

Infertility and Patriarchy in India: Causes and Consequences

Dr. Srishti

Assistant Professor, Dept. of Sociology/Women's Studies, Banasthali Vidyapith, Newai, Tonk, Rajasthan

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ABSTRACT

Infertility is a complex issue that affects millions of couples worldwide and its impact is particularly significant in patriarchal societies like India. This paper investigates the causes and implications of infertility in India within the framework of patriarchy. The patriarchal society characterized by male domination and the expectation of procreation, lays a severe burden on women with infertility. Secondary data have been considered for exploring the causes and consequences of infertility among women in patriarchal setup. Results suggest that the causes of infertility are numerous, spanning from biological aspects to sociocultural and economic issues. Infertility has far-reaching implications on women, affecting their families, and society as a whole. Women with infertility are frequently stigmatized, discriminated, and blamed, resulting in lower social status, psychological pain and low self-worth. Addressing the issue of infertility within the context of patriarchy requires a multi-faceted approach. Efforts should be made to challenge and dismantle patriarchal norms and gender inequalities that contribute to the stigmatization of infertility. Nevertheless, the cost of the treatment of infertility including the Assisted Reproductive Technology techniques is highly expensive. Hence, there is a need to enhance access to affordable and quality healthcare, including infertility treatments, particularly in rural areas. Government has also launched certain laws and regulations to regulate the practice of surrogacy and In-vitro fertilization; nonetheless, there is a long way to go.

Keywords: gender, India, infertility, patriarchy, women, women's health

Infertility

Infertility is commonly defined as the inability to conceive or sustain a pregnancy after one year of unprotected intercourse (or six months if the woman is over the age of 35) (Larsen, 2000; Mohammad & Ardalan, 2009). It's a complicated reproductive health problem that affects both men and women. Infertility can be a result of a variety of causes such as endometriosis, hormone imbalances, structural abnormalities, genetic illnesses, infections, age-related loss in fertility, and lifestyle factors. Infertility affects roughly 10-15% of couples globally (Ombelet, 2020). The number of couples seeking infertility therapy has risen considerably in recent years.

Types of Infertility

Infertility can be classified into different types based on various factors and underlying causes. The following are the types of infertility:

Primary Infertility: This refers to a condition where a couple has never been able to conceive despite regular unprotected intercourse.

Secondary Infertility: Secondary infertility occurs when a couple who has previously conceived and given birth to a child is unable to conceive again.

Male Infertility: Male infertility is attributed to factors that affect the male reproductive system, such as low sperm count, poor sperm motility, abnormal sperm morphology, erectile dysfunction, or ejaculation disorders.

Female Infertility: Female infertility involves factors that affect the female reproductive system, including ovulatory disorders such as Polycystic Ovary Syndrome (PCOS), blocked fallopian tubes, uterine abnormalities, endometriosis, or age-related decline in egg quality and quantity.

Unexplained Infertility: In some cases, despite thorough investigations, the exact cause of infertility cannot be identified. This is referred to as unexplained infertility.

The WHO (2004) estimates the overall prevalence of primary infertility in India to be between four and 16 per cent. Estimates of infertility vary widely among Indian states from three per cent in Uttar Pradesh, Himachal Pradesh and Maharashtra, to five per cent in Andhra Pradesh, and 15 per cent in Kashmir. Moreover, the prevalence of primary infertility has also been shown to vary across tribes and castes within the same region in India. In India, infertility is considered mainly a consequence of high levels of sexually transmitted diseases and genital infections (Jejeebhoy, 1998). Malnutrition and malaria can be assumed as another reason for infertility as confirmed by studies conducted in the Gambia (Greenwood et al., 1992; Weaver & Beckerleg, 1993). Major causes of infertility among Indian women are the tubal damage and tubal blockage. The tubal defects are mainly due to the complaints of infections and history of pelvic inflammatory diseases and genital tuberculosis. With the numbers of infections and severity of infections these lead to defects and adhesion of the tube leading to infertility (Shadap, 2014).

