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Health Care for the Infertile: A Sociological Perspective

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Abstract
Infertility has become a worldwide problem, particularly salient in third world nations. This has spawned a rising demand for infertility treatment. In the context of India, it has become a stigmatized health issue hidden under the country’s multilayered and complex healthcare system. The rising demand for infertility treatment is plagued by inequitable access and lack of information and awareness. It has predominantly affected the marginalised sections of the society and underscores the need to promote education among the infertile couples on the many aspects of infertility treatment. In this broader context, this review paper examines the prevalence of infertility in India and the socially constructed nature of infertility in the Indian society. It has also dwelled upon infertility treatments and access to reproductive technologies within the broader neo-liberal market context.

Keywords: infertility; treatments; accessibility; health; reproduction.

Introduction
Infertility is a disease marked by an inability to conceive after a year of unprotected conjugal life. Primary infertility pertains to the failure to ever achieve pregnancy; Secondary infertility pertains to the inability to achieve pregnancy after one prior pregnancy. According to the World Health Organisation (WHO), an estimated 60 to 80 million couples in the world suffer from infertility (WHO, 2004). The regions having the highest incidence of infertility are “South Asia, Sub-Saharan Africa, North Africa/Middle East, and Central/Eastern Europe and Central Asia” (Mascarenhas et al., 2012).

Using data from the National Family Health Survey (NFHS), a study by Purkayastha and Sharma (2021) found that primary infertility prevalence among women in India has decreased from NFHS-I (1992-1993) to NFHS-III (2005-2006). However, NFHS-IV (2015-2016) indicates an increase of 30.02% in the prevalence rate of women infertility when compared to NFHS-III (2005-2006). According to a WHO study, infertility prevalence rate in India falls between 3.9% to 16.8% (WHO 2004). Infertility prevalence rate is also found to vary across regions in the country as well. For instance, infertility rates for the states of Uttar Pradesh, Himachal Pradesh and Maharashtra stands at 3.7 percent, while Andhra
Pradesh and Kashmir region have 5 percent and 15 percent respectively (Talwar & Murali 1986; Unisa 1999; Zargar et al., 1997). Furthermore, primary infertility prevalence is also found to vary across different tribes and caste groups within a region in the country (Talwar & Murali, 1986).

Infertility has several adverse consequences on the institution of marriage. It has led to, inter alia, divorce, husbands deserting their wives, social avoidance, labelling of women as inauspicious, and incomplete (Unnithan, 2010; Bell, 2009; Reissman, 2000). In some societies the infertile women are prohibited from attending social events on the ostensible reason that it is inauspicious to have the presence of infertile women on such social occasions. How people perceive infertility is an important aspect of its constructed nature within a given socio-cultural milieu. Infertility has various psychological effects on women, including, inter alia, a negative perception of self and by others, a sense of uselessness and inadequacy, loss of self-control and powerlessness, anger and self-resentment, anxiety and stress, and a sense of isolation (Greil et al, 2010).

Domestic violence is the most common problem faced by infertile women. An estimated 30 percent of women in the world have faced domestic violence in one form or another (Sharifi et al., 2022). A study done in the context of India found that about 26 percent of women have been victims of violence from their spouses (Jeyaseelan et al., 2007). Women bear the major burden of infertility. The feeling of loss that is associated with infertility affects women more profoundly than men (Greil, 1991). Although it takes both women and men to procreate, the process of treatments is highly gendered (Nadimpally and Marwah, 2016). Women bear the major burden of infertility even when male infertility is the culprit. Inhorn (2003: 238) observed that despite men contributing significantly to worldwide infertility, they “do not bear more of the social burden for infertility”. They further attribute this to the operation of “patriarchy as a system of gendered oppression” wherein women’s bodies bear the burden of infertility through the failure to achieve childbirth while men’s bodies conceal the evidence of reproductive defect. Men usually refuse to go to clinics to get themselves checked – fearing that the problem might be with them. In a patriarchal social milieu, the acuteness of the shame and stigma associated with it makes male infertility as a direct blow to a man’s ego. Thus, the perceptions around infertility and its varying consequences across different communities underline the importance of studying infertility as a socially constructed process.

