attitudes

- What is the importance of a child in the Indian context?
- What do you feel is society's perception regarding childlessness?
- Have you ever had any negative experiences because of childlessness (during any family get together, or any occasions)?
- What do you feel is society's attitude towards you because of this?
- What do your friends feel about this?
- What do your neighbours feel about this?

1.3 Interview schedule for women and men: group not seeking treatment (group B)

The following interview schedule was prepared with a view to understanding the perceptions of women and men who are childless and who may or may not have reconciled with their status. The schedule served as a reference during the interviews. No specific sequence of questions was followed; it depended on the mode of conversation.

1.3.1 Criteria for selection

The sample for the interviews constituted women and men who were childless (or did not have a biological child), were married for at least eight years, and whose family income was more than Rs. 8000 per month.

1.3.2 Background information

Self	**Spouse**
Name:	Name:
Age:	Age:
Education:	Education:
Occupation:	Occupation:

Address:

Contact numbers:

Years of marriage:

Type of family:

Family composition:

Mother tongue:

Religion:

Day and date of the interview:

Time:

Place:

1.3.3 Importance of parenthood

- What is your idea of parenthood?
- What is the importance of a child for you and your spouse?
- Do you feel that having one's own child makes any difference to an individual or the family?
- Would it affect one's status within the family or society?
- How do you feel society looks at childless couples? Why?
- What according to you is the difference between a couple who has a child and a couple who is childless?

1.3.4 Realising the problem

- Who amongst the two of you realised that there was some problem?

- What did you do next? Whom did you consult?
- If they consulted a gynaecologist, why and when did you feel the need to consult the gynaecologist? Who decided?
- Before consulting the gynaecologist did you perceive there was a problem? What did you think about it? Who did you think the problem was with?
- Did you talk to anyone else about it (someone in the family or an outsider or a friend)?
- When and how did you realise that you were unable to conceive?
- When and how did you come to know that you or your spouse had a problem?
- If the woman has a problem: What was your reaction on learning that you had some problem? What was your husband's reaction?
- If the husband has a problem: what was your reaction on learning that you had some problem? What was your wife's reaction?

1.3.5 Treatment-seeking behaviour

- What kind of treatment did you first try (allopathic, homeopathic, ayurvedic, home remedies, etc.)?
- What did the treatment-givers advise you to do?
- Who amongst the two of you was the first one to go in for the treatment? Why?
- What were the tests that you/your spouse undertook to confirm infertility?
- What kind of treatment did the doctor suggest? What was the duration of the treatment?
- Were you informed about the success rate of the treatment that you were undergoing? If yes, then who informed you, when?
- What were the approximate costs incurred on the treatment? What do you feel about it?
- Who was the first amongst the two of you to go in for clinical examination? Who suggested it?
- Who accompanied you/your spouse to the clinic for the treatment?
- What did you feel about the treatment you/your spouse was undergoing? What do you think about the doctor's approach and inputs? Do you feel the doctor was able to give you enough time?
- How many doctors did you approach? If they have approached more than one doctor then why did you change the doctor?
- Have you heard about the assisted/new reproductive technologies? Did you use any of these? What did you feel about it?

1.3.6 Feelings regarding the treatment

- How did you feel when you were/your spouse was undergoing the tests (some kind of mental stress or pressure because of maintaining routines, etc.)?
- What was your spouse's reaction during this phase?

1.3.7 Beliefs associated with childlessness

- Apart from the treatment sought, what other things did you do to solve the problem (for example, observing some fast or doing some *puja*)?
- Did anyone else in your family or outside do something of this kind for you?

1.3.8 Perceptions regarding childlessness

- What, according to you, was the reason for your/your spouse's problem?
- What, according to the gynaecologist/urologist, was the cause?
- As a person, how would you define infertility?
- How do you think others perceive this? Why?

- Who was your major support during your treatment and who is it today (husband/wife, friend, parents, etc.)?
- Did you feel the need for any external support (e.g. a counsellor)?

1.3.9 Family as a support network

- Who are the members of your family?
- Did your family (in-laws as well as parents) know when you were consulting a gynaecologist (or about any other kind of treatment)?
- If yes, what did they feel about it? What was their reaction when they first heard about it? When were they informed about it?
- If no, then why were they not informed? Whom did they feel the problem was with, what did they have to say?
- Did you experience any problems with the family because of this specific problem? If yes, what kind of problem and what was the reason for it?
- Did they know whom the problem was with?
- If the problem is with the woman: what was their reaction on knowing about your problem?
- If the problem is with the man: what was their reaction on knowing about your problem?
- If they have not disclosed who the problem lies with, then why not?
- Who does the family feel has the problem? What do they say?
- What kind of family support did you require?
- Do you feel that your family was supporting you at each and every stage of the treatment and even afterwards? How?
- Do you feel that they will always support you?

1.3.10 Marital problems faced as a consequence of childlessness

- Have you faced/experienced any problems with your spouse because of this?
- Have you ever had any difference of opinion regarding the treatment? What kind and how did you resolve it?
- If the problem is with the husband, was he regular with his treatment?
- If no/yes, then why and what did the wife feel about it? What did he have to say about it?
- If the problem is with the wife, were you regular with your treatment? Yes/no, what did the husband feel about it?

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1.3.11 Societal attitudes

- What is the importance of a child in the Indian context?
- What do you feel is society's perception regarding childlessness?
- Have you ever had any negative experiences because of childlessness (during any family get together, or any occasions)?
- What do you feel is society's attitude towards you because of this?
- What do your friends feel about this?
- What do your neighbours feel about this?
- What do your relatives feel about this?

1.3.12 Alternatives to childlessness and coping mechanisms

- Did you think of any other alternative to having a biological child?
- Till when did you continue the treatment? Why did you stop it? Who decided?
- Have you ever considered adoption? If yes, how seriously have you thought about it?
- How do you think that your family will react to the decision of adopting a child?

