A literature review involves the systematic identification, location, scrutiny and summary of written materials that contain information on a research problem. Both research and non research related literature was reviewed from published articles as well as from internet search to broaden understanding and gain insight into psycho – social dimension of infertility.

The review of literature for the present study is organized as follows:

1. Studies related to incidence, prevalence and risk factors of infertility.

2. Studies related to psychological dimension of infertility.

3. Studies related to social dimension of infertility.

4. Studies related to management of infertility.

**2.1 STUDIES RELATED TO INCIDENCE, PREVALENCE AND RISK FACTORS OF INFERTILITY**

Infertility is otherwise called impaired fertility. It is inability to conceive and bear a child. It is found in 10 -15 percent of otherwise healthy adults of any population. The World Health Organization’s definition prepared by the scientific group on the epidemiology of the infertility has stipulated a two year reference period. Community
surveys measure infertility in terms of childlessness and American fertility society termed infertility as the disease of the male and female reproductive system.

Most medical sociologist agree that health and illness are best understood, not as objectively measurable states, but as socially constructed categories negotiated by professionals suffers and others in a socio cultural context. Decisions as to what constitutes abnormality, how to define that abnormality and what steps, if any, should be taken to deal with its conditions are all made within a social context. How suffers are seen by others and how they come to see themselves are both products of processes of social definition. Conrad and Schneider (1980) have used he term medicalization to denote the process by which certain behaviour comes to be understood as a question of health and illness, subject to the authority of medical institutions. One phenomenon that has become increasingly defined as a medical condition is infertility, usually defined in the biomedical context as the inability to conceive after 12 months of regular unprotected intercourse. The medicalization of infertility began in earnest with the development of fertility drugs in the USA in the 1950s but it has proceeded even more rapidly since the development of such assisted reproductive technologies (ART) as in vitro fertilization (IVF) and intra-cytoplasmic sperm injection. Thompson (2005) has recently described the complex ontological choreography involving precisely timed actions (for example,
injections of hormones, ejaculation of sperm and cryopreservation of gametes) among an interrelated set of actors (for example, physicians, nurses and patients) to produce a baby in the modern ART clinic.

There are two distinct traditions of research in the study of the social and psychological consequences of infertility. One tradition is characterized by the quantitative analysis of patient population – often focusing on patients being treated via ART – with the goals of improving service delivery and of assessing the need for psychological counselling procedures. Another tradition utilizes qualitative analysis to understand infertile couples experiences. These clinically oriented studies typically make use of the quantitative analysis of infertile women and men – both in developed and developing societies – outside the clinic context. Those being studied may or may not be patients in biomedical contexts but the focus of this research is not so much on improving care as on understanding the experience of infertility and the social context that shapes it. This second tradition has been more informed by developments in social scientific studies of illness experience, gender, the body and stigma.

Arthur L. Griel (2010) reviewed 10 years of published literature on the Socio-Psychological impact of Infertility. He found that 10 years ago most scholars treated infertility as a Medical condition with Psychological consequences rather as a socially constructed reality. More studies new place infertility within larger social scientific
frameworks. They have identified two vigorous research traditions in the social scientific study of Infertility. One tradition uses primarily quantitative techniques to study clinic patients in order to improve service delivery and to assess need for psychological counselling. The other tradition uses primarily quantitative research to capture the experiences of infertile people in a socio cultural context.

According to a survey of Indian Institution of Population Studies Mumbai (2010), out of 250 million individuals conservatively estimated to be attempting parenthood at any 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.

Naeimeh Tayebi (2009) conducted a study to assess the degree of sexual dysfunction among the infertile women and its correlation with age, duration of marriage and cause of infertility in Iran. The study revealed that there is a high rate of sexual dysfunction after diagnosis of infertility. The most common sexual dysfunction was orgasm disorder (83.76 percent), dyspareunia and vaginismus (80.7 percent). More than 50 percent of cases mentioned decreased frequency of coitus after diagnosis of infertility.

Sule J.O. (2008) studied prevalence of infertility among women in a south western Nigerian community. The sample was women between the age of 15 and 55 years from four hospitals of Nigeria.
The outcome of the study has shown that there is high incidence of infertility with 51.5 percent of all gynaecological admissions within the years 2001 to 2003 in four hospitals.

