Stigmatization of Infertility Amongst Couples
(A Case Study of Islamabad)

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Final Approval of Thesis

This is to certify that we have read the thesis submitted by Ms. Hamna Naru. It is our judgment that this thesis is of sufficient standard to warrant its acceptance by the Quaid-i-Azam University, Islamabad for the award of the Degree of "Master of Philosophy in Anthropology".

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ABSTRACT

Infertility is an important reproductive issue prevailing in the society because the production of offspring is necessary for the continuation of society. In Pakistan, fertility is related to women and is considered an important part of life. It is assumed that soon after the marriage a couple will prove itself to be fruitful. The present study was conducted to deal with the various aspects of individual's life which are affected by infertility. It highlighted the causes of infertility in males and females and what are the psychological and social problems of infertile among the couple. Infertility is not a problem of a single person rather it affects both partners and how infertility affects the relationship of husband and wife was also studied. The basic aim of the study was to explore the stigmatization of infertility amongst infertile couples in Islamabad.

The study was conducted in a government hospital; Federal Government Poly Clinic and in a private clinic; Mother-care, in Islamabad. Different methods like stratified sampling, interviews, observation etc. were used in order to collect the relevant data. The sample size consisted of 20 male infertile couples, 10 female primary infertile couples and 10 female secondary infertile couples, which in total makes the sample of 40 infertile couples. The sample size was equally selected from both the locales of research. There was a strong psychological disturbance observed among the couples due to infertility. Stigmatization and its fear was the basic reason that caused damages in their life. All the infertile respondents had impacts of stigmatization because it was found out that the male and female infertile couples who were educated and were from a strong social class were equally facing stigma than those who belonged to poor class and were less educated. Stigma and labeling was observed among all the infertile couples but the females were more expressive than males.

Infertility threatened the individual to be labeled as incomplete, useless, barren and abnormal person, which caused lack of confidence, respect and loss of status in the society. The social support by the family, friends and partners has however, played a vital role in dealing with stigmatization. Labeling individuals in the society on the basis of some factors caused discrimination and stigma among the married couples in both the rural and urban societies.

CHAPTER 1

INTRODUTION

The doctrine of human civilization is based on continuity of race, culture, and society with family as it is a fundamental unit that has paved the way for a very strong emphasis on the role of procreation in every society. Over the times, social scientists have understood that reproductive health issues are not only causing medical but very strong social and behavioral determinants, like spread of sexually transmitted diseases, delays in seeking care for pregnant mothers and societal pressures leading to sexual disorders.

Fertility and infertility also fall under the category of reproductive health. Family is a very important and central unit of the society. The family circulation and continuation depends upon the fertility. Family in known as a unit comprised of parents and their children. Parenthood is an expectation of a couple. With this, the couple is also expected to have children "in time", usually about 2 to 3 years after the marriage. Parenthood is desired by everyone and 'being fruitful' is a must for all in all societies.

The ability to produce children is one of the most important functions of human beings and this ability is termed as fertility. Fertility leads to a complete and happy life which is recognized as the normal life in the social circles. While analyzing Contemporary Human Sexuality, Turner and Robinson, (1993) [1] found that couples desire for children due to different reasons like; they believe children are important because they are also an extension of the family and enhance the identity of parents and their dream about how their children will accompany them in future, every parent want to help their children to be grown up and matured, they want to give their children what they themselves never had, and many couples want children because the society expects it from them, it is what the married people do.

Those who are unable to achieve pregnancy are known as infertile. Broadly speaking infertility can be divided into two categories i.e. primary and secondary infertility. As Osman (2011)[2] defined the types of infertility as:

> *"Primary infertility is used for a couple who have never achieved a pregnancy. Secondary infertility referred to a couple who have*

[1] Turner, J.S., & Rubinson, L. (1993). Contemporary Human Sexuality. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.
[2] Osman, A. A. (2011). Management of Infertility within Primary Health Care Program in Sudan. *Asian Journal of Scientific Research* 4(2), 158-164. doi: 10.3923/ajsr.2011.158.164

previously succeeded in achieving at least one pregnancy, even if this ended in abortion."

The prevalence of infertility is not uniformly around the globe, it varies from place to place and people to people. In India, according to the second National Family Health Survey report 1998-99 (NHFS-2)[3] about 3.8% of married women between the ages of 40-49 reported to be childless. The developed world is undergoing demographic transition and most couples have one or two off-springs and they consider absolute failure to reproduce more due to infertility. The American Society of Reproductive Medicine reports that infertility affected about 6.1 million women and their partners in the USA in 1997 (2.3% of 267.7 million), this figure is expected to reach 7.7 million by the year 2025 (2.2% of 386.7 million)[4].

In South Asia, fertility plays a vital role in the lives of people because it is important for gender identification and other various functions of the society. Bearing of a child is considered the central role of women; birth of a child is celebrated by mostly conservative Asian communities and this automatically sway negative implications over those who have not been able to fulfill the expected role of bearing children. Infertility does not allow such couples to live happily like others. Continuation and size of the family to be maintained are very important, therefore, those who are unable to reproduce are compelled to seek various treatments.

Situation is more complicated in Pakistani society where antiquated customs and religious mindset governs the cultural norms and shared behaviors. Most of the religious scholars strongly condemn efforts to control family size and consider any planning in this regard to be anti-religion. They believe that the number of children is important in order to spread Islam and Muslim Ummah, so it is the duty of every Muslim couple to produce as many children as possible to help Islam, on the other hand growing poverty and labor intensive agro-economy of the country makes it significant for every family to have more working hands at their disposal who can help in producing more crops and cultivation. The number of children represents the manpower and is considered the source of dignity and prestige in the society. In such circumstances, family and peer pressure to have some children on couples with some difficulty in conceiving becomes so intense that it starts their

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[3] Roy,T.K., Arnold, F., Kulkarni, S., Kishor, S., Gupta, K., Misra, V., et al. (2000). Chapter 4: Fertility and Fertility Preferences. National Family Health Survey (NFHS-2), (1998-99). India, Mumbai. International Institute for Population Sciences and ORC Macro

[4] American Society for Reproductive Medicine. Patient's fact sheet: Infertility 1997. Available from: http://www.asrm.org/Patients/FactSheets/Infertility-Fact.pdf. Retrieved on 20/11/12

marginalization. The relationships and social interactions of couples are stressed and their lives are focused on getting the problem of infertility fixed.

In Pakistan prevalence of infertility is about 21.9%, including the primary infertility of about 3.9% and 18.0% couples facing secondary infertility[5].

1.1. The Problem

The study deals with the various aspects of individual's life that are affected by infertility. It will highlight the causes of infertility in males and females and psychological and social problems of the infertile couples. Infertility is not a problem of a single person rather it affects both partners and how infertility affects the relationship of husband and wife was studied. The basic aim of study was to explore the stigmatization of infertility amongst infertile couples, in Islamabad.

1.2. Statement of the problem

Stigmatization of infertility exists in every part of the society; the present study was focused on assumption that people feel that it was the essential responsibility of the married couple to have babies and those who were unable to do so were treated and looked upon in a negative manner. It was important to understand the issue from the perspective of those who were undergoing the treatment of infertility.

The aim of the present study was to find out how people perceived the couple who was unable to have their own biological child and to explore the connection between the infertility and marital life. The stigma, social pressure, personal need etc, all were creating mental pressure for the couple. The research attempted to understand the psycho-social effects of infertility on the couple and to gather information about the basic causes of infertility prevailed in the selected cases.

So the aim of the research was to study the stigmatization of infertility in detail and studying the social perception and causes of infertility that would help to create a link between them and to understand the impact of infertility on the psychological condition and marital life in addition to investigate the social pressure of stigma that has affected every aspect of life.

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[5] Ali, S., Sophie, R., Imam, A, I., Khan, F, I., Ali, S, F., Shaikh, A., & Hasnain, S, F. (2011). Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross- sectional study. *BMC Public Health* 2011 11:760. doi: 10.1186/1471-2458-11-760

1.3. Specific objectives of the study

Formulation of a broad based planning for the research study was an important and basic requirement prior to undertaking the research study. The objectives of the study that were well before drafted keeping in mind the scope and nature of study were a guideline for the investigator to concentrate on the focus of the study within a shorter period of time specified for the researcher to stay in the locale of study. The objectives of the study were to:

- know about the stigmatization of the infertility amongst infertile couples,
- explore the psychological consequences of infertility,
- investigate the factors leading to infertility, and
- observe the effects of infertility on social life of the married couples especially on their matrimonial and family relations.

1.4. Significance of the study

Globally many anthropologists have worked on the issues related to infertility but in Pakistan there was a dearth of such scientific researches on the issue because their focus was just the women and was undertaken in the rural areas. This research will be an excellent contribution to the medical and urban anthropology as it was carried out in a urban center of Islamabad.

Fertility and reproduction are highly linked with females specifically, the researcher had explored the mind sets of men in the urban society and how they deal with infertility.

Studying the infertility and its stigmatization among couples in Pakistan is important for a number of reasons, firstly, in Pakistan, most of the people get marry to have children and most of the parents while marrying their children start thinking about their grandchildren therefore, if the marriage does not resulted in early news of a conception, the couple and their parents start worrying and this causes psychological implications. Secondly, there is a need to study the issue of infertility at a couple's level and by involving the social aspects. In Pakistan people do not talk about issues related to infertility openly, which creates problems relating to the reproduction as the major sources of distress. The current research study has covered the infertility as a whole by investigating different aspects.

1.5. THEORETICAL FRAMEWORK

Reproduction and population have always been important issues in every society around the globe and there are different theories and assumptions about the fertility and its relationship to other aspects but no particular theory is established for infertility.

This chapter will describe different social theories and define their relevance with the infertility and stigma with an anthropological perspective to understand the issue very simply. There are three frameworks which are deemed appropriate to conceptualize infertility and the social issues related to it, as per the theme of research, the Bio-Psycho-Social Theory, family system theory and the Goffman's theory of social stigma are of importance to discuss:

1.5.1. BIO-PSYCHO-SOCIAL THEORY

The Bio-Psycho-Social Theory emerged from the model proposed by George Engel, the Internist and a Psychoanalyst. Before Bio-Psycho-Social model, bio-medical model of medicine was in vogue, which propagated that the reason of any problem or particularly disease was the physically observable factors. The physiological and the biological causes were given preference. That model completely neglected other dimensions of human social and psychological life.

A Bio-Psycho-Social perspective proposes that, for any individual it is necessary to consider all three interrelated aspects of his/her life i.e., social, biological and psychological. Edward Shorter (2005)[6] mentioned:

> *"This is the implicit Bio-Psycho-Social model: the recognition that material lesions, life experiences, and current social situation all matter in the presentation of illness."*

The model emerged while treating the patients having serious health issues but the reason was unknown and later while observing the relationship between sudden death and the psychological stress. According to Engel, the biological, social and psychological, all influence in the prevention, diagnosis, causes, management and the outcome of the disease.

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[6] Shorter, E. (2005). The history of the biopsychosocial approach in medicine: before and after Engel. P.White (Ed), In *Biopsychosocial Medicine: An Integrated Approach to Understanding Illness*.1– 20. Oxford University Press

"...must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with disruptive effects of illness[7]*."*

Thus, according to the perspective of Engel the three dimensions of life i.e. biological, psychological and social, all are interlinked, each aspect exerts an influence on the other.

The biological part consists of human physiology, the body and the observable parts of human being; on the other hand the category of psychological perspective consists of the untouchable systems which are continuously going on in mind, like knowledge, cognition, beliefs, emotions and different psychological conditions which intentionally or unintentionally influence human behavior like grief, sadness, guilt, shame etc. It includes all conscious, unconscious and subconscious subsystems. The social includes the environment and social circle around the individual or the people around the individual who interact with each other. The society runs on the basis of norms and values which direct the person's behavior and activities. It includes those people and opinion of those people who are important for the individual and effects the decisions of life.

All these categories influence each other deliberately. The person who is not physically well gets into the social pressure and it leads to disturbance in psychological conditions. This can also be seen that due to some social pressure of performance the individual feels psychologically disturbed and this influence his/her health. This is how the three institutions are interconnected and dependent on each other. So in order to study the individual holistically, this model is required. As per "William Osler, an icon of modern internal medicine has argued:

'The good physician treats the disease but the great physician treats the patient who has the disease.[8]*'"*

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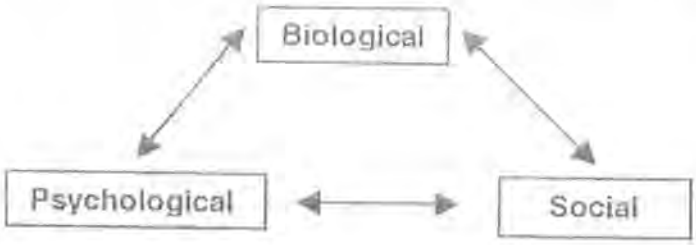
[7] Engel, G.L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 169*(4286), 129-136

[8] Shorter, E. (2005). The history of the biopsychosocial approach in medicine: before and after Engel. P.White (Ed), In *Biopsychosocial Medicine: An Integrated Approach to Understanding Illness*.1– 20. Oxford University Press

Figure 1: The Interrelation B/W Biological, Psychological & Social Aspect



Source: Dogar. I.A. (2007)[9]

Recently the theory has been criticized by S.Nassir Ghaemi (2011) [10]. First criticism was that, it was Roy R. Ginker who formulated the term 'Bio-Psycho-Social' in a lecture in 1954 (but published in 1990s). Second, Engel was not a psychiatrist and the theory he proposed at that time was especially for the psychological patients. Third, it is a simplistic conception. Lastly, the Bio-Psycho-Social model does not appear to have a coherent conceptual basis as relates to mind-body relationship.

1.5.2. FAMILY SYSTEM THEORY

"The whole world is more than the sum of its parts."

(Aristotle)

In order to understand the family systems theory, one should have the awareness about the general systems theory as the family systems theory was derived from the general systems theory.

Ludwing von Bertalanffy proposed the general system theory in 1968 that deals with the small subsystems which interrelate with each other to make a big system. The interrelationship between each component of the system is focused by this perspective. The general systems theory focuses on how the fluctuation in one part creates disturbances to other parts.

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[9] Dogar, İ, A. (2007). Biopsychosocial model, *A.P.M.C, 1*(1),11-13

[10] Ghaemi, S.N. (2011). The biopsychosocial model in psychiatry: a critique. *Existenz, An International Journal in Philosophy, Religion, Politics, and the Arts,6*(1), 1-8

A system is defined as a set of objects with relationships between the objects and the attributes of the objects[11]. The system can be understood from the example of human body, that how different organs and body parts combine together to make a body, if one of them is missing or is disabled than the whole body of individual is compromised. Same is the case with family, different family members combine together to make up a single family unit.

1.5.3. COMPONENTS OF FAMILY SYSTEMS THEORY

There are some major components of family system theory which are integrated with each other for the formation and recognition of the family by the prevailing social system, some of the components are:

1.5.3.1. HOLISM

The family is a perfect model of holism, all different family members together make up a single unit which is recognized by the society. This is the way a family gets organized and unified. Where ever the members of family go, they are recognized by the family they belong to.

1.5.3.2. HIERARCHIES

Another component of this theory is some hierarchies of relationship through which the families get organized and also gets divides into some smaller units or subsystems. Particularly marital, parental and siblings are the subcategories which are mostly there in a single family unit. The way of behavior, decisions making and etc., all depends on the subgroup from which the individual belongs.

When hierarchies exists in a system automatically there are some boundaries drawn between the sub systems and in the family system as well. The flow of information, type of behavior, limitations between the people of different generations, mobility, etc. all is managed in a family on the basis of these boundaries.

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[11] Barker, P. (2007). In Merwe E.(2010), Infertility-related stress and specific aspects of the marital relationship, *University of Stellenbosch, Master thesis, in press, p.p.(9-13).*

1.5.3.3. INTERDEPENDENCE

Family is a complete independent system which is highly depending upon the members and the subgroups which compose it.

1.6. THE DYNAMICS OF FAMILY SYSTEMS THEORY

The nature of the family systems makes the family able to survive in all kinds of environments and face the challenges of the life. The way information flows in family, the pattern of habits and the thought process that prevail among the members of the family all contribute towards different dynamic of the family system:

1.6.1. EQUILIBRIUM

The families struggle to maintain a standard life style, they try to create a balance between the resources and the challenges faced. There are certain rules and regulations in every family and all the members are supposed to follow them, anyone who tries to violate them is punished, taunted or told about how to survive in a family to maintain its existence because stepping out of its boundary by any of its member can bring problems and disturbances for the whole family.

1.6.2. FEEDBACK LOOPS

Feedback loops includes the type of interaction between the family members, if it is positive and complimenting than it leads towards growth and development at the individual and family level, and if the feedback is negative than the persons feels dejected. The type of interaction and feedback from the family affects the worldview as the family opinion influences the behavior and decision making of the person.

1.6.3. GOAL ORIENTATION

Like all other systems, the families are also always directed towards some goals and to achieve them all members work together.

1.7. THEORY OF STIGMA

The theory of stigma was proposed by the sociologist Erving Goffman in 1963 in his book stigma: Notes on the management of spoiled identity. The term stigma was first used by Greeks. It referred to the body signs which used to have some meanings attached to them. Usually these were some signs of burn or a cut which used to be the depiction of being a slave, criminal or a traitor. Later on its meanings got wider and developed with the passage of time.

Now stigmatization is done on the basis of the personal attributes; the individual gets classified as an acceptable one or as a rejected one. The respect and the type of behavior of people vary with these classifications.

Goffman, in his theory talked about the types of social identities in order to explain the stigmatization. The human social identity is basically of two types; one is the virtual social identity and the second is the actual social identity. The virtual identity includes such an ideal personality who follows the norms and values of the society and who always consider the particular "do's" of the society. The person who is assumed to fulfill the expectations of the society makes the virtual social identity. It is basically the mindset of the people that, what they want from others and how they want others to perform; whereas, the actual social identity, is the one that actually exists in reality that can be different from what people expect. It can be perform higher than expectations or lower than what was expected. Here the gap comes between what was expected to do and what actually a person did. This gap makes the society able to classify the individual on the basis of their performances and the social norms. To match the virtual social identity, the individuals always struggle and this pressure of getting stigmatized makes people scare to hide their actual social identity.

Further, Goffman described two categories of the stigma (i) discrediting and (ii) discreditable. The attribute which is not acceptable by the society is not revealed, yet, is known as discreditable and when it is revealed intentionally or unintentionally it transforms its nature and changes into a discrediting stigma called as failing or a handicap. It is known as discrediting because it affects the image of the person and the behavior of the society with that person.

People stop giving credit to the individual for any development or positive deed and they just keep criticizing and stigmatizing for the negative attribute. The hidden attribute is a

danger and at risk and is, therefore, known as discreditable as at any time it can cause an individual to lose all the credits which he/she gained previously.

1.7.1. Types of Stigma

Goffman has made a clear distinction between the three types of stigma:

- Stigma due to abnormality or defect in the body like HIV/AIDS or physical deformities;
- Stigma due to some negative traits of character, dishonesty, addiction and homosexuality;
- The local tribal stigma based on ethnicity; race, class, nation and status.

1.7.2. Categories of Stigma

Goffman further proposed the categories of people that are made in the society on the basis of relationship of individual with stigma:

- Firstly, there are people who are stigmatized by others and are rejected by the society and live by accepting the fact that they can't be the part of other category.
- Secondly, there are normal; which includes those who are not stigmatized and are accepted by the society. They always fulfill the desired expectations. They don't have a gap between virtual and actual social identity.
- Thirdly, there is also such group of people who were previously stigmatized but they moved on and fought with the stigma. They made some better place for themselves by asking their separate identity. They make the 'normal' accept that in our lives there are many times where it is not possible to meet the expectations up to the mark. The stigmatized develop the feeling of failure and starts getting frustrated as they always wish to get treated as normal.

The concept of stigma, developed by Goffman, was further studied and was modified; its meanings got extended from only visible attributes to not visible conditions. This theory has been criticized due to different reasons like, Goffman talked a little about the control on stigmatization by controlling the flow of information. Privacy and hiding the attribute can handle the situation. Secondly, there is no special focus on those who attempted

to destigmatize themselves. Thirdly, the Goffman theory of stigma has ignored the fact that the personal position in the society can affect stigmatization. The status and class matters a lot is such situations[12].

1.8. Application of Theories

The given theories can be applied on the stigmatization and infertility. The Bio-Psycho-Social School of thought believes that these three dimensions are interlinked and can be observed in infertility. Infertility can be merely due to some biological reason but it affects the social circle and surrounding of the individual. The surroundings and its opinions create psychological pressure on the person. The interrelationship between these can be seen even if, the infertile couple is positively treated by the family and friends feel psychologically motivated and hopeful.

A Systems Perspective can by applied to the study of any topic related to family, specifically in Pakistan where a family is a strong bonded group, addition in members and loss of members create disturbances in it. A family is a complex system and changes in one part of this system will have an impact on others, interrelated parts of the family and that's how the social life is affected.

The holism, hierarchies, boundaries and interdependence is seen in all the families considered as a single unit. There are boundaries and limitations of each subsystem of the family and all these are so much strongly bonded with each other that they are interdependent, so if there is some expectation which the eldest family group has from the younger, than it is assumed to be their duty to fulfill the family expectations. If they are unable to do so that creates imbalance and disturbance in the family system.

Infertility is a issue of the couple but it affects the whole family and the infertile couple gets impact by the whole family. This is due to the feedback loops which flow between the families and they may disturb the equilibrium of the marital and family relationship, family support is very important while dealing with such a situation. If there is full support by the family then the couple can deal strongly with the problem and won't get affected by stigma that much, but if there is no support from the family than stigmatization impacts gets worse.

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[12] Riessman, C.K. (2000). Stigma and everyday resistance practices: Childless women in South India. *Gender & Society, 14*, 111-135

General systems theory provides a platform to think that how infertility is linked with the larger society scale. It helps to see the broader side of the infertility that how friends and people outside the family perceive the infertility and how they play a role in stigmatization.

Some studies suggest and support the use of a family systems approach on infertility research like Andrews et al., (1991)[13]; Peterson, Newton, and Rosen, (2003)[14]; Ulbrich, Coyle, & Llabre, (1990)[15]. Most of these studies are on the different coping patterns and implication of the infertility.

Goffman theory of stigma can be applied to infertility as those who suffer from infertility are labeled in the society with negative connotations. Infertility falls in the first type of stigma which Goffman described, the stigma due to bodily abnormalities as mostly infertility is due to some medical reason. People don't deal normally with the patients of infertility, they are looked down upon and the society never allows them to live their lives as a healthy couple. Due to this labeling people get fearful of talking about this issue of infertility and they try to hide themselves or try to blame others so that they could save themselves from this label. And as Goffman talked about the virtual social identity and actual social identity; this can be applied on the infertile couple that the society expects the couple to produce a child and in actual when they fail to do so, they are labeled in a negative manner. The stigma of infertility is discrediting because the person facing infertility is not given credit for anything because he/she is unable to achieve parenthood.