If they have already adopted a child:

1. What motivated you to take this decision?
2. When did you decide to adopt a child?
3. Who decided?
4. What was your family's reaction to this?
5. Do you feel that adopting a child has made any difference to your life?

1.4 Interview schedule for gynaecologists and urologists

The following interview schedule was prepared with a view to understanding the perceptions of gynaecologists and urologists regarding childlessness and infertility. The schedule served as a reference during the interviews. No specific sequence of questions was followed; it depended on the mode of conversation.

The interview began with a brief overview of the research and the participants were oriented to the ethical dimensions that were taken care of by the researcher. Verbal informed consent was sought from each gynaecologist and urologist. The interviews were tape recorded with the consent of the doctor. In case they did not prefer recording, the investigator took running notes, which were expanded immediately.

1.4.1 Background information

Self

Name:

Age:

Education:

Occupation:

Address:

Contact numbers:

Years of practice:

Day and date of the interview:

Time:

Place:

1.4.2 Importance of parenthood

- What is your idea of parenthood?
- How would you distinguish motherhood and fatherhood?
- What is the importance of a child for an individual (man/woman)?
- What is the importance of a child for the family?
- Do you feel that having one's own child makes any difference to a person (man/woman) or the family?
- Would a child affect one's status within the family or society? Will it be different for a man and a woman?
- What is the importance of a child in Indian society (for a man and a woman)?

1.4.3 Perceptions regarding childlessness and infertility

- How do you perceive involuntary childlessness (for a man and for a woman) in the Indian social context?
- As a doctor have you observed any changes regarding childlessness in society?
- How would you define childlessness?
- What is infertility?
- What role does the family play in case of infertility?

1.4.4 Aetiology

- What are the causes for infertility?
- In whom is infertility seen more, the man or the woman, why?

1.4.5 Treatment-seeking

- When do childless couples approach medical treatment (after how many years of their marriage?)?
- How do couples react to infertility?
- How do men react on learning that they have a problem? How do their wives react?
- How do women react on learning that they have a problem? How do their husbands react?
- Among the couple, who comes in first with the problem? Who accompanies them?
- If the problem is with the man, then is the wife informed? If yes, when?
- If the problem is with the wife, then is the husband informed? If yes, when?
- How do they respond to the treatment?
- What are the common misconceptions about infertility among patients?
- What kind of treatment is given? What are the initial steps?
- What are the costs for the different kinds of treatments?
- Do you feel that the medical technology available is sufficient to treat the condition?
- What role can the government play where treatment for infertility is concerned?
- What are the assisted/new reproductive technologies available? What do you feel about them?
- Do childless couples opt for these?
- What is their attitude towards the assisted reproductive technologies?
- What is the success rate of these technologies?
- How much do they cost?
- What are the effects of the assisted technologies on individuals (men/women)?
- What is the compliance rate amongst individuals experiencing infertility?
- Do they change doctors? If yes, then what could be the reason for it?

1.4.6 Coping behaviour

- What kind of coping behaviours do you see your patients resorting to in order to cope with childlessness?
- Do they resort to alternative forms of treatments during the course of their medical treatment? If yes, what kind?

Annexure 2

2.1 Letter of appeal for participating in the research

Respected Madam/Sir,

I am a Ph.D. student/research assistant in the Department of Human Development and Family Studies, Faculty of Home Science, M.S. University of Baroda. As part of a research study related to understanding the perceptions of childless couples regarding childlessness titled 'Involuntary childlessness among the middle class in Vadodara city,' I would like to seek your consent for an interview. The research aims to derive a broad picture of childlessness and the various factors impinging on the same.

I request your participation in the research. The information obtained will be kept strictly confidential and will be used for research purposes only. Nowhere will your name and address be revealed. You may refuse to answer any question or terminate the interview at any time. However, I would be very grateful for your cooperation in participating in the research.

Enclosed herewith is a brief note about the research.

Thank you

Sincerely

Bhamini Mehta (or the research assistant)	Dr. Shagufa Kapadia
Ph.D. Student	Principal Investigator
Dept. of HDFS	Infertility Project

2.2. A brief note about the present research

Presently 5 to 10 per cent of couples worldwide are affected by infertility. India accounts for nearly 5 to 10 million couples experiencing childlessness and their number is constantly rising at the rate of 5 per cent every two years.

The present research aims at understanding the significant issues related to involuntary childlessness as perceived by childless couples and health care personnel. The participants of the research will be individual men and women experiencing involuntary childlessness. They will represent the middle/upper-middle class of society, residing in the city of Baroda. Interviews will also be conducted with selected gynaecologists and urologists of the city with a view to understanding the health system's perspective on involuntary childlessness.

The interviews are expected to lead to an in-depth understanding of childlessness in the cultural context specially its manifestations at the individual and the family level and the coping mechanisms for the same. Also it will help to draw significant implications for the health system.

Involuntary childlessness is significant in individual and family development from the cultural and the gender perspective.

2.3 Letter of informed consent

Dear friend,

If you are willing to participate in the research study on 'Involuntary childlessness among the middle class in Vadodara city,' then please fill in the following.

The information given by you will be kept strictly confidential and used for this research only. Nowhere will your name or address be revealed. If at all required, pseudo names will be used. During the interview you may refuse to answer any question or terminate the interview at any time. However, I would be very grateful for your co-operation in participating in and completing the interview.

Name:

Age:

Education:

Sex:

Occupation:

Marital status:

Number of years of marriage:

Address:

Family composition:

Type of family: Joint/Nuclear

Average annual income of the family:

Preferable date and time for the interview:

Preferable place for the interview: Home/Office/Any other place

Language preferred (please tick): Hindi/Gujarati/English

Signature:

Date:

Note: You have the right not to sign /may not sign the letter if you feel apprehensive about the same.

