INTRODUCTION

“Bringing a New Life in to the world is one of the most joyful human experiences”

1.1 WOMEN’S HEALTH

Women’s health involves women’s physical, emotional, social, cultural, political, economic and spiritual well being. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by that women herself to her full potential. The determinants of women’s health begin even before birth, their effects accumulating from one age and stage of development to the next. Some stages of development confer a biological advantage to woman, such as the greater survival rate of girls at birth and during infancy. Other stages are associated with biologically based differences that confer serious disadvantages. Thus, woman bears the greatest biological burden of reproductive health problems, Gender compounds the burden of disease at all stages of life span (World Health Organizations, 2000).

Women have the right to the enjoyment of the highest standard of physical and mental health. The enjoyment of this right is vital to their life and well being, and their ability to participate in all areas of private and public life. A major barrier for women to the achievement of the highest attainable standard of health is inequality both between men and women and among women in different geographical, social classes and indigenous and ethnic groups (Report of Third World Conference on Women in Nairobi, 1985).
Women’s health was the most controversial section debated in the platform for Action of the Fourth World conference on Women in Beijing in 1995. The controversy centred on the acceptability of sexuality and reproductive rights. Sexuality and reproduction is a critical aspect of women’s health and women’s empowerment. If women are not in control of their own bodies, through exercising the right to decide whether and when to have sexual relation and children, then taking charge of other aspects of life such as health care, education, work and politics become difficult.

It should be clearly understood that women’s health starts with her birth, truly speaking from the moment of conception and continues till death. A woman is more than a means of human reproduction and her body and mind is comprised of not only a reproductive system. A woman is complete individual with her own independent identity. Reproductive health is only a part of woman’s total health.

Women’s health is particularly susceptible to reproductive problems. The focus is on “Special Sexual and Reproductive Needs” and attention on “life cycles” instead of “experiences” thus, there is danger of privileging the sexual and biological definition of women. Women’s special needs in health arrives out of particular contexts of gender, race and economic inequality.
Rights of Women

- The right to life.
- The right to liberty and security.
- The right to equal protection under the law.
- The right to highest attainable standard of physical and mental health.
- The right to just and favourable conditions of work.
- The right not to be subjected torture, or other cruel, inhuman degrading treatment or punishment.
- The right to equality.
- The right to be free from all forms of discrimination.

(Convention on Declaration of Elimination of All forms of Violence Against Woman, 1993).

Women’s mental health is increasingly recognized as a major public health concern with impact on the well being of individuals, families and society. It is also recognized that this field is in infancy calling for more research and development of policies. An enhanced gender sensitivity in all walks of life will certainly set a better future for the mental health of the women.

1.2 REPRODUCTIVE HEALTH

It is a fundamental aspect of women’s health and is widely considered as one of the main public health priority areas in developing countries. The current focus on reproductive health
marks the need to reorient the programme priorities to focus more holistically on reproductive health needs, and on women based services that means services that respond to woman’s health needs in ways which are sensitive to the socio-cultural constraints, that women and adolescent girls face in acquiring services and expressing health needs.

It is recognized that reproductive health is a crucial part of general health and is central to human development. It affects everybody, It involves intimate and highly valued aspects of life. Not only is it a reflection of health in infancy, childhood and adolescence, it also sets the stage for health beyond the reproductive years for both women and men and has pronounced affects from one generation to another. Reproductive rights are essential to women’s advancement (National Institute of Rural Development Report 2007).

The current focus on reproductive health needs a global recognition which had been largely neglected and that the consequences have been profound, particularly for women.

The existing population programmes have been too narrowly focused on reducing the growth of population, through the provision of family planning services in India, to achieve demographic targets by increasing contraceptive prevalence and notably female sterilization and have been unresponsive to other reproductive health needs.
Reproductive Health Rights

- A satisfying and safe sex life free from the fear of disease, free from concern and violence.

- The capacity to reproduce, and the freedom to decide if, when and how often, to do so; that is, access to both infertility services on the one hand and contraceptive services on the other.

- Reproductive choice for women and men that people have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice.

- Access to safe and affordable abortion facilities.

- Access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide for a healthy infant.

- Access to services for the prevention and care of reproductive health problems, both gynecological and obstetric; in a culturally sensitive manner.

- Special attention to adolescents whose reproductive health needs have been particularly overlooked, where less importance was given in food and health care services in rural areas.

In spite of efforts made by the Government and Non Governmental Organizations on Women’s reproductive health in India, the condition is still poor. The information on women’s reproductive health in India continues to be incomplete and patchy.
(Jejeebhoy, 1995). As expected, the most comprehensive data are available on one aspect of reproductive health, that is, contraceptive use patterns. In contrast, there is almost no information available on the prevalence of reproductive tract infections, abortion related morbidity, and infertility.

Little is known about the levels, patterns, determinants or consequences of infertility in India. Evidence from (Ministry of Health and Family Welfare, 1990) a village level study in Maharashtra (Bang et al, 1989) suggests that infertility may be in the range of 6-7 percent.

Factors underlying infertility include, women’s poor health and nutritional status which can lead to repeated miscarriages and foetal wastage, unhygienic obstetric and abortion procedures, sexually transmitted diseases and tuberculosis.

Infertility can have serious consequences for female well-being in a culture which prizes reproduction, preventing her from achieving her desired family size, and exposing her to various kinds of emotional harassment or marital disharmony. The health services are rarely comprehensive enough to provide access to reliable information, sympathetic counseling and services to infertile couples. What is required is a sound referral system for infertile couples, along with primary health care, which can provide basic information and counseling.
1.3  TRENDS IN FERTILITY

The meaning of fertility is actual bearing of children. A woman’s reproductive period is roughly from 15 to 45 years for a period of 30 years. Information on fertility in India indicates that an average woman gives birth to an average of six or seven children if her married life is uninterrupted.

Fertility depends upon several factors. The higher fertility in India is attributed to universality of marriage, lower age at marriage, low level of literacy, poor level of living, limited use of contraceptives and traditional ways of life. Research indicates that the level of fertility in India is beginning to decline. The crude birth rate which was about 49 per thousand populations during 1990 has declined to about 31.3 per thousand population in 1999, and 25 per thousand populations in 2002. There are considerable inter-state variations in fertility trends. It is significant that at least ten states/Union Territories have achieved net replacement levels.
### Table No.1.1

**Total Fertility Rate for Major States in India-2006**

<table>
<thead>
<tr>
<th>States</th>
<th>Total Fertility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uttar Pradesh</td>
<td>5.8</td>
</tr>
<tr>
<td>Bihar</td>
<td>5.1</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>4.6</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>5.0</td>
</tr>
<tr>
<td>Haryana</td>
<td>4.7</td>
</tr>
<tr>
<td>Assam</td>
<td>5.0</td>
</tr>
<tr>
<td>Gujarat</td>
<td>4.1</td>
</tr>
<tr>
<td>Orissa</td>
<td>4.4</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>4.6</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>3.7</td>
</tr>
<tr>
<td>Punjab</td>
<td>4.2</td>
</tr>
<tr>
<td>West Bengal</td>
<td>3.5</td>
</tr>
<tr>
<td>Karnataka</td>
<td>4.0</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>3.4</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>3.6</td>
</tr>
<tr>
<td>Kerala</td>
<td>3.8</td>
</tr>
</tbody>
</table>

**Source:** Ministry of Health and Family Welfare Annual Report-2006

The poor reproductive health situation in India and particularly that of Indian women argues convincingly for a broad reproductive health program and a woman – centered orientation, with emphasis on voluntarism and informed choice.
Strategies must recognize that underlying women’s reproductive health is their lack of autonomy and in-egalitarian gender relations. Strategies and programmes to empower women in terms of control of economic resources in terms of information and education, in terms of their rights, as well as in terms of the self-confidence and ability to recognize, articulate and seek care for health problems are necessary conditions enabling the enhancement of women’s health and rights.

