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Health Care for the Infertile : A Sociological Perspective

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Abstract: It's no secret that infertility is a major issue in developing countries. As a result, more people are seeking out infertility therapy. As a result of the country's complicated healthcare structure, it has become a taboo subject in India. Even if the need for infertility care is on the rise, unequal access and a lack of knowledge are stumbling blocks. It's a problem that's hit low-income people the hardest, which highlights the need of getting the word out to infertile couples about all the options available to them. In this larger setting, this review article investigates the extent to which infertility is a socially constructed phenomenon in India. It has also focused on the availability of reproductive technology and the availability of infertility therapies within the larger neo-liberal market setting.

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

Introduction

If a couple has tried to conceive for a year without success, they may be suffering from infertility. Infertility may be classified as primary if a pregnancy has never been achieved, or secondary if a pregnancy has been attempted but failed. There are between 60 and 80 million infertile couples worldwide, according to the World Health Organisation (WHO, 2004). "South Asia, Sub-Saharan Africa, North Africa/Middle East, and Central/Eastern Europe and Central Asia" are the areas with the greatest rates of infertility. Purkayastha and Sharma (2021), using data from the National Family Health Survey (NFHS), discovered that the prevalence of primary infertility among women in India reduced between NFHS-I (1992-1993) and NFHS-III (2005-2006). However, compared to NFHS-III (2005-2006), NFHS-IV (2015-206) shows a 30.02 percent rise in the prevalence rate of female infertility. An estimate of India's infertility rate ranges from 3.9% to 16.8% (WHO, 2004). The frequency of infertility varies considerably from one part of the nation to another. Infertility rates range from 3.7% in the states of Uttar Pradesh, Himachal Pradesh, and Maharashtra to as high as 15% in the Kashmir area and 5% in Andhra Pradesh. Primary infertility prevalence also differs throughout ethnic and societal groupings within the same location.

There are a number of negative effects of infertility on marriage. Divorce, husbands leaving their wives, isolation, and the stigmatisation of women as unlucky and lacking have all resulted from this. Some cultures have taboos against infertile women attending social gatherings because it is thought that their presence would bring bad luck. The social and cultural context in which a person experiences infertility has a significant role in shaping their understanding of the condition. Infertility may cause a wide range of unpleasant emotions in women, including feelings of worthlessness, helplessness, anger, resentment, worry, tension, and

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loneliness. The most prevalent issue for infertile women is domestic abuse. It is believed that 30% of women worldwide have experienced some sort of domestic abuse. Researchers in India discovered that 26% of married women had experienced physical assault. The majority of infertility problems fall on women. Women experience the grief of infertility more intensely than males do. While sperm and egg are needed for pregnancy, the procedure of treatment is quite gendered. Even when male infertility is to blame, women often carry the most of the emotional and financial burden. However, contrary to popular belief, as pointed out by Inhorn (2003: 238), males "do not bear more of the social burden for infertility" in the globe. This is explained, they say, by "patriarchy as a system of gendered oppression," in which women's bodies are made to feel responsible for infertility because of their inability to give birth, while men's bodies are made to feel responsible for keeping signs of reproductive malfunction hidden. Men often avoid being evaluated because they believe the issue lies inside themselves. The shame and stigma of male infertility are especially hard to bear in a patriarchal society because of how directly they strike at a man's sense of self-worth. Therefore, the necessity of researching infertility as a socially constructed phenomenon is further emphasised by the attitudes around infertility and its varied implications across various groups.

The Social Construction of Infertility

To begin, until a couple has decided to become kids, they should not consider themselves infertile, use the term "infertility," or seek medical treatment for it. Second, regardless of whether spouse is at fault for infertility, it is often seen as a problem for the couple even though doctors address it as an issue with the person. This means that not only the person and their doctors, but also the couple and the community at large, must come to an agreement on how to define infertility. The social construction of infertility has been largely ignored in favour of treating the underlying medical condition. Some people think of it as a medical condition termed "reproductive impairment" that affects their bodies. Some people consider it a punishment for their sins in a previous life. Male infertility is described as the inability to impregnate a fertile woman, whereas female infertility is typically regarded as the inability to conceive or carry a pregnancy. This biologically focused understanding of infertility is commonly used in quantitative studies of the problem's prevalence. However, sociological studies of infertility should account for the social and subjective dimensions that shape people's understanding of infertility. For example, infertility is seen as a curse by social constructionists, hence it has a lot of negative societal connotations. WHO reports that infertility is one of the top five reproductive health problems worldwide. Though motherhood should not be the only determinant of a woman's position and status, it is often seen as the only method for women to do so in many cultures. Therefore, the infertility burden is assumed to be different for men and women. Motherhood is a sexist performance metric for women. Women who are unable to conceive are often stigmatised for having bodies that do not work optimally. Motherhood provides women with a sense of identity and more social acceptability, making infertility a devastating loss for women.