2.4 Letter of request to gynaecologists for extending support in identifying participants for the research

Respected Madam/Sir,

Sub: Seek support for a research study on 'Involuntary childlessness among the middle class in Vadodara city.'

I am a Ph.D. student/research assistant in the Department of Human Development and Family Studies, Faculty of Home Science, the M. S. University of Baroda. I am carrying out a research study focused on understanding the perceptions of childless couples regarding childlessness titled 'Involuntary childlessness among the middle class in Vadodara city.' I would appreciate very much if you could extend your support in identifying the participants for the same.

Thank you

Sincerely

Bhamini Mehta_(or the research assistant)	Dr. Shagufa Kapadia
Ph.D. Student	Principal Investigator
Dept. of HDFS	Infertility Project

Annexure 3

Tables

The tables in this section are verbatim illustrations, based on which the interpretations were made. It includes three sub-sections presenting the tables and figures related to perceptions of involuntary childlessness of individuals with biological children or planning to start a family, the groups seeking or not seeking treatment, and medical practitioners.

A. Perceptions of individuals with biological children or planning to start a family

Table 1. Importance of a child

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Personal reasons				
Gives purpose in life	14	19	33	The child is everything; he gives directions to our goals. Whatever I have to do, I have to do it for our own child.
Provides security for old age	7	2	9	A child gives a sense of security to the fathers also. Its not only the mothers who thinks that the child will give support me when I am old. There would be someone to look after me.
Proof of one's reproductive capacity		4	4	A child is necessary for the woman because it's the proof of her reproductive capacity. It is of a great significance. And for a man a child is a proof of his manliness.
Able to fulfil own desires through children	2	1	3	
Social reasons				
Eases social pressure	12	5	17	Apart from just having the desire to have a child the couple also want the social pressure to reduce, which is also an important reason in our culture or society
Forwards the family lineage	9	8	17	We feel that our generation has to be maintained. The couple would prefer having a male child because according to our system, he is the one who continues the generation.
Confers social status	8	4	12	*Aurat ki zindagi to bacche hone ya na hone par nirbhar karta hai.* (A woman's life depends on her having or not having a child). *Samaaj mein baccho ke bina aurat ki koi value nehi hoti* (In society a woman has no value without the child).
Deprives from religious rituals	3	4	7	If there is no son then the main concern is who will perform the last rites. Otherwise you will not get *mukti.*
Increases social network	1	2	3	
Familial and marital reasons				
Strengthens family bond	12	5	17	A child strengthens the bond between the husband and the wife and also binds the family members.
Makes family complete	6	4	10	

Note: The total number of responses may exceed N=60 due to multiple responses.

Table 2. Understanding of motherhood

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Brings changes in the woman(more responsible, more patient)		14	14	A child makes you more mature and responsible. You cannot afford to be angry with the child, you have to be patient in your dealings with them because they are small and they do not understand things.
Essence of womanhood	3	3	6	A woman is not just biologically but also psychologically programmed to be a mother.
No responses	27	13	40	

Table 3. Understanding of fatherhood

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Brings changes in personal characteristics(toerant, sacrificing)	14	4	18	It changes you a lot; you learn a little of what you call “sacrifice.” Like if you do not have money, you’ll postpone your needs and consider your child’s needs first.
Brings responsibilities	4	9	13	A father is responsible for the child’s education and career, since he is out of the house, meets different people, and has greater information about all these things. So he can guide the child in a better way.
Gives a sense of fulfilment and completeness	2	4	5	
Establishes paternity		1	1	
Brings no change	1		1	
No response	9	12	21	

Table 4. Attitude of the family

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Blames the woman	21	15	36	Many a times the family, how much ever educated they are, blames the woman only, for not being able to bare a child.
Threatens the woman and gets the son remarried	6	4	40	Some families torture the daughter-in-law; they pressurise their son to remarry, because they want someone to carry their family forward.
Protects men	7	2	9	If the fault lies with the man, then they are smart enough to cover up the issue, because it’s after all a matter of the family’s prestige. Also sometimes they feel that their son cannot be at fault.
Provides support	2	2	4	
No response		7	7	

Note: The total number of responses may exceed N=60 due to multiple responses.

Table 5. Factors affecting the impact of childlessness

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Women's employment	8	4	12	It depends. If she is a housewife then it is going to be more torturous for her.
Women's education	1	1	2	
Family type	2		2	
Family support	1	1	2	I think the support of the people around reduces the intensity of the problem to a great extent, especially the family.
Gender	2		2	
Importance of a child for the person		2	2	The impact of the child depends upon how important the child is for them. The impact would be more if the child holds a lot of importance in their life.
Depends upon the personality	1	1	2	Lot depends on her personality and attitude, how she views herself. If they become submissive and start pitying themselves, then the whole world would hesitate to do the same to her.
Intensity of a problem	1		1	
No response	14	29	43	

Table 6. Impact on marital relationship

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Divorce · Woman leaves the man · Man may remarry	 2 10	 1 8	21	It is such a sensitive issue. Either of them would not like it if their spouses blame them. So ultimately I feel small fights can end up with severe consequences, like a divorce.
Relationship is strained (wife taunts, degrades the man, husband ill- treats the wife)	9	7	16	The husband may get irritated with the wife for petty things. His dislike for her will gradually grow and the distance between the two may grow larger.
Blaming each other	4	2	6	The stigma of being infertile is always there. And I think that if they do not understand then this might strain their relationship. They would start fighting or blaming each other that it is because of you that we don't have a child.
Sexual life is affected	4		4	
Spouse supports	2	1	3	
No impact	2		2	
No responses		11	11	

Note: the total number of responses may exceed N=60 due to multiple responses.