The Social Construction of Infertility

Greil et al. (2011) argue that social construction of health and illness is more conspicuous in the case of infertility than other health conditions for various reasons. First, irrespective of how medical practitioners define infertility, couples may not identify or define themselves as such or seek medical treatment unless they
decide to be parents. Secondly, though medical practitioners treat infertility as a problem affecting the individual, it is often seen as a problem affecting the couples regardless of whether infertility is due to one of the partners. This, therefore, implies that defining infertility requires a negotiation not only between the individual and the medical practitioners but also between partners and the wider society. Infertility has been majorly seen as a medical problem to be treated rather than seeing it through the lens of social construction (Bates and Bates 1996). It is perceived by some as a medically diagnosed physiological characteristic called “reproductive impairment” (Greil et al., 1988: 174). Others see it as a curse inflicted upon them as a result of wrong doings in their past life.

Female infertility is commonly understood as the inability to conceive a baby or carry a pregnancy; male infertility is defined as the inability to impregnate a fertile woman (Menning, 1977). This conception of infertility, which centres on biological aspects of the problem, is widely adopted in statistical analysis of the extent of infertility. However, sociological studies of infertility should give attention to the social and subjective aspects of how people understand infertility, factoring in the socio-economic milieu in which they are located. For instance, from the perspective of social constructionists, infertility is interpreted as barrenness or a curse, which is also highly stigmatized in society (McGuirk & McGuirk, 1991).

According to WHO, infertility is a major reproductive health issue. While women’s role and status should not be determined by their fertility, in many societies, motherhood is commonly deemed as the only way for women to negotiate their significance—both within family and society (Cousineau and Domar, 2007). As such, infertility burden is perceived as gender-based (Serour, 2008; Hasanpoor-Azghady et al., 2019). Motherhood is a highly gendered role that measures a woman’s performance. Non-performing bodies of infertile women are perceived as a distortion or abnormalities that need to be corrected (Nadimpally and Marwah, 2016). In this sense, being infertile is a great loss for women because motherhood gives women a sense of identity and wider social acceptance.

**Social Responses to Infertility in India**

Infertility has various social, psychological and economic consequences. In India, infertility is often equated with bereavement and engenders a sense of low self-esteem and powerlessness. For women, having a child is seen as fulfillment of motherhood role and as a sign of femininity; for men, it is regarded as a sign of sexual potency. For women, infertility is perceived as tantamount to losing control over one’s own bodies. It engenders constant questioning and monitoring of women’s bodies for the purpose of finding any possible reasons for their inability to conceive. Both within the family and wider social circles, the quotidian life of infertile women becomes a subject of constant scrutiny regarding food habits, behaviour such as smoking and alcohol consumption, among others. The following
sections dwells upon the diverse consequences of infertility under relevant themes through the lens of social construction.

**Name-calling**: Infertility has multifarious effects in a couple’s lives. But in India, infertility is generally deemed as woman’s problem. The implication is that women bear the major burden of infertility problem and its gendered consequences. Various pejorative names – such as *manhoos or vanjh* (used in rural Rajasthan and Bhiwandi-Mumbai to connote barrenness or infertile women), possessing evil eye, and visiting tantric (person performing black magic) – are used to address infertile women that are demeaning, embarrassing and undermining a woman’s self-worth (Sheoran and Sarin, 2015; Unnithan, 2010). Name-calling is more or less a universal phenomenon. Even outside India, for example, in Bangladesh, infertile women are called by various names which have negative connotations attached to them (Papreen et al., 2000). Terms such as *poramukhi* (burnt face) are used to refer to infertile women. In medical sciences too, various terminologies – such as, “hostile mucus, blocked fallopian tubes, incompetent cervix and failure to conceive” – are used for the construction of infertility as physical impairment (Ulrich & Weatherall, 2000: 324).

**Societal and Familial Pressure**: A woman’s capability or expertise is judged on the parameters of “fertility” or the potential to give birth. More than a personal choice, it becomes the fulfilment of the wishes of the family. A woman’s body is not regarded as her own, but “for others”. Therefore, decisions concerning her body are taken up by the family, community, religion, state, etc. in that order. If for any reason a woman turns out to be infertile, she is fated to confront the glares and questions of society.

Sheoran and Sarin’s (2015) study in Haryana mentions a young infertile woman of 23 years who underwent various invasive procedures (hysterosalpingogram) just to prove to herself and her family that she is not infertile and therefore cannot be blamed for it. The inability to conceive becomes a matter of concern not just for family but even for neighbours who do not think twice before getting involved in the couples’ lives by pressurizing infertile women to seek treatment. When a woman is infertile, she experiences strain in her marital life. The societal perception deems it to be fair if the husband wants to remarry as a solution to infertility. However, in a reverse case of male infertility, society expects a “woman to be supportive of her partner’s “infecundity and take blame in social scenarios” (Rouchou, 2013: 176).

