This chapter deals with the summary and findings of the study. It also deals with conclusion drawn from the findings, implications of the study, limitations and recommendations for research in future.

SUMMARY

The study aimed to explore lived in experiences of childless women. Hence the research approach selected was Qualitative approach.

The objectives of the study were:

- To understand the perception of childlessness among women undergoing assisted reproductive technique treatment.
- To gain insight about the psychological, social and economic consequences of childlessness among women that affect them person as a whole.
- To explore health seeking behavior and coping mechanism adopted by childless women.

It was assumed that becoming a biological parent is a valued and primary role in society and every facet of a woman’s life is affected by the experience of childlessness. Socio cultural factors play a vital role in framing the importance of parenting.

Rational of doing this study was to appraise the experiences of childless women in India in terms of psychological, physical, social, marital, sexual, financial and spiritual aspects. Infertility has been recognized as a potentially serious, costly and burdensome problem for affected families. Not having children leads to losses such as the loss of individual, physical and mental well being of couples, life goals, position, reputation, self confidence and loss of privacy and grief.
Infertility is reported to be more distressing for woman than it is for man. Women invest more in having children and are more treatment oriented than man owing to psychological, social and economic consequences of infertility for them. Woman experience higher levels of stigma than man.

Qualitative research approach with hermeneutic phenomenology was opted for the study. Data were collected by face to face in depth interview using interview guide form 22 childless women who met inclusion criteria. Inclusion criteria included childless women who have never delivered full term baby, seeking artificial reproductive technique treatment and can respond in Hindi or English. Women who have not started with ART or have adopted a child were excluded. Criterion purposive sampling technique was used to select samples. Study was undertaken at selected infertility clinic providing ART services like ovulation induction, IUI, IVF, ICSI, Donor egg, Donor sperms, Donor Embryo (genetic surrogacy), sperm bank and cryo preservation of embryos completely in accordance to national guidelines regarding ART. Data were collected using interview guide and personal data sheet. Interview guide contained open ended questionnaire and was validated from 7 experts. I-CVI index was found to be between 0.85-1.00 and S-CVI was found to be 0.95.

Interview guide was used to collect data from infertile women. In depth face to face interviews were conducted in a separate room to maintain privacy during interviews. All interviews were audio taped using a digital recorder. The researcher used demographic question as introductory part to establish rapport with women and to get a glimpse of their background. The researcher asked questions and followed up the womens’ answers. Duration of interview and number of questions varied from one women to another. Length of interview lasted from 45 min to 70 minutes. Interviews were conducted from February 2014 to August 2014. All interviews were conducted in selected IVF clinic only.

To ensure validity of data researcher used rich, thick descriptions to describe in detail the experiences of childless women. The characteristics of women in the study sample with maximum variance assured intensified validity and transferability of the findings. Expert panel views were incorporated as research progress reports were presented before departmental research committee. Researcher's professional experience in Obstetrics and Gynecology area
ensured prolonged engagement with childless women. Interaction with these women in field helped researcher to know and grasp the underlying meaning of expression and experiences.

The analysis took place after each interview was complete and transcribed. During the process of data analysis firstly, each interview was read twice for overall understanding. The second step involved making summary of interviews and beginning interpretation. The analysis process required ongoing reading and re-reading of the transcripts for comparing and contracting interpretation that leads to subthemes, relational themes and eventually meta-themes. Researcher took help from two independent researchers who followed the same steps individually. Common units were identified by comparing and contrasting the text and subthemes were identified. Subthemes were discussed and a consensus was derived through intensive brainstorming with research supervisor. As coding progressed, data was checked and rechecked and findings were reorganized as relationship between subthemes emerged. The emerging themes were supported by verbatim from the transcripts. Finally, findings were given to two other peer researchers for peer debriefing for validation.

**SUMMARY OF MAJOR FINDINGS**

**Section I: Findings Related to Personal Variables of Participants**

The mean age of women was 29.68 yrs (range 23-40 yrs). Educational status ranged from being nonliterate to postgraduate with two participants being non literate and six had master’s degree. Maximum number of participants (19) were housewives where as two of them were teachers by profession and one was a counselor. Equal number of participants (10) were residing in urban and rural area where as two were in semi urban area. Monthly family income for the participants ranged from Rs 2,000/- to Rs 60,000/-. Mean duration of marriage of participants was 8.4 yrs (range 3-24 yrs) and the mean duration for trying for conceive was 7.92 yrs (1yrs 9 months–24 yrs). All the participants (22) practiced Hinduism. Most of the women (15) were living in joint family where as seven lived in nuclear family. The cause of infertility was unknown for six participants where as 14 were diagnosed with female cause of infertility and two with male cause. Among female causes of infertility was tubal blockage (06), uterine problem (02), hypothyroidism (01), genital tuberculosis (01), PCOD (01) and hormonal problems (03).
Whereas among male cause (02) azoospermia was reported among both. Most of the women (19) were suffering from primary infertility whereas three were diagnosed with secondary infertility. With regard to use of ART, nine of the women had undergone IUI, seven had ovarian stimulation for the preparation of IUI, three had IVF and two had IVF as well as IUI whereas one had undergone artificial insemination. Most of the women (17) had not used any contraception method. Among the five women those reported use of contraceptive methods, two used pills whereas three used barrier method.