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[13] Andrews, F. M., Abbey, A., & Halman, L. J. (1991). Stress from infertility, marriage factors, and subjective well-being of wives and husbands. *Journal of Health and Social Behavior,32*(3), 238-253

[14] Peterson, B. D., Newton, C. R., & Rosen, K. H. (2003). Examining congruence between partners' perceived infertility-related stress and its relationship to marital adjustment and depression in infertile couples. *Family Process, 42*(1), 59-70.

[15] Ulbrich, P. M., Coyle, A. T., & Llabre, M. M. (1990). Involuntary childlessness and marital adjustment: His and hers. *Journal of Sex and Marital Therapy, 16*(3), 147-158.

1.9. Research Methodology

Methodology is the systematic knowledge and logic in use, procedures and techniques to have enough knowledge about the research you are going to conduct. The researcher adopted many research methodologies for collecting a variety of data relating to the research topic. The quality of the research and data collected entirely depends upon the types of tools and techniques used in field for data collection. Keeping in the importance of different research methods, almost of them were utilized by the researcher for the accomplishment of research in the given timeframe:

1.9.1. Rapport-Establishment

The first step of fieldwork is to establish a good rapport with the people in an unknown locale because without their help it is not possible to collect data and complete the research.

Before starting the data collection, the researcher constantly remained in touch with the locale of study that was one government hospital and one private clinic, in Islamabad, to engage the doctors and authorities for providing a handful of information to the researcher on the topic of research. To put on their confidence they were explained about the researcher, nature of study and its aims and objectives. After the complete briefing, the researcher was permitted to interact with the patients. In order to make patients comfortable with the researcher, she regularly visited them so that they don't feel her as an alien rather someone who was trustworthy, as a result the authorities of both the hospitals, doctors, nurses and other staff including patients accepted her wholeheartedly after some weeks and co-operated with me as much as they were able to do so.

1.9.2. Observation

The observation is a structured type of research strategy widely used in many disciplines particularly the cultural anthropology. Its aim is to gain a close and intimate familiarity with a given group of individuals and their practices through an intensive involvement with people in their natural environment, usually over an extended period of time. The method originated in the field work of social anthropologists investigating the research objectives throughout the world.

The observation in rapid-assessment situations usually means going in and getting on with the job of collecting data without spending a lot of time for developing rapport. This often means going into a field situation armed with a list of questions that need to be answered and a checklist of data that needs to be collected.

Observation can be participant and non-participant. In anthropology mostly participant observation is used. An extension of participant observation is direct-reactive observation. This is a technique where the researcher is directly involved in observing the behavior of community members while actively taking notes and frequently observing the reaction of the respondents to what the researcher observed. It is an intrusive form of obtaining data but is extremely useful for gathering specific data, particularly when the data is needed rapidly. Generally speaking, this is an intensive and difficult form of data collection that requires constant interaction between the researcher and the people and consequently places stress on all parties involved. This type of participant observation is mostly used due to time limitation during the researches.

The non-participant observation is when you, as a researcher, do not get involved in the activities of the group but remains there as a passive observer, watching and listening to its activities and drawing conclusions from this[16].

In Anthropology, participant observation is the key for all data collection, in which the researcher completely acts and behaves like a respondent. But being a female researcher and due to sensitivity of the topic, it was not possible to investigate the details of sexual relationships among the married couples by interacting the male doctors and patients, the medications, and other relevant treatments which made it impossible for her to participate fully in such activities. But meeting people and spending time with them and being with them while they were experiencing hard times was useful in getting the deeper look. The researcher observed what children mean for the couples and for the whole family, how husbands and in-laws behaved with the infertile women and how the husbands felt regrets and agitated while discussing infertility that helped her to find out other important issues and in understanding the tradition of faith healing easily.

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[16] Kumar, R. (2005). *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd edition, (Vol. 15, p. 123). Sage Publications.

1.9.3. SAMPLING

Sampling is the process of selecting a smaller sample size from amongst the bigger group of people for estimating or predicting a fact, situation or outcome regarding the bigger group[17].

In the current study the method of sampling was used to select a sample size through the stratified sampling. In a stratified sampling the researcher attempted to stratify the population in such a way that the population within a stratum was homogeneous with respect to the characteristic on the basis of which it was being stratified.[18]

The total sample size was consisted of 40 infertile couples taken equally from both the hospitals, 20 infertile couples from a government hospital and 20 from a private clinic as the representative sample, while 20 couples of male infertility and 20 of female infertility, 10 male infertile and 10 female infertile couples were also chosen from each locale.

1.9.4. KEY INFORMANT

The term key informant is generally associated with qualitative research in which a researcher employs interviewing of knowledgeable participants as an important part of the method of investigation. During the fieldwork an investigator might have several informants who could be identified for the purpose. Key informants can extend the investigator's reach in situations where he or she has not, or cannot, be a direct observer, and they can illuminate the meanings of behavior that the researcher does not understand. They can also serve as a check on the information obtained from other informants, varying circumstances may determine who actually ends up serving as a key informant. Sometimes a person becomes a key informant by merit playing an important role in the social setting being studied.

Key informant interviewing is an important and major source of getting information, being an important methodology for collecting information about a social situation by talking to a selected number of the participants, it has been widely used by the anthropologists in their researches as it is particularly associated with anthropology. Unfortunately, this association of a technique with a particular discipline obscures what may be a more important consideration, its frequent use in situations where the crucial variables or questions have not

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[17] Kumar, R. (2005). *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd edition, (Vol. 15, p. 123). Sage Publications

[18] Kumar, R. (2005). *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd edition, (Vol. 15, p. 123). Sage Publications

been fully formulated or where more refined techniques are unavailable. If key informant interviewing is in fact associated with particular conditions of social research, one can confidently predict its widespread use as such exploratory or unstructured situations are confronted in research on underdeveloped areas or in the many new sub-fields of social science that are opening up.

The technique of key informant was applied by the researcher for the collection and cross checking of data that really proved to be very helpful for the researcher; it also helped in rapport establishment among the people of the community. The researcher selected 4 key informants after carefully examining the available group of learned people. The first key informant was Dr. Riffat, the second was Mr. Aslam her assistant, both of them were from government hospital. While the third key informant was Dr.Durdana and fourth was her assistant Ayesha, from a private hospital. All the respondents were helping hands in both ways, in the collection of data and bridging the gaps between the researcher and the respondents.

1.9.5. Discussions

Informal discussion helped in getting useful information in an informal way. It also helped the researcher in developing good relationships with the visitors because in such discussions matters related to different aspects of life were discussed informally through chitchat with the people. The technique was used being one of the major tools of research. Informal discussion helped her to explore many hidden facts related to the research issues. During the discussion with the respondents and other experienced people their views about social pressure and stigma were explored along with their perceptions about stigma and its consequences.

Numerous discussions with the doctors of both the hospitals were held to investigate the reasons of infertility according to their experience, while in some of the discussions; the staff that was assisting the doctors was also involved who shared their views and experiences with the researcher that was a wonderful exercise for the researcher.

1.10. Interview Guide

To collect more data from both the locales, the researcher adopted the method of interviews with the respondents to get reliable data from them. The interviews have been defined by Kumar (2005) as:

"Any person-to-person interaction between two or more individuals with a specific purpose in mind is called an interview[19]"

The researcher also used an interview guide in order to keep her focused on the planned strategy of extracting data from the respondents during the in-depth interviews by attracting them to the specific and non-controversial question on the topic of researcher in an friendly atmosphere. The researcher also used to engage them in the continuous series of in-depth interviews for cross checking the data obtained during the previous interviews. According to Kumar (2005):

"In-depth interviewing is, 'repeated face-to-face encounters between the researcher and informants directed towards understanding informant's perspectives on their lives, experiences, or situations as expressed in their own words[20]".

1.11. CASE STUDY

The case study has been defined by Charlotte, Seymour-Smith as:

"A detailed record of the experience of an individual or a series of events occurring within a given framework[21]".

It is a technique which provides authenticity and validity to the data. For her research the researcher chosen some verbatim from the cases which were interesting and provided tremendous help to her for analyzing the clear picture of the whole phenomenon, among the real lives of the people. The case studies of different people who visited the hospitals also helped the researcher by providing information regarding various issues about stigma that facilitated her to analyze the researcher objectives.

1.12. NON-VERBAL TECHNIQUES

There were numerous nonverbal techniques available for the researcher to be used for making the research more authentic and reliable. Following were the non-verbal tools applied

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[19] Kumar, R. (2005). *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd edition, (Vol. 15, p. 123). Sage Publications

[20] Kumar, R. (2005). *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd edition, (Vol. 15, p. 123). Sage Publications

[21] Charlotte, Seymour-Smith. (1956). Case Study. In Macmillan Dictionary of Anthropology (pp 32)

by the researcher during the field work at Islamabad in the hospitals that were the researcher's locales of study:

1.12.1. Field jotting

Russell Bernard described the way to use jotting:

"Keep a note pad with you at all times and that make jottings on the spot[22]*".*

Field jottings was used by the researcher to note down all the important points so no information was missed, she noted the most important things about the interviews, incidents and personal observations.

1.12.2. Field notes

After starting research, the researcher started writing fields notes on daily basis usually at the spot whenever she observed anything interesting with the research point of view thus she was able to have even minor details of her research that proved helpful at the time cross checking and compiling of the data collected through different means of investigation. The researcher used the tool of field notes during her entire spell of research that really facilitated her to remember each and every movement of the entire research period.

1.12.3. Daily Diary

Daily diary is there to write about your personal feelings, emotions and to express the inner thoughts on papers. This is the best way to feel as if there is someone to talk with and share your personal experiences as during the research work a researcher has to forget himself/herself because of the deep concentration on his research.

In order to record day-to-day events during the fieldwork, the technique of daily diary was used, which helped the researcher to remember all the activities of fieldwork. I wrote down my daily diary as a part of my routine work and felt fun in writing all what happened during the field work.

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22 Kumar, R. (2005). Research Methodology: A Step-by-Step Guide for Beginners, 2nd edition, (Vol. 15, p. 123). Sage Publications

CHAPTER 2

REVIEW OF LITERATURE

A lot of work has been done on the infertility and its various paradigms by different researchers in different times all over the world. Being as assets, their findings are the footsteps for the upcoming researchers to follow by consulting their investigative matters which are based on different aspects related to infertility and efforts to overcome the shortcoming among married couples. To validate the data collected by the researcher at Islamabad in different two hospitals, various books, journals, newspapers and booklets were consulted by her which was a unique experience and fruitful exercise. The variables for review were; infertility, causes of infertility, impact of infertility on social and psychological aspects and the stigmatization. The issue about gender differences and infertility were also seen in the literature that was available in different libraries.

Infertility has been defined by different scholars like Wishmann T.[23] mentioned:

> *"According to the definition of WHO couples who do not conceive within one year, although they have regular unprotected sexual intercourse, are regarded as being involuntarily childless."*

Infertility has two types; primary and secondary, Osman (2011. p158) [24] defined the two types of infertility as:

> *"It has two types, primary infertility, it is a term used for a couple who have never achieved a pregnancy. Secondary infertility referred to a couple who have at least one pregnancy even if this ended in abortion."*

The occurrence of infertility being the medical issue is not dependent on gender rather many more factors are the causes of its effects, the overall average of prevalence of infertility in different genders is described by Violet Kimani and Joyce Olenja (2001, p203)[25]:

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23 Wishmann, T.(2008).Psychological aspects of Infertile couples. CME Prakt Fortbild Gynakol Geburtsmed Gynakol Endokrinol 2008; 4(3):194-209. Downloaded from cme.akademos.de on Wednesday, February 15,2012

24 Osman, A. A. (2011). Management of Infertility within Primary Health Care Program in Sudan. Asian Journal of Scientific Research 4(2), 158-164. doi: 10.3923/ajsr.2011.158.164

25 Kimani. M., Olenja. J. (2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. The African Anthropologist, 8(2), 200-214.

"It is estimated that the man is responsible in 30% of the cases, the woman in approximately 40%, 20% in both and in about 10% no cause of infertility is identifiable even after thorough and complete evaluation."

The infertility is not only a woman issue but the male factor is also responsible for infertility or both men and women are having the problem due to unknown reasons but the causes which initiate infertility in males and females are different. According to the work done by TV series *Healthy Body and Healthy Mind* (2006), there are many different causes of infertility in males and females. A woman can be infertile if there is a blocked fallopian tube, the egg may be of poor quality, while the age of a women also matters a lot. Fertility rate in females decline after they reach to 35 years of age, on the other hand, a man becomes infertile if he produces too few sperm and in less numbers and if sperms are misshapen. [26]
The history about the treatment of infertility goes back to early times where the causes of infertility were thought to be mostly present in women and the physical factors which were considered as Wischmann T.[27] mentioned:

"From the 1940s until the 1990s, couples with an unfulfilled desire for a child were predominantly pathologized from a psychomatic point of view, especially as at the outset it was assumed that only 50% of all fertility disorders were due to physical reasons. The following "personality factors in female sterility were found in an older American overview: Physical and emotional immaturity; aggressive masculine type; combination of 1 and 2; hostile mother identification; motherly type; feminine erotic type; obsessive-compulsive type; disturbed, impoverished, and chronic worriers."

The involvement of religious aspect cannot be avoided in case of infertility as Violet Kimani and Joyce Olenja (2001, p205) [28] found, while studying the cultural dimensions and impact on infertile and fertile women in Kenya, that:

"..infertility is presently believed to be as a result of witchcraft and illicit brews."

People often believed that infertility is because of God's unhappiness with some of the deeds of the couple and they are punished by depriving from the blessing of child, so

[26] Information Television Network. (2006). Over Coming Infertility. Retrieved from http://www.healthybodyhealthymind.com . Retrieved at 15/1/13
[27] Wishmann, T.(2008).Psychological aspects of Infertile couples. CME Prakt Fortbild Gynakol Geburtsmed Gynakol Endokrinol 2008; 4(3):194-209. Downloaded from cme.akademos.de on Wednesday, February 15,2012
[28] Kimani, M., Olenja, J.(2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. The African Anthropologist, 8(2), 200-214.

people pray and seek help from The God to make them happy and be blessed. Wischmann T. [29] has explained the causes of infertility among women:

"This is mainly due to continual increase in the average age of first-time mothers...increase in Chlamydia infections, overweight in young girls...an increase in testicular cancer in men".

According to modern discoveries in medical sciences, the infertility is not always caused by the physiological disorders rather there are many other reasons are involved. Jackey Peretz, et al., (2009, p.362) [30] pointed out some chemicals which add the risk of infertility, while investigating infertility in cosmetologists and non-cosmetologists in Baltimore, Maryland and its surrounding countries:

"Recent studies have shown that environmental exposures to chemicals such as selenium, ethylene glycol monomethyl ether, and phthalates may be associated with poor reproductive function and therefore, reduced fertility."

Some other factors that cause risk in fertility are described by Myers et al (2005) in a report of Resolve (The National Infertility Association), USA [31], regarding the impact of environmental factors on fertility and brought some more reasons in the limelight which increase the risk of infertility and are not the physiological factors rather the chemicals and other agents which stimulate infertility are present in the living styles of the people:

"Caffeine may slightly increase the time needed to achieve pregnancy

Myers, J, P. and his co-authors (2005) [32] in a report mentioned that smoking can also become one of the reasons of infertility.

"Marijuana use clearly suppresses reproductive hormones."

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[29] Wishmann, T.(2008).Psychological aspects of Infertile couples. CME Prakt Fortbild Gynakol Geburtsmed Gynakol Endokrinol 2008; 4(3):194-209. Downloaded from cme.akademos.de on Wednesday, February 15,2012

30 Peretz, J., Gallicchio, L., Miller, S., Greene, T., Zacur, H., & Flaws, J, A.(2009). Infertility among cosmetologists. Reproductive Technilogy,28,359-364

31 Myers, J, P., Giudice, L., Carlson, A. (2005). The Impact of Environmental Factors, Body Weight & Exercise on Fertility. Resolve, The National Infertility Association, Virginia, USA Downloaded on Saturday, June20,2012 from http://familybuilding.resolve.org/site/DocServer/EnvironmentalFactors.pdf?docID=261

32 Myers, J, P., Giudice, L., Carlson, A. (2005). The Impact of Environmental Factors, Body Weight & Exercise on Fertility. Resolve, The National Infertility Association, Virginia, USA Downloaded on Saturday, June20,2012 from http://familybuilding.resolve.org/site/DocServer/EnvironmentalFactors.pdf?docID=261

In the same report, fat has also been mentioned as one of the risk increaser among women, the fatty women conceive with great difficulty due to the presence of fat molecules in their bodies.

"Fat may have several adverse effects on women's reproductive health."

Mary Lyndon Sahnley and Adrienne Asch (2009. p856)[33] also talked about effect of chemicals on the reproductive health while exploring the medical mask and the social injustice on the affected couple in Europe:

"At least forty-eight chemicals are known strongly suspected to have adverse effects on human reproduction."

Mary Lyndon Sahnley and Adrienne Asch (2009. p854)[34] also described the age factor involved in the infertility among women. The peak of fertility arouses in the middle aged women and slowly it decreases with the passage of time:

"..causes of infertility is the age of the woman attempting to have a child..Women in their twenties possess the best possibility for fertility because their eggs are healthiest. Women in their early thirties have greater difficulty conceiving."

2.1. Psychological impacts of infertility

Infertility is not only a biological problem rather it has lots of implications on the psychological condition of the couple. The reason a couple doesn't feel comfortable and comes under stress is explained by Alison Solomon (1998 p41) [35] while describing her personal experience of infertility in following words:

"In a social circle of young couples where everybody is a parent, we found ourselves the outsiders among our friends."

Edith Ittner, Wolfgang Himmel & Micheal M. Kochen(1997) mentioned that during their research they found out that the infertile patients feel psychological pressure on

[33] Shanley, M. L., Asch, A. (2009). Involuntary childlessness, reproductive technology, and social justice: The medical mask on social illness. *Chicago Journals , 34* (4), 851-874.http://www.jstor.org/stable/10.1086/597141. Accessed on: 6/2/2012
[34] Shanley, M. L., Asch, A. (2009). Involuntary childlessness, reproductive technology, and social justice: The medical mask on social illness. *Chicago Journals , 34* (4), 851-874.http://www.jstor.org/stable/10.1086/597141. Accessed on: 6/2/2012
[35] Solomon, A. (1988). Integrating infertility crisis counseling into feminist practice. *Reproductive and Genetic Engineering: Journal of international Feminist Analysis, 1*(1), 41-49

themselves and the doctors are mostly completely unaware of the feelings of patients. In order to treat patients completely, it is required that they get psychological counseling too:

"Infertility is an experience associated with feelings of distress, grief, and guilt36."

The ratio of the psychological problems in infertile couple is given by Fariba Hassani during her researched, in Iran, in 2007-2008, about the psychological therapies and compared their effects on infertile couples (2010 p25) [37]:

"Generally speaking, the psychological problems of infertile couples ranged between 25% to 60%."

The sense of insecurity which arrives due to the guilt of not providing someone what he/she wants is discussed by Ralph Matthews and Anne Martin Matthews(1986, p644) [38], as they studied the experience of infertile couples about their transition to a non-parenthood life and the interaction in the society :

"..Designated person may feel guilt and experience doubts about the continuing affection of the other partner"

The same feeling of stress and tension has reported by Ernestina S. Donkor and Jane Sandall(2009 p82) [39] while they were studying 615 women, who were seeking infertility treatments in different centers, and their coping strategies in southern Ghana:

"Women have reported being stressed due to their inability to have children."

Ernestina S. Donkor and Jane Sandall(2009 p82) [40] found that due to the fear of stigma women use to try to keep their infertility matter to themselves. The coping strategies highly depend on the social situations and the social support which either makes someone who is affected more comfortable or it can make someone's life miserable as it has a strong

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[36] Ittner, M., Himmel, W., & Kochen, M. M. (1997). Management of involuntary childlessness in general practice-patient's and doctor's views. *British Journal of General Practice, 47*, 105-106

[37] Hassani, F. (2010). Psychology of infertility and the comparison between two couple therapies, in infertile pairs. International Journal of Innovation, Management and Technology, 1(1),25-28

[38] Matthews, R., Matthews, A.M. (1986). Infertility and involuntary childlessness:The transition to nonpartenthood. *Journal of Marriage and the Family, 48*, 641-649

[39] Donkor, E., & Sandall, J. (2009). Coping strategies of women seeking infertility treatment in Southern Ghana. *African Journal of Reproductive Health,13*(4), 81-94

[40] Donkor, E., & Sandall, J. (2009). Coping strategies of women seeking infertility treatment in Southern Ghana. *African Journal of Reproductive Health,13*(4), 81-94

impact on the psychological conditions. The researchers described the coping strategies that infertile women use, so that they could minimize the grief and impacts of infertility:

"These were: avoidance of reminders of infertility, regaining control, being the best, looking for hidden meaning, giving in to feelings, and sharing the burden."

Bushra Parveen & Imtiaz Ahmed Dogar, et al., (2008,p108) [41] researched the differences in the psychosocial adjustment of educated and uneducated infertile females in Lahore by interviewing 50 diagnosed infertile women. They explained about the psychological distress due to infertility in following words:

"This (infertility) results in immense psychological trauma leading to low self-esteem, insecurity and lack of self-confidence."

Bushra Parveen & Imtiaz Ahmed Dogar, et al., (2008,p108) [42] further mentioned about the reaction which comes as a result of continuous psychological pressure among infertile women:

"Women may feel a sense of anger and resentment. A woman's sense of femaleness is often closely associated with pregnancy."

Julia McQuillan, Arthur L.Greil, & Mary Casey Jacob[43] talked about infertility in their study consisting of 580 sample of those who have experienced infertility. They noted that infertility gets worse when people provide it a status of identity provider and this increases stress, anxiety and frustration. The stress and how it initiates is a complete process which is described as (2003 p1008):

"Stress occurs when people experience events or circumstances, called stressors, for which their copping resources are inadequate. Stressors need not to be events, but can also be nonevents or failures to achieve life goals or desired identities."