**Situating infertility in different terrains**: The response against infertility varies depending on the social location of the woman, i.e., class, education, caste, religion, region, sexual orientation, among others. In other words, what is required is the situational understanding of infertility. Studies conducted by Rouchou (2013) and Boerma and Mgalla (1999) show that in China and some African countries, women
go through societal pressure of having a child, and that infertility deprives women of their basic rights, such as food, clothes, and property. In their study of male infertility in South India (Andhra Pradesh), Pujari and Unisa (2016) also found that even contemplating the idea of infertility in men is rarely entertained.

Inability to become a father affects men’s masculinity and is hidden from society at any cost. In rural Rajasthan, infertility is dreaded by many and is seen as a form of “social death” (Unnithan, 2010). Unnithan further also writes that gendered and class aspects of stigma related to infertility is found to be higher for women belonging to the poor social strata. The stigma associated with infertility not only traumatizes men and women across geographical regions, but the level of social ostracisation also varies depending on the class position of women. For example, in Kerala, poor village women fight childlessness through their everyday resistance practices. The attempt to de-stigmatize themselves through those practices is mediated by social class and age (Reissman, 2000). In Haryana, infertile women do not get any financial support from in-laws and do not get any say in decision making because they fail to attain motherhood (Sheoran and Sarin, 2015).

Having discussed the socially constructed nature of infertility and its consequences in the Indian subcontinent, the sections that follow dwells upon healthcare for the infertile and the way it has been conceptualised across different intersections. Needless to say, the capacity or opportunity to access infertility treatment and care are shaped and conditioned by the various social and political process. The way infertility is experienced or the access to reproductive technologies are largely shaped by one’s social location and agency (Culley et al., 2009). Assisted Reproductive Technologies (ARTs) have been looked upon from vantage points of the politics of the neo-liberal market which impose these technologies upon women’s bodies but are nevertheless portrayed as technological advancements in the field of medicine.

**Reproductive Politics in the Context of Neoliberalism**

The advancement of technology in the field of medicine has enhanced the relations between the markets of the First-World countries and developing countries like India. Portes (1997) explains from the perspective of economic sociology about the way neoliberal policies became the norm of the global economy. Neoliberal policy has largely shaped how nation-states sought to manage their economies. It has largely assumed the form of jettisoning the primary sector, deregulation of labor laws, abandonment of steady labor force, transnationalisation of manufacturing, among others. In this milieu of neoliberalism’s triumph, there has been a rapid advancement in reproductive technologies with its concomitant incorporation of Third World countries within its ambit. In this arena of alternative methods of reproduction, the bodies of women from Third World countries have emerged as sites of medical research, experiments and as markets for such technologies.
Reproduction or self-perpetuation is deemed as a pre-requisite for the survival and development of any social group. From this vantage point, society tends to see infertility as an incapacity to fulfill this social pre-requisite of reproduction or as a collective social problem that needs to be addressed. In this context, ART is, therefore, deemed as essential social need (Salter, 2021: 6). This implies that the broader cultural values determine the acceptability or non-acceptability of alternative means of reproduction such as ARTs. However, this demand for ART reflects or further reinforces the hegemonic power of patriarchy. This is reflected in the way the demand for ARTs is constructed, framed or legitimised as a part of the benign efforts to solve women infertility problems. This is notwithstanding the fact that male-infertility also accounts for the problems of infertility (Salter, 2021).

Corea (1985) argues that these reproductive technologies are a product of the systemic patriarchy that ultimately leads to the objectification of women. Corea further has the premonition that just as the “prostitution industry” reduces a woman’s body to market commodities, the reproductive industry would soon also render women’s bodies (such as the womb, ovaries and eggs) as market commodities. Medically assisted reproduction has now turned into a mega global business. Middle-class couples, once they attain economic security, increasingly avail the services of ARTs (such as IVF, donor gametes, or preimplantation genetic diagnosis) to achieve pregnancy or fulfill reproduction requirement. Such pursuits have now become an integral part of the reproductive tourism and involves the purchase of fertility from women belonging to low-income countries. The development of the reproductive bioeconomy is mainly about the compliance, negotiability, and general agency of females (Waldby & Cooper, 2014).

**Healthcare for Infertility:** Decisions such as defining oneself as infertile, seeking treatment (or not), making a choice regarding forms of treatment, deciding about adoption or other alternative means of having a child are embedded in social process (Culley et al., 2009). Widge & Cleland (2009) argue that asymmetrical power relations between men and women, unequal gender relations and roles hinder women’s choice, access to services and facilities and possible treatments – which in turn harm women’s reproductive health.