Section II: Findings Related to Lived In Experiences of Childless Women

This section give details about the meta-themes, themes and subthemes as emerged about the phenomenon with the help of verbatim of participants. Six meta-themes, sixteen themes and forty seven subthemes were used to describe the living in experiences of childless women.

1. IMPACT OF INFERTILITY

As women shared their infertility, the first meta-theme that emerged from the data expressed the impact of infertility. Within this three salient themes emerged as: A. Emotional impact B. Impact on personality C. Impact on life. These themes describe specific ways in which infertility has impacted women’s life. Almost all the participants reported that infertility eroded and interfered with all aspect of their lives and presents major life challenge to those who desire children.

1A: EMOTIONAL IMPACT

The first theme in this meta-theme describes the emotional impact of infertility on women. Participants reported wide range of emotions including i) Less than others ii) Constant stress iii) Hope Disappointment cycle iv) Desperation v) Feeling of guilt and self blame vi) Nobody to share.

1 A (i) Less Than Others

Infertility leads to a feeling of lacking behind. Almost all the participants shared the feeling that they are left behind than others/ friends of the same age. Feeling of not being complete was very apparent among the participants. Participants shared feeling of jealousy towards fertile women
who were able to conceive which added to the feeling of lacking. Nine out of 22 participants felt that the normal course of being married, having children and rearing them was interrupted due to infertility and they are not able to follow normal time schedule and were being left behind.

1 A (ii) Constant Stress

Participants expressed feeling bad about being infertile. Feeling of wastage of efforts in terms of taking treatment while bearing all the pain and spending money without any result was very apparent. Women felt nothing was helping them and the struggle seemed never ending. Infertility seemed to overpower women and they felt overwhelmed with the thoughts of having a child, sometimes all day long. A constant stress of having a child and fear of wasting resources was reported almost by all women.

1 A (iii) Hope Disappointment Cycle

The journey of infertility was perceived as a cycle between hope and hopelessness by participants. At one point, life seemed to be promising whereas on other occasions they saw no hope. Life with childlessness swings between hope and crashed hopes. Hopes rising with initiation of new monthly cycle or new treatment options and then crashing or feeling disappointed either due to probing by society or with initiation of monthly flow. After years of trying various modalities and when nothing seemed to help, women reported losing hope and faith and thought of leaving treatment in between.

1 A (iv) Desperation

Participants verbalized desperate desire to have a child. Life seemed to be stuck and they felt that they were unable to move ahead without having a child. Participants shared their desperation in terms of undergoing any procedure, bearing pain up to any extent and using any technique to have a child. Women seemed to be more desperate due to social pressure or constant reminder of their infertility. Participants expressed how they were ready to face any pain or investigation in order to have a child.
1 A (v) Feeling of Guilt and Self Blame

Many participants expressed the feeling of guilt specially where families were very supportive. Children were considered to bring happiness, prosperity and a woman is looked upon to give this to household. One of the objectives of marriage is to have child. Women, who were not able to bear children after marriage over the years started feeling guilty of not giving this happiness to their husband and family. This feeling of guilt lead to non expression of true desires and further bottling up of emotions. At times guilt leads to self blame and participants started projecting themselves as the cause of infertility. Failure of reproductive system to give desired results lead self projection and blame as she is supposed to be one to deliver. Societal paradox and diagnosed female cause of infertility worked as catalyst in the spiral of emotions.

1 A (vi) No Body To Share

Another trauma of infertility which participants expressed was their inability to share their thought, feelings and emotions with anyone as they could not find anyone who could understand them or they were at loss of words to explain their feelings.

1 B: IMPACT ON PERSONALITY

The second theme in experiences of infertility emerged was personality changes among participants. In this, participants revealed how infertility leads to personality change and how it affected them. Four subthemes reflected these expressions as:

i) Being more agitated ii) Emotionally weak iii) Loss of confidence and low self esteem iv) Loss of interest in life

1 B (i) Being More Agitated

Constant reminder and stress of infertility lead participants to be angry/ agitated. This change in personality was reported by almost all the participants who felt that continuous tension of infertility generated anger, agitation towards self and others surrounding them. Anger seemed to be projection of frustration of lacking and not getting what they had expected from life.