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[41] Parveen, B., Dogar, I, A., Kousar, S., Musharaf, S., Masood, A., & Afzal, S. (2008). Psychological Adjustment of Educated and Uneducated Infertile Females of Pakistan, *A.P.M.C,2*, p108-112

[42] Parveen, B., Dogar, I, A., Kousar, S., Musharaf, S., Masood, A., & Afzal, S. (2008). Psychological Adjustment of Educated and Uneducated Infertile Females of Pakistan, *A.P.M.C,2*, p108-112

[43] McQuillan, J., Greil, A, L., White, L, K., & Jacob, M, C. (2003). Frustrated fertility: Infertility and psychological distress among women. *Journal of Marriage and Family, 65*, 1007-1018. National Council on Family Relations: published by Blackwell Publishing

In case of infertility, the stressor is not an event rather the inability to achieve a social and biological goal of having a baby. The failures to achieve pregnancy trigger stress and tension among the infertile couple and family.

Petra Thorn[44] highlighted the psychological condition while dealing with infertility. She conducted study in Germany about the psychological and social considerations. The study focused on how the infertility affects the psychological wellbeing of couple and how it changes the concept of self as:

> *"Grieving infertility often involves typical reactions such as shock, disbelief, anger, blame, shame and guilt, and includes depressive reactions and low self-esteem."*

Farida Hassani (2010 p25)[45] while comparing two psychological therapies on infertile couples she mentioned the problems faced by infertile couples which are mostly talked about in different researches:

> *"Some researchers have paid considerable attention to the fact that problems such as lack of self-esteem, sense of bereavement, threat, depression, and feeling of guilt, anxiety, frustration, emotional pressures and some sexual problems are common among infertile couples."*

After writing the most researched psychological impacts of infertility Fariba Hassani (2010 p26)[46] wrote on next page about the personal reaction which occurs as a result of continuous psychological pressure and social mismanagement. When people are not psychologically in a healthy state they start changing their personality unintentionally:

> *"The psychological reactions of the individual are in the form of despair, sadness, denial."*

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[44] Thorn, P. (2009). Understanding infertility: Psychological and social considerations from a counseling perspective. *International Journal of Fertility and Sterility, 3*(2). 48-51

[45] Hassani, F. (2010). Psychology of infertility and the comparison between two couple therapies, in infertile pairs. *International Journal of Innovation, Management and Technology, 1*(1),25-28

[46] Hassani, F. (2010). Psychology of infertility and the comparison between two couple therapies, in infertile pairs. *International Journal of Innovation, Management and Technology, 1*(1),25-28

Sumera Ali, & Raafay Sophie et al., (2011)[47] explored the knowledge and perception about infertility in Karachi. They found out that people have limited knowledge about infertility and this increases myths and misconceptions regarding infertility and the infertile couple. These myths and perception of people increases the psychological damage, they talked about the psychological affects by saying that:

"Psychologically, the infertile woman exhibits significantly higher psychopathology in the form of tension, hostility, anxiety, depression, self blame and suicidal ideation."

Christine Dunkel-Schetter and Marci Lobel reviwed 30 descriptive and 25 empirical articles and presented the list of emotional responses and arranged them in a table according to their frequency and intensity among the infertile couple which are found in most of the articles (1991 p30-31)[48]:

"Five emotional responses are recurrent themes: (1) Grief and depression; (2) anger; (3) guilt; (4) shock or denial; and (5) anxiety."

Christine Dunkel-Schetter and Marci Lobel[49] further mentioned about the research done by an author Mahlstedt who studied depression and grief:

"Mahlstedt suggests that depression is caused both by the loss that infertile individuals feel as well as the chronic strains that are experienced during infertility diagnosis and treatment."

Describing the feeling of loss, Christine Dunkel-Schetter and Marci Lobel (p33) told that infertile couple feels loss of control; control over events, inability to control their emotions, and lose control over their sexual relationship and privacy[50].

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[47] Ali, S., Sophie, R., Imam, A, I., Khan, F, I., Ali, S, F., Shaikh, A., & Hasnain, S, F. (2011). Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross- sectional study. *BMC Public Health* 2011 11:760. doi: 10.1186/1471-2458-11-760

[48] Dunkel-Schetter, C., & Lobel, M. (1991). Psychological reactions to infertility. In Stanton, A., & Dunkel-Schetter, C (Eds.), Infertility perspectives from stress and coping research. (29-57). New York, Plenum

[49] Dunkel-Schetter, C., & Lobel, M. (1991). Psychological reactions to infertility. In Stanton, A., & Dunkel-Schetter, C (Eds.), Infertility perspectives from stress and coping research. (29-57). New York, Plenum

[50] Dunkel-Schetter, C., & Lobel, M. (1991). Psychological reactions to infertility. In Stanton, A., & Dunkel-Schetter, C (Eds.), Infertility perspectives from stress and coping research. (29-57). New York, Plenum

2.2. PERCEPTION OF PEOPLE TOWARDS INFERTILE COUPLES

Social pressure is created for the couples who are unable to have a baby and this makes them feel as an alien and stigmatized. S.J.Dyer, N.Abrahams, M.Hoffman and Z.M.Van der Spuy(2002 p1665)[51] wrote about the negative social consequences of infertility that women face in South African urban community. They found intense emotional drawbacks of infertility whether it is due to the behaviors of others or due to personal guilt:

> *"Many women experienced this pressure particularly at family gatherings and felt reminded both intentionally and unintentionally, of their different status as an infertile woman."*

S.J.Dyer et al., (2002 p1666) while elaborating the result of their research mentioned the importance of social support by quoting that:

> *"For many women the psychological implications and social consequences of involuntary childlessness were compounded by a lack of support."*

The importance of parenthood in society has also been touched by the Brown University's anthropologist Marida Hollos,[52] (2009) researched about the stigma of infertility in Nigeria and compared two local communities and their living patterns. She stated that fertility is important in every aspect, especially women:

> *"Motherhood continues to define an individual woman's treatment in her community, self-respect, and her understanding of womanhood"*

Being fertile is like a social obligation on each couple. The inability to produce offspring is not the matter of one person rather it is the issue of a couple. No matter, who is the primarily effected by infertility, the consequences are there for both. The societal norms prevailing in society makes it complex for both the gender. The infertile couple feels threatened because fertility is not just the issue about a child rather it has broader meanings linked to it. For men and women societies have different sets of rules and responsibilities and

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[51] Dyer, S.J./ Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have childre': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

[52] Hollos, M. (2009, April21). Brown Anthropologist Examines Stigma of Infertility in Nigeria. Retrieved April3, 2012, from http://news.brown.edu/pressreleases/2009/04/infertility

if they are unable to fulfill then the society stigmatize. That is why, infertility creates a sense of threat in both genders but the nature of threat and fears is slightly different in both genders. Marcia C. Inhorn (1994 p460)[53] explained the same phenomenon is the following way:

"..infertility as a threat: to women's identity, status, and economic security; to men's procreativity; to lineage continuity; to familial and community harmony; and to the reproduction of society itself.."

The social pressure is at peak when surrounded by a number of people, therefore, attending family gatherings and events is a big issue for infertile couple. They don't feel comfortable in such environment where everyone asks them about baby or they get neglected because they don't have babies. The same point is explained by Alison Solomon (1988 p41) [54] while sharing the experience of infertility:

"Festive gathering always revolved around the children and activities for them and, especially when the men would all go off together I would be left with the women and children feeling useless."

The social pressure is further discussed by Another anthropologist, Susan Forsythe (2009 p33) [55] discussed about how the issue of infertility is not just limited to a medical domain rather it is now more considered as a social phenomenon as society, around the globe, attaches different misconceptions and beliefs. She explored the most common belief which is there about womanhood and children, in following manner:

"The societal beliefs that a woman should have children and that she is not complete until she has her own biological children has forced women and couples to seek infertility treatments."

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[53] Inhorn, M. C. (1994). Interpreting infertility: Medical anthropological perspectives. Soc. Sci. Med, 39(4),459-461

[54] Solomon, A. (1988). Integrating infertility crisis counseling into feminist practice. *Reproductive and Genetic Engineering: Journal of international Feminist Analysis, 1*(1), 41-49

[55] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

According to Ralph Matthews and Anne Martin Matthews (1986 p644) [56] there are different factors which influence the social pressure and the way in which the couple cope with them. The most commonly observed factors are following three:

"The way in which the couple deal with such pressures and the extent to which these pressures influence their marriage and lead to a reality reconstruction depend on three sets of factors: (a) the duration and outcome of their infertility investigation and the decisions they have had to make during it; (b) the extent to which the couple have developed shared constructs that enable them to deal with the situation they face, as well as the character of such constructs; and (c) the responses of significant other people, including other family members, to their situation."

While explaining the importance of social support Ernestina Donkor and Jane Sandall mentioned (2009 p82) [57] about the social support while elaborating the coping strategies:

"Social support has been identified as playing a positive role in the experience of infertility."

The social pressure has further been discussed by Bushra Parveen, Imtiaz Ahmed Dogar, Sumaira Kousar, Sadia Musharaf, Afsheen Masood, and Samreen Afzal (2008 p109) [58] as they study the comparison in psychosocial adjustment of educated and uneducated infertile women in Pakistan by focusing on 50 infertile females of Lahore:

"Families, in particular prospective grandparents, may place added pressure on people by publicizing their expectations."

Sarwat Sultana and Azam Tahir (2011, p.242) [59] conducted a research on 200 fertile and 200 infertile couples from different cities of Pakistan. They studied the psychological consequences of infertility which arouses due to the societal pressure and the fear of being stigmatized as incomplete or disabled one:

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[56] Matthews, R., Matthews, A,M. (1986). Infertility and involuntary childlessness:The transition to nonpartenthood. *Journal of Marriage and the Family, 48*, 641-649

[57] Donkor, E., & Sandall, J. (2009). Coping strategies of women seeking infertility treatment in Southern Ghana. *African Journal of Reproductive Health,13*(4), 81-94

[58] Parveen, B., Dogar, I, A., Kousar, S., Musharaf, S., Masood, A., & Afzal, S. (2008). Psychological Adjustment of Educated and Uneducated Infertile Females of Pakistan, *A.P.M.C,2*, p108-112

[59] Sultana, S., & Tahir, A. (2011). Psycholoigal consequences of infertility. *Hellenic Journal of Psychology,8*,229-247

"Infertile couples in particular, are under severe social pressures to meet the expectations of performing traditional feminine and masculine roles particularly with reference to their ability to produce children."

Sonja L. Nieuwenhuis, Akin-Tunde A. Odukogbe, Sally Theobald and Xiaoyun Liv (2009, p.92) [60] studied in Nigeria among 42 men, women and professionals. The aim of their study was to find out the perception of infertility, the consequences of infertility and the coping strategies. They explained that the infertile women feel bad about themselves because they are not treated in a good manner:

"If she fails to conceive she may be taunted by her in-laws, neighbors and relatives and called different names, such as male pawpaw, barren sister, empty basket, witch or walnut."

Sonja L. Nieuwenhuis, Akin-Tunde A. Odukogbe, Sally Theobald and Xiaoyun Liv (2009, p.92)[61] while talking about the maltreatment of infertile in the society, further mentioned a quote by their infertile respondent who told about the perception of people about being fertile and having babies is important for family:

"It is always believed that children make a home. So if a woman is finding it difficult to reproduce, she is looked at as a failure."

2.3. Stigmatization of infertility

Wood, K.; Aggleton (2004) has commented on the stigmatization of infertility, according to him:

"Stigma has been described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others."[62]

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[60] Nieuwenhuis, S,L., Odukogbe, Akin-Tunde,A., Theobald, S., & Liv, X. (2009). The impact of infertility on infertile men and women in Ibadan, Oyo State, Nigeria: A qualitative study. *African Journal of Reproductive Health, 13*(3),85-98

[61] Nieuwenhuis, S,L., Odukogbe, Akin-Tunde,A., Theobald, S., & Liv, X. (2009). The impact of infertility on infertile men and women in Ibadan, Oyo State, Nigeria: A qualitative study. *African Journal of Reproductive Health, 13*(3),85-98

[62] Wood, K.; Aggleton, P. Promoting Young People's Sexual and Reproductive Health: Stigma, Discrimination and Human Rights. Guide to Good Practice, Safe Passages to Adulthood. *University of Southampton, UK (2004) 48 pp. ISBN 0 85432 806 8*

"All over the world, stigma in relation to sexuality is gendered. Expectations of young men and young women differ."[63]

Bruce G. Link and Jo C. Phelan (2001, p.364)[64] studied different definitions of the stigma and tried to conceptualize it. They mentioned different definitions of stigma given by different scholars:

"Stafford and Scott propose that stigma is a characteristic of persons that is contrary to a norm of a social unit where norm is defined as a shared belief that a person ought to behave in a certain way at a certain time. Crocker et al. indicate that stigmatized individuals possess some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context."

Link and Phelan (2001, p.367)[65] after studying the above definitions and observing the societies and the perception prevailing in societies conceptualize the term stigma in following way:

"Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the component of stigma to unfold."

P. Slade, C.O. Neill, A.J. Simpson and H. Lashen (2007, p.2309)[66] also defined stigma in their article as:

"A stigma is defined as a negative sense of social difference from others, that is, so outside the socially defined norm, it is both deeply discrediting and devalues the individual."

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[63] Wood, K.; Aggleton, P. Promoting Young People's Sexual and Reproductive Health: Stigma, Discrimination and Human Rights. Guide to Good Practice, Safe Passages to Adulthood. *University of Southampton, UK (2004) 48 pp. ISBN 0 85432 806 8*

[64] Link, B. G., & Phelan, J. C.(2001). Conceptualizing Stigma. *Annual Review of Sociology,27*, 363-385

[65] Link, B. G., & Phelan, J. C.(2001). Conceptualizing Stigma. *Annual Review of Sociology,27*, 363-385

[66] Slade, P., O'Neill, C., Simpsom, A.J. and Lashen, H. (2007). The relationship between perceived stigma, disclosure patterns, support and distress in new attendees at an infertility clinic. *Human Reproduction, 23*(8), 2309-2317

P. Slade, C.O. Neill, A.J. Simpson and H. Lashen (2007, p.2309) have further described the relationship between stigma of infertility and the threat to individual personality:

"Infertility may threaten self-esteem due to its potentially stigmatizing nature."

P. Slade, C.O'Neill, A.J. Simpson and H. Lashen (2007 p2309) had researched about the link between perceived stigma, support and the patterns of communication with infertility. They studied 87 women and 64 men who were new attendees at an infertility clinic. The following conclusion of their study provides a new dimension for research, which highlights the importance of disclosure in society and its impact:

"Stigma and the wider social context should be considered when supporting people with fertility problems. Greater disclosure may be associated with higher distress in women."

S.J.Dyer et al., (2002, p.1665) [67] has also elaborated the stigma among the South African urban community, that the stigma hits women and their statuses in the families and community very badly:

"Many women felt stigmatized and the ridiculed in their families and in the community."

Ching-pei Wu and Chyi-in Wu(2006)[68] conducted a research in three hospitals about people caring about privacy while talking about infertility. They found out that it is the stigma which makes people feels that they should not talk about infertility openly and should keep it a secret as much as it is possible. Talking about the stigmatization they stated:

"Individuals feel stigmatized because of the cultural value has deeply embedded in their minds. If they do efforts but can't reach the "normal" standards, they may easily perceive the feeling of failure."

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[67] Dyer, S.J., Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

[68] Wu, Ching-Pei., and Wu, Chyi-In. (2006). Stigma of infertility and privacy invasion in medical spaces. Paper presented at *The North American Chinese Sociologists Association Mini-Conference*. Montreal, Canada.

Susan Forsythe (2009, p.25) [69] talked about the myths and beliefs that exists in almost every society regarding infertility and infertile women:

"Throughout the world there are many beliefs and misconceptions about infertility...Women who are the ones at fault when it comes to infertility..(it is) because of their psychological makeup..Infertility is caused by sexual disorder."

Susan Forsythe (2009, p.29)[70] talked about why the couple feels the stigma and feels that they are not normal like others. Basically, it is the social norms which direct the behaviors and the thought processes. It is the social norm that when a couple gets married they should produce babies and they should want to fulfill this norm. A couple is not accepted as normal unable to produce and when they show their no interest in having babies.

"The stigma the couples feel may be caused by internalizing these social norms: (i) all married couples should reproduce and (ii) all married couples should want to reproduce."

Further explaining the social norms and stigma Susan Forsythe (2009, p.29)[71] mentioned work of Greil, who is famous for his theory of stigma. Stigma of infertility according to Greil is a secret stigma because it is something felt internally by the couple. The couple feels guilty and not normal because they have been socialized in the society where there are important norms regarding fertility and reproduction.

"Greil believes that infertility is a secret stigma.. Infertility them would be seen as something 'felt' by the couple because they have internalized society's norms in regards to reproduction."

Sumera Ali et al. (2011 p2) [72] also talked about the societal norms and the stigma attached to it if they are violated. The stigmatized individual feels completely as a failure in

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[69] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

[70] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

[71] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

[72] Ali, S., Sophie, R., Imam, A, I., Khan, F, I., Ali, S, F., Shaikh, A., & Hasnain, S, F. (2011). Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross- sectional study. *BMC Public Health* 2011 11:760. doi: 10.1186/1471-2458-11-760

every aspect and people behave according to the label with him/her. The feeling of failure creates distress and various other negative effects on the couple:

"Infertility is a source of distress for couples as societal norms and perceived religious dictums may equate infertility with failure on a personal, interpersonal, emotional or social level."

A.M. Pottinger, C. McKenzie, J.Fredericks, V.DaCosta, S. Wynter, D. Everett and Y. Walters (2006 p238) [73] conducted a research to identify the differences in coping strategies and psychological distress among infertile couples in West Indies. They wrote about the negative school of thoughts in the society which increased the negative feelings in couples facing infertility:

"The existing negative attitudes and beliefs about infertility are bound to contribute to a couples' sense of despair, distress and morbidity."

Catherine Kohler Riessman (2000, p.111)[74] conducted in-depth study on the lives of childless women in South India. She also highlighted that the stigma exists in the society but it is more often seen among the childless woman as motherhood defines the feminity:

"Women encounter stigma if they do not become mothers."

Ernestina S. Donkar and Jane Sandall (2009, p.82) [75] stated that they found out that it were women who were expressing more about stigma. They studied the coping strategies in Ghana. It is seen that even in such a place where infertility is not a common feature, people feel scared of being labeled especially the females:

"Women have expressed feeling of stigmatization as a consequence of infertility."

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[73] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

[74] Riessman, C.K. (2000). Stigma and everyday resistance practices: Childless women in South India, *Gender & Society, 14*, 111-135

[75] Donkor, E., & Sandall, J. (2009). Coping strategies of women seeking infertility treatment in Southern Ghana. *African Journal of Reproductive Health,13*(4), 81-94

Petra Thorn (2009 p49) [76], the social worker from Germany also talked about the social norm and infertility. She explored that the stigma is in great frequency in those societies where people prefer big families and the number of family members represent prestige. When someone is unable to fulfill the requirements of the place where he/she lives than that person gets labeled and same is the case with infertility especially in the societies of large families. She mentioned the fact as:

> *"On a social level, infertility in most cultures remains associated with social stigma and taboo. Couples who cannot reproduce break social norms and conventions. Social stigmatization tends to be greater in pro-natalistic societies in which (large) families are desired and/or the norm."*

Talking about the types of societies that encourage large number of children, South Asia is the place where mostly people believe that children are the source of blessings and are compulsory for the complete and normal life. Those couples who are not able to have their babies experience the negative impacts on their lives. Particularly females are considered to be responsible for the fertility and Sumera Ali et al. (2011, p.2) [77] they mentioned the same about India, people expect females to produce babies and if they don't, people punish them:

> *"Social stigma regarding infertility is especially common across South Asia. For e.g. in Andhra Pradesh, India 70% of women experiencing infertility reported being punished with physical violence for their failure."*

2.4. Effect of infertility on marital relationship

P. Slade, C.O'Neill et al. (2007, p.2310) [78] observed that during the research on disclosure patterns and support among infertile couples, there is a strong link between the social support and ability to face the negative impacts. The support from the partner is very important, if the partner provides comfort and support to other partner, she/he can handle other societal issues with strong nerves:

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[76] Thorn, P. (2009). Understanding infertility: Psychological and social considerations from a counseling perspective. *International Journal of Fertility and Sterility, 3*(2). 48-51

[77] Ali, S., Sophie, R., Imam, A, I., Khan, F, I., Ali, S, F., Shaikh, A., & Hasnain, S, F. (2011). Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross- sectional study. *BMC Public Health* 2011 11:760. doi: 10.1186/1471-2458-11-760

[78] Slade, P., O'Neill, C., Simpsom, A.J. and Lashen, H. (2007). The relationship between perceived stigma, disclosure patterns, support and distress in new attendees at an infertility clinic. *Human Reproduction, 23*(8), 2309-2317

"In the context of a stigmatizing stressor, the need for the partner for support and emotional well-being may well increase."

In case of having no support from the partner, other partner gets weak and unable to bear the consequences with courage. In most of the cases it is seen that the marriage gets affected due to infertility, while the husbands do not support their wives as the fertility is considered to be the female related issue. Those wives get upset and always fear about the worse consequences. S. J. Dyer, N. Abrahams, M. Hoffman and Z.M. van der Spuy (2002, p.1664)[79] talked about the negative effects of infertility on the marital life:

"Women feared and experienced this threat in two different ways: abandonment and/or divorce or infidelity."

On the other hand, S. J. Dyer, N. Abrahams, M. Hoffman and Z.M. van der Spuy (2002 p1665)[80] also mentioned that during their study they observed that there were some couples who were not having any problems due to infertility:

"Not all women felt threatened in their relationship. Several women described their husband as being supportive and understanding."

According to S. J. Dyer, N. Abrahams, M. Hoffman and Z.M. van der Spuy (2002, p.1665)[81] some, out of those who were happy, were scared and insecure due to infertility and its duration. As the time of treatment and the duration of infertility increases, the hope of the couples starts decreasing. Females who do not have baby do not feel secure and always consider themselves as someone having lower status in the family:

"..a few women were concerned that a good relationship might change if the problem of infertility persisted."

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[79] Dyer, S.J., Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

[80] Dyer, S.J., Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

[81] Dyer, S.J., Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

Christine Dunkel-Schetter and Marci Lobel (1991, p.35) [82] argued about the four types of effects on marital life:

"Effects on marital interaction and satisfaction appear to be of four varieties. First, some people report increased anger, hostility, or resentment toward their spouse which may result from blaming a partner or feeling blamed, from feeling lack of spouse understanding or emotional support, or feeling that one's spouse is not equally committed to having children. Second, some spouses are anxious about the status of their relationship and they occasionally report fears of abandonment or breakup. Third, some articles report that individuals feel unable to disclose their feelings to a spouse, increasing a sense of isolation from their partner. The fourth type of effect on marriage is positive as opposed to negative; increased closeness, love, and support from their partners."