Boivin J.Bunting (2007) reviewed existing population surveys on the prevalence of infertility and proportion of couples seeking medical help for fertility problems in developed and developing countries. The findings have shown that prevalence of infertility in developed countries ranged from 3.3 percent to 16.7 percent and in developing countries 6.9 percent to 9.3 percent. The mean prevalence of infertility was 9 percent. In his study it is estimated that approximately 72.4 million women are currently infertile world wide out of which 56 percent of women are seeking medical care.

Kumar D (2007) studied the prevalence of female infertility and its socio economic factors in tribal communities of central India. The data was collected through structured interview schedule from 1,305 people from 284 households. The findings of the study have shown that the prevalence of female infertility was 14.2 percent and it is higher in Khairwar tribes than in non Khairwar tribes in India.

Kelly weeder (2006) studied the impact of life style risk factors on female infertility in United States of America study revealed that over 2 million couples in the United States are infertile. The sample was 824 women between the ages of 16 to 45 years. The literature reflects a number of potential life style risks that have been
associated with infertility. The results of the study revealed the following risk factors, increasing age, history of an ectopic pregnancy, smoking, obesity and their self reported health status.

Moray LT Norman RJ (2002) studied relationship between obesity and Over weight and obesity are serious and prevalent conditions in western countries and causing many health consequences including reproductive dysfunctions. Excess fat in the abdominal area is strongly related to disorders of reproductive system. Moderate weight loss and reduction of abdominal fat improves menstrual regularity, ovulation, infertility in women. Weight loss should be promoted as an internal treatment option for obese women with infertility. Gradual weight loss is best achieved through sensible eating plans, regular exercise, cognitive behaviour therapy and a supportive group environment. Adoption of these principles in a primary health care setting can aid in the treatment of infertility related to obesity.

Mohsin G.M.D. Awardy (2001) conducted a study to measure the prevalence of primary and secondary infertility among rural women and also studied some risk factors in rural areas Egypt. The study revealed that the overall prevalence of infertility was 10.4 percent; The study showed that 7.9 percent reported secondary infertility and 2.5 percent reported primary infertility. The prevalence of primary infertility was higher among women under 30 years than older ages, Secondary infertility increases with advance in
age. Both types of infertility were higher among women married under the age of 16 years or above 30 years.

Larsen (2000) studied estimates of infertility prevalence in less well developed countries (i.e. 28 countries in Sub Saharan Africa, China, Chile and India) in surveys involving 1,20,160 women. The prevalence of lifetime infertility ranged from 5.0 to 25.7 percent, the lowest estimated rate of childlessness in the first 5 – 8 yrs of marriage was 1.3 percent in China, whereas the highest estimated rate was 16.4 percent using average to Sub Saharan African Countries. The range of infertility prevalence was 8 – 28 percent for the 28 countries.

Pasch and Christensen (2000) enumerated shortcomings in social scientific research on infertility as small sample sizes, poor sampling methods, use of non-standardized methods, lack of adequate control groups and studies being conducted in infertility treatment centres with which the researcher is affiliated. Many studies rely primarily on self-reported data.

Shireen Jejeebhoy (1998) presented a profile on infertility in India – levels, patterns and consequences, priorities for social sciences research. Globally infertility affects 50 to 80 million couples. The infertility has been relatively neglected both as a health problem and as a subject for social science research in South Asia. The consequences of infertility for women are devastating. Infertility is leading marital instability, harassment, low self-esteem and negative attitudes.
There is an increase when compared to the research done by Okonofua in 1995 in which infertility is accounted for only 19 percent of all gynecological admissions. The commonest causes for infertility were tubal factor (39.5 percent) uterine factor (30 percent) and ovarian factor (13 percent) respectively. There was also prevalence of infertility between the ages of 15 to 25 years at the rate of 17 percent, 26 to 35 years at the rate of 31.5 percent. The majority of the cases were between the ages of 36 to 45 years of age.

2.2 STUDIES RELATED TO PSYCHOLOGICAL DIMENSION OF INFERTILITY

Florence E. Omu (2010) conducted a study on emotional reactions of couples attending an infertility clinic in Kuwait. A mixed methods research design was used. The study revealed that the unfulfilled desire of millions of infertile couples worldwide to have their own biological children results in emotional distress. The emotional reactions experienced were anxiety depression, reduced libido. The emotions expressed were similar and in addition to anger, feelings of devastation, powerlessness, sense of failure and frustration.