1 B (ii) Emotionally Weak
Constant tension and stress wore out participants and left them emotionally weak and devastated. Participants reported that they felt like crying on little things and had feeling of giving up. Women felt that people were trying to find fault in them and that constant struggle to preserve self breaks their defense and made them more vulnerable to comments. On the other hand, five participants reported enhanced strength from this experience. These women expressed that the experience of infertility helped them to become mature, tolerant and patient. Despite being in constant struggle and trauma, participants reported that they were able to learn and develop with it.

1 B (iii) Loss of Confidence and Low Self Esteem

Feelings of guilt, self blame and emotional weakness ended up in loss of confidence among childless women. Childless women stated feeling low and loosing self control. Five participants shared lack of confidence and low self esteem due to infertility. They compared themselves to others and felt low and hurt. Women started looking at self through eyes of others, lost confidence and self esteem.

1 B (iv) Loss of Interest

Women reported losing interest in things overtime. Everything seemed useless above the need of having a child. World around them kept moving at its pace, however they were overwhelmed with the thought of child and became oblivious to the surroundings. Each and everything in life focused on infertility. Four participants expressed loss of interest in materialistic things due to infertility. Nothing held their interest and all earlier desires and wishes had come to a halt.

1 C: IMPACT ON LIFE

Participants felt that infertility had profound impact on their lives. In this section, they expressed that while others of same age were enjoying life with their children, they are making rounds to clinics for treatment. Every round and corner took a turn towards their infertility and they simply are not able to enjoy life. Two subthemes contained expression of these as: i) Unfulfilled dreams ii) No life in life.

1 C (i) Unfulfilled Dreams
Many participants expressed that their wish to have a child took over all other aims of life or altered timeline. Many of them reported leaving their job, dream of settling abroad and to achieve great heights in life. Those long cherished dreams and efforts to achieve them were diverted towards having a baby or to deal with infertility. Everything else took backstage while dealing with infertility became a prime importance.

1. C (ii) No Life in Life

Life seemed to hold no promise for infertile women. Many of the participants reported having no interest in life anymore. Constant stress prevented them from having leisure time as others of same age. Apart from this, majority of them felt lack of happiness in life. Infertility seemed to take away everything from them and they were left with a dry and purposeless life to deal with. Participants expressed that they were not able to get any leisure time for themselves due to continuous struggle and making rounds to the clinic for treatment.

2. ENVIRONMENTAL INFLUENCE

The meta-theme of environmental influences on infertility was identified from the 22 participants’ description of their infertility experience. Further analysis of the data within this theme revealed three salient sub themes:

A) Influence of society B) Influence of religion C) Influence of culture

2 A: INFLUENCE OF SOCIETY

All participants reported perceived societal messages and believe regarding infertility. Society seemed to influence the experiences of women with infertility. The way they perceived importance of motherhood was influenced to a great deal by societal messages and beliefs. This theme comprised of four subtheme as:

(i) Blame for infertility (ii) Social pressure to conceive (iii) Remarriage of husband (iv) Reputation in society

2 A (i) Blame for Infertility
With delayed pregnancy, women become target of blame by the society. They reported being tormented with taunts and abuses from family members and sometimes neighbors. Participants expressed feeling of loss and facing blame on regular basis. Women were often compared with other women who were fertile and were able to retain their position in family and society. Often daughter-in-laws were blamed for the expenditure that occurred on treatment. Infertile women were considered as inauspicious and one participant even reported being discriminated.

2 A (ii) Social Pressure

In some cases, relatives mostly of the husband’s family had frequent contacts with the women and this made the pressure even worse for the participants. Family members tended to get involved in decision making and everyday life of the couple, especially when they lived in a joint family. When a participant was unable to have a child, the family becomes more involved in the couple’s lives and added to her agony. They suggested solutions to the couple without even being asked. Nearly all participants in the study faced social pressure, directed mostly by close relatives, neighbors and in-laws, for the non performance of the given role of a woman. Social pressure and stigma was higher among participants who lived in rural area and those with low socio economic status.

2 A (iii) Fear of Remarriage of Husband

Just like other developing countries, child bearing is considered a social requirement and a necessity for married women in India too. These norms are deeply rooted in the belief system of the people and are supported by religious and traditional perspective. Thus, motherhood was considered a virtue of the new bride, lack of which made her incompetent. Once she was not able to prove her significance by conceiving, remarriage of husband was a commonly quoted alternate. Quite often, if the wife was the case of infertility, she suggested to her spouse to find another partner, so that he could experience fatherhood. Participants often were pressurized for second marriage of their husbands.