Parenthood is undeniably one of the most universally desired goals in adulthood, and most people have life plans that include children. However, not all couples who desire a pregnancy will achieve one spontaneously and a portion of couples will need medical help to resolve underlying fertility problems.

Infertility has been recognized as public health issue world wide by the World Health Organization (WHO). In the opening lecture of a WHO international meeting, Dr Mahmood Fathalla focused on accessibility as a key millennium challenge for those involved in the delivery of infertility treatment and assisted reproduction. (Vayena et al., 2001).

The desire to have children is virtually universal; the right to reproduce is recognized by the Supreme Court as a basic civil right. Whether driven by biology, emotional needs or societal pressures, at some point in their lives most adults seek to have a child, generally taking it for granted that they will be able to do so, by the usual biological route when ever they choose. (Jacky Boivin 2010).
For women, pregnancy and motherhood are developmental milestones that are highly emphasized by our culture. Living as an involuntarily childless woman is challenging for feminity and female role. Even within modern definitions of feminity and womanhood, having children is very much the norm.

Infertility or the inability to conceive a child, is a condition which affects millions of people all over the world each year and has a profound impact on the persons self-esteem, personal relationships, sense of purpose – not to mention health and pocket. It is a complex life crisis which evokes many feelings.

1.4 HISTORICAL ASPECTS

The problem of infertility is as old as civilization itself, religious, cultural and social values all glorified fertility and a childless marriage has been considered a great misfortune for centuries.

Before modern treatment, different agents from animals for example horse’s milk was used to promote fertility. According to legend, certain animals were used to transfer magic power to a woman to enable her to bear a child. Customs of similar nature or still prevalent in some parts of India. The Myths were dispersed when Loevenhock identified the Sperm in 1678 using a Microscope and De Graat discovered ovulation in the same century. In 1827 Van Baer discovered the ovarian follicle. Intense research in reproductive biology has resulted in greater opportunities to solve fertility problems using modern techniques.
Traditionally infertility has been regarded as a women’s problem and woman alone was blamed for childlessness. Only in the last 20-30 years men have been included in the infertility testing.

In any society and religion, the ultimate aim is perpetuation of the race. Thus, the foremost and the most important role of the human being is that of procreator (Kumari, 1988), Childlessness, which contradicts normative standards and cultural expectations is condemned. Forced childlessness, widely known as Infertility is considered as a curse, and it is a devastating experience for the couple, especially to women who has to bear the brunt of the society. In India, women are symbolized as the image of procreation. Motherhood is considered as a source of power and status of women that determines the strength of her marital bonds. Infertility is viewed as a deviance from the cultural norms and renders the woman helpless. It also provides a ground for divorce (Sayeed, 2000).

1.5 DEFINITIONS

Infertility is a product of the biological and environmental factors. World Health Organizations (W.H.O. 1991) defined primary infertility as the percentage of never pregnant women exposed to the risk of pregnancy for the last two years without conceiving and secondary infertility as one where a couple previously conceived, but was unable to conceive subsequently despite cohabitation and exposure to pregnancy for a period of two or more years.
An extended definition of infertility includes women who can conceive but cannot carry a pregnancy to the full term; that is women who suffer repeated or habitual abortions.

1.6 Magnitude of the Problem

Infertility is a global health issue, affecting approximately 8-10 percent of couples worldwide. In some societies of sub-Saharan Africa (known as the infertility belt) one third of all couples are unable to conceive during their reproductive lives. The 1981 census of India estimated infertility to be in the range of 4-6 percent. A global review of infertility from the World Fertility Survey and others estimated similar rates of infertility in other cities in South Asia. Infertility is not merely a health problem; it is also a matter of social injustice and inequality (Kumar 2010).

India accounts for nearly to 5 to 10 million of infertile couples and this number is constantly rising at the rate of 5 percent every two years (Nagaraj, 2000). WHO epidemiological studies (2000) quoted the prevalence rates for infertility in India as 3% in primary and 8% in Secondary infertility. The study further explained that, globally poor countries have higher rates of infertility rates than wealthy countries. The highest infertility rates up to 50 percent are found in some countries of sub-Saharan Africa (Doyal, 1991).

It is estimated that only 5% of the world’s coupled population chooses not to have children (Daniluk, 1988), therefore child bearing is a significant, normative social role for women and men across
cultures, when one considers how much more closely female identity is tied to motherhood it becomes apparent that the inability to have a child presents as a crisis in more women’s life.

Centre for Disease Control, USA Survey states that approximately 6.1 million women in USA between ages of 15-45 years are with impaired ability to have children. Further more one in six couples experience problems with fertility in terms of both conceiving child and carrying a viable pregnancy to term (Libson, Myers 2000).

Infertility has been relatively neglected both as a health problem and as a subject for Social Science research in South Asia, as in the developing world more generally, the general thrust of both programmes and research has been on the correlates of high fertility and its regulation, rather than understanding the context of infertility, its causes and consequence.

It is estimated that globally infertility affects between 50-80 millions couples at some point in their reproductive lives, and has a variety of biological and behavioral determinants (UNFPA 1999).

Prevention and appropriate treatment of infertility has been included in the International Council for Population Development Programme of Action as a reproductive health care component all countries should strive to make accessible through the primary health care system. The overall objective is to improve the quality of life of individuals and help them achieve their reproductive goals. In
India, since child bearing is highly valued, and childlessness can have devastating consequences for women, infertility is perceived as a very serious problem. Also the psychological and social consequences of infertility cannot be ignored and should be addressed, keeping in mind its stage of development and the realities of resources availability. (National Consultation on Infertility Prevention & Management, New Delhi, 1999).

It is estimated that between 15 to 20 percent couples in India are infertile. While provision of contraceptive advice and care to all couples in reproductive age group is important, it is equally essential that couples who do not have children have access to essential clinical examination, investigation management and counseling.