Table 7. Views on health system

Categories	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Perceptions about the role of the government				
Need to address the issue properly	9	4	13	Government is unable to take care of primary health needs, so some of these advanced technologies cannot be made available to people.
Provide better infrastructure	1	2	3	In government hospitals, I think that the cost of the treatment is quite low and affordable, but they lack the necessary infrastructure. That is the problem.
Needs to prioritise	3	1	3	I don't think that it is an immediate priority for the government but for the person, it is. But I think that the government should look at it.
Provide counselling	2		2	
Provide treatment at lower cost		1	1	I think the treatments are too costly which everyone cannot afford. I think that the government should come up with some schemes to help such couples.
Provide referral services		1	1	
Perceptions about private clinics				
Make adoption process easier		1	1	
Needs being addressed, but expensive Caters to higher classes	11	3	14	Private clinics are good. I think they have proper infrastructure and facilities but they are too costly. Normal people cannot afford them.
Role of doctors				
Should not be money-minded	2	5	7	I think today doctors are too money-minded. They know how to fill their pockets. I think they should keep aside their professionalism and treat patients, especially infertility patients with sensitivity.
Sensitive and empathetic		7	7	I think such couples need to be dealt with sensitively and not just mechanically. Doctors need to provide psychological support to such patients.
Should provide information		2	2	
Counsel the patients	1	1	2	

Table 8. Ways of coping

Way of coping	M	W	Total	Verbatim illustrations
	N=30	N=30	N=60	
Adopt	20	12	32	Adoption is a very good solution to infertility because it gives something you can never experience till you have your own child, whether it's your own or it is adopted.
Divert the mind	5	4	9	They need to keep busy all the time. If they get time to think, their mind would automatically drift in that direction.
Primary control - seek treatment		6	6	We are seeking treatment and doing our best.
Predictive control – accept the situation	1	3	4	Accept the state
Vicarious control		3	3	If they are not ready to go for adoption, they can help other children with their education.
Interpretative control	2		2	My uncle is an astrologer; he said we would surely get one.
Withdrawal	1		1	
No response	1	2	3	

Table 9. Views about adoption

Views about adoption	Verbatim illustrations
Facilitating factors	
Increase in societal acceptance	
Urban anonymity	In urban areas it is much easier to adopt because in rural areas, people know everybody. So when the child grows up, somebody may tell him that you are an adopted child.
Social and personal satisfaction	They would definitely receive some satisfaction in investing in a child, seeing him or her grow up.
Apprehensions	
Psychological implications	There will some psychological difficulty that the mother would face on giving away her own child. The trauma is felt by all— the child, the biological parent and the parent who has adopted.
Lack of acceptance (spouse, family and society)	
Concern about the origin of the child	God knows if it is a legal or illegal, or an illegitimate child, which caste it belongs to… all these concerns are there. Then it depends on what stand the couple wants to take.
Lengthy adoption procedures	You have to go through a number of procedures. Thinking of such things the couple would decide it is okay not to have rather than to go through so much.

B. Involuntary childlessness: groups seeking and not seeking treatment

Table 10. Importance of a child

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Societal reasons						
Family lineage	5	3	-	3	11	If we don't have a child *pidhi aage kaise badhegi* (How will the family lineage move ahead).
Societal pressure	3	-	-	2	5	In our society not having a child is like a taboo.
Increased social status	3	2	-	-	5	You should have your own child because it increases your name in the society. *Tamaru naam vadhe* (glorifies your name).
Religious reasons	-	-	-	1	1	In Hindu philosophy, a son is important for performing the death rites and a daughter for *kanyadaan*
Personal reasons						
Gives purpose to life	4	12	2	8	26	A child is important. *Unse hi to zindagi chalti hai. Unke siva to life hi nahin hota hai.* (Life goes on with them. There is no life without them).
Personal desire (brings happiness)	4+3	6+2	1	1	25	Arrival of a child is a joyous occasion.
Support during old age	4	1	1	1	8	
Increases social network	-	-	1	1	2	We think that if we have children then we would have a wider circle than what we have.
Fulfilment of desires through children	1	-	-	-	1	I had a dream of going abroad to study, but unfortunately it did not happen. So I think when I have a child, I will educate him abroad. The things I could not do, I will do for him.
Table 10 continued: Family and marital reasons						
Important for my spouse	-	5	-	-	5	My husband says even if we have to spend lot of money a child is a must.
Makes the family complete	1	3	-	1	5	*Bachha hai to parivaar pura lagta hai.* (If there is a child, the family feels complete).
Strengthens the marital bond	-	2	-	3	5	A child strengthens the relation between the husband and the wife, the life changes.

Table 11. Feelings regarding childlessness

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Negative feeling						
Incompleteness	1	12	1	2	16	I am feeling as though I am missing something in my life.
Denial	-	5	-	-	5	I feel *mere saath hi aisa kyon hua, maine to kisika kuchh nahin bigada hai.* (Why did this happen to me? I have not done any wrong to anyone).
Helplessness	-	-	3	-	3	
Spouse's feelings					7	
Tense PMS (premenstrual syndrome)	1+2	-	-	-	3	For me it does not matter but I have seen her crying many times. She feels blue around her menstruation.
Lonely	1	-	1	-	2	She used to feel very upset and very lonely. While I was preoccupied with my career.
Optimistic	2	-	-	-	2	She is very supportive, she says *thai jase* (it will happen
Positive feelings						
Accept the state	-	-	2	1	3	You have to accept certain facts of life. I have taken this for granted. I am practical

Table 12. Societal attitudes towards childlessness

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Negative attitude Negative comments	5	9	-	7	21	Some people have come and told me that *aey to vanjhan chhe* (she is barren).
Interference and intrusive questions	5	3	2	4	14	People say *ke itne saal ho gaye hai shaadi ko aur ahbi tak nahin hua* (You have been married for so long but still you haven't got a child).
Deprecating behaviour (blame the woman Isolate and segregate the couple Pity them, Treat as deviant)	3	-	2+1	3+2	5+6	Finally, as usual in Indian culture *mein ladies ko hi they consider na.* (In Indian culture ladies are only blamed). Some would indirectly say that you are inauspicious. If a couple doesn't have any children they are boycotted by the society. Normal thing nahin hai ... not having children, it is not acceptable in our society.
Positive attitude						
Support	-	2	3	6	11	
Non-interference	-	5	-	-	5	

Table 13. Dealing with comments

Categories	Verbatim illustrations
Retorting	I simply tell them to mind their own business.
Respond casually	I tell people that treatment *chal raha hai* and one has to wait and watch.
Ignore	*Log to bolte rahte hai, sabki sunoge to jeena mushkil ho jayega* (People will keep talking, if you keep listening to them, it will be difficult for you to live).
Respond in a forthright manner	People ask me *ke kitne bachhe hain,* I tell them *ke* sorry I don't have, they say sorry we didn't know, I say why are you sorry, I should be sorry.