Nadimpally and Marwah (2016) argue that along with gender, sex and sexuality get constructed through ARTs through the level of discourse, as needing control, and at the level of treatment, through regulation and medicalisation. The socio-economic and political conditions of a country – such as, inter alia, level of educational attainments and quality of healthcare – constitute vital variables that determine access to treatments in different countries (Ombelet, 2011). Data on the economic disadvantages of infertility in low and middle-income countries is limited (Dyer & Patel, 2012). Restrictions and limited access to infertility treatment may happen due to social, cultural, and economic reasons.
Disparities in Infertility Treatment: The utilization of healthcare is different from access to healthcare. According to Culley et al. (2012), access to infertility treatment is a complex concept. It includes need, demand, and supply. Access to infertility treatment is different for developed and developing countries. In developed countries, which are regarded as well-endowed (owing to the availability of resources), where there is need and demand, the supply of new reproductive technologies (NRTs) is mostly accessible. The NRTs are expensive; in some countries, such technologies are acquired by institutions of public healthcare or are covered under private medical insurance (Serour, 2008; Inhorn and Gurtin, 2012). In developing countries, where there is a high degree of need and demand, there is a noticeable lack of supply. NRTs are either not or scarcely available or accessible. Most of the population lack the wherewithal to have access to them. It is not just that these treatments are out of reach for the low-income women, but for the middle- and upper-class women, even if they can afford them, there are very less chances that the treatments will be successful for them.

The socio-economic position of any country is an important variable when it comes to studying infertility treatments which are by and large expensive and perceived differently by different social classes. In developing countries, women of low socio-economic status have different experiences of infertility and cannot afford the various treatments of infertility. As a result, the experiences of socio-economically disadvantaged women, in general, remain invisible (Bell, 2009). Not only is there a lack of information about infertility treatment but are also subjected to less treatment as compared to affluent women. They are perceived as having high fertility levels and contributing to a rising population, while at the same time being excluded from institutions (such as society/family, market/commerce, and state) that control reproduction. While for the upper-strata women not having a child can be a choice, lower-class women do not have that luxury of choice.

Infertility Treatments in India

In Asia, the most prevalent cause of infertility is sexually transmitted infection (STI) and unsafe management of abortion and delivery (Cates et al., 1985). In India, SIT prevalence is found to be high among women having infertility and pelvic inflammatory disease (Kushtagi et al., 1991). The various treatments available for infertility, such as intrauterine insemination (IUI) in vitro fertilization (IVF), and ICSI are unequally accessible among the infertile population. The disparities can be understood in health care that is available in the districts. Hospitals are situated far away from homes in the villages and the health care centers fail to meet the demand of the reproductive health services of women. Poor infrastructure and inadequate health care services lead to ignorance in treating infertility effectively.
In India, the health sector is divided into public and private. The public health sector in India is large but a mere 1.5% of Gross Domestic Product (GDP) has been spent on health in the year 2018-19 compared to 9%-10% in European nations (Desk, 2021). The major difficulties that characterise the public sector infertility management include, inter alia, lack of infrastructure, skills and trainings – a typical feature of developing nations. Further, there is also the prioritisation of other health issues to the neglect of infertility treatment and the lack of regulatory mechanisms. There is a non-implementation of clear protocols at primary, secondary, and tertiary levels (Widge & Cleland, 2009). No days are fixed for infertility consultations in the public sector facilities and there is a lack of provision of information to patients and a clear referral chain (Mulgaonkar, 2001; Unisa, 1999)

Infertile couples are therefore more inclined towards treatment from the private sector. ART services are mostly available in the private health sector. Public health sectors, on the other hand, generally lack the necessary facilities (such as sperm banking or donor materials). Public health sectors have infertility treatment only at the primary and secondary levels and is more time-consuming for the patient. On the other hand, tertiary health care services are however beyond the reach of common people or are hardly accessible in small towns and in the rural hinterlands (Widge & Cleland, 2009).

Despite the presence of infertility treatments, it has been found that only half of the population experiencing fertility issues, go for infertility care (Boivin et al., 2007). Couples usually do not go for treatment until the time they decide to have a baby (Greil et al., 2011). The development of the various treatments in the medical field indicates that infertile couples can be helped to conceive (Culley, Hudson, & Rooij, 2012). However, studies indicate that there is less than a 50 percent chance of the treatment leading to pregnancy). For those who cannot afford the expense of IVF, the relatively cheap and low-tech treatments are drug therapy and IUI (Culley et al., 2012).