The focus at the Community Health Centre level will be to identify infertile couples and undertake clinical examination to detect the obvious causes of infertility, carry out preliminary investigations such as sperm count, diagnostic curettage and tubal patency testing. Depending upon the finding, the couples may then be referred to centers with appropriate facilities for diagnosis and management. By carrying out simple diagnostic procedures available at the primary health care institutions, it is possible to reduce the number of couples requiring referral. Initial screening at primary health care level and subsequent referral is a cost – effective method for management of infertility both for the health care system and those requiring such services”. (Government of India, Planning Commission Delhi, Ninth five year plan para 3.5.77, 1997-2002.)
### Table No.1.2

**Incidence of Infertility in different Countries in the World**

<table>
<thead>
<tr>
<th>Country</th>
<th>Incidence in Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>21,59,230</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>4,43,166</td>
</tr>
<tr>
<td>Germany</td>
<td>6,06,063</td>
</tr>
<tr>
<td>Russia</td>
<td>10,58,632</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>1,89,676</td>
</tr>
<tr>
<td>China</td>
<td>95,50,349</td>
</tr>
<tr>
<td>Japan</td>
<td>9,36,272</td>
</tr>
<tr>
<td>India</td>
<td>78,31,401</td>
</tr>
<tr>
<td>South Africa</td>
<td>3,26,826</td>
</tr>
<tr>
<td>Australia</td>
<td>1,46,420</td>
</tr>
</tbody>
</table>

**Source:** Nation Wide Health Information Centre-2007

### Table No.1.3

**Proportion of Infertility due to Reproductive tract Infections**

<table>
<thead>
<tr>
<th>Region</th>
<th>Proportions in percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>50-80</td>
</tr>
<tr>
<td>Asia</td>
<td>15-40</td>
</tr>
<tr>
<td>Latin America</td>
<td>35</td>
</tr>
<tr>
<td>Industrialized Countries</td>
<td>10-35</td>
</tr>
</tbody>
</table>

**Source:** Wasserheit and Holmes 2002.
In India, data from various community based studies on childlessness from different States shows that between 5-18 percent of the women reported childlessness as one of their gynecological problems, childlessness varies across the States, Haryana and Assam showed an infertility rate of 1.4 percent Andhra Pradesh showed an infertility rate of 4.4 percent.

**Figure No.1.1**

*Incidence of Infertility in India*

![Graph showing incidence of infertility in India](image)

**Source:** Indian Institute of Population Sciences, 2009
**Table No. 1.4**

**States on a Swing in Infertility Incidence**

<table>
<thead>
<tr>
<th>Name of the State</th>
<th>Percentage Of Information Infertility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haryana</td>
<td>2.52</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>3.57</td>
</tr>
<tr>
<td>MP</td>
<td>4.23</td>
</tr>
<tr>
<td>Punjab</td>
<td>4.93</td>
</tr>
<tr>
<td>Karnataka</td>
<td>6.73</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>8.72</td>
</tr>
<tr>
<td>Tamilnadu</td>
<td>10.92</td>
</tr>
</tbody>
</table>

**Source:** India Today June 2010

**Table No. 1.5**

**Primary and Secondary Infertility Rates in Asia**

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary Infertility (%)</th>
<th>Secondary Infertility (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>India</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Nepal</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Thailand</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

**Source:** World Fertility Survey -2000
No consolidated statistics for the country is available on the causes of infertility. However compilations of studies from various hospitals (Wadia maternity Hospital, Bombay, KG Medical College, Lucknow, Cama Albless Hospital, Bombay, J.N. Medical College Aligarh) shows that most common cause of female infertility is tubal factor. WHO multi center study (2000) of Indian males show that 73 percent of male infertility had no demonstrable causes, which is comparatively less in Africa (46 percent) and developed countries (49 percent) varicocoele as a cause was found to be less in India (2.2 percent) in comparison with Africa (20 percent) and other developed countries which is 11 percent. (Myths and Facts 2000).

Infertility will become more common in future generations with more couples needing help to have a baby. About 20 percent of couples trying to conceive are affected by infertility with up to 6 percent of children being conceived through assisted reproductive techniques. Even China seems to be suffering from the same problem with infertility raising from 3 percent in 1980’s to 10 percent now.

Out of 250 million individuals conservatively estimated to be attempting parenthood, at a given time 13 to 19 million couples are likely to be infertile based on the census reports of India (2011, 2001, 1991, 1981) childlessness in India has risen by 50 percent since 1981.

According to a study conducted by Indian Institute of Population Sciences, Mumbai 2010.
• One out of five couples is childless and these numbers are growing. 16 percent of the married women are childless in cities.

• 27 percent of childless women had marital problems compared to 2 percent with children.

• 10 percent of young males have severe defects in sperm quality, quantity and production.

• 20-30 percent is the growth rate of infertility sector in India.

• 40,000 cycles of infertility treatment are done Nation wide up from 7,000 in the year 2000.

• The number of IVF clinics has raised from 31 in 2000 to about 800 now

A new term doing the rounds on the infertility front is “voluntary infertility” a typical urban Indian syndrome. At the route of it is the idea that biological clock is not a myth. 90 percent of women’s eggs degrade at the end of her 37th year. And at the centre of phenomena is the educated, independent, career minded new women, who defers marriage and child bearing till she can afford all the good things in life. But by the time she decides to have a baby her biological clock often slows down, she requires the help of an Assisted reproductive technology specialist to make a baby happen. (Damayanthi Datta 2010).
1.7 CAUSES OF INFERTILITY

The aetiology of infertility is of major importance when any therapeutic or preventive measures are to be implemented. Various factors contribute to a couple’s infertility. It is often difficult to attribute the infertility to any one factor and thus clearly identify a cause of infertility. The causes of infertility globally, may be affecting the woman (in 40% percent), the man (in 40% percent) or unknown (20% percent). This implies that where infertility is concerned, there is no discrepancy in its prevalence rate in terms of sex differences.

**Figure No.1.2**

**Causes of Infertility**

Source: Bobak, 2000
In female tubal factor was the more common cause (30 Percent) and anovulation is the second common cause (22 Percent), Hyper prolactinemia in 10 Percent of cases and endometrial TB in 2.6 Percent of case. 40 percent of women had no demonstrable cause for infertility (W.H.O. Multi Center Study, Chandigarh, 1993)

One of the most common causes of infertility is sexually transmitted infections (Jeejebholy, 1995) and pelvic inflammatory disease. The WHO multi centric study traces prior infections in 64 percent of female patients experiencing infertility.

The frequency of etiologic factors accounting for male infertility vary in different countries knowledge of the male contribution to infertility still lags behind knowledge of the female contribution. The
leading causes in male include genital tract infections varicocoele, testicular atrophy and hypothalamus pituitary – testicular dysfunction, Genital tract infections account for over 50 per cent of male infertility developing countries.

Table No. 1.7
Causes of Male Infertility in India

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage of Infertility</th>
</tr>
</thead>
<tbody>
<tr>
<td>No demonstrable Cause</td>
<td>73</td>
</tr>
<tr>
<td>Accessory Gland Infection</td>
<td>8.8</td>
</tr>
<tr>
<td>Primary Idiopathic Testicular failure</td>
<td>7.6</td>
</tr>
<tr>
<td>Idiopathic low motility</td>
<td>5.7</td>
</tr>
<tr>
<td>Varicocoele</td>
<td>2.2</td>
</tr>
<tr>
<td>Immunological Factor</td>
<td>2.8</td>
</tr>
<tr>
<td>Klinefelters syndrome</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: Multicentric Studies, WHO 2000

The influencing factors which affect the probability of conception are age of the women, lack of understanding of reproductive biology, coital frequency, nutrition (underweight or obesity), exposure to toxic agents like mining, semiconductor industry, contaminated air, water food, lead, toxic fumes, pesticides, smoking and alcohol, surgery, exposure to radiations, female Genital mutilation which affects millions of girls and women in Africa and Middle East also leads to infertility.
The new female causes of infertility are sexually transmitted infections, polycystic ovariam syndrome, genital TB etc., Coping with stress can cause hormonal changes especially high prolactin levels which are found in almost one third of infertility cases. Obesity can cause infertility, 40 percent of women attending infertility clinics are found to be obese. Other factors include job pressure, vehicular pollution, postponing parenthood, junk food, smoking, alcohols, drugs, electro magnetic radiation, stress, sleep deprivation, environmental toxicity and genetic predisposition. (India Today June 2010)

The following myths about causes of infertility were identified in a study in rural Gujarat (2000).