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Social Responses to Infertility in India

The social, psychological, and economic repercussions of infertility are varied. Low self-esteem and helplessness are common reactions to infertility in India, where the condition is typically connected with grief. Having a child is perceived as a sign of sexual potency for males and a fulfilment of the parenting role for women. Women often equate infertility with feeling helpless over their body. It encourages incessant probing and monitoring of women's bodies to ascertain the cause(s) of infertility. Every aspect of infertile women's daily lives, including what they eat, how much they drink, and whether or not they smoke, come under intense scrutiny from friends, family, and the broader community. The following sections use the lens of social construction to examine the varied outcomes of infertility across many key topics. Name-calling: The implications of infertility on a couple's life are far-reaching. However, in India, infertility is often seen as a female issue. The infertility crisis and its sexist repercussions fall disproportionately on women's shoulders. Many derogatory terms, including "manhoos" (a term used in rural Rajasthan and Bhiwandi-Mumbai to refer to infertile women), "vanjh" (a term used in Mumbai's Gayatri Colony), "evil eye," and "visiting tantric" (a person who performs black magic), are used to refer to infertile women. The use of derogatory labels is widespread. Outside of India, for instance in Bangladesh, women who are unable to produce children are often given derogatory labels. Infertile women are sometimes referred to by derogatory terms like poramukhi (burnt face). In the medical field, infertility is conceptualised in a variety of ways, including "hostile mucus, blocked fallopian tubes, incompetent cervix, and failure to conceive." Family and social expectations: A woman's competence or skill is measured by her "fertility," or her capacity to have children. It's more than just a matter of taste; it's the realisation of everyone's dreams. The female body is considered "for others," not the lady herself. Therefore, her family, community, religion, state, etc., take precedence when making choices about her body. If a woman is unable to have a child, she will inevitably face the judgement and scrutiny of others. A woman's marriage is tested when she is unable to conceive a child. Social norms support a husband's right to seek a second wife in order to address infertility. In the event of male infertility, however, women are expected to shoulder the burden of their partners' infertility and shoulder the responsibility in social situations. Infertility's varied landscapes: A woman's social position (her class, education, caste, religion, area, and sexual orientation, among others) determines the kind of action used to combat infertility. What is needed, therefore, is contextual knowledge about infertility. According to research by Rouchou (2013) and Boerma and Mgalla (1999), infertility denies women in China and certain African nations access to food, clothing, and property, and subjects them to social pressure to have a family. Pujari and Unisa (2016) discovered the same thing in their research on male infertility in the southern Indian state of Andhra Pradesh. Men who struggle with infertility often feel pressure to keep their struggles private. Many people in rural Rajasthan see infertility as akin to "social death" (Unnithan, 2010). In addition, Unnithan notes that women from lower socioeconomic backgrounds are more likely to experience gendered and class-based stigma around infertility. Although infertility is a traumatic experience for men and

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women everywhere, the degree to which they are socially shunned varies with a woman's socioeconomic status. Poor rural women in Kerala, for instance, actively battle childlessness in their daily lives. Class and age have a role in how successful people are in removing stigma via those methods. If a woman in Haryana is unable to have children, she will not get any financial or political assistance from her husband's family. Following a discussion of the socially constructed causes and effects of infertility in the Indian subcontinent, the following parts will focus on the healthcare of the infertile and how it has been conceived of from a variety of perspectives. Obviously, different social and political processes affect and constrain people's ability to seek infertility treatment and care. One's socioeconomic position and level of autonomy greatly affect one's experience with infertility and one's access to reproductive technology.Although ARTs are often promoted as technical advances in medicine, they have been seen from the perspective of the politics of the neo-liberal market, which imposes these technologies onto the bodies of women.

Reproductive Politics in the Context of Neoliberalism

Market ties between the developed world and emerging economies like India have strengthened because to medical technology advancements. From a socioeconomic point of view, Portes (1997) describes how neoliberal policies spread over the world and became the standard. How nations have approached economic management has been heavily influenced by neoliberal policies. It has taken many forms, including the decline of agriculture, the loosening of labour regulations, the loss of a stable labour force, and the globalisation of industry. In the wake of neoliberalism's success, reproductive technologies have advanced rapidly, bringing formerly excluded Third World nations into the fold. Women from developing nations have become research subjects, experimental subjects, and consumer commodities in the marketplace for reproductive technology.