2 A (iv) Reputation in Society

Participants were considered lower to others due to their inability to fulfill predesigned role of female as approved by society. Participants also expressed that giving birth to a child boosted up their respect and honor in the society. They also verbalized their feeling of being treated as
second citizens by the society due to their infertility and how other fertile women were given more importance even though they did not possess any talent.

2 B. INFLUENCE OF CULTURE

The second theme that emerged under environmental influence was influence of culture which further comprised of four subthemes: i) Cost of treatment to be borne by women’s parents ii) Decision making iii) Nondisclosure of male infertility iv) Preference for a male child

2 B (i) Cost of Treatment to be borne by Women’s Parents

Under this subtheme, women shared their experiences of being subjected to humiliation and lack of finances. If a female was diagnosed as the cause of infertility, her parents were supposed to bear the burden of the treatment. It may be noted that these experiences were more profound among women belonging to low socioeconomic status with lower level of education.

2 B (ii) Decision Making

In patriarchal culture, a woman is expected to be submissive and must agree to the decisions made by her husband in order to prove herself as a dutiful wife. Newly married woman are not entitled to make major decisions regarding her life as well as treatment. Treatment seeking methods were also decided by family members and couples had no say in it. It was presumed that male partner had no medical problem therefore; his medical examination becomes a family issue.

2 B (iii) Non Disclosure of Male Infertility

Male infertility carries a bigger taboo and as his virility is questioned. Men are supposed to be masculine and capable of producing and their infertility poses a question to their capability as men and a threat to their responsibility to carry family lineage. Infertility is primarily considered a female disease. Whenever a male was diagnosed with infertility, the wife had to bear the brunt
and hide it from others as this was a big blow to the male ego. Couples opted not to go to nearby hospital/clinic for treatment for the fear of being recognized by people.

2B (iv) Preference of Male Child

In the Indian culture, a boy is preferred to a girl child owing to cultural norms and religious beliefs. As per cultural norms, a girl child moves to her in-laws house after marriage and only a boy can look after parents in old age. Children of boy only can carry forward family lineage and only a male child can secure the future of his parents. Participants expressed that even though they do not differentiate between a boy or girl child, social and cultural norms however forced them to follow such rules and wish for a male child.

2 C. INFLUENCE OF RELIGION

Third theme under influence of environment emerged as influence of religion. During the interview, all participants at one time or another expressed their faith in God and majority of them attributed their struggle to their past deeds (karmas). Two subthemes under this theme are: i) Divine intervention ii) Game of destiny and past karma

2 C (i) Divine Intervention

In India, religion has a strong influence on life. Many beliefs and values related to procreation are embedded in daily life and originate from holy books and ancient stories. God is considered as creator and He only can give life. Belief in God played a significant role in the life of infertile women who believed in divine interventions to bless and help them to recover from struggle of infertility.

2C (ii) Game of Destiny and Past Karma

As per Hindu Mythology, apart from God a person’s own deeds are also believed to decide the course of life. Participants believed that their struggle might be the result of their past karmas. Destiny of a person is decided by the karma which he/she perform. Thirteen participants expressed their belief in destiny and karma which originated from faith in God and religion.
They perceived infertility as a punishment for their past karmas. Thus religion played a significant role in perception and experiences of infertility among women and provided them an anchor during turmoil of emotions.

3. EFFECT ON RELATIONS

Third meta-theme which emerged from the interviews was effect of infertility on relations. Relations were categorized under three subthemes as: A) Marital relations B) Relations with family C) Social relations.

3A: MARITAL RELATIONS

Majority of the participants felt that their relation with husband was good. They felt that their husband had been supportive through their journey. Whereas three participants who were not fortunate enough to have support of their husbands had to bear the wrath of taunting and neglect. It mainly occurred among participants with low socioeconomic status due to lack of funds for expensive treatment. Financial aspect of treatment and failure to conceive distorted the marital relations. Almost all participants felt that their husbands did not share their feelings with them even if wives asked for it. Many a times wives felt that husbands also want to have a child but did not say so. All participants expressed that their sexual life has been altered due to infertility and at times husbands complain about it. Childless women face various problems in their sexual relations due to infertility which in turn have indirect effect marital relations.

3B: RELATION WITH FAMILY

Infertility impacts all aspects of woman’s life including relations with family. As a daughter in-law of family, a newly married woman is expected to give good news of pregnancy as soon as possible. When this does not happen, families who are educated and live in cities try to help these couples by suggesting different treatment modalities, whereas those who are less educated and live in villages start blaming and taunting woman thus leading to perverted family relations. Two subthemes emerged from the theme of relations with family as: i) Family support ii) Parental family support.