- Women are primarily responsible for infertility
- Excessive heat in the body causes infertility in women
- Consumption of hot food causes infertility
- Infertile women are haunted by evil spirits
- Evil eye of some women cast on the couple
- Use of family planning methods before first pregnancy could cause infertility.
- Karma is responsible for childlessness.
1.8 INVESTIGATIONS AND TREATMENT

The WHO Study (2000) at Chandigarh had reported that couples with primary infertility had more interest in therapy than those with secondary infertility. 75 percent of couples had duration of infertility of more than 2 years prior to coming for investigations. The woman was found to usually initiate the first contact with a physician.

Couple may delay seeking medical advice, because they fear a final definitive diagnosis and also they dread the emotional stress and physical discomforts of the tests they will have to undergo. In seeking medical attention they are admitting failure in their efforts to conceive. Many couples have unrealistic expectations about testing and treatment. In one study infertile women’s partners frequently associated the semen analysis with feelings of shame, embarrassment, degradation and stress. In another study 26 percent of men refused to have their semen analyzed. The scanty data on the sources of infertility treatment shows that it ranges from spiritual healers, local indigenous practisioners to private infertility clinics. (United Nation Population Fund 1989).

Assisted reproductive techniques include artificial insemination, Invitro fertilization, embryo transfer, gamete / zygote intrafallopean transfer, Intracytoplasmic sperm injection etc. IVF centers in the private sector in India are simply mushrooming.
Assisted reproductive technologies have given a new hope to childless couples, although they are extremely demanding, physically and emotionally and financially with no surety of success (Manish 2010).

Many Studies of infertile couples have shown that 12-56 percent reported pregnancy after completion of investigation but before treatment was even started, and 27 percent while diagnostic procedures were carried out, only 35 percent completed the treatment before the onset of pregnancy. Thus many couples believed to be infertile are likely to conceive naturally over the course of time. WHO guidelines on Diagnosis and Treatment of Infertility recommended that during the first treatment contact with infertile couple, information should be given that the chance of successful outcome (conception and delivery of a child) may be as low as 50 percent and therefore the alternative solution of adoption may be borne in mind.

1.9 PSYCHOLOGICAL DIMENSION OF INFERTILITY

Once an Infertility Patient Said,

“My infertility is a blow to my self-esteem, a violation of my privacy, an assault on my sexuality, a final exam on my ability to cope, an affront to my sense of justice, a painful reminder that nothing can be taken for granted. My infertility is a break in the continuity of life. It is above all, a wound to my body, to my Psyche, to my soul”

Infertility is one of the areas of medical practice, in which biology, Psychology, sexuality clearly intersect. The inability to create a life, and the invasive, time consuming medical investigations and treatment undertaken present a challenge to the psycho-social integrity and relationship stability of many infertile couples. The outcome of treatment has long term implications for many patients to the remainder of their lives.

The discovery of infertility can provide a complex psycho-social crisis in either or both members of an infertile couple that may take several years to resolve. In the realms of hormonal assays, ultrasound, assisted reproductive techniques an important aspect that of the emotions of the infertile couples, usually takes a back seat and is ignored.

The woman or couple facing infertility exhibits behaviors of the grieving process that are associated with other types of loss, the loss of one’s genetic continuity with the generations to come, leads to loss of self esteem, to a sense of inadequacy as a woman or man, to a loss of control over one’s destiny, and to a reduced sense of self.

Infertile individuals have impaired self concept and greater dissatisfaction with their marriages. The investigative process leads to a loss of spontaneity and control over the couple’s marital relationships and sometimes a loss of control over progress towards career and life goals.
In addition to facing problems in the body organs, infertile couples experience psychological problems such as depression, anxiety, aggression, guilt feeling, criticism, fright, feeling of discontent, jealousy, solitude, lack of confidence, feeling of being unwanted, flexibility with their partner, and sexual dissatisfaction. (Fatemeh 2008).

1.9.1 Psychological Impact of infertility

The following are the behavioral characteristics of people facing the psychological impact of Infertility (Barbara Eck Menning(1982)). All the people do not have all the reactions described, nor can it be predicted how long any one reaction will last for an individual.

(a) Surprise: The first reaction most people have to the news of infertility is one of total shock and surprise. Most couples in their childbearing years are used to thinking in terms of prevention of pregnancy. They naturally assume that they could have children if and when they desire them, it is ironic that most couples discover their infertility after having used some form of birth control for many years. The discovery of an infertility problem is felt most keenly by those who are highly achievement oriented and who believe themselves capable of surrounding any obstacle, if only enough effort and will are exerted.

(b) Denial: “This cannot happen to me” is often the reaction to infertility. Denial serves a purpose. It allows the body and mind to adjust at their own rate to an overwhelming situation. Denial is only
dangerous when it becomes a long term or permanent coping mechanism. Chronically depressed women state that they never really wanted a family, and both men and women who refused to apply the label “infertile” do themselves in spite of 5-10yrs of involuntary chilliness. Psychotherapy of some duration is usually indicated in people who need this level of defense.

(c) Anger: Anger is a predictable response to loss of control. The Anger may be quite rational focused on real and correctly perceived insults, such as social pressure from family and friends to “produce” and the pain and inconvenience of the tests and treatments. Sometimes the anger is more irrational projected in to targets such as the doctor or the marriage partner or even into social issues such as pre-choice abortion advocates or people who “breed like rabbits”. Their irrational anger is usually affront for more primary feelings, such as intense loss and grief which cannot yet be acknowledged. Whatever the source or the type of anger, it is necessary that the person be able to ventilate it.

(d) Isolation: It is common for infertile couples to state that they are the only people they know who cannot achieve a pregnancy. Infertility is a difficult subject for most people to discuss. It is very personal and inherently sexual. Couple may keep their infertility as a secret because they do not wish to be objects of pity, or fear of receiving unsolicited advice such as “relax or why don’t you take a second honeymoon”. Secrecy may have several negative effects. It usually increases the pressuring and needling from family and
friends about the plans of the couples to start a family. More important, it cuts the couple off from potential sources of comfort and support in a time of great stress. In extreme cases, infertile couples may be so sensitized to the sight of pregnant women or children that they withdraw from any social situation which might produce such a contact. This may even involve a change of work or living situation. Isolation may occur between the couple as well. The woman may despair over her husband’s inability to empathize with her feelings about menstruation. The man may find it impossible to share his anxiety over being “counted & scored” in semen analysis or having to perform sex on demand whether he feels like it or not. The results may be a breakdown in communication and a loss of pleasure in the sexual relationship.

Marital stress and tension over sex are commonly present in certain phases of infertility. Since the couple often have no others to ventilate their feelings, they may presume that not only they are infertile but their marriage and sex life are in jeopardy. It is always a relief when infertile couples find each other and hear that they share the same frustration and concerns. One of the most helpful ways to ease the isolation of infertility is help couples find each other and join in a support group experience.

(e) Guilt : The infertile couple review their mutual and individual histories and search for a guilty deed for which they are being punished, some of the common guilt producers are premarital sex, use of birth control, a previous abortion, venereal disease, extra
marital sex, masturbation, homosexual thoughts or acts, and even sexual pleasure. Once the guilty deed is discovered, the infertile person may go to great lengths to atone and achieve forgiveness. Atoning may take any form, from religious acts to personal denial to working in painful areas such as counseling of unwed mothers or teaching other peoples children. Guilt and atonement appear to have no relationship to the educational level of person. People who have poor self esteem seem particularly vulnerable to guilty thoughts about infertility. Believing in their hearts that they really do not deserve a pregnancy and child. They may keep their infertility as a secret for fear of discovery how bad they really are.