Sarwat Sultana and Azam Tahir (2011, p.230) [83] also talked about the issue of relation between infertility and marital life as infertility is a issue which is directly related to the couple. The support of one another can make the journey of treatment a healthy one but if infertility starts damaging the relationship then the wellbeing and the complete lives get compromised:

"Infertility has a tremendous negative impact on the well being of couple."

Sarwat Sultana and Azam Tahir (2011, p.231)[84] further said it is observed that the partner feels threatened about losing his/her partner. No matter how supportive the partner is, the other partner feels insecure about future support system. Especially, the females studied, feel that if they donot conceive soon, they'll face negative consequences particularly affecting their marital life:

"Feeling a psychological distance or withdrawal from one's partner is often observed in infertile couples."

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[82] Dunkel-Schetter, C., & Lobel, M. (1991). Psychological reactions to infertility. In Stanton, A., & Dunkel-Schetter, C (Eds.), Infertility perspectives from stress and coping research. (29-57). New York, Plenum

[83] Sultana, S., & Tahir, A. (2011). Psycholoigal consequences of infertility. *Hellenic Journal of Psychology,8*,229-247

[84] Sultana, S., & Tahir, A. (2011). Psycholoigal consequences of infertility. *Hellenic Journal of Psychology,8*,229-247

Fariba Hassani (2010, p.26) [85] also mentioned that she found out during her research that most of the studies which focus on infertility and social impacts of infertility, show a clear negative effect of infertility on marital life:

> *"Researchers believe that the infertility stress has an impact on marriage adjustment and the life quality of the couple."*

In every society, the roles of individuals are assigned according to the gender distribution, males are brought up in a particular manner in a particular society and same is with the females. From the early stages of life the socialization of child defines the concept of self and the worldview for him/her. In the case of infertility, the concept is related to both genders differently. The extent of stigmatization, the expectations of society, the reactions etc, all vary accordingly, even the primary infertile person among the couple also get affected due to gender differences.

Violet Kimani and Joyce Olenja (2001, p.208)[86] talked about how infertility is perceived for women and men in such social and psychological circumstances where every social action is decided on the basis of gender of the individual:

> *"The ability is therefore, seen as the true mark of womanhood and the pride of the man."*

2.5. Women and Infertility

Reproduction and babies are more related to the woman in all societies. Violet Kimani and Joyce Olenja (2001, p.204) [87] talked about women experiencing infertility as:

> *"Women view reproduction not as an isolated episode but as an event which is integrated with other aspects of her life. Having a baby designates a new status and identity as well as defines new roles."*

For women, having a baby is not just about having a complete family rather its about her identity and status. Child and reproduction is not just personal affair rather it's the social

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[85] Hassani, F. (2010). Psychology of infertility and the comparison between two couple therapies, in infertile pairs. *International Journal of Innovation, Management and Technology, 1*(1),25-28

[86] Kimani, M., Olenja, J.(2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. *The African Anthropologist, 8*(2), 200-214.

[87] Kimani, M., Olenja, J.(2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. *The African Anthropologist, 8*(2), 200-214.

matter which defines their status and roles in the society. To be respected and to be a complete woman, it is required to have a baby. Further Violet Kimani and Joyce Olenja (2001, p.204)[88] discussed about the perception of people towards infertile women as:

"...infertile woman is considered very unfortunate and a social misfit among fellow women..to many women, this is their destiny."

Susan Forsythe (2009 29)[89] mentioned while talking about infertile women and their experience of infertility that:

"Women feel that infertility ruins their identity more so than men."

Mostly women are blamed for having no babies or for being late in conceiving. The infertile females get threatened when they donot conceive early after marriage. The fear of being stigmatized and loosing self-identity is seen in almost all infertile females.

Infertility can be in male or female or both. But females often develop self pity and blame themselves for the loss. Females get more hopeless than men and develop guilt. The feelings of infertile women are also explored by A.M. Pottinger, C. Mckenzie et al. (2006, p.238)[90]:

"Women are more likely in blame themselves and to describe a greater sense of loss of control"

Talking further about gender differences while dealing with infertility and coping strategies adopted by both sexes. A.M. Pottinger, C. Mckenzie et al. (2006, p.240)[91] elaborated more about self-blame tendency as:

"Gender differences were found to be statistically significant for two of the coping strategies. More women engaged in excessive self-blame than men."

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[88] Kimani, M., Olenja, J.(2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. *The African Anthropologist, 8*(2), 200-214.

[89] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

[90] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

[91] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

Marcia C. Inhorn and Frank van Balen (2002, p.152) [92] also mentioned the issue prevailing in society regarding the fertility as a source of identity and as a symbol of being a complete woman:

"Making babies is how women are expected to form adult identities the world over."

Fertility and children are considered to be always linked with females. Even if there is support or not, it is the female who has to put more effort to conceive. Bushra Parveen et al. (2008, p.109) [93] stated that:

"In most cases husbands assume infertility in wives. If a couple is issueless it is wife who is expected to seek medical treatment or spiritual blessings for infertility."

Sarwat Sultana and Azam Tahir wrote about the gender differences while going through infertility (2011, p.230) [94]. In the time of difficulty the responses and the reactions alter with alteration in gender. Male when get depressed and the frustration of being helpless makes them more aggressive and on the other hand females get more into self blame which leads further into psychological disorders of more complexity:

"When males feel powerless and experience low self-esteem they try to reclaim it through aggressive behavior. On the other hand, for females, aggression is a transitory loss of self-control arising out of high stress, social pressure and extreme sense of guilt."

The same difference among females and males has been explored by Fariba Hassani (2009, p.26) [95]:

"The differences that exist between men and women concerning infertility can sometimes cause mutual problems between the couples. Women usually externalize the

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[92] Riessman, C. K. (2002). Positioning gender identity in narratives of infertility: South Indian women's lives in context. In Inhorn, M. C., and Balen, F. *Infertility around the globe* (152-170). California,U.S.A: University of California Press

[93] Parveen, B., Dogar, I, A., Kousar, S., Musharaf, S., Masood, A., & Afzal, S. (2008). Psychological Adjustment of Educated and Uneducated Infertile Females of Pakistan, *A.P.M.C,2*, p108-112

[94] Sultana, S., & Tahir, A. (2011). Psycholoigal consequences of infertility. *Hellenic Journal of Psychology,8*,229-247

[95] Hassani, F. (2010). Psychology of infertility and the comparison between two couple therapies, in infertile pairs. *International Journal of Innovation, Management and Technology, 1*(1),25-28

problem and show emotional reactions, while men seldom express themselves which is sometimes wrongly interpreted as being indifferent. In fact women show strongest emotional response and speak more about the problem than men."

The expression of feelings varies among men and women. Males express their feelings openly but women are more introvert and do not show their feelings. Some males prefer not to show their grief as it do not suits manhood. Not being expressive or extrovert may lead to different sort of interpretations among the social circle. Whereas, the factor of being expressive make women more emotionally stronger and stable than men.

Another aspect of difference among the approach of women and men is given by Sonja L. Nieuwenhuis, Akin-Tunde A. Odukogbe, Sally Theobald and Xiaoyun Liv (2009, p.85)[96] , they stated:

"Infertile women prioritize the psychological impact of infertility while men prioritize the economic impact, and reported spending between 55-100% of their income to address infertility"

For women, if infertility is a matter of their identities and social status, than for men its is about their manhood and dignity. To achieve their goals, the couple seeks treatments which is expensive and takes time. The treatment is mostly women oriented but the economic factor is unavoidable, the financial pressure increases much tension on the male members and ultimately results in marital issues.

2.6. MEN AND INFERTILITY

Fertility and women are linked as integral parts of majority of studies, while some are focused on the relationship between males and infertility. Violet Kimani and Joyce Olenja described (2001, p.211)[97]:

"..an infertile man is well cushioned and even protected from ridicule an infertile woman suffers displacement, has to bear the image of spoilt identity.."

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[96] Nieuwenhuis, S,L., Odukogbe, Akin-Tunde,A., Theobald, S., & Liv, X. (2009). The impact of infertility on infertile men and women in Ibadan, Oyo State, Nigeria: A qualitative study. *African Journal of Reproductive Health, 13*(3),85-98

[97] Kimani, M., Olenja, J.(2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. *The African Anthropologist, 8*(2), 200-214.

Susan Frosythe (2009, p.29) [98] mentioned while talking about gender differences and stigmatization of infertility that most of the infertile women agreed that they are stigmatized but talking about male infertility and males among the infertile couples, women feel that the males feel more stigma than themselves:

"..the women Miall interviewed felt that infertile men have a greater stigma than infertile women"

Males are not that often asked about children and being fertile but the society do not stop labeling them in a negative matter. The manhood and the ability to pregnant their wives are most important part of their lives and when infertility ruins this, they feel upset and incomplete. The frustration and tension leads to indulge them in more issues. A.M. Pottinger et al. (2006, p.238) [99] also discussed men and infertility experience as:

"Men may also engage in extra-marital affairs and are likely to experience sexual, dysfunction.."

Talking about men infertility experience A.M. Pottinger et al. (2006, p.239)[100] further stated the coping strategies of men:

"The strategies that men used more often were those that allowed them to avoid talking about their experience, namely 'keeping feelings to themselves' and 'making self better by eating, drinking or smoking'."

For men to avoid the shame and guilt is easier than women, they can just ignore the people and their comments while women are more answerable.

After explaining A.M. Pottinger et al. (2006, p.241)[101] concluded:

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[98] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

[99] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

[100] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

[101] Pottinger, A., McKenzie, C., Fredericks, J., DaCosta, V., Wynter, S., Everett, D., and Walters, Y. (2006). Gender differences in coping with infertility among couples undergoing counseling for in vitro fertilization treatment. *West Indian Med J,55*(4),237-242

"The lack of fertility for men therefore seems to result in frustration about their unfulfilled aspirations."

The relationship between body image and infertility is described by Mohammad Mehdi Akhondi et al. (2011, p.295) [102]:

"Scientists have shown that disease and sickness cause loss of body control and a sense of uselessness leading to a negative body perception."

The worldview and the perception of people are made on the basis of what individual feels about himself/herself and what he/she feels about their standing in society. If a person feels that he/she is complete and have control on various aspects, they feel that they are normal and the outer world is normal as well. But if a person is not internally satisfied he/she won't be able to develop a positive image of self and world. Infertility is such a disorder which creates a feeling of distorted body image as Mohammad Mehdi Akhondi et al. (2011, p.297)[103] elaborated:

"Cash demonstrated that body image distortion in infertile men anticipated depression."

The inferiority complex about self-image and distortion of bodily view due to infertility makes them feel that they are not normal. Mohammad Mehdi Akhondi et al. (2011, p.297)[104] mentioned the feeling of negativity about self also in these words:

"Infertile men believed they are unhealthier."

Petra Thorn (2009 p49) [105] talked about men in infertility as being more threat to the psychological wellbeing of husbands than infertility of wives. The rate of infertility is increased among both genders but the treatment is more among the females so it is a common assumption that its something related to women. If the husbands get diagnosed they feel that

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[102] Akhondi, M. M., Dadkhah, A., Bagherpur, A., Ardakani, Z. B., Kamali, K., Biaafar, H., and Ghorbani, B. (2011). Study of body image in fertile and infertile men. *J Reprod Infertil,12*(4),295-298.
[103] Akhondi, M. M., Dadkhah, A., Bagherpur, A., Ardakani, Z. B., Kamali, K., Biaafar, H., and Ghorbani, B. (2011). Study of body image in fertile and infertile men. *J Reprod Infertil,12*(4),295-298.
[104] Akhondi, M. M., Dadkhah, A., Bagherpur, A., Ardakani, Z. B., Kamali, K., Biaafar, H., and Ghorbani, B. (2011). Study of body image in fertile and infertile men. *J Reprod Infertil,12*(4),295-298.
[105] Thorn, P. (2009). Understanding infertility: Psychological and social considerations from a counseling perspective. *International Journal of Fertility and Sterility, 3*(2). 48-51

they are some strange beings and continuous tension and frustration among them creates more stressful situation:

"Male infertility tends to be associated with a more significant taboo than female infertility. Thus, it is not surprising that men indicate high levels of stress when male factor infertility diagnosed."

Sonja L. Nieuwenhuis, Akin-Tunde A. Odukogbe, Sally Theobald and Xiaoyun Liv (2009, p.95) [106] stated that there is difference among genders and impact of infertility. For women it is more related to the social consequences and for men it causes more psychological damage which leads to the negative changes in their personality and social life:

"Infertility is stigmatized. Women lack support from the extended family, while the men suffer because of the impact of infertility on themselves and psychological impact on their wives."

Quran is the Holy book, covering all aspects of life. Infertility is also discussed in the holy book Quran. In a more direct and complete verse, the Almighty God has directed the humanity to have their completed in Him as He is the only Giver and Taker:

قَدِيرٌ عَلِيمٌ إِنَّهُ عَقِيمًا يَشَاءُ مَنْ وَيَجْعَلُ وَإِنَاثًا ذُكْرَانًا يُزَوِّجُهُمْ أَوْ

"or He gives both male and female [to whomever He wills], and causes to be barren whomever He wills: for, verily, He is all-knowing, infinite in His power". (42:50)

[106] Nieuwenhuis, S,L., Odukogbe, Akin-Tunde,A., Theobald, S., & Liv, X. (2009). The impact of infertility on infertile men and women in Ibadan, Oyo State, Nigeria: A qualitative study. *African Journal of Reproductive Health, 13*(3),85-98

CHAPTER 3

AREA PROFILE

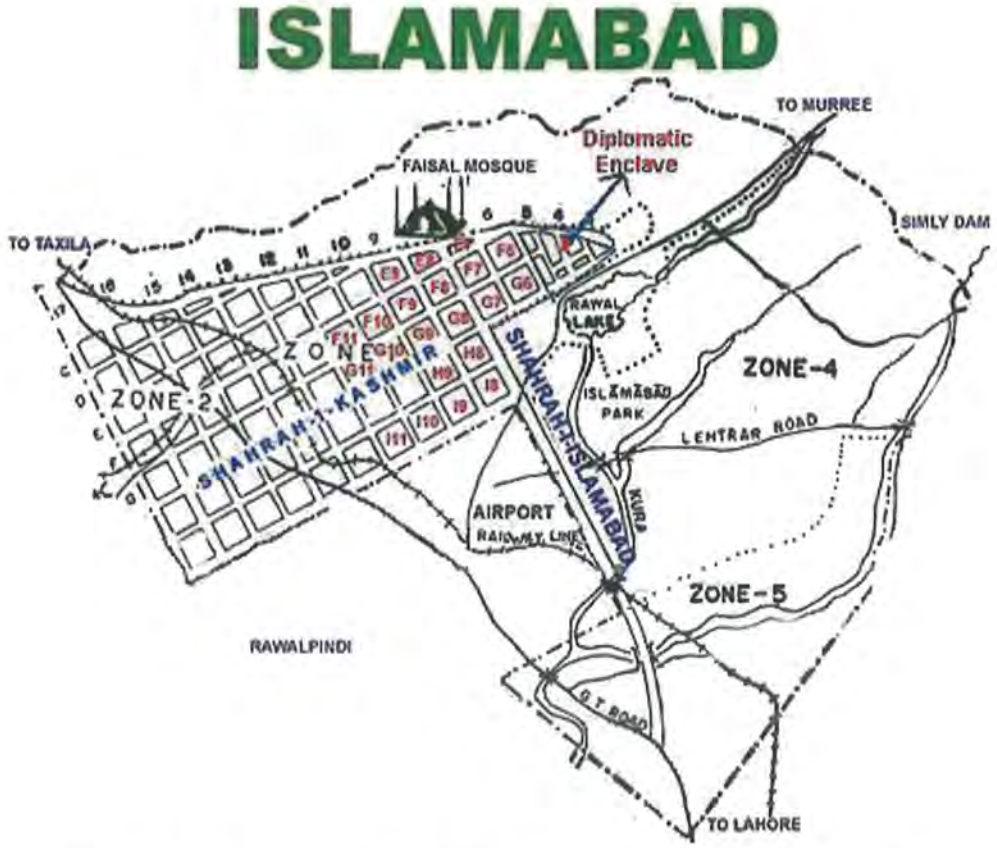
The study was conducted in the capital city of Islamabad, the selection of the locale of study was for its stratification criteria, the feasibility and permission granted by the authorities, where two main hospitals one government and the other a private, were chosen to study different groups of people. Among the hospitals, one was Federal Government, Polyclinic Hospital, while the other was the private clinic of Dr. Durdana Kazmi. The selection of the hospitals was the frequency of patients, willingness of the respondents and permission for frequent visits by the researcher to interact with the doctors, nurses and other staff and also with the patients who were under treatment there.

The capital city of Islamabad was one of the greenest and most well-planned cities of South Asia, according to its literally meaning it was the *abode of Islam.* As per its literary meanings, it embodies the Islamic values and the aspirations of the Muslims of South Asia which culminated in the establishment of Pakistan in 1947. Its freshness and beauty symbolized the hopes and aspirations of the people of Pakistan to revive in a modern context of glory and the grandeur of the Muslim rule in South Asia.

Islamabad was located on the northern most edge of the tract known as Potohar plateau. The site was an uneven table and land was gradually rising from 500 to 600 meters (above the sea level), in the extreme north the hills rose more steeply. The highest point was 1600 meters above the sea level. Most of the Margallah range was in the North West composed of hilly tracks belonging to the Eocene division of the tertiary period and were about 60 million years old. The rock formation consisted of gray and dark colored lime stone with layers of shale containing fossils. The land gradually sloped towards south. The land was composed either of alluvium (clay or slit) or of gravel caps. The plains were formed of alluvial deposits laid by the past and the present river systems in varying thickness. A large part of the area was undulating and at various places it was badly dissected by gullies and ravines. The Korang stream has been dammed at a place named Rawal to form the Lake called Rawal Dam, another dam has been built on the Soan River to form the Simly Dam.

Islamabad Federal Capital lies between 33° -28' and 33o- 48'north latitudes and 72° – 48' and 73° – 22' east longitudes. It was bounded by Haripur district of the NWFP to the north and by Rawalpindi district of Punjab on all other sides107.

Figure 2: Map Of Islamabad



Source: http://cdn4.vtourist.com/4/337199-Map_of_Islamabad_Islamabad.jpg[108]

3.1. PROFILE OF THE LOCALE

The locales of the present study were Federal Government Polyclinic Hospital and Mother-care clinic in Islamabad where the data collection was carried out by the researcher.

3.1.1. FEDERAL GOVERNMENT POLYCLINIC HOSPITAL (FGPC):

The Federal Government Polyclinic (FGPC) Hospital, Islamabad was the oldest hospital of the federal capital; its bed strength was 10 in 1966 that was increased to 547 beds

[107] Population census Organization, (1998). District census report of Islamabad (1998). *Statistics division, Government of Pakistan.*

[108] Map of Islamabad. http://cdn4.vtourist.com/4/337199-Map_of_Islamabad_Islamabad.jpg. Retrived on 4/4/2012.

with 28 indoor specialties. The FGPC was the declared services hospital for federal Government employees and their dependents mandated to provide free of cost treatment to them. Furthermore, after the directions of the government, the services were made open to general population. The hospital has clientele from twin cities, upper Punjab, lower KPK, AJK, GB, & FATA.

The Hospital also provided static and mobile medical cover to national international dignitaries in Islamabad. The emergency services were managed round-the-clock. The distinguishing feature of FGPC was the provision of free-of-cost consultation, tests, treatment, drugs and material to all patients, and it worked in two shifts, morning and evening. There were 28 dispensaries, 2 Maternal and child health centers and 2 civil surgeon centers were also working as subordinate care facilities in difference sectors of Islamabad and Rawalpindi[109].

3.1.1.1. GYNECOLOGY WARD IN FGPC

Around 45-60 Gynecology & Obstetric patients were provided indoor care each day through fresh admittance to 94 beds in the main hospital and 66 beds in attached centers. Around 25-30 deliveries were arranged and provided full free care in the labor room facilities. Three units of Gynae & Obs of different surgeons, nurses and paramedics provided 3 days antenatal services and three days gynecological and obstetric consultations, including OPD diagnosis and therapy of infertility cases. On Wednesday, Thursday and Friday there were the fixed days for checkups during the working hours 9:00 am to 2:00pm.

The Gynae ward was located on the link road in front of G.P.O Melody market divided in different sections. At the entrance there was a big hall decorated with benches and two reception tables where the staff noted the details about each patient. After the registration, the patients were moved to the corridors used as the waiting area. The assistant of the doctor in charge calls the names of the patient and the patient goes in doctor's room for checkup. There were 4 main offices for doctors and 4 rooms for the medical officers and other staff members. The other sections consisted of operation room and rooms for admitting patients.

The researcher was allowed to interact with the patients in the in the waiting area, while the doctors and staffs in their rooms.

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[109] Naru, I. A. (2012). Brief report about structure and performance of FGPolyclinic. CAND, Government of Pakistan

Figure 3: Board At Enterance Of Gynae F.G.P.C.

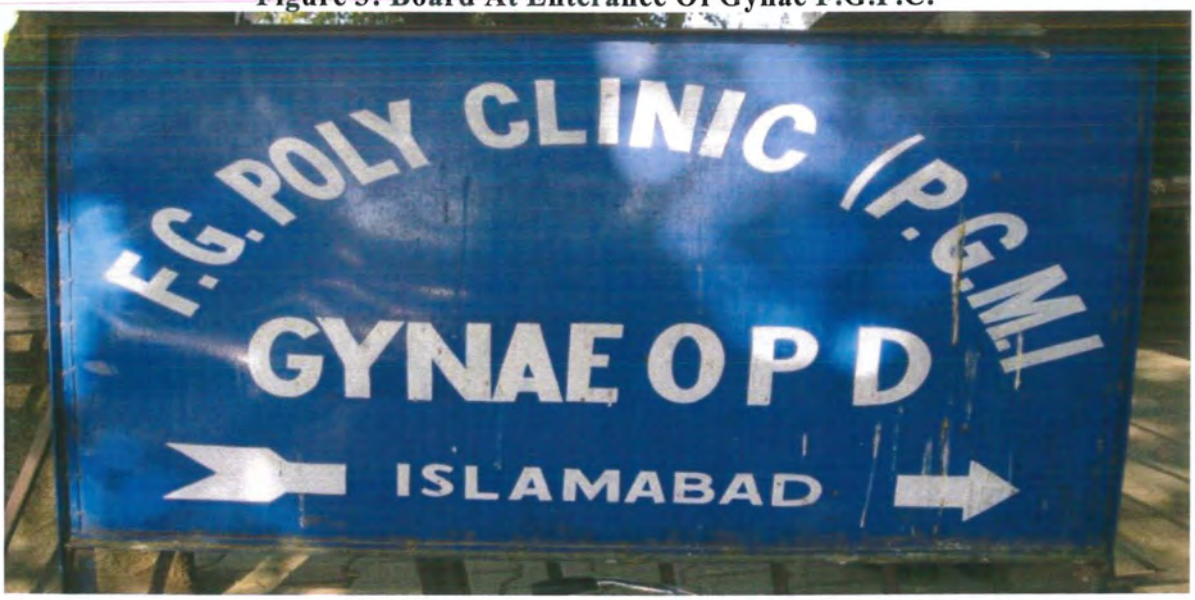


Figure 4: F.G.P.C. Dr. Riffat Checking Her Patient

Figure 5: F.G.P.C. - The Waiting Area Inside

3.1.2. MOTHER CARE CLINIC

The other hospital selected as the second locale was the Private clinic Mother Care hospital established for checkups of gynecologist and obstetrician attended by Dr. Durdana Kazmi.