3B (i) Family Support
Overall, it is the womenfolk (mother-in-law) in the family who supports or jabs women with infertility. Participants who had family support expressed to be less pressurized and stable as compared to those who did not enjoy family support. Family support at times proposed suggestions for treatment, paying for treatment and preventing daughter-in-law from taunts and feeling low. Few of the participants expressed non-cooperation from in-laws family and faced the threat of husband’s remarriage.

3 B (ii) Parental Family Support

Participants expressed that they received maximum support from their parental family especially their mothers. Participants stated that they were able to share with their mother and often sought advice. They felt comfortable among parental family and did not mind being asked about treatment or pregnancy. Mothers helped in seeking treatment and accompanied participants to the clinics at times. They shared that they could easily discuss their feelings with their mothers but on the other hand they were hesitant to share their feelings with mother-in-law.

3 C. SOCIAL RELATIONS

Under the meta-theme of effects of infertility on relations, third theme emerged as social relations. The subtheme under this was social isolation. Participants shared their feelings of remaining aloof and not sharing their feelings with anyone.

3C (i) Social Isolation

Participants expressed their unwillingness to share their feelings with friends as people made fun of them or gossiped later. The stigma related to infertility and absence of true empathizer lead to social alienation and isolation among women. As infertility is associated with stigma and considered as a private issue, participants did not discuss their feelings openly with their friends. Participant stated that they avoided social gathering and celebrations as people kept probing and asking questions which made them uncomfortable.

4. TREATMENT SEEKING BEHAVIOUR
The meta-theme of treatment seeking behavior was identified from the description of 22 participants of their experience with infertility. Further analysis of data under this meta-theme revealed three themes as: A) Modalities Adopted, B) Burden of Treatment C) Knowledge related to ART.

3 A (i) Modalities Adopted

Participants expressed in detail about the treatment journey and different treatment modalities adopted by them. Majority of participants sought help within a year of marriage from a variety of so called “traditional healers” including herbalists, lay midwives, spiritual healers, diviners etc. Participants expressed that their desire to try anything to conceive, even taking injections from quacks or traditional healers. Even those who were educated and had scientific outlook also tried these methods with hope to be blessed. Role of astrologers was also very apparent as per religious belief that positions of stars also play a major role in procreation. Participants also expressed to take a break in between the treatment sometimes to try naturally and sometimes after getting fed up with all that. Participants expressed changing treatment providers after every few months when did not conceived with treatment of the same.

4 A (ii) Experiences Related to Treatment Modalities

Experience of treatment was stated as highly stressful and emotionally draining. From shuffling between doctors, waiting for investigation reports, taking injections and uncertainty made it an ordeal for women. Participants felt that they have not been taken care of well and have not been explained about the ART by medical team. Things were new to them and they could not understand the procedure as nobody explained it. Experience with public health was stated as very harsh with lack of empathy, care and few who tried these facilities felt very heart broken with that experience.

4 A (iii) Consideration of Others View

Views of others played an important role in shaping the treatment seeking behavior of participants. Suggestions related to treatment were provided to participants by family members and neighbors with a hope to have child and participants followed those suggestions. Family members, relatives and neighbors played a significant role in pursuing couples to seek treatment by any method to which couples usually complied. India is a pronatalist society and presence of
a child is considered a must for family and fulfilled life. Hence, suggestions poured in after sometime of marriage and six participants reported to be influenced by those suggestions and sought treatment in an attempt to conceive.

4 B. BURDEN OF TREATMENT

Second theme under the treatment seeking behavior emerged as burden of treatment with three subthemes as i) Effect on health, ii) Financial burden and iii) Stressful day of visit to clinic.

4 B (i) Effect on Health

Participants expressed their concern regarding effect of treatment and medicines on their health and shared signs like losing strength, falling hair, indigestion etc. But they also expressed their wish to overlook every effect in pursuit of conception and having a baby.

4 B (ii) Financial Burden

All participants expressed that treatment was very costly and quite a few of them were facing financial adversity due to this. Participants shared that strong desire to have a child and to avoid taunting and social pressure, they did not hesitate to take loan for treatment. Some of them sought financial help from parents or dear ones. Maximum brunt of infertility was borne by those who belonged to low socioeconomic status in terms of financial adversity.

4 B (iii) Stressful Day of Visit

Third subtheme in burden of treatment emerged as stressful day of visit to clinic. The day of visit to the clinic was perceived as stressful due to test reports and results. Apart from all this, managing household work along with travelling to IVF clinic was another stressor expressed by participants.
4 C: KNOWLEDGE RELATED TO ART

Third theme under the meta-theme of treatment modalities emerged as knowledge related to artificial reproductive treatment with two subtheme as: i) Lack of knowledge and myths related to ART ii) Fear of failure.