Infertility and Patriarchy

Biological, medical, and socio-cultural variables can all have an impact on infertility. As a social system patriarchy perpetuates gender inequalities and power imbalances between men and women. Hence, in a patriarchal society like India, infertile women are stigmatized, abused, mistreated and discriminated within family and otherwise. However, the trauma and torture is severe for woman suffering from

primary infertility. Women diagnosed with primary infertility experience more distress than their male counterparts. Nevertheless, both men and women feel a loss of identity and have strong sentiments of defectiveness and incapacity. In a patriarchal set up, even if a male is infertile, a woman is often blamed for it and stigmatized. A childless couple has to face prejudice and societal bias. When a young couple fails to conceive, family starts blaming the woman for it. Moreover, if a woman has a career, then people blame her for being overambitious. Such situation is rampant in the educated Indian middle-class families. It has also been observed that among couples, it is mandatory for a woman to go for fertility test; however, a man always has an option of saying no and opting out strengthening the patriarchal forces all the more.

Pronatalism is widespread in western society, with many people believing that having children is a natural and unavoidable element of being a woman (Rowland, 1992). According to Peter (1989) western feminist thinkers too acknowledge the fact that fertility, pregnancy, birth, and child rearing are cultural achievements. If a woman fails to attain any of it, she is bound to face the consequences. Lindemann (2018), evince that the toxic legacy of infertility makes the identity of a woman binary: she is either infertile or a mother. Everything else fades into the background, her sense of self-esteem superseded by her sense of inadequacy. A study by Brase & Brase (2012) highlights the concept of baby fever, a phenomenon of physical and emotional craving to have children among childless couples. But this desire to reproduce doesn't appear to be innate. The need to have a baby is imposed by the society itself. As per the study by Shattuck & Schwartz (1991), infertility is not a neutral phrase since the medical jargons such as, hostile mucus, blocked fallopian tubes, incompetent cervix, and failure to conceive, demonstrate how women's infertility is considered as a physical impairment. In contrast, the male

causes of infertility are stated in less conclusive terms, such as subnormal or low sperm motility. Women also interpreted infertility as impairment on the basis of assumptions about motherhood as a natural, biological function (Ulrich & Weatherall, 2000).

Renowned anthropologist Martin (2010) argues that it is critical to consider the social and cultural aspects that influence reproductive experiences rather than viewing infertility as a simply biology or physiological problem. She refutes the concept that infertility is purely a personal issue, emphasizing the significance of understanding how larger social institutions influence reproductive health.

Medical anthropologist and feminist academic Inhorn (2015) has extensively researched on the social and cultural components of infertility among Egyptian women. Her research focuses on the interconnections of gender, culture, and reproductive technologies, notably in the Middle East and North Africa. Women who are unable to bear children are rejected by their husbands and ostracized by society, often living as outcasts and perceived as inferior and useless (Lunefeld & van Steirteghem, 2004: 321).

The paper hence, attempts to explore the causes and impact of infertility among Indian women through secondary data. The aim of the study has been to adopt a feminist lens in fathoming the phenomenon of infertility among women from patriarchal society belonging to the developing countries in general and Indian women in particular.

Causes of Infertility

There are various possible causes of infertility in Indian women. It's vital to understand that infertility can be caused by both male and female factors, or by a mix of the two. Nevertheless, the trauma of being childless is born by women only since they are considered as *Prakriti* with innate ability to give birth and nurture. Following are

some of the most prevalent causes of primary infertility among women:

PCOS (Polycystic Ovary Syndrome): PCOS is a hormonal condition characterized by numerous cysts on the ovaries. It can cause infertility by interfering with regular ovulation. Women with PCOS need longer time to achieve their first childbirth. PCOS is one of the most frequent endocrine and metabolic disorders in reproductive-age women. In the absence of another diagnosis, it is a diverse syndrome characterized by symptoms of androgen excess and ovarian dysfunction. Women with PCOS have a lower fertility rate and give birth to fewer children per woman than women without PCOS (Persson, Elenis, Turkmen, Kramer, Yong, & Poromma, 2019; Bharali, Rajendran, Goswami, Singal, & Rajendran, 2022).