(f) Grief: The most compelling feeling of conclusive infertility is grief. This state may be preceded by a period of depression as the final testing or treatments are of no use. Once all hope for pregnancy and live birth is abandoned the appropriate and necessary response is grieving.

It is a strange and puzzling type of grief, involving the loss of potential, not actual life. Society has elaborate rituals to comfort the bereaved in death. Infertility is different “There is no funeral, no wake, no grave” and family and friends may never even know. The infertile couple often reach this point of grief alone.

Infertility which is conclusive represents many losses; the loss of children, the loss of generic continuity, the loss of fertility, and all that, that means to sexuality and the loss of pregnancy experience itself.
For each Individual some aspects of loss are keener than others. Grieving may be accompanied by weeping, sobbing, and physical symptoms such as loss of appetite, exhaustion, choking or tightness in the throat. Assisting a person or couple through grief work is a rewarding experience.

(g) Resolution: The desired goal of any crisis, including infertility is its successful resolution. The process of resolution requires that each of the difficult feelings described above are to be identified, worked through, and overcome. “Feelings are never laid away forever” they may be reactivated by special reminders such as anniversaries of losses or by new and different crises. However the feelings are never as difficult or overwhelming as they initially were. Reactivation is usually brief and can be accepted by the person.

After resolution couples feel there is a return of energy, a series of optimism and faith returns. The concepts of sexuality, self image, and self esteem are reworked to become disconnected from child bearing. Plans for the future are begun again, building a way around the obstacle of infertility. The couple are ready to act with confidence in selecting an alternative life plan such as adoption, once resolution is achieved the couple is ready to proceed with their lives.

1.9.2 Impact Factors Responsible for psychological ailments

(a) Loss of a relationship with an emotionally important person:
Ending relationship may be an actuality or just an unspoken fear of many infertile couples. A couple may sever relationships with friends
and family. These breaks usually occur because of well-intentioned but insensitive remarks by others which leave the infertile person feeling unacceptable, misunderstood, unloved or ashamed.

They feel depleted of physical and emotional energy. They may become less able to fulfill each other’s needs, and thereby suffer a loss of closeness. Couples sometimes become polarized because infertility affects them differently or because they cope differently. Couple becomes depressed not only by their failure to conceive, but also by their loss of closeness and ability to understand.

(b) Loss of Health, Important Body Functions, Body Image:
Regardless of the causes of infertility both men and women believe their bodies are damaged or defective, something is not functioning as it should. Uncomfortable and sometimes, unsuccessful treatments, undignified positions experimental medications can make the couple feel vulnerable and can contribute to a poor body image.

Another respect of this loss is the loss of sexual spontaneity, since the course of treatment often requires scheduled sexual intercourses, sex becomes divided in to sex for love, and sex for doctor. Each month the medical evaluation probes in to the couples sex life and evaluates the frequency and timing of intercourse, Thus, violating a deep sense of privacy. Constant intrusion in to the most intimate aspects of one’s sex life can cause men and women to feel less sexual, avoid sexual activity, and failure to respond sexually in fertile times.
A physically and emotionally healthy person enters the treatment process and in no time finds her/himself taking medication, having surgery and becoming depressed. Men and women may enter the hospital for diagnostic or corrective surgery feeling good, and then leave the hospital physically debilitated and all for an “illness” that others do not understand.

(c) **Loss of Status or Prestige:** Society places eminent value on parenthood. Couples think that their work to society is lessened by their inability to produce children. They also feel that being infertile jeopardizes their individual sexual identities. They feel it as a threat to the feminity and masculinity in the society. The infertile couple feels different, less acceptable and left out.

(d) **Loss of Self Esteem:** For adults, self esteem is enhanced by the accomplishment of basic personal academic and professional tasks as well as by the perceptions how others see them. For some couples, failure to complete such an important personal life task as procreation is likely to diminish their pride in themselves both as a unit and individually.

Others suffer intensely when they find that validation from family and friends gets harder and harder, as one patient said “No one asks me about my accomplishments”, It’s only how many children do you have ? The couples self respect and pride get lost in that vicious circle, negative self statements are often followed by a sense of hopelessness and despair.
(e) **Loss of Self Confidence**: People who have been self directed, been in control of their lives, and believe that hard work leads to success in all tasks are devastated by the infertility experience. Despite the enormous price they pay in terms of money, time, persistence, commitment to a schedule and sacrifice to self and marriage that they cannot do what every one else can do with little effort: “get pregnant”, Competence in this task is beyond their grasp. This failure involves all aspects of their lives they have become controlled by the drive to achieve their goal to conceive.

(f) **Loss of Security**: Job security and advancement are often affected by infertility procedures Men and women turn down promotions which involve relocating because they have so much invested in infertility treatment with a particular physician. Women avoid career changes which might interfere with the freedom to leave the work place for medical appointments and carefully scheduled sexual encounters with their husbands. Couples may become insecure with the financial burden of repeated appointments, operations and medications. These changes will make them less confident about their position. On a deeper level there is a loss of security about the fairness and predictability of life.

(g) **Loss of a Fantasy**: After years of trying unsuccessfully to conceive many couples experience great despair. They are both frustrated and sad that they have been unable to have a child. They may never be parents and, thus never experience all that accompanies parenthood, socially, personally, religiously from being
pregnant, and giving birth, to preparing for baptism and later selecting a school, to escorting daughters, down the aisle in matrimony, and so beginning again the continuous cycle of life. Being a parent is a part of ones vision of an idealized adult self: losing that vision hurts deeply.

**Loss of something of symbolic value:** Paradoxically the couple yearns for the child that may never be and mourns over the child that never was. The couple finds it hard to comprehend this intangible loss, but they ache nevertheless. Children actually remind them of the children they do not have, pregnant women remind them of the mysteries of pregnancy they may never experience. They lounge for the sense of family that children embody.

There is increasing evidence that a behavioural treatment approach might be efficacious in the treatment of emotional aspects of infertility and may lead to increased conception rate. Siebel & Benson (1990) has found that a behavioral treatment programme based on relaxation responses showed statistically significant decrease in anxiety, depression, and fatigue as well as in vigor; in addition 34 percent of these women became pregnant within 6 months of completing the programme. These findings established a role for stress reduction in the long term treatment of infertility.

Cook 1987, described infertility as a crisis that generates a multitude of affective, cognitive, physical and behavioural experiences. Further more it involves an interaction among the diagnostic condition, possible treatment interventions, social
constructions about parenthood, reactions of others, and individual characteristics. Couples are willing to sell their lands and property to pay for infertility treatment and investigations.

Infertility will also threaten her religious eligibility to perform certain functions. An Infertile woman is not considered feminine and also her mere presence on occasions is considered a bad omen. She is believed to be incomplete and lacking in the softer emotions of parous women. The constant threat of divorce and humiliation leads many woman to spend time and money in fertility promoting rituals, sacrifices, pilgrimages, the cycle of denial, treatment, frustration-resignation leads to considerable emotional strain (Prakasamma, 1994).