Fatemeh Ramazadeh (2009) assessed emotional adjustment of infertile couples and the psychological outcome of infertility in different phases of treatment. Results showed that more infertile women suffered from personality instability as compared to fertile women. The instability was more prevalent among infertile house
wives’ than infertile working women. The study identified the psychological outcomes of infertility as depression, anxiety, relationship and sexual problems and personality disorders. More than half of the Infertile couples learn to cope with this problem upto some extent. But a significant percent of couples showed signs of inability to adjust with the problem which highlights the importance of psychotherapy.

Petra thorn (2009) examined infertility from psychological and social consideration with a counselling perspective. Among infertile women depressive reactions such as hopelessness, despair, feelings of failure and reduced self esteem are common. The levels of anxiety and depression are higher among women than men. There is evidence that men and women experiencing infertility react differently and manage this crisis in different ways. Many women perceive the inability to conceive to be one of the most upsetting life events. Couple often perceive intercourse as futile as it does not result in the conception of a child. Sexuality therefore became a task oriented exercise and pleasurable and intimate aspects neglected. Gender differences are also prevalent in grieving reactions. Women often show their emotion openly and weep and men distance themselves emotionally. Infertility is a major life crisis. It may be a chronic sorrow which re-emerges periodically even though childlessness has been accepted.

Luis Maria (2008) studied the psychological impact of infertility. Infertility is an atypical clinical problem and the discovery
of infertility brings about a significant crisis in the lives of people involved. The surprise arises from being faced with unexpected situation. There is a deep rooted belief in human beings that procreation is a voluntary process accessible to any one simply as a result of frequent intercourse. Thus infertility produces frustration over unfulfilled desire and expectations of paternity. The psychologists in infertility field should give attention to couples with the following goals. 1) Restructuring the values of biological paternity, self concept and the negative consequences of self devaluation process. 2) Interventions for the management and prevention of anxiety, depressive behaviours, self blame and social isolation and for the normalization of sexuality. 3) Strengthening of relationship with regard to direct communication, decision making, emotional support and sexual relations. 4) Preparation for the medical procedures couples have to deal with and their consequences and for an assertive relationship with the health professionals.

Katherine E, Williams (2007) conducted a critical review of literature and implications for future research on mood disorders and fertility in women. Previous studies report that mood disorders may be associated with decreased fertility rates. Most studies report that women seeking treatment for infertility have an increased rate of depressive symptoms and this may decrease the success rate of fertility treatment. Treatments for infertility may independently influence the mood though their effect on estrogen and progesterone,
which have been shown to influence the mood through their action on serotonin. In conclusion a range of existing studies suggests that fertility and mood disorders are related in a complex way. Future studies should use clinical interviews and standardized and validated measures to confirm the diagnosis of mood disorders and control for the variables like treatment, desire for children, age, menstrual cycle regularity, frequency of sexual intercourse in assessing the interrelationship between the mood disorders and fertility.

Kehua Wang (2007) conducted a study to assess the psychological characteristics and marital quality of infertile women registered for invitro fertilization in china. The data was collected from 300 infertile women. The findings revealed that the stresses associated with infertility and IVF treatment had a negative impact on Chinese women psychological health status and marital quality. The findings emphasize the need to include psychological and socio cultural considerations with medical intervention for infertility.

Liora Baor (2005) Examined psychological considerations of infertility. The diagnosis and treatment of infertility may have deleterious effects on women and men’s subjective wellbeing. The apparently healthy couples suddenly become “patients” who’s most intimate elements of life being to revolve around a physician’s scheme. Infertility potentially will lead to significant negative consequences when treatment fails. The losses that accompany
infertility are loss of relationship with spouse and with social network, loss of health, impaired body image, loss of prestige, loss of self esteem, loss of confidence and control, loss of sexuality, loss of finance and loss of hope. Prevalent emotional responses include grief, depression, anger, guilt, shock or denial and anxiety.

Freda MC Devine KS (2003) conducted a study to describe women is experiences of miscarriage after infertility treatment. The findings revealed that women feel an inner struggle between hope and hopelessness for future fertility, running out of time, anger, frustration, lack understanding by others guilty feelings, feeling alone, grieving intensely and gaining strength from adversity.