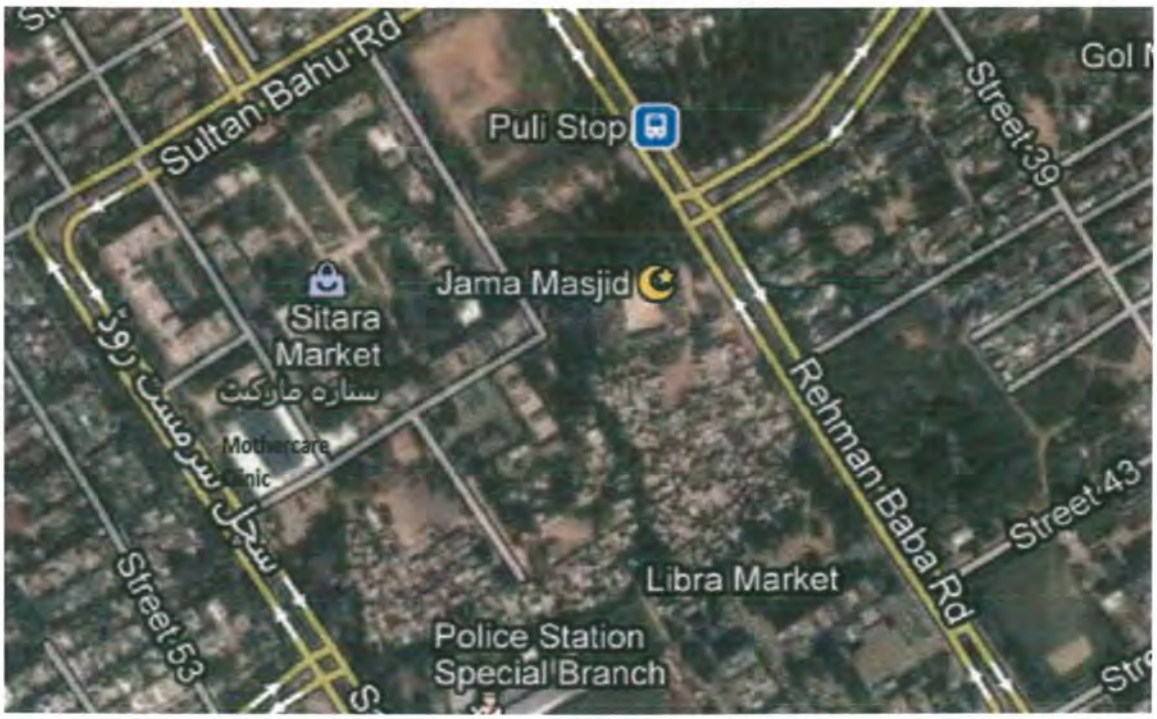
It was situated in markaz sector G-7, Islamabad, located in a plaza on the main road. The main door was of off-white color, while there was no sign board indicating the presence of the clinic. The clinic was functional for six days a week except Sunday being the closed holiday and the timings of the clinic were 4 pm till 9 pm.

There was a small corridor at the entrance of the clinic. After passing through the corridor, there was a passage, on its left side, there was a hall partitioned for different purpose, at the one corner, there was reception and on the corner there was a wash room and the adjoining areas was used as the waiting room for ladies decorated with plastic chairs placed for the patients and their attendants. On the right side of passage, there was another room used as male waiting room decorated with plastic chairs for the male patients and their attendants.

In between the above mentioned rooms, there was another room used for the examination of the patients, it was a medium sized room consisted of an office table for the doctor, a steel chair for the patient and a bed for the patients. In the examination room, there was a shelf used to keep the equipment, books and doctor's notes etc. An ultrasound machine was installed with the doctor's table used very frequently, curtains were hanged with the windows and doors to maintain the privacy, while two chairs were placed at other corner for the patients called for ultrasound and their attendants.

The researcher was permitted to interview the patients in the waiting rooms, where 20 infertile couples were chosen as respondents.

Figure 6: Map Showing Mothercare



Source: http://mw2.google.com/mw-panoramio/photos/small/30849144.jpg[110]

[110] http://mw2.google.com/mw-panoramio/photos/small/30849144.jpg. Retrieved at 12/05/2012

3.1.2.1. Staff members

In the Mother care unit, there were different categories of limited staff working for examination and diagnoses the infertile men and women with zeal and zest. The staff position has been given in the following table:

Table 1: Staff Members At Mothercare Clinic

Sr. No.	**Staff Members**	**Responsibilities**
01	Dr.Durdana Kazmi	The Gynecologist
02	Rabnawaz Khan	To manage reception and details of clinic
03	Ayesha	To assist doctor while examining the patients and managing equipment

Figure 7: Ayesha, The Assistant At Clinic

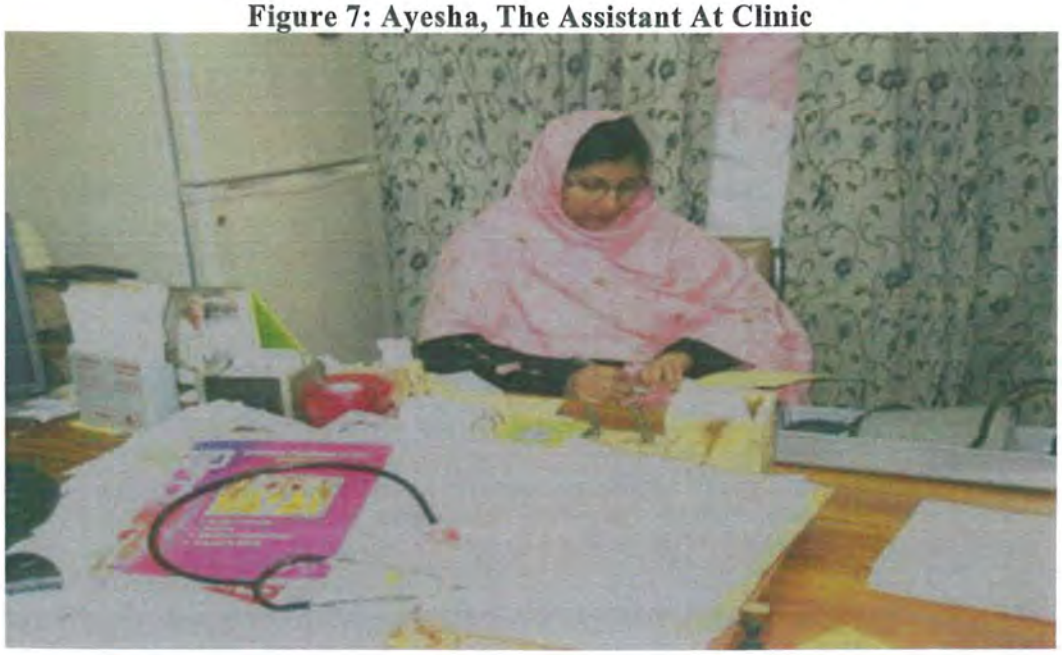
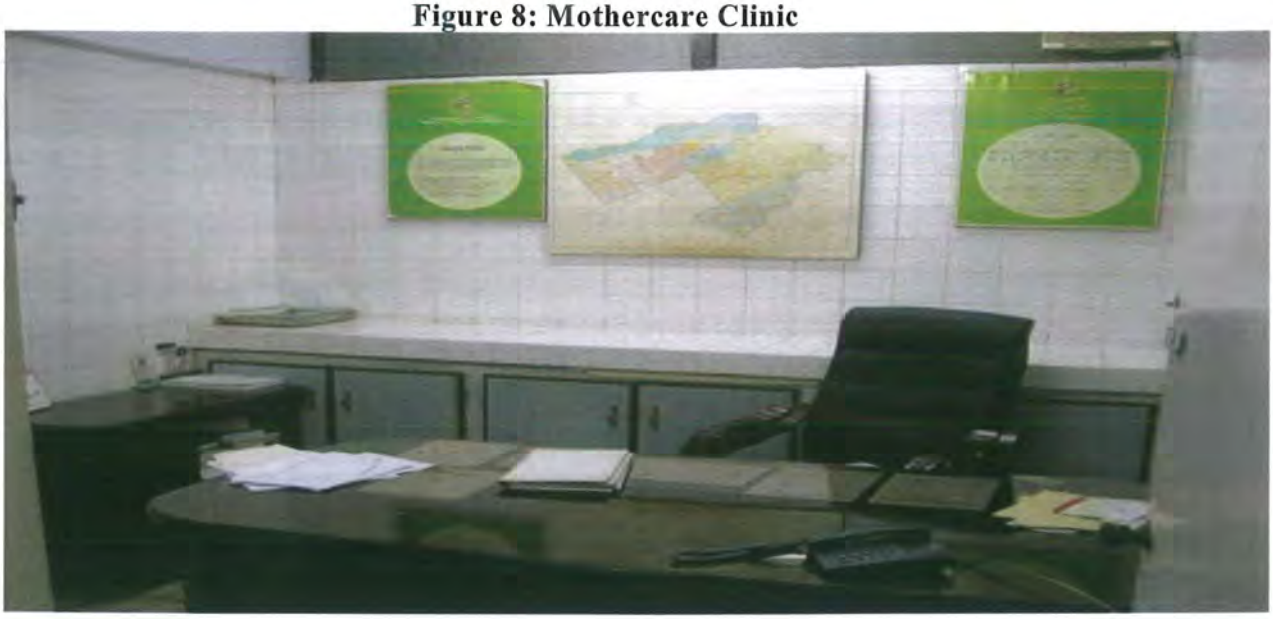


Figure 8: Mothercare Clinic



3.1.2.2. Electricity

The presence of electricity was the main priority of the clinic's administration that was necessary for the running of different machines used for the examination of the patients. During the frequent visits, it was observed by the researcher that there was no electricity problem as she observed fans, water coolers, lights and machines working all the day without any break. In case of electricity load shedding, a generator was installed outside the clinic that was functioning during the un-availability of electricity for the smooth functioning of the clinic.

3.1.2.3. Residential Facilities

The Mother care clinic was not a proper hospital, therefore the indoor hospitalization facility was not there, the purpose of the clinic was to diagnose the symptoms and to provide medical treatment, while the patients requiring hospitalization, they were referred to the hospitals but preferably to the Policlinic hospital, Islamabad.

3.2. RESPONDENT'S PROFILE

There were 40 infertile couples, who gave interviews. They were having different lifestyles and backgrounds. The study shows the relation of different aspects of couple's life with infertile and stigmatization. The details about the respondents collected are described below:

3.2.1. CASTE OF RESPONDENTS

The reason behind selecting two different locales was to know about the difference in life experiences with respect to the difference in life settlement and backgrounds. People belonging to different caste systems were met at the locales. The stratification according to castes is clearly described in the table below:

Table 2: Castes Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Castes	No. of Respondents	Percentage %	Castes	No. of Respondents	Percentage %
01	Syed	5	25	Hashmi	2	10
02	Khan	4	20	Syed	3	15
03	Rajpoot	3	15	Rajpoot	9	45
04	Chaudhary	2	10	Satti	2	10
05	Malik Awan	6	30	Chishti	1	5
06	-	-	-	Raja	3	15
Total		20	100	Total	20	100

According to the data given in the table, Maliks, Awans were constituting 30% majority among the total respondents, while 25% were Syeds, 20% were Khans, 10% Chaudharies and 15% Rajpoots. Among the patients of mother care clinic, 45% were the infertile couples who were from Rajpoot caste and 15% were Syeds and Rajas.

The difference in castes systems and the family setup was found not that much influential in the study, as the infertile couples were stigmatized irrespective of the caste. This

showed that the stigmatization is present in all types of families, among respondents. The Khan caste, claimed to be the pure pathans and the husbands, who belong to Khan caste were strictly against second marriages for the sake of purity and dignity.

3.2.2. RESIDENTIAL AREA

People from different areas came to visit the hospital and clinic for treatment. The majority of respondents were from the twin cities of Islamabad and Rawalpindi in both the locales. The figures and the places are mentioned as follows:

Table 3: Residential Area Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Places	No. of Respondents	Percentage %	Places	No. of Respondents	Percentage %
01	Islamabad	7	35	Islamabad	12	60
02	Azad Kashmir	2	10	Lahore	2	10
03	Muzafarabad	4	20	Rawalpindi	4	20
04	Rawalpindi	5	25	Taxila	2	10
05	Dera Ismail Khan	1	5	-	-	-
Total		20	100	Total	20	100

In the government hospital, there were more people who came from other areas as compared to those who came to private hospital. In FGPC respondents were from Muzafarabad, Azad Kashmir and Dera Ismail Khan, while some of the respondents were from Lahore, Rawalpindi, Islamabad and Taxila.

As FGPC is a government hospital, people come from different areas to get checked, because it is affordable and the government servants can be facilitated there. Whereas, Mother care is a private clinic which makes it less convenient for the people living in farther areas to visit the clinic, as it adds the expenses of travelling, medication and tests. Therefore, it is seen that majority of respondents at clinic were from Islamabad and Rawalpindi.

3.2.3. SOCIO-ECONOMIC STATUS

People elaborated their economic conditions and about their perception regarding their socio-economic class they belong to. The below table shows that there was a division among the classes of people in the government hospital, 50% respondents were from lower middle class, 40% were from middle class, while 10% were from the upper class according to the data collected from the hospital.

In the Mother care clinic, the position of respondent's classes was little bit different, according to the data, and 50% respondents were from the middle class, 5% from the lower middle class, while 45% were from upper class. The classification was either to highlight their social and economic status or to hide their income and assets what the case might be, the class system was there among the people.

Table 4: Socio-Economic Status Of Respondents

Sr.No.	**Respondents in Government Hospital**			**Respondents in Private Hospital**		
	Socio-Economic Status	No. of Couples	Percentage %	Socio-Economic Status	No. of Couples	Percentage %
01	Lower	10	50	Lower	1	5
02	Middle	8	40	Middle	10	50
03	Upper	2	10	Upper	9	45
Total		20	100	Total	20	100

The sample of the study consisted to two locales with different types of setups. This allowed to collect data from different types of respondents. It was seen that in government hospital there was a low number of cases who belong to upper class; on the other hand, in private clinic the case was totally opposite.

The data shows that stigmatization of infertility, is not directly linked to the socio-economic positions. Those infertile couples who belong to upper class were facing same social and psychological issues that are faced by the infertile couples of lower class.

3.2.4. FAMILY TYPE

A majority of infertile couples that was 65% of the sample size lived in a joint family system, while the respondents of FGPC 35% were living in the nuclear system; the division has been highlighted in the following table:

Table 5: Types Of Family Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Types of Family	No. of Respondents	Percentage %	Types of Family	No. of Respondents	Percentage %
01	Nuclear	7	35	Nuclear	5	25
02	Joint	13	65	Joint	15	75
Total		20	100	Total	20	100

The position of Mother care clinic as given the above table was the same with little different, according to the data collected by the researcher, 25% of respondents lived in the nuclear families, 75% lived in joint families. The ratio was in line with the traditional Pakistani family system, the people preferred to live in joint families but some of the educated families were inclined to live separately with their children in a nuclear family pattern.

With respect to stigmatization of infertility, it was observed that the couples living in joint family were facing more social issues and psychological pressure than those who live in nuclear family. Those who live in nuclear family used to feel social pressure more when they had to meet the family unit in some gathering or some other place.

3.2.5. TYPE OF MARRIAGES

The respondents were asked about their types of marriages in order to observe the relationship between their marital satisfaction and infertility. There was just one couple in FGPC, out of the sample who had love marriage, the rest of the 19 couples had an arrange marriage. The following table shows that 95% were those who had arranged marriage and 5%

had love. Whereas, in mother care clinic, 85% were those respondents who had arranged marriage and 15% were those who had love marriage

Table 6: Types Of Marriage Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Types of Marriage	No. of Respondents	Percentage %	Types of Marriage	No. of Respondents	Percentage %
01	Love	1	5	Love	3	15
02	Arrange	19	95	Arrange	17	85
Total		20	100	Total	20	100

Infertile couples, who had love marriage, were observed to be more supportive than those who had arrange marriage. But the stigma and discrimination was faced by both. The infertile couples, of love marriage, were blamed more than those who had arrange marriage, on the basis of the personal choices of spouse they made by themselves. But the partners were more sensitive to each other and were defensive to protect each other.

There are two types of marriages; one is the exogamy and the other endogamy. The endogamy marriage system is where marriages are arranged outside the family, the partners do not belonged to the same family or lineage. The endogamous marriages are arranged within the family and lineage, called cousin marriages, such type of marriages are most popular among the people lived in the rural settings.

The details about their marriages were also asked from the respondent couples. In FGPC 11 couples were married in their families and they were close relatives, 9 couples were married out of their families. In Mother care clinic 10 were married in the families and 10 out of family. The details of marriage pattern have been given in the following table:

Table 7: Types Of Marriage Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Types of Marriage	No. of Respondents	Percentage %	Types of Marriage	No. of Respondents	Percentage %
01	Endogamy	11	55	Endogamy	10	50
02	Exogamy	9	45	Exogamy	10	50
Total		20	100	Total	20	100

The majority was of endogamous marriages among infertile couples with the percentage of 55% and 45% were exogamy in the government hospital, while 50% ratio was of both endogamous and exogamous among the respondents at private clinic.

Doctors believe that the cousin marriages are an important factor in the infertility. Due to cousin marriages the rate of infertility is getting high as the gene pool is not mixing some new gene pool and the interlinking is causing new physiological problems.

3.2.6. DURATION OF MARRIAGE

The duration of marriage, being an important issue for fertility and infertility was observed carefully by some of the families because with the increase in time period the age of couple increases too.

Table 8: Duration Of Marriage Of Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Time Period	No. of Respondents	Percentage %	Time Period	No. of Respondents	Percentage %
01	1-3 years	11	55	1-3 years	9	45
02	4-6 years	5	25	4-6 years	5	25
03	7-9 years and above	4	20	7-9 years and above	6	30
Total		20	100	Total	20	100

In FGPC 55% were those couples who were married 1-3 years before. Those couples were facing female primary infertility or male infertility, 20% were those couples who were married since 7-9 years and above were facing secondary infertility, while the remaining 25% were married since 4-6 years. In Mother care clinic, 45% were those who were married since 1-3 years and 30% were those who got married 7-9 years ago and the remaining 25% were those couples who got married before 4-6 years.

The research explored, that the more the duration of marriage was, the more psychological and social issues were arising all around. The infertile wives were seen to be developing insecurities and psychological issues with the passage of time. This was mainly

due to the increase in social pressure with the increase in time span. The psychological problems like; hopelessness, guilt, frustration and aggression were increasing with time.

3.2.7. AGE OF RESPONDENTS IN GOVERNMENT HOSPITAL

Age groups and fertility are linked with each other as there are studies which claim that with the increase in age there is a decrease in fertility. The following table shows the age brackets of the female respondents.

Table 9 : Age Of Respondents In Government Hospital

Sr.No.	Female Respondents in Government Hospital			Male Respondents in Government Hospital		
	Age (years)	No. of Respondents	Percentage %	Age (years)	No. of Respondents	Percentage %
01	20-25	5	25	20-25	2	10
02	26-31	10	50	26-31	7	35
03	32-37 and above	5	25	32-37 and above	11	55
Total		20	100	Total	20	100

It was found out that females were having fertility issues in a very young age. The female respondents found at FGPC were mostly those who belonged to the age bracket of 26-31, 25% were between 20-25 years and other 25% were those females who belonged to age bracket of 32-37. In that age group, secondary infertility was found. On the other hand, the age of husbands were found to be mostly above 30 years.

3.2.8. AGE OF RESPONDENTS IN PRIVATE HOSPITAL

The age of males was also observed as a factor of fertility among the married couples, the following table shows that the majority of males were those who belonged to age group of 32-37 years and above, same as it was seen in FGPC. Among the married couples, male partners were more aged than the female.

Table 10: Age Of Respondents In Private Hospital

Sr.No.	Female Respondents in Private Hospital			Male Respondents in Private Hospital		
	Age (years)	No. of Respondents	Percentage %	Age (years)	No. of Respondents	Percentage %
01	20-25	4	20	20-25	2	10
02	26-31	12	60	26-31	10	50
03	32-37 and above	4	20	32-37 and above	8	40
Total		20	100	Total	20	100

The females of 26-31 years were found to be in majority. The age difference between husbands and wives was not found to be a prominent factor among the respondents. The difference was seen among the age of males visiting government hospital and private. The one, visiting private hospital were mostly from the age bracket of 26-31 years. They were those couples who were striving for baby from the beginning of their married life.

3.2.9. HEAD OF HOUSEHOLD

Most of the houses were run by the husband as the head of the family supported by his sons either married or unmarried, while the decision making authority and the financial control was of the father-in-law. Among 7 married couples, husbands were the head of household, while in the case of the remaining 3 couples; the head of household were elder brother-in-law as explained in the following table:

Table 11: Head Of Household

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Head of Household	No. of Respondents	Percentage %	Head of Household	No. of Respondents	Percentage %
01	Husbands	7	35	Husbands	15	75
02	Father-in-Law	10	50	Father-in-Law	5	25

03	Brother-in-Law	3	15	-	-	-
Total		20	100	Total	20	100

The above table shows that 50% households were run by the fathers-in-law of wives respondents at FGPC, while in 35% houses, husbands were the head of the household and in remaining 15% brothers-in-law were heads of household. In the Mothercare clinic, out of 20 couples, 75% of houses were headed by the husbands while remaining 25% were looked after by the fathers-in-law.

The head of household, in some extent affect the stigmatization of infertility amongst the couples. As those couples in which the husband is the head of household, the wives of such husbands face two types of conditions; either they are in severe family pressure for the continuity of his name or they are slightly having the upper hand because of the husband's hold in house. Those who have other family members as the head are always suppressed and discriminated on the basis of social factors.