Women who seek treatment for infertility are likely to spend at least 3 years trying to have a child without a guaranteed positive outcome (Gerritis. T, 2001). In addition to the tremendous costs associated with most fertility treatments, there are additional stresses of an emotional, physical and social nature, the affective consequences of infertility that are most often cited include, depression, sadness, frustration, and hostility, helplessness and powerlessness, shame, poor self esteem, and isolation (Daniluk 1998, Domar etal 2000). These affective reactions are similar to grief reactions experienced with other significant losses such as death, the loss of a life goal, the experience of pregnancy, health and personal control and closeness to any intimate partner, family and friends.
1.10 SOCIAL DIMENSION OF INFERTILITY

“A Baby is Treasure
Treasure, Treasure and Treasure
Home is full of Treasure
The garden is full with pleasure
Those who have not got the treasure
Have no life and pleasure
What have they to boast
Why don’t they burn to roast”

(As cited in a folklore rhyme)

The social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions. Couples do not define themselves as infertile or present themselves for treatment unless they embrace parenthood as desired social role. The presence of infertility is signaled, not by the presence of pathological symptoms, but by the absence of a desired state. Infertility is best understood as a socially constructed process where by individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct an appropriate course of action.

The study of infertility has much to contribute to the sociology of health and illness by providing researches with an ideal vantage point from which to study such features of medicalized health care,
(Griel 2010). Globally reproductive medicine is a high technology, highly profitable, but virtually unregulated industry, Middle and upper class women face, mounting social pressure to undergo treatment, family members, clergy and the State can all promote pronatalist ideologies - often associated with religious fundamentalism to encourage women’s participation in fertility treatment that may last for months or even years.

At the same time, infertility among poor women remains largely untreated, this may be partly due to an implicit notions which seems both racist and classist that some potential babies are “priceless” and are worth expensive fertility treatments, where as others or not. Another reason is that in poor countries, Governments and Ministries of Health are often preoccupied with population control. Women’s groups have criticized that health services in poor countries are subordinating reproductive care and primary care is given to population goals. They argue that the targets of population control dehumanize mothers and families.

The legacy of eugenics – a Pseudoscience that advocated reproduction by the wealthy, but curtailed child bearing for the poor and socially marginalized is still seen in despite resolutions issued by the women’s meetings at Cairo and Beejing. The population control orthodoxy had been slow to change for example the stringent family planning requirements imposed by programmes of World Bank and other International institutions. A corollary of denying poor women’s
fertility treatment is imposing contraception on them. Coercive and unethical sterilization programmes are still being reported at the turn of the 20th century. (Still man & king 1999).

There are many problems with infertility treatment itself, which feminist activists and scholars have identified and protested against since 1980’s. Reproductive medicine is often invasive. Intimately intrusive, medically risking, physically painful, emotionally draining, as well as expensive. It is not very effective at producing healthy babies.

Feminists have also criticized reproductive medicine for promoting a consumerist ideology of child bearing that commercializes babies and children and ultimately dehumanize motherhood. Many women find the rising costs of the fertility treatment acceptable, particularly if it results in a healthy baby. Research has found that even the best informed patients, potential parents consistently underestimate its physical, emotional and financial burdens.

Infertility is considered as a disease, a disability and a condition, which requires treatment. Some feminists consider it as a disability as it prevents people from participating in the basic human activity of procreation (Ruthman, 1989) they argue that as a disability.
Infertility should be managed holistically, and medical treatment should be widely available for those who want it, still other feminist decry “Medicalization of children” (Marsh & Roner, 1996). They argue that rather than turn to medicine for a Cure society should promote culturally acceptable alternatives to parent hood and encourage adoption for people who want to raise children.

1.11 PREVENTION OF INFERTILITY

Much infertility is directly preventable, yet, millions of women and men each year seek high cost, high technology treatment for infertility. Investment in prevention remains grossly inadequate. A significant cause of infertility is pelvic inflammatory disease due to infections of reproductive tract, sexually transmitted diseases etc. Much of the infertility caused by these infections could be prevented through health education, sex education, access to condoms, early screening and treatment.

Other preventable causes are smoking, occupational risk exposure to industrial chemicals, contaminated drinking water, food, air, nuclear radiation, many women are exposed to unsafe concentrations of toxic substances in household products like cleansers, pesticides, bleaches. Preventing harm from toxic materials involves shifting social and political priorities away from profits and towards protecting human being and environment. It also involves stricter workplace standards and regulations to protect workers health and fertility.
1.12 IMPORTANCE OF COUNSELING

Counselors need to be aware of the different challenges that women might be facing in the process of seeking medical treatment for infertility, based on such factors as age, health status, the women who are in the beginning stages of treatment will have different needs than women who are nearing the conclusion of treatment and who have yet to bear a child.

Counselors need to be aware that women and men often have different emotional reactions to infertility (Gerrits, 2001, Gibson & Myen 2000, 2002) research suggests that women experience more marital difficulties and more sexual difficulties compared to men. Women also report that they experience more stress in their personal and social lives, compared to their male partners. One of the reasons cited for these findings is that women have greater physical and emotional involvement with infertility and most of its medical treatment (Gibson & Myers 2000).

Grief work for infertility can take on many meanings, depending on the reactions and needs of each woman, infertility experts have remarked that although infertility is like a death, there are no rituals or public gathering and memorials to mark this loss or to facilitate the process of adjusting to the loss (Daniluk, 1991, Gibson Myers 2000).

One technique that can be helpful to infertile women is the creation of ritual that marks the loss and creates an emotional space
for expression of grief. The safety of the counseling relationship can provide the client with the opportunity to mourn and commemorate the loss of fertility in any way that is personally and culturally appropriate for the client. Some of the methods used include writing a letter to unborn child, visualization or guided fantasy, healing and forgiveness ceremonies and other rituals that can symbolize the loss that infertility represses (Danilluk, 1991).

Women’s internal and external responses to losses such as infertility are highly complex and valid, the intrapersonal, social and cultural and situational characteristics of bereaved women, and the personal and societal significance of each of these specific losses impact women’s relations to and resolutions of bereavement.

1.13 GENDER AND INFERTILITY

Today’s social construct is based on patriarchic ideology. In Patriarchy men are looked upon as superior and privileged in the domestic as well as public sphere, and have the social sanctity to exercise power over women. The society priorities the needs and aspirations of men and strives to fulfill them through subjugation of women with traditional cultural practices.

Women are treated as secondary and given lesser importance in opportunities. Women have low access to power and decision making bodies, lack of access to wealth and other assets and have lesser income. Moreover women are oppressed and seen as objects to
retain the supremacy of men. Thus, it resulted in the differences between men and women, which are referred as gender gaps. Validating the biological difference between man and women into gender division and thereby establishing gender discrimination as the core value of patriarchy. The discrimination perpetuated and maintained by all the informal institutional like family society and formal institutions also practice discrimination in a subtle way and in some cases it is explicit.

The roles expected of women and men to behave and respond in a particular way are categorized as productive roles, reproductive and community roles according to Caroline Moser. Gender roles are affected by age, class, race, ethnicity, religion and by the geographical, economic and political environment. Changes in gender roles often occur in response to changing economic, natural or political circumstances, including development efforts. Both men and women play multiple roles in society. The gender roles of women can be identified as reproductive, productive and community managing roles, while men’s roles are categorized as either productive or community politics.