Fallopian Tube Blockage: Blocked or damaged fallopian tubes can prevent the sperm from reaching the egg or the fertilized egg from reaching the uterus, resulting in infertility. This can be caused by infections such as pelvic inflammatory disease (PID), endometriosis, or previous surgeries. Tubal factors account for approximately 14% of cases of subfertility. Tubal occlusion may be caused by pelvic inflammatory disease, previous tubal / pelvic surgery, endometriosis, salpingitis isthmica nodosa, obliterative fibrosis, as well as mucus polyps and intra-luminal debris (Allen & Brown, 2010).

Uterine Abnormalities: Structural abnormalities of the uterus, such as fibroids, polyps, or congenital malformations, can affect fertility by interfering with implantation or increasing the risk of miscarriage. Congenital uterine abnormalities are a diverse range of uterine shapes that might impair reproductive potential (Letterie, 2011).

Endometriosis: Endometriosis occurs when the tissue lining the uterus (endometrium) grows outside the uterus. Endometriosis is characterized as the presence of endometrial like tissue (glands and stroma) outside the uterus that causes a chronic inflammatory

response, scar tissue, and adhesions that can damage a woman's pelvic anatomy. This condition can cause scarring, inflammation, and adhesions, which can interfere with the fallopian tubes and ovaries, leading to infertility (Practice Committee of the American Society for Reproductive Medicine, 2004).

Ovulation Disorders: Irregular or absent ovulation can make it difficult for women to conceive. Conditions like hypothalamic dysfunction, polycystic ovary syndrome (PCOS), and premature ovarian failure (POF) can disrupt ovulation (Collins et al, 1986).

Hormonal Imbalances: Imbalances in hormones such as follicle-stimulating hormone (FSH), luteinizing hormone (LH), thyroid hormones, or prolactin can disrupt ovulation and fertility. Hormones play an important role in the development and regulation of reproductive function and the menstrual cycle of women. Extremes of body weight tend to affect the homeostasis of the hypothalamo-pituitary-gonadal axis (Olooto et al 2012).

Age-related Factors: As women age, their fertility naturally declines. In India, cultural and social factors often lead to delayed marriage and childbearing, increasing the risk of infertility due to age-related factors. The woman's age is the most crucial factor of a couple's fertility. As a result, the rate of infertility rises with age, and the success rates of infertility therapies decline. The age of female partners had a substantial impact on the outcomes of so-called traditional infertility treatments (those accessible before to the period of assisted reproduction), with pregnancy rates much lower in women over 35 years old compared to younger patients (Balasch, 2010).

Unexplained Infertility: In some cases, the cause of infertility remains unknown even after a thorough evaluation. This can be frustrating for couples seeking treatment. 30% of couples who are unable to conceive for no apparent reason are classified as having unexplained infertility. The treatment of unexplained infertility is

empirical in nature. There is no agreed-upon definition of unexplained infertility. The literature differs based on the duration of infertility and the age of the female partner. It can occur in two ways: in some couples, it is caused by an undetectable factor, and in others, it is caused by decreased fecundity (Ray, Shah, Gudi, & Homburg, 2012).

Poor Egg Quality: As women age, the quality of their eggs can decline, making it more difficult to conceive and increasing the risk of miscarriage. The decline in fertility is a result of a decline in egg quality as well as egg quantity (Nasseri & Grifo, 1998).

Emotional and Psychological Factors: Stress, anxiety, and other emotional factors can affect hormonal balance and disrupt the reproductive system, leading to infertility. Some authors have suggested that psychological factors may be a primary cause of infertility; others have suggested that the state of primary infertility itself can provoke psychological symptoms (Edelmann, & Connolly, 1986). In a patriarchal set up the amount of psychological stress is prevalent among women leading to depression, anxiety and infertility.