3.2.10. Education of wives visiting the Government hospital

Education among the infertile wives was also investigate by the researcher, 30% of the females were educated up to intermediate level, 10% were graduates, 10% were educated up to secondary level, 20% were middle pass and 15% were educated up to primary level, while 15% were uneducated. The details have been given in the following table:

Table 12: Education Of Wives

Sr.No.	Wives in Government Hospital			Wives in Private Hospital		
	Levels of Education	No. of Wives	Percentage %	Levels of Education	No. of Wives	Percentage %
01	Primary	3	15	Primary	0	-
02	Middle	4	20	Middle	1	5
03	Secondary	2	10	Secondary	4	20
04	Intermediate	6	30	Intermediate	3	15
05	Graduation	2	10	Graduation	6	30
06	Post-	0	-	Post-	5	25

	Graduation			Graduation		
07	None	3	15	None	1	5
Total		20	100	Total	20	100

According to the data collected from the Mother care clinic, 25% of the respondents were post graduates, 30% were graduates, 15% were educated up to intermediate level, 20% were of secondary school level, 5% were educated up to middle level, while 5% were uneducated.

In the present study, there was no bond found out between education and stigmatization of infertility. The wives who were educated and were not educated were almost equally facing the consequences of infertility. The level of insecurity and the psychological issues were going on with both types of women. The coping strategies were also same for both.

3.2.11. EDUCATION OF HUSBANDS VISITING GOVERNMENT HOSPITAL

Researches show that there is a close relationship between education and the ways of dealing the problems. Therefore, it was important to study that whether education of both partners has any relation with the stigmatization of infertility.

Table 13: Education Of Husbands

Sr.No.	**Husbands in Government Hospital**			**Husbands in Private Hospital**		
	Levels of Education	No. of Husbands	Percentage %	Levels of Education	No. of Husbands	Percentage %
01	Primary	1	5	Primary	1	5
02	Middle	2	10	Middle	1	5
03	Secondary	3	15	Secondary	2	10
04	Intermediate	4	20	Intermediate	2	10
05	Graduation	7	35	Graduation	5	25

06	Post-Graduation	2	10	Post-Graduation	9	45
07	None	1	5	None	0	-
Total		20	100	Total	20	100

Among the husbands visiting the government hospital, 35% of them were graduates and 20% were those who got education up to secondary level, 15% received education till intermediate, 10% middle and 5% primary, 2 of the respondents were even postgraduates and 5% were uneducated. The respondent husbands, among the infertile couple were also postgraduates and graduates. There was no one with uneducated background and some of them were those who received education up to early levels like primary and secondary. In percentages, the table clearly shows that, the majority of males 45% were post-graduates, 25% were graduates, 20% were educated up to secondary and intermediate level, while 10% were either middle or primary.

It was explored that there was difference among the coping strategies of educated males and uneducated males. The husbands who were educated were handling the situation of stigmatization either by ignoring the critical situations or by being supportive towards their partners. Those husbands who have less education were coping in a different manner i.e. through shouting and yelling at family members and colleagues. The lack of temperament was a common and a more serious issue found out between the less educated husbands.

3.2.12. Occupation of Wives Visiting Government Hospital

Almost all of the respondent wives were house wives, very few were teachers. The main purpose of doing job was to remain busy to avoid any kind of tensions.

Table 14: Occupation Of Wives

Sr.No.	Wives in Government Hospital			Wives in Private Hospital		
	Occupation	No. of Wives	Percentage %	Occupation	No. of Wives	Percentage %
01	Government Employee	0	-	Government Employee	3	15

02	Skilled Worker	0	-	Skilled Worker	2	10
03	Private Employee	0	-	Private Employee	2	10
04	Teacher	3	15	Teacher	4	20
05	Housewife	17	85	Housewife	9	45
Total		20	100	Total	20	100

The above table shows the percentage values of the occupation of wives interviewed in FGPC, 85% were housewives and 15% were teachers. In Mother care clinic, majority of wives were housewives but other than that a few were employed or earning through skilled labor, teaching and jobs in private organizations. The above table clarifies that 45% were housewives, 20% were teachers in different schools, and 10% were skilled workers, while 15% were government employees. Housewives claimed that their lives are more miserable because they have to deal with family more than their husbands and they have no one around to support them at the time when others are taunting them. Whereas, the working women had their issues that they had to answer people outside their families, but, they also said they feel that they have advantage of spending less time at home. This helps in keeping themselves busy and avoid the feeling of being lonely.

3.2.13. Occupation of Husbands Visiting the Hospitals

Majority of the husbands that were interviewed in the government hospital were educated and were earning hands, a single husband respondent was unemployed, whereas, some were government and private employees. The following table clarifies the job stratification among husbands:

Table 15: Occupation Of Husbands

Sr.No.	Husbands in Government Hospital			Husbands in Private Hospital		
	Occupation	No. of Husbands	Percentage %	Occupation	No. of Husbands	Percentage %
01	Government Employee	9	45	Government Employee	8	40
02	Skilled Worker	0	-	Skilled Worker	1	5

03	Private Employee	2	10	Private Employee	3	15
04	Teacher	2	10	Teacher	3	15
05	Banker	1	5	Banker	0	-
06	Laborer	2	10	Laborer	0	-
07	Business	3	15	Business	5	25
08	Unemployed	1	5	Unemployed	0	-
Total		20	100	Total	20	100

The table shows in percentages of majority of husbands were government employees with 45% of value, 15% were involved in some business, 10% were private employees and 10% were teachers, 5% were bankers, 10% were earning their livelihood through labor, while 5% were unemployed. The respondents interviewed in the Mother care clinic, 40% were government employees, 15% were working in private organizations, 15% were teachers, 25% were running their businesses, 5% were skilled workers, while non was observed unemployed.

The type of employment and the stigmatization of infertility among males was found to be interlinked. As males who were not having a happy married family life were starting having problems in their careers as they are unable to concentrate on their work assignments properly. This relationship was also found to be tense, among males when their colleagues used to ask them about their children or when others share the news about family.

All aspects of life are interlinked with each other. Changes in one factor causes changes in other and sometimes the intensity of one factor depends on the other factors. The relationship between the types of living, other dimensions of individual's life and stigmatization of infertility is observed in the present chapter.

CHAPTER 4

INFERTILITY AND ITS FACTORS

This chapter consists of data regarding the overall experience of infertility shared with the married couples visiting the hospitals. The start of the journey of infertility amongst the couples, their initial experience of planning for baby and treatment strategies were explored, the data collected has been included in this chapter, while the causes of infertility among the male and female respondents have also been made the part of the chapter.

4.1. Planning of a baby

According to the research findings, 90% of the respondents were planning for their babies from the very start of their marriage. In both the government and the private clinic, couples were of the view that they wanted their babies within first year of their marriage. And those who were facing secondary infertility were planning for their second baby after 2-3 years of first baby.

Beyond the scope of planning, it was a common assumption that the couple had attached with themselves and hoped to achieve the conception as soon as possible. After 3-4 months of marriage, a couple has expectation for giving a *good news* to his family, the label of good news; used for pregnancy, while the *bad news* has been labeled with the inability to get pregnant.

4.2. Realization of infertility

A majority of 75% of women felt that after some months of marriage when people started expecting *good news* and getting no positive signs, got frustrated that made them realized that there must be some problem among the couple. While other 25% were those who told that they as a couple realized that there might be some problem which is causing delay and so, they decided to get checked from a doctor.

The respondents consulted the doctor for seeking help to address infertility very early within few months of marriage such as from 2 to 6 months after their marriage. The main reason of consulting the doctor so early was also that the woman partner started having irregular menstruation, while the ovulation was not occurring. Both the husband and wife

were affected when there was no hope of pregnancy and the husband has no answer to his parent's question about a baby.

A similar example was observed in the hospital during the research work by the researcher, Amara a thirty five years old infertile women from Rawalpindi was there in the treatment room, where she was contacted by the researcher to share her views about her infertility, its causes and the perceptions of the family members.
She stated:

> *"After 4 months of her marriage, people started asking about her dates of monthly cycles and they used to gossip with each other near dates. They used to observe me from head to toe during those dates. Every time when they used to ask me and I had no good news for them, people use to give disappointed comments, as if, I am a failure and have to try again to win competition".*

4.3. WHO ADVISED FOR THE TREATMENT

As per the research findings, 90% of the husbands were not advised by others for treatment but the wives were asked to go through a proper checkup. In some cases, wives encouraged the husbands for getting them checked or the mothers motivated the wives for the medical examination and treatment.

For females most of the time, it was either mother or mother-in-law, sisters-in-laws, close friends and husbands used to advised for getting treatment, only 5 of the respondents agreed to getting treatment after realizing fertility issued among them.

People, by continuously asking about the pregnancy and treatment, ultimately were causing a psychological and social damage through pressurizing the couple. As the instructions by the family and friends to seek help in order to have a baby made the couple in-secured for their disability that encouraged them to proceed for treatment. Women being more linked to reproduction were asked and advised more than the man that was the main reason of frustrated and anxiety among them.

4.4. GETTING OF TREATMENT

Most of the couples started their treatment very early even immediately after the marriage after waiting the pregnancy process for a year or so. Due to the curiosity of not

conceiving and answering others, the females usually went to doctors immediately after the feelings that something was wrong with them.

The couples with secondary infertility went for treatment after 2 to 3 years of gap between their first conceptions. And if the first pregnancy was not of a live baby then the couples seek treatment after 6 months of abortion.

The start of treatment and seeking help of some other source began when people started getting more curious about pregnancy. The medical treatment of majority of couples was usually started after one year with the hope of getting the desired results with the blessing of Allah.

4.5. TYPES OF FERTILITY PATIENTS

According to the researcher's observation it was understood that the infertility was of different kinds as Osman (2011)[111] mentioned that there are two types of infertility, one is known as primary infertility in which the female never conceives and the other type is known as the secondary infertility, in which the female conceives once. In secondary infertility it is not necessary that the first conception leads into a live birth, while the duration of non-conceiving should be more than a year of having unprotected intercourse.

Keeping in mind the stratification and ethics of research by having balance in all dimensions among different variables, the respondents were having both types of infertility and were chosen equally from both the locales, 10 of the couples were having female infertility and 10 male infertility from each locale. Among the female infertile cases, 5 were those who were facing primary infertility and other 5 were those who were facing secondary infertility.

Although the cases of secondary infertility were not seen in that much frequency as the cases of primary infertility were found. After the literature reviewed, it was found that most of the researches showed the ratio of secondary infertility more than the primary infertility.

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[111] Osman, A. A. (2011). Management of Infertility within Primary Health Care Program in Sudan. *Asian Journal of Scientific Research 4*(2), 158-164. doi: 10.3923/ajsr.2011.158.164

Table 16: Types Of Infertility Among The Respondents

Sr.No.	Respondents in Government Hospital			Respondents in Private Hospital		
	Types of Infertility	No. of Respondents	Percentage %	Types of Infertility	No. of Respondents	Percentage %
01	Primary	5	25	Primary	5	25
02	Secondary	5	25	Secondary	5	25
03	Male	10	50	Male	10	50
Total		20	100	Total	20	100

4.6. TREATMENT OF PARTNER

In 85% cases, the female partner had to get herself treated first and the male partner is checked, if required. There were very few cases in which males got checked first and that was for their personal satisfaction; to know that whether they are alright or not. Due to one reason or the other, both the partners are advised by doctor to carry out their checkup to clarify the situation.

Among those cases in which females were fertile and male were infertile, the females were the first one who got themselves checked before males. Males were initially reluctant in giving the tests but after seeing that the reports of their wives are normal they agreed for giving their samples.

Riesman, C. K. (2002)[112], observed during the research that the males were not ready to give their samples for tests as they were not ready to allow others to judge their manliness. The females were blamed and forced to get them checked from one place to other to get successful treatment, but in the present research it was investigated that the males were not reluctant rather they agreed upon getting themselves checked to satisfy their wives.

[112] Riessman, C. K. (2002). Positioning gender identity in narratives of infertility: South Indian women's lives in context. In Inhorn, M. C., and Balen, F. Infertility around the globe (152-170). California,U.S.A: University of California Press

Out of the sample, there was just 1 male respondent who was not willing to undergo the medical checkup that was Amjad, a 37 years old man from rural Muzafarabad who came to FGPC told the researcher:

"I know I am a complete man. I don't need to get proves from some laboratory. It is the female who has duty to reproduce which is allotted from Allah. Therefore, as a man I am helping her financially to get treated as I did for my first wife. But now-a-days, females are barren due to their fault."

4.7. Causes of Delay

As Violet Kimani and Joyce Olenja (2001, p203) [113] mentioned in their research that there are different causes of delay in conception. The factors which cause infertility can be various and they vary from person to person and environment to environment. The reasons are different in males and in females due to anatomy.

Among the female respondents, the cause of infertility diagnosed was hormonal issue, other common factor was ovarian cysts, and there were only 3 cases in which the infertility was their family issue.

Table 17: Causes Of Infertility Among Females

Sr. No.	Common Problems	No. of Females	Percentage
01	Harmonal Issues	12	60%
02	Cysts	5	25%
03	In Family	3	15%

Male infertility was found in 20 cases, the reasons of infertility in males were more related to sperms rather than the structural or purely genetic reason, and 10 males were infertile because they were having dead sperms. The movement of sperms in right speed and right direction was required otherwise there was some issue with male fertility, while other 6 were because of low sperm count, as along with the speed and direction, the sperm count was

113 Kimani. M., Olenja. J. (2001). Infertility: Cultural dimensions and impact on women in selected communities in Kenya. *The African Anthropologist, 8*(2), 200-214.

also an important factor to influence the infertility, however, the remaining 6 males were having unknown reasons linked with stress and nutritional imbalance.

Table 18: Causes Of Infertility Among Males

Sr. No.	Common Problems	No. of Males	Percentage
01	Dead Sperms	10	50%
02	Stress and Nutritional Imbalance	4	20%
03	Poor Sperm Count	6	30%

In females there was no stress relating to infertility, though the stress was there as a result of infertility but stress as a cause of infertility was absent. In those males who were having such issues were asked to take break from the work load to focus their healthy life.

Violet Kimani and Joyce Olenja (2001) have also worked upon the issue of infertility. They have also noticed that the main factor that were causing infertility were physiological in both genders. In females it was mostly due to the hormonal issues that shift in the age of puberty and in males it was due to the bad quality of sperms.

4.8. Religion and Infertility

In South Asia, religion plays a vital role in every aspect of life. In the case of infertility, supernatural factors are also believed to be the cause of infertility. In Pakistan religion is supposed to be very important in every field of life. Islam as a religion is considered to be the complete set of beliefs for the solutions for every problem. So people try to find out the solutions of every difficult situation through their religious believes including the cure of infertility.

There were some respondents who had a feeling that some people who are jealous have done some black magic that caused infertility, while majority of them with their other family members believed that, to be blessed with a child is in the hands of Allah.

The couples, especially the women used to pray for His blessing from Allah, recite different *wazeefe*, ask people for *dua*, some consult the *peer* and had faith in *taveez* and *manats*.

Most of the religious practices for the treatment of infertility are performed by the wives because of their religious belief system, having a strong faith that Allah is listening to them and when He will get happy, He will bless them with a child.

All the respondents admitted that they were hopeful from Allah. No matter what the reports declared, it's totally upon Him being the Divine and Ultimate power.

Safia, a thirty three years old lady who was there in the Mother care clinic probably for medical checkup told the researcher:

"My family believes that my infertility is caused by the spell. They feel that the family, who wanted me to get married to their son but I refused, is responsible for this. They have caused bandish. Therefore, they took me to different peer sahib for ilaj."

For infertile women, Islam is a source of relief and also a type of threat that people use against them. In Islam women are given high status because of their ability to give birth. Motherhood is considered to be a way to please Allah and they feel that motherhood will glorify them with Allah's blessings, on the other hand, when they are not capable of having a child, they are threatened in the name of Islam as in Islam, there is a concept of divorce and women are blackmailed on the basis of these factors as Islam.

Most of the women want to have children to have a secure future and to get a more strong status in the family. For male infertility, women don't have choice except to accept it as a natural nuisance.

4.9. Suggestion by the Doctor

Majority of couples are prescribed medication and different tests and are asked to revisit the place afterwards. Among those couple in which females are primarily affected by infertility are given medication and in some cases both are given multi-vitamins, while in case of male infertility, the male is given medication.

Dr. Riffat, Gynecologist from Polyclinic shared that:

"Now a days the rate of infertility is increasing and its increasing in both genders. It is due to lack of fresh vegetables, less exercise, smoking and some bad dietary habits. I recommend the couple to try to change their life styles and adopt a healthy and balanced diet."

Dr. Durdana from Mothercare Clinic was of the view:

"The couple gets a lot of stressed out and stress plays a very vital role conception as it directly affects the health of women and the relationship of husband and wife. The approach of family and perception of society are important as they are the reason that the couple visits us very soon after their marriage as they start getting fearful of being known as an infertile person in the society."

4.10. Home Remedies:

The home remedies were used by the 10 female respondents order to conceive, some used kehwa of Nabi Booti, while some of them used a mixture of jambul leaves with honey for the purpose. The remedies were advised either by mothers or mothers-in-laws being the indigenous method for child bearing inherited by them from their elders having village background.

Amina Bibi was one of them who practiced the herbs for pregnancy; she was interviewed while she was at FGPC for her checkup. She told the researcher:

"Her sister-in-law gave her a herb when she came back from Hajj. My mother-in-law told me that someone told her about the effectiveness of herb as its from Madina and has Islamic reference. So she used to give me kehwa. I used it for two months and still using it."

4.11. Adoption

Other than being pregnant and giving birth to a child, there are different other methods through which one can enjoy a complete family life, one of such method is known as adoption. There are now different centers which are established for orphan and homeless children from where one can adopt a child of his choice, in Islamabad Edhi center was known as most popular and reliable one of the centers.

In the present study it was observed that the adoption was not liked by the couples and their families as a solution of the infertility. The couples and their families wanted a baby but it should be of their own lineage. Adoption would be the last choice according to some minority respondents but majority was against it. According to Arshad, a 35 years old man from Rawalpindi:

"I belong to a Pathan family. And my father is particular about purity of lineage. Adoption is not allowed as the adopted child does not have the same genes of the family plus that can also create problems for the child."

People were hesitating to adopt a child as in our society lineage and its purity are highly respected and the adopted child brings lots of doubts with him, like, doubt regarding family background and the caste. As it is believed that the family background and the genes one child carry matters a lot. Another point that was observed by the researcher that the couples were not ready to adopt a child as it could let people ask other questions about their character in future and the society also stigmatize a child who was not biologically a member of the family.

4.12. SECOND MARRIAGE

Second marriage as an option for having a baby was gaining importance as observed among the respondents. Majority of men and women were against second marriage but there were some cases in which the females were so much frustrated that they were pushing their husbands for second marriage and in very few cases males deliberately wanted second marriage as they used to feel that they could not handle the family pressure and humiliation. A similar case was observed by the researcher during her visits to the government hospital.

Rashida, thirty two years old female from Islamabad was there in the Poly clinic hospital, Islamabad, she told the researcher:

"I am tired of taunts and humiliation. I want my husband to get marry with some other woman. I know his mother will ask him to remarry soon. I don't want him to get tense and leave me. I want to support him. As if it's me who is having a fault in herself. So I should be punished. He has all rights to enjoy his life and have babies. I want to see him happy that's it. Whatever happens to me, I will deal with it."

4.12.1. DESIRE OF SECOND BABY

There were 10 couples who were going through secondary infertility and accepting another child to complete their families. There was no pressure or stigma felt by them but they had the desire to have a baby of a different sex as most of them were having daughters and trying to have a son but were unable to do so. Secondary infertility was found among

women above thirty five and early forties. The desire for having a boy was found amongst the men and women who have been struggling through medication and other indigenous methodologies for the same. A same case was explored in the FGPC.

Sadia a thirty years old secondary infertile woman from Muzafarabad came to the FGPC hospital for her checkup for having another baby.
She stated that:

"We have a daughter. We want a daughter as we live in a nuclear family. We are happy with daughter but the desire for a son is because I feel that when we'll not be in this world who will take care of her. Husband feels that for continuation of family name we should have a son. We want a complete and a happy family."

One of the couples who were facing secondary infertility had no live baby. They aborted their first baby and struggling for a live baby. Samrina a twenty six years old secondary infertile female, from Islamabad at Mother care clinic stated:

"I became pregnant immediately after marriage. My husband went to UK. We were not ready for a child at that time because husband was trying to establish himself. We didn't plan a baby soon so I aborted that baby. Now after one year we are trying to have a baby but it seems that Allah is punishing us for our previous abortion."

4.13. Treatment of Siblings

Most of the couples used to feel that they are not treated equally along with their siblings The infertile couple indulge into complex situation by thinking that if others were caring for them than it must be due to some of their gains, especially the infertile women were of the view that the equal opportunities as compared to other members of the family, reason being the role of their sister-in-laws who had a biased attitude towards them, while the infertile men also do not feel comfortable in the family due to their shortcomings for having no more children to complete their family.

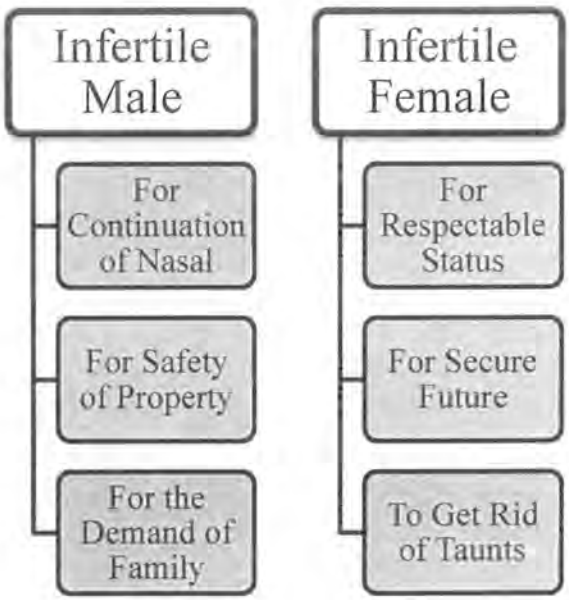
4.14. IMPORTANCE OF A CHILD

Conceiving a baby was the basic goal of every couple but the importance of having a baby was different among them. The frustration and desperation of achieving parenthood varies with the meaning of having a baby in one's life.

For female respondents, majority depicted a baby as a source to make their status strong in the society, while they wanted to get rid of being answerable to everyone, also they wanted to secure their future by having someone of their own to care them in the future. Moreover, there was a stress on them by their husbands to have more children as per their elder's practice. The majority of husbands and their families were requiring the male babies for the continuation of their lineage (*nasal*) and safety of their property.