In the case of deprived sections of women, infertility is caused by lack of access to nutritious food, reproductive tract infections, etc (Qadeer, 2009; Unnithan, 2010). Sabala & Gopal (2010) argue that the modern medical system views women’s bodies as vulnerable and prone to illnesses. Most of the large-scale profits in the medical industry are achieved by exercising tremendous control over women’s bodies, as well as by manipulating their reproductive health. Technology and the medical community took advantage of the vulnerability of childless couples by exposing them to artificial reproductive technology with the promise of providing a biological child. These technologies are harmful to women (Corea, 1985). The medical profession has a major role to play in assisting women through technological “invasion” and it is done to attain the ideal body for coherence and manageability. The drawbacks in healthcare discussed above demand an
understanding of the loopholes in existing policies and laws in India related to the reproductive health of women.

Public Health Policy and Infertility in India

The state along with other civil bodies has addressed women’s health issues but the policies and approaches have not provided enough attention to infertility. The report by Ministry of Health and Family Welfare, entitled “A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health’ (RMNCH+A) in India”, has recognized issues regarding reproductive, maternal, and child health. It seeks to comprehensively address the healthcare needs of women – from home to the community level (Ministry of Health and Family Welfare, 2013). However, the program has a limited focus on infertility services (Sharma, 2018).

There is a lack of statistics on infertility in the NFHS-5 (2019-2021)iv survey as well. The decreasing fertility rates in most states mentioned in the survey shows the pro-natalist nature of the country and a disregard to recognize the rates of infertility in the country. The National Population Policy boasts of successfully bringing down the total fertility rate from 2.9% in 2005 to 2.2% in 2017 in one of the reports released by the Ministry of Health and Family Welfare (2020). It has by and large overlooked the issue of infertility despite the various policies and interventions on reproductive and child health programs. While the National Population Policy is supposed to address issues of contraception, maternal health, and child survival, it fails to address infertility which is also part of maternal health. Even if infertility has been mentioned in the report, the target has been largely tribal groups and migrant populations who may not be necessarily in need of fertility regulation (Department of Family Welfare, n.d.). The only development that has happened is the propagation of infertility services, but these are limited only to the upper and upper-middle classes. For instance, ART services remain unaffordable for the socially disadvantaged group of women (Widge and Cleland, 2009).

The ART regulation bills of 2014 and 2020 sought to regulate ART banks and clinics with an aim to provide safe and ethical practice of ARTs. While the 2014 bill made provisions for establishing National Advisory Board, the State Advisory Boards, and the National Registry, the 2020 Bill speaks of protecting women and children from exploitation. However, the repeated attempts to regulate the ART industry across the country still fails to address the needs of many infertile couples. It brings in a capitalist approach instead of a well-being approach (Kotiswaran, 2020). The regulation bills speak of a lack of proper protocols and accreditations, the absence of proper laws to protect, for example, surrogate mothers from exploitation, among others. The public health system has largely focused on pregnant women and those trying to prevent unwanted pregnancies. In this context,
as much as it is important to focus on such issues, it is also necessary to extend attention to those who would like to get pregnant but are unable to conceive.

In the area of reproductive health, attention is paid to sexual health and contraceptive services rather than infertility treatment (Culley et al., 2009). It must be noted here that although there is a small fraction of the population suffering from infertility, it is an important reproductive health and rights issue. The effective prevention and management of infertility, as Widge & Cleland (2009) observe, are crucial to women’s reproductive health and their physical and mental well-being.

The situation in India remains dichotomous in a certain way. For a pro-natalist country, a woman’s role is centered around the ability to bear a child. While the state, on the one hand, promotes IVF and ART, which fulfills the purpose of a certain privileged section of women, on the other hand, it fails to give marginalized women access to affordable infertility treatment. It is more focused on reducing the fertility of poor women than improving it (Culley et al., 2012).

There is a lot of information on fertility statistics in almost all government reports but there is a dearth of statistics on infertility in those reports. The lack of such statistics is a result of pro-natalism in Indian society, which is also represented in the way infertility is perceived by the Indian society differed on lines of caste, class, gender, and sexuality. The barriers to ART treatment in developing countries are its expensive nature and low success rate. Barriers also include shortcomings of healthcare systems that even struggle with infectious diseases like malaria, tuberculosis, gonorrhea, and HIV; the public health strategies that that focused on reducing total fertility rates; and ignoring the experiences of infertile women in the backdrop of the disparities in infertility treatment.