4 C (i) Lack of Knowledge and Myths Related to ART

Participants expressed lack of adequate information regarding ART and mostly relied upon the general talk for knowledge related to it. Infertility being stigmatized is not being discussed openly and often women taking treatment also do not share about it at great length. Participants also expressed dissatisfaction with the inadequate information provided by health care providers. Further data analysis revealed myths prevalent in community regarding ART especially IUI. Participants shared that they do not disclose about the mode of treatment to anyone with fear of stigma attached with it.

4 C (ii) Fear of Failure

Intensive and rigorous treatment regimen of IVF was a source of fear among one forth of participants. Participants expressed their fear related to injections and procedure due to lack of knowledge and side effects of medicines administrated during regimen. Women entered in treatment with high hopes or took ART as last resort to end their struggle with infertility. This made them more vulnerable and fearful regarding failure after spending so much money and bearing pain. They could not think of life after IVF failure and termed it as most devastating experience they had ever faced.

5. COPING WITH INFERTILITY

The fifth meta-theme which emerged form interviews of participants focused on how they coped with infertility. Infertility was explained by participants as major stress in life, but the coping strategies to encounter this stress varied among them. Two salient themes identified with in this meta-theme were A) Emotion Focused Strategies and B) Problem Focused Strategies. Even
though participants used both strategies but emotion focused strategies were used more frequently.

5A. EMOTION FOCUSED COPING STRATEGIES

Under these strategies participants used three types of emotional coping as Continence (efforts to set emotions and actions), Escape (cognitive efforts to avoid problem) and Avoidance (minimizing importance of situation). Many times participants used more than one strategy to cope with profound stress and trauma of infertility. Participants shared their coping behavior with regard to infertility in terms of turning to God for strength, crying alone, watching TV, listening songs, sitting alone and avoiding thinking about situation.

5 B. PROBLEM FOCUSED COPING STRATEGIES

Problem focused strategies include one’s effective acts with respect to stressful condition and to remove or change the source of stress. Under this subtheme participants shared use of social support demand, taking responsibility (accepting self-role in problem in an effort to solve things) and double positive evaluation (adding positive meaning and focusing on personal growth). Here also participants used various techniques in congruence with emotion focused strategies.

Participants tried to share their thoughts with other childless women and with others to seek social support, try to be part of social life and to deal with their pain. Apart from these, all participants actively participated and tried various treatment modalities as coping such as taking responsibility for the crisis of infertility and tried to deal with it.

6. DESIRE OF MOTHERHOOD

The sixth meta-theme identified by participants description of their experiences with infertility focused on desire of motherhood. From the participants description two sub themes emerged from data. The two subthemes were: A) Factors affecting desire for motherhood B) Adoption.
6A. FACTORS AFFECTING DESIRE FOR MOTHERHOOD

The first theme under the meta-theme emerged as factors affecting desire of motherhood. The main reason for preference for children was to get relief from social pressure to procreate and to maintain family lineage and inheritance. Life without children was perceived not worth living as there was no aim or happiness in life. Participants also expressed desire to experience motherhood by virtue of children and seeing others enjoy their life with kids. Women expressed that their husbands also wished for baby though do not say directly and women could sense their need of having a child which in turn built their trouble and guilt.

6B ADOPTION

Second theme under the meta-theme of desire of motherhood emerged as adoption. This theme of adoption included three subtheme as i) Self views, ii) Husband’s view and iii) View of family.

6B (i) Self Views

Participants expressed their desire to adopt in order to experience motherhood. Adoption was only acceptable from own family as blood line has to be continued. Very few were ready for adoption outside the family. But first preference for majority of women was own biological child. Few participants were aware about the option of surrogacy. Regarding donor egg or sperm, donor egg were more acceptable than donor sperm considering cultural and social norms.

6B (ii) View of Husband

Participants expressed their husband view related to adoption. For majority husbands were not ready for adoption stating various reasons. Only two participants expressed that seeing and sensing their pain and despair their husbands have agreed for adoption even though among these two, one of participant herself was not ready for it.

6B (iii) View of Family

Participants those who were ready for adoption expressed their inability to do so due family constraints as family were not accepting and supportive for adoption. Even though these participants wanted to go for adoption but they could not do so.