Table 14. Family attitude towards childlessness

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
	N=20	N=20	N=5	N=10	N=55	
Family is supportive	6	13	3	2	24	*Aaa loko kasu kheta nathi* (family members don't say anything). Normally they do feel bad, that we should conceive, they bless us, but their attitude is not negative, why there is no child.
Uncooperative	2	7	1	2	13	They tease me that when are you going to have one.
No response	12	0	1	6	19	

Table 15. Impact of childlessness on marital relations

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M N=20	W N=20	M N=5	W N=10	N=55	
No impact	8	11	2	6	27	Minor conflicts do keep happening but for medications, treatments, doctors or visit to the hospital we have never fought.
Negative impact(marital discord, sexual life affected)	1	2	1	7	11	Sometimes we have some fights, mein *usko thoda suna bhi deti hoon, and ke tere kaaran mujhe bachha nahin ho raha hain. Mein usko aisa pinch karke bolti hu ke kaise life ho gaya hai na?* (Sometimes I tell him that it's because of you that I am not able to conceive. I also tell him in a pinching way).
						She used to always be tense during intercourse, she was more interested to conceive than to enjoy it or take it as a normal act.
Marital bond strengthened	2				2	In fact we have come closer as we are working towards solving a common problem.
No response	9	7	2		18	

Table 16. Causes of infertility

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Problem with sperm count	10	5	1	2	18	I have a problem with my sperm count, azoospermia. *Mujhme bachha paida karne ki takat nahin hain* (I don't have the capacity to father a child).
Problem with the ovaries	3	6		1	10	*Woh beej hai na woh ladies mein hota hain woh ban nahin raha hain* (The ovulation is not occurring).
Hormonal imbalance	2	5			7	Actually I have some hormonal problems. My hormones are really high.
Unexplained infertility	2		1	2	6	There is no specific reason that *iske wajah se pregnancy nahin ho rahi hai* (for the pregnancy to not occur).
Tubal Blockage	2	2			4	The right side of the tube was opened, which was earlier blocked. When operation was done like laproscopy, then we came to know the problem. After the treatment the right side is open now the left is blocked.
Structural problems				3	3	When the laproscopy was done they found that my one ovary and one fallopian tube is not there.

Table 17. Causes of infertility as perceived by self

Self-perceived causes	Verbatim illustrations
Heredity	
Size of the penis	Personally, during the intercourse, I used to feel that my sperm used to spill outside, so I suspected that maybe I had a problem in my size.
Electrocution leading to low sperm count	When I was 3 to 4 years of age I got electrocuted. Probably this could have affected my sperm count or hormones.
Blood cancer	My brother had blood cancer so his sperms are low because *bhaare dava garam pade* (heavy dosage of medication generates heat in the body) [which is not congenial for the production of sperms].

Table 18. Support network

Categories	Verbatim illustrations
Women's natal family	
Spouse	My husband has supported me all through. *Uska support jyada hai* (his support is a lot). Nobody will bother as much as my husband does.
Friends	I have a friend who is my greatest support.
Self	I myself have been my greatest support, i.e. my confidence. I fall into depression sometimes but then I revive on my own, I manage on my own.

Table 19. Approach of the doctor

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Performs duties and is sensitive(gives treatment, answers queries, supportive, provides information)	13	8		7	28	He is very good, even if I get three minutes with him, he will explain to you whatever is required.
Insensitive and mechanical approach	6	4	1	2	13	She discussed our problems in front of other doctors and she was quite insulting.

Table 20. Reasons for changing doctors

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Doctor's attitude (Did not give enough time, did not give adequate information, was insensitive, expensive, incompetent)	10	6	2	1	19	Dissatisfaction was there because response *nahin dete they* (they did not respond well). We were not comfortable with the doctor.
Treatment-related(Did not like the treatment, did not get expected results, treatment lasted very long, side effects).	6	4	2	2	16	Because of my gynaecologist's treatment my weight started increasing. My husband was not satisfied with the treatment.
Practical problems (Clinic was very far, husband got transferred)	1	3			4	The doctor's clinic was quite far away from my residence, so it was not feasible going and coming, so we decided to discontinue the treatment.
Influence of other peoples' opinion	1	2			3	Someone told that Dr. XYZ is good and my friend got results and so then we go there.
To take second opinion		1		1	2	My doctor said that normally you can do with one only (one fallopian tune and ovary), it does not make any difference but then we thought why not consult another doctor.
No specific reason	1				1	