Lok IH Lee Dt (2002) conducted a prospective study to assess psychiatric morbidity in Chinese infertile women who underwent treatment with assisted reproductive technology and also the impact of treatment failure. The 30 items general health questionnaire and Beck depression inventory method were employed before and 3 weeks after assisted reproductive technology treatment. The findings revealed that one third of the women who sought infertility treatment had an impaired psychological wellbeing. Following failed treatment, there was a further deterioration in mental health. And about 10 percent of participants were severely depressed. Proper psychological care and counselling should be an integral part of Infertility management among Chinese population.
Wischmann T (2000) Evaluated the psychological effects of counselling and couple therapy with infertile couples in Germany. Three independent samples of patients were compared. The 23 couples waiting group, 110 couples counselling group and, 24 couples’ therapy group. The study showed the relieving effects of psychological counselling and couple therapy for infertile couples. Couple therapy showed stronger effects than counselling. Effects were also stronger in women than in men. The aim of counselling and couple therapy should be to enhance the quality of the life of infertile couple and offer psychological support to cope with infertility and its medical treatment.

KA. Sanders, N.W Bruce (1997) conducted a prospective study to identify psychosocial stress and fertility. They have compared average stress levels during the month of conceptions to those of previous infertile months in a group of normal women. The findings revealed that the women had more favourable mood states during the months of conception than during the non conception cycles. The findings support the view that relief from the stress promotes fertility and psychosocial stress contributes to infertility.

Williams (1997) conducted a qualitative study to identify characteristics of Infertile women, In depth interviews were conducted and 11 themes were extracted from Infertile women. They are negative identify, a sense of worthlessness and inadequacy, a feeling of lack of personal control, anger and resentment, grief and
depression, anxiety and stress, lower life satisfaction, envy of other mothers, loss of the dream of co-creating, emotional roller coaster and a sense of isolation.

Imeson M. MC Murray A (1996) conducted a phenomenological study on couples experiences of infertility. The study revealed that all couples undergoing infertility treatment experienced life changes which included life style changes, various physical and emotional changes, and changes in their relationships. There was a perceived loss of control of over many aspects of their lifes, couple also described a cycle, alternating feelings of hope and disappointment. Most of the couples reported feelings of social isolation associated with being infertile. Findings of this study contribute to recommendations for improving the way the Doctors and nurses’ guide, counsel and support infertile women.

M. Stauber (1993) studied the psychosomatic aspects of infertility. Results of the study showed that coping with an ultimately frustrated desire for children by couples is accompanied by great difficulties in many cases. These difficulties were disturbed life’s perspectives, strong suffering, coping with renunciation, negative social resonance, depressed mood. Infertility may have its causes in a psycho pathology. The study suggested that holistic view of the infertile couple should start with consideration of psychological interrelationship within both partners, as well as with various organic causes of childlessness. The study also suggested exchange
of experiences and allowing necessary emotional let down by couples to release their stress.

Davis DC Dearman CN (1991) conducted a study to explore the coping patterns of infertile women. The researchers reviewed 30 women and evaluated data using content analysis. Six ways of coping with Infertility for identified (i) Increasing the space or distancing oneself from remainders of infertility. (ii) Instituting measures for regaining control. (iii) acting to increase the self esteem by being the best. (iv) Looking for hidden meaning for infertility. (v) Giving into feelings (vi) Sharing the burden with others.

Kopitzke EJ, Berg BJ (1991) studied physical and emotional stress associated with components of the infertility investigation among professionals and patients. The findings revealed that patients nurse’s physician perceive infertility treatment from unique vantage points creating differences in perceptions that have implications for patient care. These factors include era of professional training, stage of life, and changes resulting from advancing technology. These factors influenced the health care professional’s perceptions of infertility distress.

Olshansky EF (1990) studied psychosocial implications of pregnancy after infertility. The study revealed that couples experience profound psychological changes related to the “Identify shift” that they must make from infertility to pregnancy. They often
straddle between the two worlds of infertility and fertility not feeling completely a part of either world. Health care workers play a key role in counselling, educating and supporting these couples.

Mc Cormick TM (1980) Studied infertility out of control. The findings revealed a perceived loss of control over many aspects of life often accompanies the problem of infertility. Most of the couples feel lack of control in their life style, relationship and reproductive capacities.