Though infertility affects both, men and women, yet women, particularly in developing countries, often have to bear the sole blame and are subject to maltreatment on this account. In many parts of the country, infertility is a socially accepted ground for
divorce by the husband. There is ample evidence of these unhappy women seeking the help of unscrupulous practitioners who exploit such situations and order unnecessary and expensive investigations and treatment. It is crucial that this dimension is addressed.

In most cultures, like the Indian, from childhood itself the nuances of motherhood are imbibed into the personality of a girl child, either by encouraging her to play motherly roles of caring for the younger siblings or by restricting her play to that with dolls around the house.

The reproductive role of women is highly recognized in these settings and the onset of puberty is greatly rejoiced, accompanied by celebrations that declare her fertility and mark her capability for future motherhood. As Dube (1998) describes, “menstruation is likened to the process of flowering or blossoming – the necessary stage before fruit can appear”. In most of the cultures, the girl is made to eat nourishing food like coconut, milk and ‘ghee’.

And this process may continue from a few days to months or years after her first menstruation. The main idea behind providing her with nourishing food is to strengthen her reproductive organs and thus facilitate the process of child bearing in the near future. Along with this, the girl is restricted from strenuous activities of play like jumping, running, riding a bicycle, to protect her reproductive organs (Dube, 1998)
Importantly, a woman’s status is determined by whether or not she fulfils her roles and responsibilities towards the family and the society, through her main, significant role of procreation. Even the unborn child in the womb of the mother plays a role in acquiring a higher status and acceptance of the woman in the community. It bestows a positive identity on her and she is recognized as fully adult and complete in the true sense on attaining motherhood (Phoenix & Woollett. 1994; Jung, 1989) motherhood confirms a woman’s status as a renewer of the race, granting her respect, which was not extended to her as a wife. She undergoes a feeling of abundant cultural reverence, removal of all the restrictions, gestures of affection by the in-laws and relatives and a sense of personal growth. The roots of such behavior lie in the religious tradition that indicates the birth of a child, especially a male, as the essential step towards the family’s salvation. There are religious texts that enforce this feeling by describing the varied suffering of childless souls after death (Kakar, 1978).

In recent times, fatherhood is becoming the focus of social science research. Research related to the cultural significance of fatherhood and how it affects the socialization of men is missing. The terms fatherhood and manhood are considered as two distinct concepts, unlike womanhood and motherhood.

Infertility is more traumatic for women than for men. An integral part of the female role and identity for the vast majority of
women is bearing and rearing children. Women often associate fertility with femininity, sexuality, body image and self-esteem. Thus infertility can create feelings of physical inferiority that can overshadow all other personal or social value.

These feelings of self defect and despondency are further augmented by pressure of in-laws and husband who are keen to have a child. This disharmony with in – laws has been reported in 32.5 percent and with husband in 16 percent of infertile women in a North Indian study. This pressure varies from taunting and abusing to beating threat to abandon, and re-marriage.

In patriarchal societies, contemplating the idea of infertility in men is rare. However, even men are pressurized to prove their virility. The father's blood not only contributes to the shaping of the child, but gives the child a name, lineage and clan (Dube, 1986). Yet, the society easily makes concessions for them. The greatest example is the epic ‘Mahabharata’ where reference is made to ‘sowing’ a substitute ‘beeja’ (seed implying sperm) in the ‘Kshetra’ (field implying womb) for obtaining progeny. The socio-historical structure does not allow the woman to accept the fact that the problem could lie with the man.

Although sexual problems are universal and the findings represent a fair tran cultural concept, these are more pertinent in Indian women. For an average Indian husband, his entire sexual
relationship is extremely goal oriented and revolves around fertility. Failure of conception is an obvious sexual failure, and it is always the woman who is blamed.

The male factor in infertility is traditionally either not believed at all or considered insignificant. The infertile woman is, therefore likely to live a life of unimportance, ambivalence and even worthlessness.

1.14 NEED FOR THE STUDY

“The interaction of the heart, mind, spirit and body is critical to the women’s health and well being. Although body may be strong and functioning well, when a women’s thoughts and emotions are filled with fear, in security and confusion and conflict, she has little energy or optimism, she cannot be healthy. (Asian and Pacific Woman’s Resource and Action Series, 1989).

Infertility primarily refers to the biological inability of a man or a woman to contribute to conception. Infertility is a world wide problem as well, as a complex issue, as infertility affects between 18 million and 168 million people in the world today. Approximately one in ten couples experience primary and secondary infertility (Cambridge website 2007).

The complexity of infertility issue comes from different arenas. One thing the couples own demand or the couple’s biological demands to bear children is representing one aspect. Another
dimension is the societal demands placed by the society on their expected roles to have children. Couples often suffer from a sense of personal failure as well as social stigma as result to being infertile (WHO report, 1975).

Infertility is a problem with very definite psychological and social implications. The social pressures namely the stigma of infertility often leads to marital disharmony, divorce and ostracism. The suffering experienced by the infertile couple is very real. Women in particular in addition to stigmatization, suffer from severe negative social consequences. Infertility signifies the most severe emotional crisis. (Larsen, 2004)

Parenting is viewed by most of the couples as their central role in life, and the thought of not achieving it can be very upsetting. Motherhood is considered the ultimate meaning of womanhood. Many infertile women say that they cannot imagine a life that does not include children and that their childless state makes it difficult to maintain friendship with other women who have children. Several authors have found out that infertile husbands were less disappointed than their wives at the thought of not having children.

Infertility is perceived as a threat women’s social existence. It threatens the social acceptability of a woman, her legitimate role as a wife, her marital stability, security, and bonding and her role in the family and community. Though there was a drastic change in the
statistical report of infertility over the past, it is evidenced that the literature review of the past five chronologically descending years showed that it remains stagnant at the rate of 10percent -15percent (Pillitterei, a.2003;ICMR.2000) and 15percent-20percent (Carcio, 2011). It is estimated that about 8 percent to 12 percent of all couples experience some from of infertility during their reproductive lives.

In India womanhood is seen as unfulfilled, unless she makes herself a wife and mother. Any woman who is infertile is treated as a social outcast and avoided so that her disease does not taint other women.

Though not in wider population it is found among certain cultures that husband is often pressurized to abandon his wife and marry another woman without his fertility being questioned. Indian society attaches connotations of respect and power to women hood and at the same time attributes this reverence to the ability of the individual female to marriage and child bearing.

The weight age stays with the women’s reproductive capacity. This capacity is acclaimed as the societal power. When the couple faces altered fertility state, it is identified only through the women. Thus in many incidences, she is viewed as a person without resource to keep up the ideology of womanhood. This is how infertility is perceived and addressed as women-centered issue. Adding to this in
contrary, women willingly yield to the societal pressures by taking the blame and guilt on them even when the problem lies with the partner. This leads to the psychological problem and gets exaggerated when her need becomes a craving want. She starts living with anticipations that are short lived, but reappears when the couples reattempt to have their biological child at every menstrual cycle. The woman is dragged between repeated expectations and failures that result in distress. Distress, whether mental or physical is harmful to self and others.

Women held themselves more responsible for the couple’s infertility and generally protect their partner even when the problem is male factor. Men showed scant interest in joining both in the infertility diagnosis and treatment.