Table 21. Feelings regarding treatment

Categories	Grp. skg. trt. (A)		Grp. not skg. trt. (B)		Total	Verbatim illustrations
	M	W	M	W		
Dissatisfaction with doctor's approach	7			1	8	We must get proper result. For six months, eight months we have taken the prescribed medications and there is no result. Money is no constraint, but if we spend money for some work, then the work should be done.
Tired and bored	1	3		4	8	At times I tell my friends that I am tired and bugged with the treatment. Since four years I have been taking medicines. Now I am tired of the side effects.
Bad and depressed		3			3	Sometimes I do get depressed, but it also happens very rarely.
Expensive	3				3	I liked the treatment but the thing is, there will be five to six cycles of IUI and each cycle will cost Rs. 2000. Now I am with my family and so I can afford to spend. If I lived separately it would have been difficult.
Accept all the discomforts for the good results	2	1			3	My wife experiences some side effects but it is okay with us because the joy of getting the child is more than the pain.
Mental and physical drain				4	4	We did a lot, tried a lot and are now tired… in all ways … mentally, physically and financially.
Inconvenience of testing procedures	1				1	The people in the pathological laboratory were not cooperative, we have to run from one lab to another with the semen sample and they treated us very badly.
Wondering why the treatment failed			1		1	We went to proper doctors, took proper advise, proper guidance, proper treatments. Even then it has failed. Why?
No particular feeling		1			1	I didn't feel as such… I can't say that there was this specific feeling but I felt that okay, I'll go to the doctor and everything will be fine.
Feeling stressed		2	1		3	Of course the cause is there and the time also being a big constraint I couldn't afford to leave my business and go (to another city).
Spousal non cooperation				2	2	The NRTs are well advanced and I feel everybody should take this, but my husband does not believe in this. I have told him number of times but he says no.

Category	Gender	Frequency Grp. (A)	Frequency Grp. (B)	Illustrative comments
Observe fast / *badha* / *puja*	W	12	4	*Torture to lagta hi hai, na par aisa koi kuch bolta nahin hai* (It is torturous, but nobody says anything directly).
	M	10	1	*Hamne mannat maangi thi hamari kul devi ki mandir mein* (We had asked for blessings at the temple of our family deity).
Approach an astrologer	W	7	5	*Davai lena padta hai to lena padega, bas ho jaye wahi bahut hai* (If medicines need to be taken, they must be taken, but conceiving would be worth it). I showed my horoscope, everyone has said that *aapka hoga par late hoga* (you will have a child but late).
	M	2	2	Yes we do believe, we have shown it to some people and they say we do have a child but quite late.
Attribute to destiny	W	7	3	I believe in destiny. *Naseeb ma hase to thase* (if we are destined to have one child, we will).
	M	6	2	Unnecessarily taking tension is of no use, it's not going to help us in any way. God has given birth to all of us, He decides all our actions and whatever is destined to happen will happen.
Rationalise	W	2	4	One of my brother's friends, his wife had a normal delivery. But during the fifth month they came to know that the blood that should reach the heart was not actually reaching so the baby expired. I think it is very difficult to tolerate once you have a child in your hand and then god takes it back. *Bhagwan e mane aa stage ma rakhi chhe to ema kaik saru hase that* is why *mane laae chhe ke je thay chhe te saara maate thay chhe* (I feel that as god has kept me in this stage so this must be for some good reason only, so whatever happens, happens for the best).
	M	4	4	I don't have time to talk to my parents to that extent. I am not available when they need me; they are living their own life.This is a theory of evolution that everyone comes for his own self.
Seek emotional solace through other children	W	2	6	When I am all alone at home I think about my state and start crying. I treat my sister-in-law's children as my own. They live with me.
	M	2	2	It (adoption) is risky in taking an unknown character, blood is always speaking. A *pandit* in Kashi was given blood in the hospital. After some days he came to know that it was a Muslim's blood, he said that his characteristics got transferred through blood. I spend money for them (small children) like anything, when I see any child I don't hesitate to spend rupees. I told my wife that it would be our responsibility to educate our brother's daughter.
Divert the mind	W	2	1	At times when I am all alone, I do feel ... that is why I feel that I should get involved in something. Earlier I had decided that I won't work but now I am looking for a job.
	M	3	1	Women go into the routine work and so depression goes away. I keep myself busy all the day.
Adopt	W	7	3	The treatment costs quite a bit, till date we have spent around Rs. 80,000.
	M	1	1	My sister is adopted (by my uncle). I know there can be problems because the person is adopting somebody's child, the biological parents or real parents cannot restrain themselves. So we will adopt but from outside the family.

C. Perceptions of medical practitioners

Table 23. Different approaches to treatment

Categories	Verbatim illustrations
History-taking	First time we take a detailed history, we do examination and we give a probable diagnosis.
Making efforts to involve both wife and husband	• I usually make it a point to call the husbands and get the history from the husband himself. • She will say "*ben maro gharwalo nahi aav"* (madam, my husband won't come). We investigate her and ultimately when everything is right in her, we call the mother-in-law and explain it to her to get her son just once, and if he does not want to come to the hospital, you take this form, you go to the lab and just give us the report. • We need to call them so often that if the husband is working, it is not possible and we don't blame him. First visit he is present and then whenever he is required he is there... then she will have to come alone.
Explaining infertility	• We show them the different charts—what is the basic treatment required, where does the fault lie. What is the ideal time for conception, what are the options open for you? • Initially I explain to them about sex and then I tell them that step-by-step we will have to investigate if we don't get results. • For patients coming just once, there is no point spending lot of time. So when I am confident that this patient is going to come to me for months together then we call these patients in a group for discussion.
Removing misconceptions	There are wrong ideas about menstruation. Many patients feel that if you have intercourse during that time then only you can conceive or then only you can have a male child.
Starting immediate treatment	If a person gets married at the age of ... say the woman is already 35, we don't wait for three years.
Deciding upon the time and mode of treatment	• I tell everything to my patients because they are mature enough to understand their problem. Once a patient understands his/her problem, then they are ready to accept the medical line of treatment. • In cases of azoospermia, I just don't pass time by giving some medicine. I tell them very plainly that go to the gynaecologist and go in for donor sperm.
Reassuring and counselling	• If morphology and motility is fine, then the low count in itself does not say that this is not going to work. Ultimately the pregnancy may take a little longer time also. We have to reassure them. • Infertility needs a lot of counselling, they should be listened to carefully, what their problems are, if we spend 5-10 minutes with them, give attention to their social problems, that helps a lot.
Referrals	In case of psychogenic causes, we refer them to psychiatrists.