2.3 STUDIES RELATED TO SOCIAL DIMENSION OF INFERTILITY

Sami N.Ali T.S. (2006) Studied psychosocial consequences of secondary infertility in 400 women from Karachi. In the study showed that 67.7 percent of women stated that their inability to give live births or give birth to sons has resulted in marital dissonance, 20 percent were threatened for divorce, 38 percent of their husbands were remarried. 26 percent of the women were returned to parents home by their in-laws or husbands. Secondary infertility was described a cause of violence against infertile women. 10.5 percent of the women reported physical and verbal abuse by husbands and in-laws, nearly 70 percent of women are facing verbal abuse, they have suffered with severe mental stress. The study revealed that the experience of infertility was traumatic and stressful experience. The infertility women were subjected to contempt and exploitation resulting in severe psychological stress.
Nene UA, coyaji K (2005) conducted a study to explore infertility a label of choice in case of sexually dysfunctional couples. Data was collected from 40 couples by interview method. The findings revealed that sexual activity decreased as the number of childless years increased but inter spouse relationship gets stronger and more supportive. The couples never revealed their sexual dysfunction to others. When the husband was sexually dysfunctional, their wife’s preferred to label their situation as infertility in order to avoid stigma. In planning the treatment, clinicians should give more attention of the specific cultural context of these aspects.

Wischmann. T (2001) conducted a study on psychosocial characteristics of infertile couples. A total of 564 couples were examined using the questionnaires pertaining to socio demographic factors, motives for wanting a child, dimensions of life satisfactions, couples relationships, physical and psychic complaints and a personality inventory. The results revealed that there were remarkable differences in psychological variables between the infertile couples and representative sample. The infertile women showed higher scores on depression and anxiety scales. For some couples the infertility crisis was seen as a cumulative trauma which indicates that these couples have a marked need for infertility counselling.

Nahar Papreen etal (2000) explored experiences of living with infertility among urban slum populations in Bangladesh, In depth interviews were conducted with 60 women and 60 men randomly
selected form Bangladesh Hospitals and 20 case studies were discussed. The findings of the study revealed that, leading causes for infertility were perceived to be evil spirits, physiological defects in women and psychosocial problems in women and physiological defects in men. Herbalists and traditional healers were considered the leading treatment options for women while for men it was remarriage followed by herbalists and traditional healers. Childlessness was found to result in perceived role failure with social and emotional consequences for both men and women. Infertility resulted in social stigmatization of the couple particularly of the women. It places the women at the risk of social familial displacement and woman clearly bears the greatest burden of infertility. Successful programmes for dealing with infertility in Bangladesh need to include both appropriate and effective sources of treatment at community level and community based interventions to demystify the causes of infertility.

Shagufa Kapadia, Bhamini Mehta (2000) conducted an ethnographic study on psychosocial implications involuntary childlessness in urban middle class of Baroda city India. The study revealed that motherhood and fatherhood are perceived in relation to the traditional and cultural values. Gender differences are indicated in women’s and men’s descriptions of the roles and responsibilities of father and mother. The psychological manifestations of childlessness are more evident in women. Most of the respondents suggested adoption as way of coping. The study also addressed the role of the Government in providing low cost facilities for treatment. Treatment
seeking was described as strenuous process along with being frustrating as there was no guarantee of positive results despite high cost. The socio-cultural nature of the experience of the infertility clearly revealed though the treatment process.

Unisa.S. (1999) Studied childlessness in Andhra Pradesh, treatmental seeking and consequences. The study revealed that two thirds of women in infertility couples experienced violence from their husbands of whom 13 percent thought this was due to infertility. Some respondents in the study mentioned suicide as a potential means of escaping violence, but a very low risk of women being divorced by their husbands because of infertility.

Gerrots.T, (1997) conducted an anthropological study of social and cultural aspects of infertility in Mozambique. The experiences, perceptions and problems of infertile women were studied. The study revealed that infertility is considered as a serious reproductive health problem in Mozambique. They have a matrilineal kinship system which means having children is critical to social and economic survival. Infertile women are excluded from cultural ceremonies and face concerns about who will care for them. In the interview infertile women said they sought help from traditional healers. Only half of the sample consulted a hospital physician but, they failed to understand the medical explanations provided. Women attributed their infertility to personality causes such as possession by spirits or
witch crafts. Extramarital sexual relations and child fostering represented an alternative, non medical responses to infertility. Overall the findings confirm that women’s experiences with infertility are closely related to social and cultural context.