CONCLUSION
Based on present findings it can be concluded that after marriage child birth is uppermost obligation of Indian women. Infertility experience and its effects on women is very sensitive topic, as achievement of motherhood is considered a responsibility of a daughter-in-law in family. Infertility was perceived as a life crisis and had an impact on all spheres of life of childless women. Marital and social relations got affected. Probing and feeling of incomplete leads women not to participate in social activities and preferred to be alone and not to share their true feelings with anyone. Childlessness leads to psychological consequences and women encapsulate themselves to avoid social repercussions of the same. Childlessness had major religious and social implications for women because fertility proves identity of women and is highly valued. Because of social norms childless women reported to have lesser status and prestige in community. Women face threat of remarriage of husband and to be send back to parent’s home especially in low income group with low education. All childless women were trying to have a baby with the help of allopathic treatment (ART) along with religious practices but the lack of information and knowledge related to infertility treatment made the alternative remedies also acceptable. Women shared using emotional focused and problem focused coping strategies. Adoption was not accepted as a coping strategy by majority of women owning to reasons ranging from non cooperation of husband and family to social stigma related to the same. Feeling of motherhood, continuing of family lineage, security in old age and to escape from the social stigma and blaming were the main reasons stated by women regarding need of child.

**IMPLICATIONS OF THE STUDY**

The findings of the study have several implications discussed in the following areas:

**Nursing Practice**

As childlessness happens to be highly emotional phenomena eroding all spheres of womens’ life, nurses working in infertility units can utilize counseling skills to let women explore their behaviors for coping with infertility and emotions, seeking support, sense of control and optimism. Nurses can design and implement psychological support programmes for woman/couples to deal with emotional and sexual inadequacies which childless woman
experience. Keeping in mind the personal and social beliefs in mind health education programs in clinics can help couples to find when and where to seek help. This in turn will decrease misconceptions and anxiety. Nurses can use of evidence based practice to inculcate alternative therapies and medicines for the treatment of infertility and can provide practical skill training such as relaxation skills. Going through diagnostic procedures and advance technological procedure can be traumatic and stressful for woman. Nurses should work towards creating comfortable medical environment to reduce the stress of treatment.

Nurses are expected to be problem solvers and multi taskers who take on a multitude of responsibilities. They are the most important bridge between highly technical information and physician prescriptions and their patients’ ability to understand and implement the treatment. They should be aware of patient centered fertility care and provide Information to women regarding procedures, medication regimen and lab investigation. Nurses are in a potentially unique position in the assisted reproductive technology environment in that, unlike other professionals who move in and out during the treatment cycle, they maintain a more constant contact with the client. Working in fertility units can lead to new roles on knowing, trusting and intimacy in nurse patient relationship. The continuous nursing presence can include coordinating between multiple components of ART process, women’s emotional and physical experience and different roles of the specialist team members. Nurses are also expected to follow legal and ethical protocols in line to national guidelines and maintain confidentiality of couple’s status.

Nursing Education

Although content related to the infertility and clinical experience in obstetrics and gynecology is incorporated into the basic nursing education at undergraduate and post graduate curriculum in midwifery nursing, an awareness needs to be created among nursing students at basic and post basic level regarding the magnitude of problem and significance of empathetic care in reducing stress among childless women. Analysis of the syllabus of different nursing programmes reflect that though content related to infertility and experience are incorporated in curriculum but only conventional methods of teaching are still in practice. Teaching of new advance technologies can be done via media as videos and webinars. Standards of nursing practice and protocols should be developed and updated on an ongoing basis regarding care of childless woman. Student nurses undergoing various nursing programmes should be provided
with adequate learning experience in infertility clinics and community health care settings. Further, an advance sub specialty of “fertility nursing” can be developed with input from science of psychology and medicine to enable nurses in these settings to deal with paradox of technological advancement and emotions of infertile women/ couples and to help them to deal with this crisis of life. Nurses should receive training in acquiring skills of counseling in the provision of support to childless woman to ensure safe and effective practice.

**Nursing Administration**

The role of the infertility nurse is continually expanding and changing to meet the demands of couples undergoing assisted reproduction. Members of the nursing staff are involved in initial consultation, transvaginal ultrasound scanning, intrauterine inseminations, administration of medication, sperm preparation and pregnancy tests. Infertility nurses play a major role in ovulation induction programmes and monitoring of woman. The staff development programme for nursing personnel in clinical area are inadequate in existing health care system. In the event of ever growing challenges for infertility nurses, nurse administrators have a responsibility to provide these nurses with staff development opportunities. Nurse administrators should create and provide continuing education opportunities for fertility nurses if quality nursing care is expected. Clinical nurse specialists and certified nurses should be prepared and should be encouraged to be resource parsons for other health care providers to provide specialized care.