Table 24. Causes of infertility

Categories	(N=10)	Verbatim illustrations
Medical conditions		
• Specific dysfunction (in ovulation, tubal blockage, blockage of vas deferens)	10	In childhood if they have had some major viral infections like mumps.
• Chronic illness	9	It is known to destroy the functioning of the testes to produce sperms.
• Mumps during childhood	5	
• Infections	3	
• Intake of other medicines	2	
• Congenital problems	1	
• Irregular menstruation	1	
• Obesity	1	
Social causes		
• Smoking/chewing tobacco	6	Things like addiction to tobacco and smoking may cause decreased sperm motility
• Alcohol abuse		
• Tight clothing	5	
• Lack of knowledge about sexuality	4	
	4	
Environmental causes		
• Professional hazards (e.g., working in the heat for long hours)	4	Nowadays even they say there are lot of fibro estrogens in the diet, estrogens that are derived from the plant, that is decreasing the count
• Environmental pollutants	3	
• Fibro estrogens in diet	1	
Psychological causes		
• Stress	8	Suppose a female egg can survive for 24 hours. He is busy in his job, he comes late and then he is not in a mood. He doesn't get an erection. He doesn't have the desire. When he has the desire she is not ovulating.
Unexplained infertility	2	If no such cause is there that can be pinpointed, we say unexplained infertility.

Table 24. Causes of infertility

Categories	(N=10)	Verbatim illustrations
Medical treatment		
• Artificial insemination	5	They go for alternative therapies, artificial insemination very easily.
• Operations to remove blockages	2	
• Stimulation for spermatogenesis	1	We can give some pills to increase the count.
Rectifying practices		
• Counselling (convincing husbands for investigations, helping them accept the reality, etc.)	3	First of all if somebody is busy, running here and there after their business or any other such thing, then he should have a change in his lifestyle.
• Suggesting lifestyle modifications (e.g., lessening work load)	3	
• Providing information about sexual intercourse	3	
Other alternatives		
• Donor sperms	6	It is very difficult for oligospermia patients to get convinced for adoption as opposed to azoopermia.
• Adoption	5	She should adopt a child and that will save her money also. And once the child is there in the house the whole perceptions towards life will change.
• Surrogate motherhood	1	

Table 26. Attitudes and concerns of patients seeking treatment for infertility

Categories	Verbatim illustrations
Non-acceptance	When such infertile couples come they are so anxious and tense, they feel as though they are to be blamed. They still can't accept the fact. They feel they have failed somewhere, humans can't accept failure; if they aren't getting a child it means they are failures, especially educated couples.
Blame the woman	Still in our society, male patients don't agree to complete check-ups sometimes, or they hide their things. Blame goes to women. Male partner will not accept the responsibility for infertility very readily. They will find out one or the other excuse and will not go for proper investigation. When men find out that they have problems, they are slightly more considerate towards their wives.
Expectations from doctors	Whenever they are directed to see a specialist, they have high hopes, so first meeting they are anxious but at the same time they have full hopes that he is going to do something for us.
High costs/expenses	Actually men are more interested in adopting rather then spending a lot of money on IVF.
Fear of male infertility	Sometimes, the men are having the fear that if something is wrong with me, so what will I do and so I don't want to get investigated, don't tell me to come.
Urgency to conceive to achieve social status	The childless couple feels that they are socially incomplete, that is why they keep changing their doctors. They just want to get pregnant, by hook or by crook. Sometimes, I feel the thought of becoming a parent is so much, they are not even listening to what you are explaining.
Undermining psychological treatment	If I tell a patient that you have so and so problem of infertility, this is the treatment and I think you need to have one or two sessions of hypnosis before that, she will think I am a fool, "*is se to kuch nahi hone wala hai"* (nothing will happen with this).
Accepting adoption	They try for some years, then they feel it too much, or the pressures of the treatment, the pressures of the stigma they go in for adoption, but still adoption is not that easily accepted.

Table 27. Spousal reaction to male infertility

Categories	Verbatim illustrations
Support	They accept the fact and they support their husbands morally; if the wife has some problem the husband cannot accept it that fast, there the ego comes in between, but usually ladies are good, they cope.
Dominate	Suppose the husband's sperm count is less, then really the wife dominates.... "*maru to badhu barabar che ne"* (everything is fine with me)? The way she looks at her husband is really disturbing.
Hide male infertility	The woman is so docile that she doesn't say that fault is lying with her husband.
Confidence from absolving self of blame	The lady suddenly becomes very dominant, she feels that there is nothing wrong with me, so she has an "*auzaar"* (weapon) through which they fight with society, in-laws, family. But couples who really love each other, they both feel unhappy and try to find a solution.

Table 28. Doctors' perceptions of men's reactions to infertility

Categories	Verbatim illustrations
Non-acceptance	He certainly can't be at fault; the problem has to be with the wife. It may take a little longer to accept that the problem is with him and not with her. I have seen patients who come and cry. Their husbands, see even if the problem lies with the husband, the poor female is blamed, "*ke tereko baccha nahi hota ha"*" (you are unable to conceive), I will divorce you.
Physiological repercussions	Husbands start getting impotent after knowing of infertility.
Psychological impact (depression, insecurity)	There is little depression, that is there in males. Some 95 per cent do feel bad about it, they take it to their heart, then it is very difficult to counsel them. Males take it in a very bad way, many a times they don't show it, but it becomes a direct blow on their psyche. We are more sympathetic towards the women; don't we have to see from the man's point of view also? We don't, when probably he also must be having his own anguish. He behaves in this manner perhaps because of his own insecurities and fears. I think both must be suffering in their own ways.

Annexure 4

From the researchers' diaries

Female researcher: Working on this project has been a really challenging and learning experience, which will help me in future endeavours. As a research assistant, my job was data collection, data interpretation and analysis, and writing the report.