2.4 STUDIES RELATED TO MANAGEMENT OF INFERTILITY

Remah M Kamel (2010) conducted a study on management of the infertile couple- an evidence based protocol Infertility is a common clinical and public health problem. It does not affect the couple’s life only, but it also affects the health care services and social environment. The feelings experienced by the infertile couples include depression, grief, guilt, shame and inadequacy with social isolation. The findings of the study revealed that the more common causes of infertility are male factor such as sperm abnormalities, female factors such as ovulation dysfunction, tubal pathology and unexplained infertility. Fertility clinics should address the psychosocial and emotional needs of infertile couples as well as their medical needs.

Inhorn MC fakih M.H. (2006) conducted a qualitative study to compare barriers to infertility care among African Americans and Arab Americans. They have used semi structured reproductive histories and open ended ethnographic interviews. The study revealed that Arab Americans experience disparities in access to infertility care largely because of poverty and social Marginalization.
Bitler M, Schmidt L (2006) Studied health disparities and infertility. The data was collected from 31,047 women in the age group of 15 – 44 years. The results revealed that infertility is more common for non-Hispanic black women. The study found that racial, ethnic, and educational disparities exist in infertility status and treatment.

Sara Jane Cox (2006) conducted a study to identify maternal self esteem after successful treatment for infertility. The existing literature has established a relationship between infertility and low levels of self esteem. The findings of the study have shown that women who have taken I.V.F. treatment and women who have conceived normally are having normal self concepts as measured by self esteem.

Brinton LA, westhoff CL (2005) conducted a study to identify infertility as predictor of subsequent cancer risk. A retrospective cohort study of 12,193 US women evaluated for infertility. Among them they have identified 581 women has cancer in the latter years. The study revealed that infertility is a risk factor for cancers like uterine, ovarian, tubal, and thyroid cancers.

Yael Benyamini (2005) conducted a study to identify the difficulties experienced by the women undergoing infertility treatment. 240 women in treatment process were the sample, a cross-sectional survey method was used. The study identified 22
types of difficulties faced by the infertility patients. Among them important difficulties were uncertainty and lack of control, family and social pressures, lack of support from partner, anxiety and worry, disruption of daily routine, lack of spontaneity in sexual relationship.

Daniluk (2001) reported that out of 65 Infertile couples she interviewed, it was the woman who initiated the treatment in all cases. Wives are much more likely to initiate treatment than husbands. Although women are very much treatment oriented, they find the experience of treatment highly stressful (Peddietal 2005) discovered that Infertility treatment for women is unpleasant and emotionally draining. Infertility patients want to receive patient centred care.

Many methodological shortcomings in infertility research noted by Greil (1997) still persist. Pasch and Christensen (2000) enumerated the following shortcomings in social scientific research on infertility; small sample sizes, poor sampling methods, use of non standardized measures, lack of adequate control groups and studies being conducted in infertility treatment centres with which the researchers is affiliated. Henning et al., (2002) criticize the many studies that rely primarily on self-report data, those that do not allow the separation of the psychological consequence of infertility from the psychological consequences of the infertility treatment and reliance on cross-sectional data.
Marcel vekemans (1994) discussed whether the infertility treatment is a luxury, desire or necessity. In Africa 85 percent of infertility is related to sexually transmitted diseases and reproductive tract infections. Endometriosis is more common in Asian women and ovulate is more common in developed countries. It was found in a large study of 8000 couples that Africa has unique profile of infertility. The biggest problem with infertility is that it has never been taken seriously as a public health issue instead it is a dark stigma, left to distressed individuals to solve in the free market of private medicine. An attempt should be made to eradicate of idea of infertility as a disgrace. Emphasis should be placed on prevention. In each country a list of services which the public health system can offer should be prepared and in countries with limited resources, services for family planning, sexually transmitted diseases and infertility should be integrated.

Blenner JL (1990) explored 25 couples perceptions as they underwent infertility assessment and treatment. This was a grounded theory study to develop a substantive theory of attaining self care in infertility treatment. This theory describes infertile patient’s movement from a passive to an active role. The process consists of four sequential phases. A) Perceiving that physicians lack a complete picture b) actively acquiring knowledge c) taking control over the problem d) being satisfied with treatment. The findings of the study offer a self care model that nurses can initiate on behalf of
infertile and similar patients responding to long term highly technological treatment.

The review of literature collected and presented by the researcher is related to the prevalence, Psychological and social dimension of Infertility. This review of literature has helped the researcher to co-relate Psycho-social dimension of Infertility among women with the findings of the present study.