If the couple don't get any fruitful result from the ongoing treatment, most of them specially the wives wanted to discontinue the treatment they were getting from a specific doctor of clinic and wanted to continue the treatment but with the change of doctor, while some were in favor of remarrying their husbands for having children. Majority of husbands who were infertile were not ready to get more treatment, they felt that they have tried their best by getting treatment and were reluctant for further treatment.

Figure 9: Respondent's View About Importance of Child



Source: Field Data

CHAPTER 5

IMPACT OF INFERTILITY

The respondent couples were shattered and were disappointed when they first came to know about being infertile, but were of the view that the first report was not that much alarming because the infertility was curable. The hopelessness and disappointment gained intensity when despite treatment for months they were unable to conceive.

Out of 30, there were 3 such cases in which females before marriage were slightly conscious about having some issues in conceiving as they were having problem in reproductive system i.e. with cycles and one of them having cysts removed, while two of them told about their physical issues to their husbands and in-laws before marriage as one was expecting love marriage and the other was getting married to her first cousin.

5.1. Psychological Impact

The psychological conditions were affected by infertility and most of the symptoms were same in all cases like the following:

5.1.1. Aggression

Among the female respondents, majority was of the view that they were more clam than before, some were more aggressive and could ant control their temperament. It was observed that the females having more supportive male partners were calm in nature because of having a close interaction with their husbands for having an opportunity to share their problems with them but those who have no one supportive used to have more issues with fluctuation of temperament.

Majority of the husbands responded positively about change in their temperaments that was because of their disability and continued treatments for which they were getting more aggressive. Those males who were calm in house were unable to control temperament in offices and other gathering. They pretend to be calm in home so that their families don't get disturbed.

5.1.2. HABIT OF CRYING AT EVERY ISSUE

With the loss of temperament, the majority of respondents feel that after entering the cycle of being labeled as infertile and getting treatments, there is another issue of loss of control of expression of emotions.

Almost all females told that they felt that they cry more than usual, even at some occasion of happiness they were unable to cheer and felt sad and could not control their tears. Some females told that they were so much disappointed for facing problems due to infertility had no more ability to shed their tears any more.

Male respondents were of the view that they wanted to cry but they could not because crying was not suited to men especially in the presence of their wives weak physical condition.

5.1.3. DEPRESSION

Depression was common in males and females but the intensity was lower among those couples who were facing secondary infertility because of their satisfaction for having a child, while the males were however, not accepting to share their depression with their wives. The wives of such males were stating that males never showed their sadness for having no children, but being their wives, they understood their unhappiness over the situation.

Majority of the males were concerned with their wives depression for being infertile that gets worse when their cycle starts.

Fariba Hassani (2010) also studied the infertile couples and the coping strategies. She also found out that the rate of psychological issues is high among the infertile couples. Depression, anxiety and tension are mostly reported by the infertile people.

5.1.4. LOSS OF APPETITE

Infertile females were having two extremes about appetite, almost half of them said that there was a big change in their dietary pattern and do not feel appetite for eating as much as they used to eat before their marriage, on the other hand there were some females who felt

more hunger that increased their body weight, the change in the diet was the result of their continuous depression, while among the males, the appetite and its changes behaviors were not there and if so, they were not related to infertility rather due to increase in body activity at their work places which used to make them hungry.

5.1.5. Self-Confidence

The infertile couples mentioned that they don't felt confident about themselves any more, while the couples having secondary infertility showed no positive response about the issue for having one baby instead of having none.

The prominent loss of self-confidence was reported among the couples having male infertility issue, they faced more self-confidence issues because their continuous mobility outside the household and facing different kinds of people and their questions.

5.1.6. Tension and anxiety

Tension was another problem among the infertile couple respondents that had bad impacts on their families, the stress and tension was the main cause problems faced by the infertile couples. The tension was more aggravated while interacting with the outside people who were eagerly putting some questions about their siblings.

Social pressure and fear of other social issues made the couple more tense that increased with the prolonged treatment without any positive results, while the day-to-day increasing age was also a problem for them.

5.1.7. Lack of self-interest

Among the respondents, the infertility caused damage in psychological body image of self and the worldview. They also showed same reaction, the infertility has made them to stop thinking about themselves. They don't felt about maintaining them for looking good. Mostly females having such issues, believed that they don't felt good about themselves and were not interested in themselves because their body was not normal. One infertile respondent stated that, *"decorating a body is useless if it's empty from inside."*

Males who were infertile felt that they were not normal, their negative thinking made them more careless towards their health and maintenance, while the male having no infertility were not facing such issues.

Myers, J, P., Giudice, L., Carlson, A. (2005) also mentioned the same issue about the change in the perception about self.

5.1.8. Feeling of loneliness

Tension, depression and all the psychological impacts that were faced by the respondents were due to the increase in feeling of loneliness, the phenomena was more visible among the females because of having no hope for children who could be the best source of support in their old ages. The feeling increased when the infertile couple came across the couples having with them their children and having a complete family.

5.1.9. Frustration

Frustration was another strong impact observed among the infertile couples, who could not achieved their goals in spite of continuous treatment. The female respondents reported that their husbands were more frustrated about having a baby. The frustration among males was the reason of motivating their wives to take necessary measures either through the treatment or home remedies to become pregnant, while the male respondent's view point was that the females were more frustrated and their frustration was the reason that had many other psychological problems for having no children.

5.1.10. Guilt

Guilt was reported by all male and female infertile respondents, they thought that they were the reason for depriving their partners and their families from the blessing of children. It was their personal disability which has made their partners weak and put them to face the social problems, on the other hand the partners of the infertile male/female felt guilt that they were unable to help their partners to make them normal.

Edith Ittner, Wolfgang Himmel & Micheal M. Kochen(1997)[114], Bushra Parveen & Imtiaz Ahmed Dogar, et al., (2008)[115], Christine Dunkel-Schetter and Marci Lobel (1991)[116]

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[114] Ittner, M., Himmel, W., & Kochen, M, M. (1997). Management of involuntary childlessness in general practice-patient's and doctor's views. British Journal of General Practice, 47, 105-106

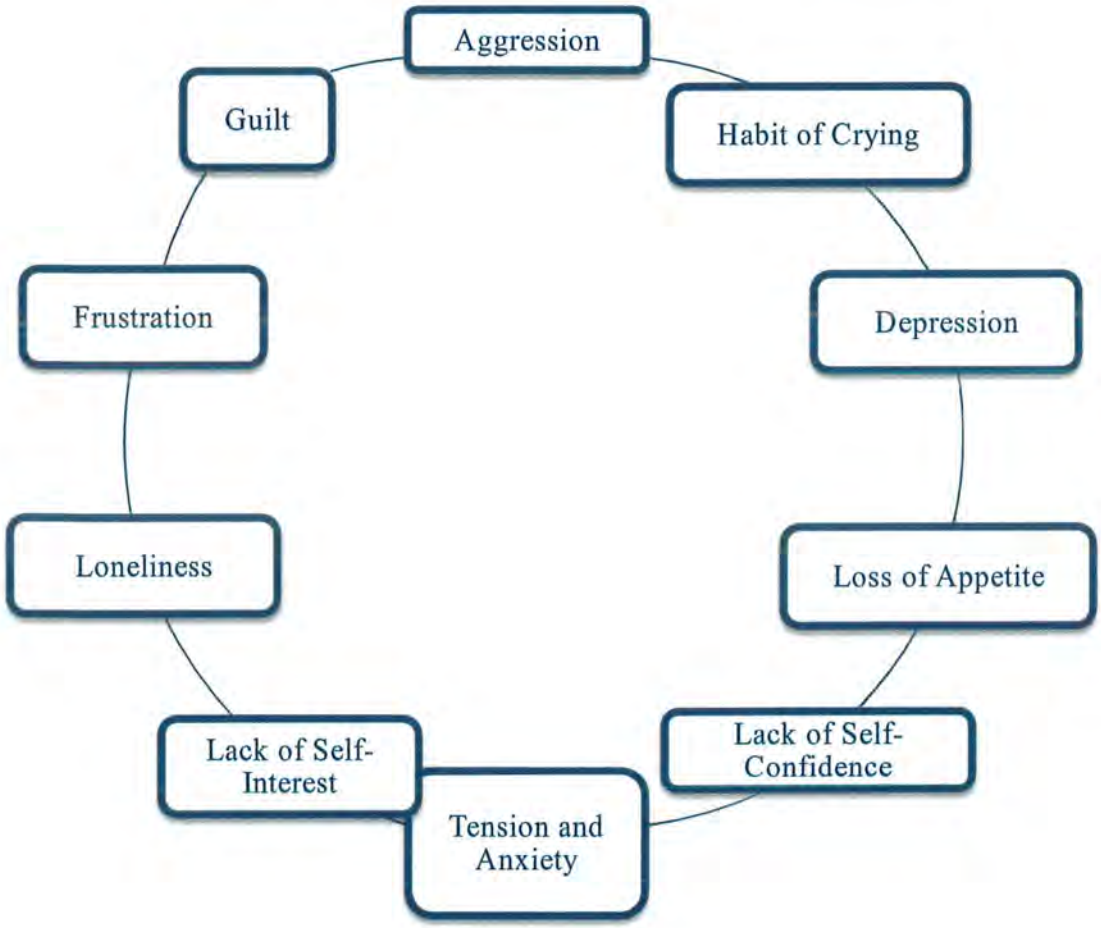
[115] Parveen, B., Dogar, I, A., Kousar, S., Musharaf, S., Masood, A., & Afzal, S. (2008). Psychological Adjustment of Educated and Uneducated Infertile Females of Pakistan, A.P.M.C,2, p108-112

[116] Dunkel-Schetter, C., & Lobel, M. (1991). Psychological reactions to infertility. In Stanton, A., & Dunkel-Schetter, C (Eds.), Infertility perspectives from stress and coping research. (29-57). New York, Plenum

and some more researchers observed the same psychological impacts of infertility on the infertile couple, as found in the present study.

Sarwat Sultana and Azam Tahir (2011, p.242) [117] conducted a research on 200 fertile and 200 infertile couples from different cities of Pakistan. They studied that infertility affects immensely on the psychological well being of both partners and this is mainly due to the societal pressures which create sense of insecurities and lack of self-belief among the couple.

Figure 10: Psychological Impacts of Infertility



Source: Field Data

[117] Sultana, S., & Tahir, A. (2011). Psycholoigal consequences of infertility. *Hellenic Journal of Psychology,8*,229-247

5.2. Reaction to other kids

Most of the couples were comfortable while meeting and playing with other kids. Some husbands complained that their wives get annoyed when they meet the families of friends and relatives completed with kids.

On the other hand majority of wives told that their husbands were very fond of children and whenever they got a chance to play with the kids their joy was remarkable. A similar case was studied in the hospital during the researcher's visit.

Tazeem was a patient of infertility and was under examination at the Mothercare Clinic, the researcher met her in one of her visits. She narrated her feelings being an infertile person having no children.

She argued:

> *"I enjoy with other kids but when my sister-in-law comes with her daughter I feel as I lost. She got married the next day to me, she got pregnant after four months of her marriage and I am still trying hard to become a mother. She never says anything to me but I don't know why I cannot see her playing with her daughter."*

5.3. Feelings while communicating with others

For husbands the communication was not a problem as they told that they usually ignored others so that no one talks about their personal matters. In the family, there were however, some problems with mother and brothers, they had some reservations about their wives, but the intensity was not that much sever. The women were more answerable to their family and other people around them as they were used to communicate with the women relatives about their inability to produce siblings and asking the way out of the situation. Thus with the increased interaction, they were not much comfortable but they had to answer their question in one way or the other.

Feeling of being incomplete makes a person unable to communicate with others. The psychological pressure and tension gets more on nerves while interacting with other people.

The fear of being stigmatized and having negative impression on others makes it difficult to interact comfortably. Lack of confidence occurs with the passage of time which causes problem with the continuous interaction.

Donkor and Sandall (2009) conducted a research in Ghana, to know about the coping strategies that are adopted by infertile women living there. It was concluded by them that male mostly adopt the refusal strategy i.e. they try to avoid the situations and the women cope by either refusal or by making herself immune.

5.4. Psychological Condition Before and After Infertility

The majority of the wives respondents were of the view that infertility has affected them psychologically, while before experiencing infertility they were in a relaxed state of mind but during their treatment of infertility they thought that they were living a better life before their marriage.

The husbands, with the passage of time were getting frustrated even on small issues, they were of the opinion and before their efforts to have a baby their lives smooth and happy but they were trapped in a closed tunnel where there was no light of hope.

The difference between the psychological well-being before and after the knowledge of being infertile shows that it was the fear of stigma and social pressure which caused damage in the psychological condition.

5.5. Persons Around

The respondent wives used to share their feelings openly with their husbands and mothers, but some other family members around them avoiding them because of their reservations for not having children and if they involved in the discussion, the situation gets worse. The sharing of feelings comfortably with the people around them is highlighted in the following table:

Table 19: People Around Wives When They Feel Low

Sr. No.	People	No. of Responses
01	Husband	7
02	Mother	8
03	Friend	2

04	None	3

The respondent husbands were of the opinion that they were unable to share their feelings in the family because of keeping the household atmosphere cool and comfortable because the restlessness and frustration was already there for having no children. They were considered much strong and able to deal with every situation, but if they share their shattered feelings with other family members that would affect their masculine image. Sharing with friends or being alone was the better option according for them. The husbands responded to some of the question raised by the researcher to observe their in-depth feelings that are highlighted in the following table.

Table 20: People Around Husbands When They Feel Low

Sr. No.	People	No. of Responses
01	Wife	3
02	Mother	2
03	Friend	6
04	None	4

5.6. Support from In-Laws

As per social behavior prevailed in the conservative society, the married women were usually not respected and supported by their in-laws that was the primary factor for providing timely treatment to cure the infertility, while the supportive families though were rare but were the source of encouragement for their sons and their daughters-in-laws for dealing with such problems very easily because the social support has always played an important role for facing the social problems, while the non-supportive in-laws families not only aggravated the situation but increased the psychological problems for both husband and wife.

According to the respondent wives who were supported by their in-laws, were happily proceeding further for treatment and hoping to complete their families with the addition of newborns. They were considering them secure, protected and safe from any upcoming damage with the support of their in-laws.

A study will elaborate the hidden feelings of infertile women; the short study was conducted with a female patient in the FGPC.

Zahida 25 year old female from Bari Imam, Islamabad was sitting in the corridor of Polyclinic hospital where she was contacted by the researcher to know about her perceptions about the support of her in-laws.
She stated:

> *"My brother-in-law and father-in-law, live near to my house and used to beat me with shoes. They claim that I have ruined their family and blamed me for causing embarrassment for their brother/son. My mother-in-law used to beat me and she used to taunt me that you act as if you are a woman but you are just a mess who is there to consume my son's wealth and not ready to give him some happiness."*

5.7. PARTNER'S SATISFACTION

The satisfaction from family is important but the support and sense of security provided by one partner to the other plays important role in lives. A majority of the wives respondents and their husbands were supported by each other specifically to deal with the infertility by curing through medicines and other indigenous and religious methods. Some of the respondents were of the view that the support from the husband decreased with the passage of time with the growing hopelessness even by having long treatment and the growing irritation of the family members that was creating a fear of divorce for the innocent women. But the important factor of sexual satisfaction and dissatisfaction from both sides was not mentioned by any of the respondent.

5.8. BEHAVIOR OF PARTNERS

Majority of the respondents told that they were in good relations with their husbands, their behavior was not changed rather they became more caring because of treatment and its related problems, while they supported them for the maintenance of their good relations with the family members and their negative intentions. They made the family and wives to believe on God's will, He was the sole authority to give and take anything but with His own will. But the non-supportive husbands blamed their wives being unable to conceive and supported the ill intentions of their family members that harassed the women and created fears in their minds about the future consequences. In such cases, the wives sustained their relationship

with their husband through one way or the other, but some of them also complained that their husbands sometimes used to say; *"I am going to marry with someone else who is more useful than you."*

A similar case was identified by the researcher when she was on field duty in the Policlinic hospital, Islamabad. Ali a twenty seven years old husband of an infertile woman, came with his wife from Azad Kashmir to consult the specialist doctor for investigating the problem faced by his wife for not conceiving. He shares his views with the researcher about the behavioral aspects.

According to Ali:

> *"I don't allow anyone to comment on my wife. As we had love marriage. My wife told my sister before our marriage about problem in her cycles which was due to ovarian cysts. She told that doctors have warned her that she may be having difficulty in pregnancy. We all knew everything but accepted her. Therefore, I don't allow anyone to speak about her. According to my belief, Aulad Allah Admi ki kismet se deta hai aur barkat aurat ki kismet se. So it is me who should be answerable not her."*

There were male respondents who were having some issues with the behavior of their wives as the infertile women were the source of disrespect in the society that effected the bonding of the couple, while the role of the husbands was not responsible for their disrespect so the change in the wave's behavior was irritating for the husbands. A comparable example was identified by the researcher in the Policlinic hospital, Islamabad during her field work there. Adnan a thirty year's old husband of a fertile woman from Islamabad was on a usual visit to his doctor who narrated his view point and said:

> *"My wife is nature wise very calm but when she gets angry she sometimes unintentionally hurt me with her comments like; If you were not a complete man you shouldn't have agreed to marry me. You have destroyed my life. People blame me but I don't have any fault."*

CHAPTER 6

STIGMATIZATION OF INFERTILITY

This chapter includes data gathered about the stigmatization of infertility and the perception of the people about the couples facing infertility, while the link between stigmatization and other dimensions are included in the text.

6.1. Social Pressure

The respondent couples used to feel pressurized by the society, especially when people asked the couple about having a child. The pressure was created when despite of treatment the report's result were negative. Most wives responded that they were anxious for having a baby because they were in pressure. Even if they were supported by their families, still they felt a severe mental pressure. Husbands feel pressurized as they feel that every time their manhood was challenged if their wives don't conceive.

The social pressure on the couple was caused due to the perception of people and fear of being negatively labeled. A relevant case was identified by the researcher in the Mother care clinic, Islamabad.

Sadia, thirty five year old, infertile woman from Islamabad, met at the clinic who told the researcher that:

> "I was once a daughter, sister and someone's friend. And after getting married I became a wife, a daughter-in-law for just some limited time period. Later on I am just a sick woman who is unable to provide a child to the family who loved me just because I was supposed to give them a baby. I am no one without having my child"

P. Slade, C.O'Neill, A.J. Simpson and H. Lashen (2007) researched about the link between perceived stigma, support and the patterns of communication with infertility. They studied 87 women and 64 men who were new attendees at an infertility clinic and found out that the greater disclosure to people makes increase in the social pressure and this causes psychological trauma and taboo of being labeled.

6.2. NEGATIVE EFFECT

Among the respondent women, the negative effect of being infertile was the insecurity feelings and worry about their future. The men responded that infertility has destroyed the calmness of their families and were worried about the future of their married life. The continuation of *Nasl* was an important issue for the infertile males and their families. Whether infertility was in the male or in female, the major concerns were the same in both cases. A pertinent case was examined in the hospital, the perception of a husband are highlighted in the following lines:

Arif Hussain, twenty nine years old man from Dera Ismail khan, was worried about his wife infertility, who was elder in age married on the family pressure.
He said that:

> *"I got married for the sake of my family and Islam. I am there for her but if after this treatment she won't conceive I am going to leave her and I will go for Jehad because continuation of nasl is also practiced in Islam. And if she is unable to do so I am going to leave her."*

6.3. TIME AT HOME

The respondent wives kept them busy in the household chores, other felt continuous stress and pressure due to boredom and non-supportive family attitude. They wished to bail out of the situation of abuse and violence by virtue of infertility and giving birth to a child to secure their future.

They were used to perform their boring routine by washing clothes, cleaning home, and cooking food, watching television, while those who work felt their routine hectic, they have to work outside the home till evening and after that works at home make them busy.

Majority of males used to have good time at home, the issue for them was when there was some tension going on in between the husband and wife involving other members of family. A applicable example was observed by the researcher in the Mother care clinic.

Irshad Baig, thirty eight year old husband of an infertile wife came from Islamabad said:

"I wish I had never got married. After getting married there is a continuous flow of tensions in my life. And after knowing about the infertility of my wife, everyone at my home tries to hurt her. Whenever I come home there is some fuss created. Now I have started doing over time for the sake of calmness in my life."

6.4. EVENT'S EXPERIENCE

The most of the respondents experienced pressure especially in family gatherings and felt inferior intentionally or unintentionally of their status being infertile. In such events, they used to sit alone silently without any wish of interaction with the relatives women having children. They avoided such events, but the family pressure compelled them to participate were usually ignored or taunted in the one or the other by the women folk related to the in-law's family.

The insulting and avoiding attitude of the participants of events was intolerable and against their ego, therefore they always preferred to avoid such gatherings because of their inability to continue the generation of their in-laws but were not intentional contributors.

The male respondents told that they don't go to events due to their working schedule and those who used to visit have good time except having difficulty in facing the people. An example has been quoted that was pragmatic and relevant to the situation:

Razia, twenty eight years old, from Islamabad was met at FGPC, Islamabad and she shared her views with the researcher.
She told:

"While living in city the social gatherings are not that much difficult as here we don't know much people. But our basically we belong to Talaganag and when we go there for some family occasion everyone asks me about pregnancy and gossip about me.Once there was godh bharai of my husband's cousin. My in-laws and other family members didn't allow me to greet her or sit near her. According to everyone there, if I sit near her, she'll catch my infertility."

Another version of the problem that was explained by a infetile women at the same hospital. Sajda, thirty years old, an infertile woman, from Azad Kashmir to the researcher:

"My mother-in-law didn't allow me to hug my sister-in-law during her pregnancy. So that she is not harmed from me..."

6.5. Asking about the children

The respondent infertile women told that most of the people asked them about their children by looking at their belly, probably having sympathies with them, while the men were usually asked the same question by their relatives and friends having concern with them, but the men were not that much upset for answering the questions and were reluctant to shared their views about their family matters in detail but the women were not comfortable at all because of their inability. Amna was a infertile women met with the researcher during her field work at the hospital. She narrated the problems she faced to answer the questions of relatives.

"People ask me a lot, like, when are you giving us good news?, when we are having sweets?, I saw a dream in which you are having fruits in your arms this means you are pregnant, are you? When they ask me these questions, they make me feel as if everyone is waiting and I am getting late in achieving something."

6.6. Infertility a curse

The infertility was perceived by the majority of women respondents as a difficult problem for them to be repeatedly explained to others, they were of the view that people knowingly were asking the same question time and again just to tease them that was a kind of misbehavior that was un-tolerable for them especially in a formal or informal gathering. Most of the family women were aware of the fact that non-bearing of a child was due to their husband's infertility, but were continuously asking the women to explain that was the sort of insult not only to them but for their husbands and their manhood because of not making their wives pregnant. The fear of being stigmatized and to be left alone was the main reason that infertility was difficult to bear for the couple.