I found data collection to be the most challenging and also frustrating. It was frustrating because most of the time we had to run from one clinic to another to identify respondents, especially the group seeking treatment. Our running around did not ensure that we would get the respondents as per our research criteria. Even if we identified the respondents, it was hard to convince them and get them to agree to the interview. Even if they agreed to the interview, they would just end up answering "yes" or "no." Infertility is a sensitive issue and people are hardly likely to want to talk about it in public. Getting them to talk about it with a researcher was especially difficult. Working on an issue such as infertility calls for a lot of sensitivity and empathetic understanding on the part of the researcher. I was unaware of the magnanimity of the problem until I actually interviewed the respondents.

When my male colleague, who interviewed the male respondents, and I went to the clinic on the first day, everyone took us to be a couple who had come to seek treatment. This was most embarrassing. But I quickly clarified and introduced my colleague and myself.

A lot of things troubled me. Firstly, how would I approach the respondents so that they did not feel offended? Initially, we decided that the doctors would identify the respondents and introduce us to them. When the respondents agreed to participate, only then would we go and meet them. But since the doctors did not have enough time to engage in such things, it was generally their assistants who would do the groundwork. Then I would take the respondents to a separate room, give them all the necessary details, and ask them if they would like to participate. Still, I felt that the sensitivity needed to approach the couples was lacking, because the assistants would just loudly point to the couple that fit the research criteria, which really embarrassed the respondents. Despite repeatedly telling them not to do this, the assistant would repeat their actions and I felt helpless. It took some effort to finally make them understand. In such research, a lot depends upon the way you approach the respondents.

Secondly, during the interviews I sometimes forgot the question to be asked and ended up looking at the respondent blankly. Then I would admit that I had forgotten the question. This in fact made the atmosphere lighter. And gradually, as I progressed with the interviews, this problem did not recur.

My job was to interview the female respondents. I noticed that although people say that women are verbose and would easily agree to be interviewed, the women in fact were not open when talking about their marital life and their family. They would try and present a good picture of everything, although their expressions and gestures defied what they were saying. Women who had been undergoing treatment for many years were more cooperative and they would willingly narrate their experience, be it good or bad, while those who had just started with the treatment were a bit hesitant and uncooperative. They would restrict their answers to "yes" or "no." Sometimes I would keep asking them the same question in order to get the answers, not recognising the fact that they just might not be willing to give the answers. I realised this during the mock interview session held in the workshop.

Another problem during the interviews with the group seeking treatment was that while narrating any event related to their state they would often end up crying, which would make me uncomfortable and not knowing what to do or what to say. At the workshop that I attended to learn interviewing techniques, it was suggested that in such a situation we should switch off the recorder and remain silent and give the respondents time to calm down. Although I did this, I still felt bad knowing that it was my question that led to such

an outcome. Some of the respondents, at the end of the interview, mentioned that they were feeling better after sharing their experiences.

During the interviews, I noticed that it was better to start off with questions pertaining to their present state, which were easier for them to relate to, rather than beginning by asking "what is the importance of a child for you?" or "what is parenthood to you?" Such a question, when asked at the very beginning, makes the respondents uncomfortable because they have to answer something that they haven't experienced as yet. At times the answer was, "Oh! I have never thought about it before!"

At times I asked some question and got weird replies. Some respondents would stare at me. Then I had to rephrase my question. The training helped me to recognise these signs.

The women in the general category were the easiest to interview. They would freely answer any questions, perhaps because they were not suffering from the problem. This group was so verbose that sometimes I had to remind them of the question I had asked. A majority seemed to be waiting for someone to vent their marital frustration. They would give me all sorts of advice, be it related to marriage or planning children.

Interviewing the gynaecologists and urologists was the most satisfying experience. In spite of their busy schedule they would consent to the interviews and would provide in-depth information about infertility.

The workshop on interview techniques was of immense help. It helped me to refine my interviewing skills. I tried to follow the guidelines that we were provided in this workshop, but gradually I found that there is nothing like a standard format. With experience you gradually tend to develop your own way although some basic things don't change. I am from a quantitative background, it was a bit difficult for me to grasp the concepts in order to analyse the data. I learnt along the way.

Male researcher: The infertility project was a big learning experience for me. My job as a research assistant included data collection, analysis, interpretation and report-writing. I had to interview the males from the sample group.

Interviewing was not as easy as I had imagined. This was the first time I was going to formally interview people (informed consent, audio recording, etc.). Initially, I was hesitant, I had my inhibitions, the whole thing was so new. But as my experience grew, I recognised that influencing the direction of an interview and getting quality depends a lot on the confidence and comfort level of the interviewers.

There were times when I would simply go blank and end up repeating a question I had already asked just to fill up the silence. However, with experience, my confidence grew and many a times I felt I could empathise with the patients. This helped the interviews to roll smoothly and would lead to an active interaction.

There were certain things I realised: Talk to the subjects in the language they feel comfortable with; don't start talking about the project and the interviews right away. First introduce yourself, talk a little about things in general before moving on to the topic. This helped me in building rapport.

There were a few male respondents whom I would categorise as resistant in varying degrees. Some would prefer answering only "yes" or "no." Others would respond too positively: "no we have no problems," "our family is very loving." Some of the subjects responded actively and with a lot of zeal. They were open to questions and to discuss. Quite a few respondents were verbose about many things like the question "what is the importance of a child for you." Sometimes I would ask some question and get a totally different answer. So I would have to rephrase the question.

Some male subjects wouldn't accept the fact that the problem lies with them. They would blame the wife. One such couple was seeking treatment for more than eight years.

The interviews with the gynaecologists/ urologists were comfortable. They were mostly giving a third person opinion and medical information. With the general group too, since their opinion was more detached, interviewing was easier.

One needs tact to interview groups seeking treatment. They are in a distressful condition and inclined to defend themselves from anything they may consider threatening.