Infertile women have been found to be more neurotic, dependent, and anxious than infertile men. Experiencing conflict over their feminity and fear associated with reproduction. Infertility is not an absolute condition, the ability to conceive varies. Women may find themselves increasingly despairing at the thought of never becoming pregnant, social events loom as infertile women begin to dread social occasions, they may also get isolated from members and work colleagues. Further the cost of treatment may also cause economic burdens and influence the utilization of treatment, options.
The investigations and treatment for infertility are also highly stressful. The initial medical interview focuses on the couples sexual performance and history taking including frequency of sexual intercourse, premarital, extra marital relationships, previous pregnancies, abortions, attitudes about sex and usual sexual practices. The patient may see such questions as threatening, embarrassing, intrusive, demeaning and even inappropriate.

Side effects from medication, recovery from surgery, loss of time at work because of frequent physicians appointment and high financial costs of treatment have all been described as stressful by the infertile couple.

Both the diagnosis and treatment of infertility have a profound impact on couples lives. It is a process which invades one’s body, one’s personality, one’s job, and one’s mind, Diagnoses are often vague, inconclusive, and treatment is painful, embarrassing, intrusive and time consuming.

Concepts of Women’s studies applicable to Psycho – Social dimension of Infertility among Women are Patriarchy, Gender and Sex, Biological determinism, equal and different, Participation, decisions making and empowerment.

Empowering women and improving their status is crucial to combat infertility problem. It is the assertion that women have a right to be free of needless exploitation, pain and coercion, whether
at the hands of family members, providers of medical care. Identifying these hazards to reproductive health and working for collective solutions, continuous to be an important focus of feminists internationally.

Female Genital Mutilation (FGM) which affects Millions of girls and Women primarily in parts of Africa and Middle East also leads to infertility. About 130 millions girls are subjected to FGM each year (Seager, 2000), Rape and sexual abuse also lead to infection, injuries, unwanted pregnancies and other outcomes that threaten the fertility of Survivors.

In all cultures women’s social status and identifying are linked to motherhood. In Some Cultures, particularly those in which Woman are poor and illiterate, Motherhood is women’s only socially condoned role. In any society, infertility can be devastating to a woman who wants to bear and rear children but for many women it is also socially and economically calamitous.

In cultures that devalue woman and girls, an infertile woman may be abused or abandoned. In some part of India husbands and extended families have ostracized, maltreated, and even killed women who did not become pregnant (Doyal, 1995) women who survive such mistreatment may face destitution, despair and social death.
The cultural motherhood mandate enforces a woman to establish her fertility. The episode of infertility thus becomes more of a personal tragedy for a woman reducing her status to one of a social outcast. It can create a sense of embarrassment, frustration and a feeling of personal failure for women, in addition to harassment by the family members, rejection and ostracism by the society, such familial and societal pressures have direct implications for the physical and psychological health of a woman. The society’s expectation of attaining parent hood after marriage fosters the feelings of incompleteness in the infertile couples. Infertility has significant consequences on the marital life of the couple. (Klein & Rowland, 1999).

It is crucial that clinicians providing primary care for women recognize the importance of social and psychological issues and how they relate to the biological aspects of health and disease (the bio-psycho-social model) Personality traits, anxiety, depression, environmental factors, family and job stress and relationship issues have a signature effect on women’s health.

Unlike some diagnosis infertility has definite medical and psychological components which are inseparable. The stresses of trying and failing to conceive for a long time have significant affects on individual, relationships and even careers. Patients often report that no part of their lives including and most importantly, the treatment itself is untouched by the disheartening experience of
being infertile. Therefore it is recommended that specialists in infertility know about and attend to the psychological and social components of their patient’s medical problem.

Infertile couples have been the subject of a substantial body of research, however, most studies to date focus on the physiological effects of infertility and do not take into account the context in which the experience takes place or the meanings that people assign to this experience.

Caring is emotional awareness, and non caring is emotional distance. Infertility is an issue for men and women but it is the women who experience the majority of diagnostic and treatment procedures. The numerous physical demands made of women during infertility investigation and treatment is associated with significant emotional and informational needs.

Motherhood is believed to be the most important role for women and the perceived essence of a woman’s identity. For women fertility is more important than anything else in their lives. Infertile women are often suspicious of their self worth and identity. Infertility represents a potential threat to the social wellbeing and security.

At the Asia and Pacific Symposium Intraregional co-operation in Reproductive Health Research (China 1998). The Symposium participants endorsed the Regional reproductive Health Research priorities and voted for the five top priorities such as:
➢ Reproductive health at the era of RTIS \ STD’S and HIV\ AIDS

➢ Fertility regulation

➢ Adolescent Reproductive Health needs

➢ Unsafe abortion and safe motherhood

➢ Infertility including its prevalence, management and prevention.

The infertile couple is subjected to a variety of family and social pressures and conflicts. In many Asian countries involuntary infertility represents a social stigma borne by the women. Failure to bear children is an accepted basis for divorce. In several parts of Asia infertility services do not exist, accessibility and availability of general health services are very much limited as well.

The experience of infertility is shaped by patriarchy but the degree of male dominance and the range of roles other than motherhood open to women vary from society to society. In Egypt women bear the burden of infertility even when they know there is a male cause (In horn 2003) several studies demonstrate that infertile women who experience rejection or pressure from husbands and firmly experience higher levels of distress (Gulseren 2006).

Child bearing and rearing are central to women’s power and wellbeing. In developing countries, there is pressure to prove one’s fertility after marriage. Motherhood is tightly connected to marriage. Many women experience infertility as a “Secret Stigma”. The Stigma and distress of infertility is greater in developing countries (Doger 2005).
In developing countries policy makers and scholars are often more concerned about over population than infertility. The viewpoint of those who suffer from infertility is often quite different from that of those who make the policy. From the point of views of National and International policy, over population is the most important problem. But women perceive infertility to be the chief threat. Studies on infertility in developed societies more often treat infertility as a medical, ethical, psychological issue and pay less attention to the socio cultural context. (Bos et al 2005)

Thus, the psycho social dimension of infertile women is very important aspect to be studied especially when the magnitude of infertility is rising due to various reasons. In India there is only limited research available on psycho – social aspects of infertility. It is also observed by the researcher that less attention is paid by the health care providers to understand infertile women’s emotions and social problem. In view of all the above statements the researcher is interested to study psycho – social dimension of infertility among women.

**1.15 OPERATIONAL DEFINITIONS**

Infertile women: Married women in the age group of 20-45 years, who are unable to conceive within 2 years of marital life without using any contraception. It refers to infertile women attending selected infertility clinics in Hyderabad, at the time of data collection.
Psychological Dimension: It is defined as a state of balance between the individual and the surrounding world. It is a state of harmony between oneself and other. The present study explores the psychological reactions of the infertile women and their coping mechanisms.

Social dimension: Social wellbeing implies harmony and integrity within the individual, between each individual and other members of society in which they live. The present study explores the effect of infertility on marital life, family support, and societal attitude towards the women with infertility.

1.16 ORGANIZATION OF THE THESIS

The thesis comprises of five chapters, which has been organized under the following chapters

Chapter-1

Chapter one deals with the introduction and need for the study. It also discusses psycho-social dimension of infertility.

Chapter-2

Chapter two describes the review of literature focusing on National and International perspectives on psycho-social dimension of infertility.
Chapter-3

Chapter three explains the research methodology covering aim of the study and specific objectives. It also includes research design, setting, population sample size, sample criteria, sampling technique, description of interview guide, pilot study, method of data collection and plan for data analysis.

Chapter-4

Chapter four describes data analysis with qualitative techniques on psycho-social dimension of infertility.

Chapter-5

Chapter five deals with summary, discussion implications, recommendations and conclusion.