6.7. Stigma

Due to the factors explained above, the infertile couples felt that stigma was there and the society was not transforming according to the changing social customs that do not allow anyone to stigmatize others for the fault not being created by them.

Stigma was a difficult issue to probe into directly, especially when couples were together, however, during individual interviews it was noted that women were facing much worse situation than their spouses, they were marginalized, discredited and treated poorly by the relatives unlike other couples who had successfully born a child. Despite of realizing the fact that the infertility was not intentional, the people were pursuing their agenda to stigmatize the infertile couples. Most of the infertile women realized the infertility as a stigmatizing and shameful attribute for their self-identity and social status being the human beings.

Almost all the respondents were of the opinion that they were stigmatized and ridiculed in their families and in their communities that was not bearable for them, they were forced to consider them as out casted, disrespectful and an unbearable object especially from the husband's family, while prior to the realization of involuntary childlessness; the individual probably identifies him/herself as a normal, conforming member of society. It may be therefore, that social reaction to the disclosure of infertility played a part in the establishment of a stigmatized identity.

6.8. Stigma from the family

The infertile female respondents were mostly worried about the stigmatization by their in-laws family members as the matter of infertility was the most sensitive issue for them. Infertility and perception of people made the infertile couples more sensitive towards all the social issues.

The male infertile respondents feared about stigma more than the females, they thought more about the social consequences whereas males take things in a more introvert way. They feel as if their personality was the main issue for the problems and everyone was labeling them due to that particular issue, the feeling caused more sense of being humiliated

and insecure. Same kinds of findings were observed by S.J.Dyer et al., (2002) [118] during their study work.

6.9. Perception of People

The stigmatization was caused on the basis of perception of people. Psychological impact and the social implications, all aroused due to the continuous pressure of being stigmatized because people do not accept someone who was not able to follow the social norm of society, no matter, if the disability was by nature. A similar instance is quoted to see the general perception about the issue.

Khursheed, mother-in-law of Naila, thirty years old infertile woman from Muzafarabad
She stated:

> *"Its my daughter-in-law who is not interested to produce a child. She is a drama queen. In front of her husband she acts innocent but I know she is a witch and she is not doing her effort. Sometimes I feel she is taking medicines for infertility so that she could tease me."*

6.10. Naming of infertility

It was told by the majority of the infertile women respondents that the infertility was given different names by the society, the labeling was permanent unless the couple gets a baby. The negative labels and connotations were used for stigmatizing the infertile women especially.

Mostly the infertile women were branded as barren and *baanjh,beabaad* and *banjar aurat* in the local term and males were called as *naamard* or sometimes they were abused by people calling them *khusra.*

Therefore, infertility is not just considered as the medical problem. It is more of a social and psychological problem and a threat to the identity of a person having not fault on his/her part.

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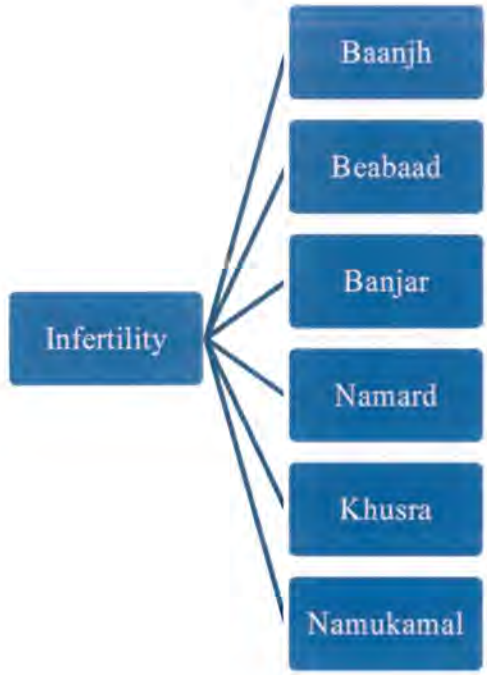
[118] Dyer, S.J., Abrahams, N., Hoffman, M. & van der Spuy, Z.M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction, 17*(6). 1663-1668

Figure 11: Naming of Infertility



6.11. STIGMA AND TYPE OF FAMILY

The difference between the types of family structure and the intensity of stigma was observed during the study. The respondents having a nuclear family were under severe psychological pressure, while social disturbances were more found among those who were having joint family. Those respondents who were living in the nuclear family were found less stressed in normal lives than others. The stress and tension increased when they have to face family members in some social gathering or interact with the families through other mediums like internet, telephone etc.

In Islamabad the family system was very strong, therefore majority lived in the joint families and those who don't lived in a joint family have a very strong bonding with their families that's why the connection and interruption in theirs does not stopped.

6.12. STIGMA AND MALE INFERTILITY

Stigma was also observed among those couples who were facing male infertility, they were more under stress. Male infertile partners remained in stress and the reason for their stress was the fear of being stigmatized as an incomplete man. Females who were having male infertile partners were worried and stigmatized and equally blamed for infertility. Male infertility factors were less recognized because the people without asking assumed that the fault must be in the females for not having a baby.

6.13. SELF-STIGMATIZATION

The stigma of infertility was more self-created among the infertile respondent couples as Forsythe, S. (2009)[119], mentioned that the stigma of infertility is a type of stigma which is more felt by the individual. People can hide their fear of being stigmatized and can limit their personal information to one extent so that no one else talks or labels them accordingly. The infertility is a issue which brings a sense of insecurity and the lack of confidence to the individual. The feeling and guilt of being infertile is the main reason that the individual feels threatened to infertility and being labeled as a different and unlike individual of the society. Susan Forsythe (2009)[120] also mentioned about Greil and his work in which he proposed the same dimension of the stigma of infertility; he called the stigma of infertility as the "hidden stigma".

Majority of women reported that they used to feel a sense of being stigmatized within them as they had an incomplete family and were the cause of disturbance in the lives of their husbands.

6.14. HIDING OF TREATMENT

The fear of being labeled as an infertile and abnormal, the couples avoided describing about their getting a treatment. Husbands mentioned that they don't have any issue while telling other people that they were having treatment but majority of them used to tell others that their wives were getting treatment., while the females were reluctant to answer the

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[119] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. Journal of the Manitoba Anthropology Students' Association, 28, 22-36

[120] Forsythe, S. (2009). Social stigma and the medicalisation of infertility. *Journal of the Manitoba Anthropology Students' Association, 28*, 22-36

repeated questions by others, they told simply about being treated by doctors and hoping for a successful result.

6.15. Stigma and urban surrounding

Stigma was thought to be more among those who lived in rural setting. The previous researches done were mostly in the rural settings and were focused on the women related issues. Through the present study, it was found out that stigma prevailed among those who lived in the urban areas. Although the intensity and expression was different for those who lived or belonged to some rural background, 70% of the respondents believed that the stigma was present in the society but the people don't admit it and expressed their narrow mindedness in a hidden way, while 30% believed that the people and their mind sets were the same. It was mentioned that the socialization and the thought process of society remained the same that caused labeling and discrimination among the infertile couples and their families. Stigmatization was there since past many decades and it was hoped to be prevailed in future too.

CHAPTER 7

SUMMARY AND CONCLUSION

The human society is continuously in the process of evolution based on the rules of nature which allows an individual to live for a specific time limit in the world and to arrive in the world on a specific time. The whole system of birth and death is important for society to be functional.

The current research has explored the factors that contributed towards the infertility, according to the research findings, the causes of infertility were different among males and females, while the social implications faced by the infertile couples were also studied. The main objectives of the study were to closely examine the stigmatization present among the infertile couples to understand the psychological impact of infertility on the affected couples in terms of their marital relationship.

The present study on *stigmatization among infertile couples* in the government hospital and private clinic was a modest contribution to the existed anthropological literature as the study enhanced general understanding about the types of perception people had about the infertile couples. Through the dynamic findings of the current, it will help in understanding the reasons behind infertility along with types of complications faced by the couples, while the impact of medical issues on the social, psychological and personal life of the couples was the main core of the study. It was explored that why people felt the importance of a child and why they were seeking treatments for it. The importance of a child was observed in both the couples and their family members, but the reason of importance was different among them, females wanted child for their protection and males and the in-laws of females wanted a child for the continuation of their generation. This research will be a step forward to be used to generate basic framework for undertaking multi-facility larger studies and even some comparative analysis for future studies

Anthropology is open to both qualitative and quantitative research methodology in order to study the specific research topic in detail. Anthropologist must be having a number of tools through which he/she could collect as much data as possible. As in anthropology triangulation makes the work much reliable and verifiable therefore, by using different means of data collection, one gets a strong base for analysis. During the field work, the researcher used anthropological research methods to facilitate the research study and to help her for

collecting the in-depth information regarding her field of inquiry including Rapport building, Key informant, Non-participant observation, Case study, Informal discussion and Interview guide.

The study was conducted in the capital city of Pakistan, Islamabad, where two locales were selected for research in order to study variety of people and to study the relationship of their differences and stigma attached. The one locale was the Federal Government Polyclinic (FGPC) Hospital and other was the Mothercare clinic, Islamabad.

The Federal Government Polyclinic (PGMI) Hospital, Islamabad was an oldest hospital of Islamabad having different wards and different specialists' doctors. The gynae ward was located at the link road in front of G.P.O, melody market. There were two receptions where the staff noted the details about each patient. After the registration at the receptions, patients moved toward the passage of ward and the corridors that were used as the waiting areas for the patients. After the patients were called by the doctor's assistant, they moved to the doctor's room for their checkup. Three units of Gynae & Observation headed by the surgeons were functioning with nurses and paramedics for providing 3 days antenatal services and three days gynecological and obstetric consultations, including OPD diagnosis and therapy of infertility cases. The days fixed for the checkup were from Wednesday to Friday, while working hours were from 9:00 am to 2:00pm.

The Mother care clinic was located in G-7 sector, in the Sitara market established for the checkups by the gynecologist and obstetrician Dr. Durdana Kazmi for six days a week, while Sunday was off being the closed holiday. The timings of the clinic were from 4 pm till 9 pm. There were three basic rooms in the clinic, one was a hall divided for different purpose, in one corner, there was a reception and on the other side, there was attached toilet. Other room was used as waiting room for the ladies decorated with sufficient amount of chairs, while the side room was the male's waiting room provided with plastic chairs. In between the waiting rooms, there was another room used as the main room for examination adorned with a table for the doctor and a bed for the patients, while an ultrasound machine was placed along with the table used to examine the patients.

The sample size was selected through the method of stratified random sampling for the research that was 40 infertile couples comprising of 20 infertile couples from the government hospital and 20 from the Mother care clinic and 20 couples of male infertility

and 20 of female infertility, while 10 male infertile and 10 female infertile were selected from each locale.

FGPC and Mothercare clinic were located in Islamabad, visited not only by the Islamabad residents, but from all over the country but the majority of patients was observed came from Rawalpindi, Lahore, Peshawar, Muzafarabad, Taxila, Azad Kashmir and Dera Ismail Khan belonged to different caste groups like Rajpoots, Syeds and Malik Awan.

In the government sector most of the respondents were from lower socio-economic status and in private clinic majority was of those who belong to middle, middle upper and middle lower classes. But the responses and the consequences faced by all of them were same. There was no linked found between the status and the impact of infertility.

The difference was observed between the impact of infertility among those who were living in nuclear family system and those who were living in a joint family system. Majority of respondents were living in a joint family that was causing more consequences in their lives as they have to face family more than those who lived alone. In the joint families mothers-in-laws, sisters-in-laws and wives of brother-in-laws were considered to be the problem creators for the infertile wives who faced taunts and abusive language most frequently, on the other hand, those couples who got supportive families were protected. The couples lived in nuclear families also had issues with non-supportive family members but the intensity was different because they could faced frequent taunts and stigma from the mother-in-laws and sister-in-laws on daily basis. But among those couples, who lived in a nuclear family but has lots of interaction with other family members faced almost similar consequences to those who lived in joint families.

In Islamabad, most of the marriages were arranged within the family and caste by the parents, while the love marriages were practiced on very low scale, only 4 couples having love marriage were observed by the researcher during the course of field work. According to the doctors, the inter marriage concept could be one of the main reasons of infertility, as the cousin marriages in consecutive generations made medically a more risky combination. The infertility was found to be running in family of 3 female respondents; according to one of them the infertility was not present in immediate family but was in second cousins, while others had infertile cases in their immediate family.

Two different locales allowed to interview people of different backgrounds, socio-economic status and different education levels. In the government hospital, the majority of

respondents were females but both male and females were having education of intermediate level, while in the Mother care clinic most of the respondents were either graduated or post-graduates. The difference in their socio-cultural status was clearly observed, the respondents of the clinic were most qualified with a better social background than the government hospital. Among the respondents, the variation of education was caused the variation in their occupations, according to the data, most of the women were housewives, while few were working women but the number of working women was greater than the government hospital. As far as the male occupation was concerned, almost all of them were employed in both the cases.

As per earlier researches the majority of the couples faced secondary infertility in Pakistan but in both the locales, it was difficult to mark out the secondary infertile couples as there was more case of primary infertility, while the tracing out the male infertile couples was also not easily because the people were reluctant to disclose the male infertility. The identification of such couples was marked out with the help of doctors, their medical reports and by using different techniques like probing, in-depth interviews and regular interaction with them.

Most of the couples faced primary infertility were not of a very old age, they were young and started their treatment after a year of their marriage. They were young and started treatment after 1 or more year after their marriage but the people with secondary infertility were found to be of slightly more age.

Majority of females were advised for treatments from their mother-in-laws and mothers but the male attention was not drawn by any of the family member. In spite of the advices by others non- conceiving a married woman was the indication that there was something wrong with any one of the partners.

The factors which caused infertility in men and women were also explored during the research work in Islamabad. According to the research findings, most of females were having issues with hormonal imbalance and ovarian cysts, while 10 of the males were infertile because they were having dead sperms and the movement of sperms in right speed and right direction was missing that was required to get their wives pregnant. The other 6 were because of low sperm count because with the speed and direction, the sperm count was also an important factor, while the remaining 6 males were having unknown reasons linked with

stress and nutritional imbalance which were not found in the females but were advised by the doctors to take care of their diets and to keep them relaxed.

In Pakistan, people believed in religion in every aspect of life, the infertile couples have importance of religion in different manners, even if they are disappointed from medical help still they are not hopeless from Allah, they ask Allah to bless them with children, females feel threatened as Islam permitted man for polygyny and divorce, the family takes females for different religious practices to the religious practitioners to help them to get rid of the infertility caused by the supernatural forces which can be treated only through prayers and other religious rituals.

Some of the females of both the locales in Islamabad were practicing different home remedies with spiritual practices to end their infertility and to end the infertility among their husbands, the women were taking help from the religious practices by reciting Quranic verses, taking of *tavees* from the religious healers.

The second marriage was also least liked by the majority respondents, most of the females were afraid of their husband's second marriage that might end their married life, the feelings were more observed among the less educated women interviewed at FGPC. Adoption was slightly acceptable for infertile females but most of the males were reluctant to adopt a child which was not their own blood and their pure *nasl* would not be continued. The second marriage was also not liked by most of the males, while females felt threatened of their husband's second marriage, while a minority of the males was observed interested for availing second marriage opportunity to prove them perfect.

The desire of second child was found among the couples having secondary infertility. Most of them were those who were having son as first baby and were wishful to have a daughter to complete their families, while some of them were struggling for having a baby boy for the continuation of their lineage and providing protection to their daughters. The psychological pressure was found among all the respondents who were going through infertility, aggression, habit of crying, depression, loss of appetite, lack of self-confidence, tension, anxiety, lack of self-interest, feelings of being lonely, frustration and guilt was found among all. The level of aggression was found more in the males and female infertile respondents were going through sever trauma, tension, depression, loss of control on emotions but lack of self-confidence and self-interest was found among both males and females. The level of these consequences was found to be low among those couples who

were having secondary infertility; they were slightly satisfied from others. All the psychological implications were found among all the respondents of both the locales.

Among the respondents, a majority of the husbands was observed supportive for getting treatment to their wives after going through their examination, while one of the male respondents was not ready for checkup as he believed that it was the issue of manhood and self-esteem. Emotional and financial support was the most important requirement for the infertile females that was provided by their husbands or by their families.

The social implication and psychological consequences were getting momentum with the passage of time because of the social pressure and fear of being stigmatized. All couples reported that they were keen for the treatment more because they feel that there was a continuous social pressure on them.

Negative effects of being infertile were different for both the partners, the fear of losing husband, loosing status in the family, not being recognized and left alone were the main worries for infertile females. They believed that the most negative effect of infertility was to be at a weaker end and to keep on listening to taunts and be stigmatized. For the infertile males, the most important negative impact of infertility was the loss of family name and to be a center for everyone to taunt. The negative impacts were observed the same among the respondents of both the locales.

The stigma of being infertile was found among most of the females, according to them the people do not wanted them to see in gatherings, particularly the majority of the infertile females who have in-laws in some rural areas were stigmatized. Everyone at gathering acts as if infertility could spread though their presence in the gathering. Male respondents didn't show any such feeling that they felt isolated in family gatherings, but some of them mentioned that they avoided gathering not to allow anyone to interact with them on the children issues.

The stigma of infertility was found more among the females than the males because females were more often asked about the "*good news*" than the males.

Infertile men claimed that they felt being more stigmatized but less expressive, the reason the tradition to make a female responsible for infertility but with the passage of time, things have been changed and everyone knew that it could be both male and females. To avoid stigma, man used to hide about their infertility but majority felt that they could hide it when their friends and family started pressurizing them to remarry.

Stigma was caused by the negative perception of what people felt about the infertile couples, naming them with abusive names and taunting them caused social and psychological problem, the stigma was observed in both males and females. There was no link established between the education level, socio-economic status and being stigmatized. The social and psychological sufferings were the same but a couple having once child and facing secondary infertility had the threat of being infertile gradually.

The anthropological inquiry undertaken by the researcher was fully successful in achieving its objectives and paving ways for the better understanding of the stigmatization and perception of people about infertile couples and also exploring the psychological and social consequences of infertility in Islamabad and particular in Pakistan, however, a larger multi-dimensional center for future studies is required for which the study will contribute and prove its worth as a milestone.

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GLOSSARY

S.No.	Words	Meanings
01	**Admi**	Man
02	**Aulad**	Children
03	**Aurat**	Woman
04	**Baanjh**	Infertile
05	**Bandish**	To cause spell
06	**Banjar**	Infertile
07	**Barkat**	To be blessed
08	**Beabaad**	Barren, infertile
09	**Dua**	To pray for the betterment
10	**Ilaj**	Treatment
11	**Kahwa**	Type of tea without milk
12	**Khusra**	Third gender
13	**Kismet**	Fortune
14	**Manat**	Votive
15	**Namard**	Not to be a complete man
16	**Nasl**	Generation
17	**Peer**	Religious practitioner
18	**Taveez**	Amulet, wear a charm or talisman
19	**Wazeefe**	Incantation or recital, the Quranic verses prescribed for treatment as a prayer.

Annexure

Interview Guide

Topic: Stigmatization of Infertility

The objectives of my research are:

- To know about the stigmatization of the infertility amongst infertile couple
- To explore the psychological consequences of infertility
- To describe the factors leading to infertility
- To observe the effects of infertility on social life of couple specially on their matrimonial and family relations

Biographical Data:

1. Name:: 2. Gender: 3. Age:
4. Married to: 5. Family Type:
6. Type of Marriage:
7. Caste:
8. Education:
9. Profession: 10.. Working Status of Spouse
11. Residence:
12. Head of Household:
13. What do you regard your socio-economic status to be within your current living environment:
    - Lower Class
    - Middle Class
    - Upper Class
    - Other:
14. Number of your siblings:
15. Number of your partner's siblings:

16. Number of children your siblings have:

17. Number of children your partner's siblings have:

18. How long you have been married:

19. When you started treatment:

20. Your next appointment is on:

About Infertility:

1. If you had been using contraception, how long has it now been that you had stopped using contraception:
2. When you started to plan about having a baby
3. When you first thought that you or your partner is having some issue with fertility
4. When you first thought to get treated
5. Is your partner also getting treated? If yes than where?
6. You started treatment first or your partner?
7. Who advised you for the treatment
8. What was your/ your partner's first treatment received
9. Have you ever thought about adopting a child/ childless living or someother option
10. Is anyone else in your family or your partner's facing infertility
11. Are other siblings who have kids treated differently from you?
12. What would be the next step if you don't get fruitful result from here

Psychological Consequences:

13. How you felt when you first realized that you have fertility problem
14. How do you feel to spend time with people who have kids
15. What difference you feel in your psychological conditions before and after establishing infertility
16. How do you feel when other people ask you about your kids
17. Are you comfortable in telling that infertility primarily affected you, or do you tell people this about your partner

Perceived Factors Leading to Infertility:

18. What is the real cause of delay in conception in your opinion?
19. What the doctors are suggesting?
20. What do you feel, who is more responsible in fertility, a male partner or female? Why?
21. Reasons on delay, present in you:
22. Reasons of delay present in your partner:
23. Are you getting treatment from other place too?
24. Have you ever tried some home remedies?
25. Have you ever tried some spiritual source of healing?
26. In family n friends, who suggests you more for the treatment and what they suggest
27. Who suggests your partner more for treatment and what they suggest

Stigmatization for Affected

28. Do you feel family and friends treat you differently
29. How you spend time at home
30. Is it a good time that you spend there
31. How you feel in family get together and other events
32. Do you or others compare you with other people who have kids and how
33. How oftenly people ask you about child
34. How do you feel when they ask you
35. Why do you feel a child is necessary for you
36. Why do you feel infertility is difficult to bear
37. How people behave with you
38. Do you find any difference in treatment by your family
39. What is the greatest challenge you are facing due to infertility
40. Why do you think infertility is a stigma

41. What frightens you most regarding your childlessness

42. What was the worst comment you heard from someone about this issue

Effects on the Social Life

43. Who is the person who is around you when you need someone

44. What are the negative effects of having no baby

45. Your family and in-laws support you?

46. What do you feel why your family wants you to conceive

47. Overall, what impact, if any, did this experience have on your life

48. What was the reaction of your family towards childlessness

49. Did family/community pressure have anything to do with your desire to have child

50. How your partner behaves with you

51. You can freely express your true feelings to your partner?

52. What do you think, how infertility affected your marital life

53. Do you think your partner is satisfied from you

54. Ever your partner made some comments that put you down?

55. How important is a child for your partner

56. Ever any other person made some comments that put you down