Summary and Conclusion

The paper has attempted to give a comprehensive outlook on how infertility is socially constructed in different settings. It brought in the arguments surrounding reproductive politics and its interplay in the neo-liberal market. The paper then discussed infertility treatments and critically analyzed the nature of healthcare for infertile women in India. Although government facilities have infertility treatment available, it is largely ineffective. This happens for several reasons, such as the lack of coordination between gynecologists and other medical professionals. Exploitation is prone to take place as the quality and costs of private services vary. When poor women cannot afford expensive treatments, they go for traditional healers, quacks, and private physicians. This not only takes a lot of time but also gives preference to supernatural beliefs over science (Culley & Datta, 2002).

This therefore points towards the need for taking steps that would be instrumental for ensuring that all have access to infertility treatment. Many a times, women are
oblivious of the fact that they may meet the necessary criteria to avail infertility treatment. Further, they also tend to rely on the information shared to them by their family members and circle of friends. This underlines the importance of provisions for professional counselling services and other provisions of social supports (Greil & Mcquillan, 2011). In this context, various reproductive health programmes “can be an entry point for couples with infertility problems”. In certain countries, such as in India and Nigeria, various non-governmental associations have played a vital role in making infertility treatment and management accessible to the larger society (Widge & Cleland, 2009).

Infertility is a rising problem in developing countries, both in rural and urban areas. The social construction of infertility spread across different societies clearly shows that it is a universal problem and that there is a demand for its treatments as well. While some countries give the sole authority to the private health sector, in some other countries like Egypt and Turkey, there is state subsidization to cover the cost of infertility treatment. Therefore, patients’ support networks should also be implemented in tune with the right to have equitable access to infertility treatment (Dill, 2007). To minimize the stress on the couples, there is also a need for medical practitioners and counselors to make couples aware of the success rates of various types of treatment and also the possible effects of couples’ background (age, time, and termination of treatment).

There are many recommendations for the management of infertility in the public health context. Brugha & Zwi (1998) stress on the need for infertility treatment to be affordable, effective and sustainable. There are debates as to whether infertility treatment should at all be included in reproductive health and whether the government should recognize such treatments as important as others. The under-documentation of infertility-related problems among women (especially in rural areas) in India leads to less discussion around this topic both in academia and in the reproductive health-related rights of women. Public health care systems should also pay attention on streamlining infertility services in the backdrop of largely unregulated privatised health care system. This would mitigate the anxiety and financial burdens of poor patients (Widge & Cleland, 2009).

There is no government report which directly records the rate of infertility in India. This absence of statistics does not go well with the huge reproductive industry that is booming in the name of providing alternative reproductive options to infertile women. During population surveys, the enumerators take cognizance only of the number of children in each household. In short, fertility statistics are taken. Until and unless the national reports recognize infertility as a legitimate issue faced by women, the regulation of the reproductive industry will not be possible. This underscores the need for a more research focus upon the reasons behind people not going for infertility treatment even when they know it is needed.
The stigma associated with infertility can be eradicated through awareness campaigns and free-flow communications between doctors and patients. As infertile women feel ashamed and cornered, they end up blaming themselves and, thereby, leading to various mental health problems. Therefore, support groups should be formed whereby infertile women can come together and discuss their problems with others who are going through similar situations in the presence of necessary health officials. Government must make provisions for subsidized infertility treatments and introduce them as policies of infertility care. Lastly, priority needs to be given to solution-oriented and evidence-based research on infertility.

Notes

i Hysterosalpingography or HSG pertains to a procedure that utilises X-ray to determine the shape and conditions of the uterus and fallopian tubes.

ii Pre-implantation genetic diagnosis or PGD pertains to a lab procedure – using In Vitro Fertilization (IVF) – to explore the presence of or reduce any genetic defects in the embryos or oocytes.

iii Intracytoplasmic Sperm Injection or ICSI is a treatment procedure, involving In Vitro Fertilization (IVF), for cases of male-infertility.

iv The National Family Health Survey (NFHS-5 2019-2021) presents statistics in four different schedules: Household, Women, Man, and Biomarker. The Woman’s Schedule covers a range of topics – woman’s characteristics, marriage, fertility, contraception, children’s immunizations, and healthcare, to nutrition, reproductive health, sexual behaviour, HIV/AIDS, women’s empowerment, and domestic violence.

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