A continuing education department, well equipped with innovative information technology should be established to conduct regular in service education programmes for nurse to update their knowledge, decision making and skills regarding providing care to childless couples keeping in view of their socio cultural and religious believes. Nurse administrator must equip Infertility clinics with recent literature available and should make funds allocated for specialized training or fellowships for fertility nurses.

**Community Health Nurse**

Infertility is highly sensitive and private yet a social phenomenon. Religious and social believes have implications on treatment seeking behavior of childless women. Community health nurse can take initiative to provide an integrated, professionally facilitated group support to the couples suffering with infertility. Owing to high incidence rate of reproductive tract infection and
sexually transmitted infections providing sexual and reproductive health education is an important strategy that can reduce the prevalence and gender specific burden of infertility. To rule out sexually transmitted infections initial assessment can be done by community health nurse. Education regarding association between sexually transmitted infections and tubal infertility should be disseminated via basic fertility education with help of village health worker. Dissemination of reproductive health and fertility knowledge via leaflets, health talks or organizing programmes in community can be implemented.

Sensitization, counseling, foster care and awareness in community with help of elderly, local and religious leaders are needed so the childless women are not stigmatized and discriminated based on social and religious beliefs. To build up reproductive health and to empower women community health nurse can conduct informative session among adolescents and young women regarding reproductive and fertility health. Community based interventions for infertility require an understanding of perceived causes of infertility and reasons behind treatment seeking behavior from community perspective. While organizing and implementing reproductive health programs socio cultural beliefs that enhance human health needs to be appreciated while others that hinder health can be identified. Community health nurse should create awareness regarding available treatment option to prevent quacks and traditional healers to take advantage of desperate couples.

**Policy Makers**

As infertile woman had vast collection of negative feelings simultaneously, so specialized medical and psychological support programes needs to initiate to combat social and emotional problems. Policies related to financial and insurance aids can play an important role in reducing the families’ vulnerability during medical treatment. There is need to improve medical facility especially in rural area because seeking treatment from religious or traditional healers is more common there. Policies related to conduct physical assessment and simple diagnostic procedures to be carried out by primary health care providers and specialized tertiary care centers can reduce the treatment burden on couples. Local health care providers can be empowered in terms of knowledge and skill to carry out initial diagnostic tests.

Regularization of private health sector with public private partnership with careful monitoring can reduce misuse or exploitation of couples. Guidelines should ensure that rights of childless
women are not compromised. The results of the study suggest that the role of public sector in infertility management is limited and does not provide quality care. Infertility services need to be provided and streamlined in public sector as this would save the anxiety and expenditure of poor patients. To provide comprehensive care to childless women considerations of priorities in health resource allocation, costs, feasibility, quality control, sustainability and equity and access to health care are important in public health care facilities. Financial burden of treatment was main barrier in appropriate treatment seeking among participants of current study. Access to effective health care treatment with in boundaries of affordability should be improved. Assessment and treatment of infertility can be incorporated in Indian System of alternative therapies under National policy of AYUSH.

Mass Media

Mass media can play vital role in creating awareness. Online sources e.g forums and informational websites are simple and effective way to meet psychological needs of couples. Articles in newspapers and magazines in simple language can help in great deal to overcome the myths related to ART among general public.

Health shows and talks on television can be an effective strategies to reach masses to enhance knowledge related to causes and available treatment modalities. Discussion forum may involve people with religious, social and scientific outlook to discuss all aspects on infertility. Media can propagate and aware masses regarding information on adoption agencies and legal procedures for the couples who want to go for it but have lack of knowledge about agencies and procedure involved.

LIMITATIONS OF STUDY

- Collection of data from one infertility clinic can be the limitation of study. Exploration of experiences of childless women from multi centers could have helped in wider generalization of findings.

RECOMMENDATIONS

1. A similar study can be conducted to explore experiences of male partner and childless couple as a unit.
2. A study can be conducted to gain insight in the experience of childless women who have undergone successful ART treatment.

3. Similar study can be conducted on childless women who have received extensive infertility treatment and have discontinued treatment.

4. A study using Mixed Method Design can be conducted to understand the extent of impact of infertility among childless couples.

5. An outcome evaluation of psychosocial interventions provided to childless couples can be done.

6. A qualitative exploration of experiences of couples those who have adopted a child may be undertaken.

7. A study to assess the effectiveness of self-help groups/support groups on coping abilities of childless women can be conducted.

8. A meta-analysis of existing studies can be conducted to explore the mechanism of integration of comprehensive infertility care in the existing health care program.

9. Longitudinal evaluation of community education programs to reduce stigma and misconceptions in society related to infertility may be undertaken.

10. A qualitative study to analyze the gains through loss in terms of post traumatic growth among couples after unsuccessful assisted reproductive technology treatment may be conducted.