In order to maintain and grow, all social groups need to reproduce or self-perpetuate. From this vantage point, infertility is seen as a failure to meet the social need of reproduction or as a social issue that must be handled on a societal level. Therefore, ART is considered a basic human need here. This suggests that the general cultural norms govern whether or not ARTs, or other forms of alternative reproduction, are accepted. The dominant strength of patriarchy is reflected in or strengthened by this need for ART. This is mirrored in how the need for ARTs is created, articulated, or legitimised as part of the good faith attempts to address women's infertility issues. Despite the fact that male infertility contributes to the infertility crisis, some believe that reproductive technologies are a byproduct of entrenched patriarchy that leads to the objectification of women. Corea also fears that, similar to how the "prostitution industry" treats women's bodies as mere commodities, the reproductive industry will treat women's bodies (including the womb, ovaries, and eggs) as mere commodities in the near future. Nowadays, medically assisted reproduction is a multibillion dollar industry all over the world. Once middle-class couples have achieved financial stability, they are more likely to use assisted

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reproductive technologies (such as in vitro fertilisation [IVF], donor gametes [DGx], or preimplantation genetic diagnosis [PGD]) to conceive a child or meet their reproductive needs. Buying fertility services from women in low-income nations is an increasingly common aspect of the reproductive tourism industry. Women's compliance, negotiating power, and overall agency are crucial to the advancement of the reproductive bioeconomy. Medical Care for Fertility Issues: Asymmetrical power relations between men and women, unequal gender relations and roles, and the embedding of decisions like self-definition as infertile, seeking treatment (or not), choosing among forms of treatment, and considering adoption or other alternative means of having a child into a larger social process are argued to negatively impact women's reproductive health. According to Nadimpally and Marwah (2016), sex and sexuality are produced via ARTs in the same ways as gender: at the level of discourse, as something that must be controlled, and at the level of treatment, as something that must be regulated and medicalized. Treatment accessibility is strongly influenced by a country's socioeconomic and political climate, including factors like its level of education and the quality of its healthcare system. There is a lack of information on the economic costs of infertility in poor and middle-income nations. Access to infertility therapy may be hampered by social, cultural, and economic factors.

Public Health Policy and Infertility in India

While the government and non-government organisations have worked to improve women's health, infertility has been mostly overlooked. Concerns about reproductive, maternal, and child health have been acknowledged in a study titled "A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health' (RMNCH+A) in India" from the Ministry of Health and Family Welfare. The program's stated goal is to "meet women where they are" (at home and in the community) in terms of healthcare (Ministry of Health and Family Welfare, 2013). However, infertility services are just a minor part of the programme (Sharma, 2018). The National Family Health Survey (NFHS-5) (2019-2021) iv also lacks data on infertility. Despite the survey's findings that fertility rates are falling in most states, the pro-natalist culture of the United States has failed to acknowledge the prevalence of infertility. One study from the Ministry of Health and Family Welfare (2020) states that the overall fertility rate has decreased from 2.9% in 2005 to 2.2% in 2017 because to the National Population Policy. There have been many policies and actions on reproductive and child health programmes, but the problem of infertility has been mostly ignored. Although infertility is related to maternal health, the National Population Policy only addresses concerns of contraception, mother health, and child survival. Department of Family Welfare (n.d.) notes that even if infertility is highlighted, much of the focus is on migratory and tribal communities, neither of whom may have an actual need for birth control. Only a rise in the availability of infertility treatments for the wealthy and somewhat well-off has occurred. For example, women from low socioeconomic backgrounds continue to be priced out of access to ART treatments (Widge & Cleland, 2009). Safe and ethical ART practise was a goal of both the 2014 and 2020 ART regulatory laws that attempted

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to regulate ART banks and clinics. The focus of the 2020 law has shifted from creating a National Advisory Board and State Advisory Boards as well as a National Registry to safeguarding vulnerable populations including women and children against exploitation, which was addressed in the 2014 bill. Numerous infertile couples remain unmet despite national efforts to control the assisted reproductive technology (ART) business. It introduces a market-based strategy rather than a focus on people's happiness (Kotiswaran, 2020). Lack of suitable procedures and accreditations, as well as the absence of proper regulations protecting, for example, pregnant women from exploitation, are cited as problems by the regulating proposals. Pregnant women and those striving to avoid unintended pregnancies have been prioritised by the public health system.

Conclusion

The social stigma associated with infertility may be reduced by education campaigns and improved communication between doctors and their patients. Many infertile women experience mental discomfort because they internalise the social stigma of their condition and start to blame themselves. Under the guidance of trained medical specialists, it is crucial to establish groups of support where infertile women may meet and chat to others going through the same challenges. Subsidising infertility treatments is an important part of government policy that should be implemented. Finding answers and expanding on previous studies is the ultimate goal of infertility research.

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