Lifestyle Related Aspects: Unhealthy lifestyle choices, such as smoking, excessive alcohol consumption, drug abuse, and poor nutrition, can contribute to infertility. According to a study by Anderson, Nisenblat & Norman (2010), weight, vitamin and iodine intake, alcohol and caffeine usage, smoking, substance abuse, stress, environmental pollutants, immunizations, and oxidative stress can all affect a person's time to pregnancy and their chances of having a healthy, live birth. Several factors have been claimed to influence women's fertility; in particular, lifestyle-related issues have garnered a lot of attention in the previous decade. Due to societal and professional pressures, women's reproductive age has steadily migrated to their 30s. The later age of childbirth, together with modern living, provides a longer window of opportunity for various lifestyle and genetic perturbations to alter

fertility (Bala, Singh, Rajender & Singh, 2020). Cocaine, marijuana and alcohol use, caffeine consumption, and overuse of thyroid medications are plausible risk factors responsible for primary infertility among women (Buck, Sever, Batt, & Mendola, 1997).

Infertility in India and the developing world

Only after giving birth to a child is a woman's life considered worth or complete in a patriarchal society like India. She does not receive respect from her family or society until she becomes a mother. In India becoming a parent is regarded as one of the most significant life achievements. Because of the value of fertility and the lack of understanding regarding infertility, it is not uncommon to discover a male with multiple wives merely because he was unable to have a progeny from his first marriage (Gupta, 2002; Manimekalai, Poulpunitha & Veeramani, 2020).

Inhorn (1995) studied about the impact of infertility among Egyptian women and found that infertility's social repercussions place poor Egyptian urban women at the centre of a network of stormy relationships with spouses, in-laws, and neighbours. In Egyptian society women are often blamed for infertility and face threats of divorce or polygyny, harassment, and communal ostracism. Infertility and Patriarchy delves at the lives of infertile women, whose personal tales depict their everyday fight to avoid marginalization and shame.

A study by Guntupalli & Chenchelgudem (2004) on infertility among Chenchu tribe of the Nallamalai forest area of Andhra Pradesh, India and came up with some startling findings such as Chenchus associate infertility with spirits and dietary habits, and their treatment-seeking behaviour is based on traditional herbal knowledge and spiritual beliefs. Consumption of umbilical cord is also thought to be a fertility treatment. In this investigation, it was discovered that medical assistance was sought entirely from

traditional healers rather than qualified medical practitioners. Most women who infertility at some point in their lives had reported being treated with herbal tea or paste derived from medicinal roots, leaves, or seeds. Most women think that animal sacrifice and prayer to the Goddess *Pinnamma* can heal infertility. In India infertility is often considered as a curse of God. In non-Western societies including India, supernatural beliefs and alternative sources of treatment are preferred. Though biomedicine has made tremendous progress in the field of infertility, it is not available and accessible for poor and rural couples.

Another study on tribal society of Khairwars belonging to Sidhi district of Madhya Pradesh by Kumar (2007) had similar findings. It confirmed that tribal people are heavily dependent on traditional medicinal practices to heal infertility. The study also revealed that infertile tribal women suffer most profoundly in their relationship with their in-laws and other community members.

Rouchou (2013) conducted a study on consequences of infertility in developing countries and opined that every culture holds different reasons and beliefs as to why infertility is stigmatized however, discriminatory practices adopted are universal. In developing countries, social stigmas attached to infertility include, loss of social status, social isolation, women are not allowed to join auspicious occasions, sometimes gifts and financial benefits received by women during marriage are taken away when she is diagnosed with infertility leaving a long-lasting psychological impact on women. The subsequent section sheds light on the profound impact of infertility on women.

Impact of Infertility on women

Infertility has a significant impact on women from patriarchal society and their families. There are four major impacts of infertility on women which are the following:

I. Sociocultural Stigma associated with infertility:

In patriarchal families the gender of a child is directly related to the extent of respect and freedom a mother will enjoy. This is the reason why women with girl child are often subjected to discrimination compared to those in the family with a male child. In such a scenario, not having any offspring itself becomes a stigma questioning the femininity of a woman and putting a question mark on her entire existence. Bornstein (2021) in her study among the couples with infertility in rural Malawi considers infertility-related stigma a public health issue. She contends that infertility is related with a number of negative health effects, including societal stigma, relationship instability/divorce, depression, and intimate partner violence in some cases. In societies where gender roles and social status are intrinsically tied to parenthood, such consequences are intensified. Infertility can strain relationships with extended family members, who may put pressure on couples to have children or make offensive comments. It can also cause problems with property inheritance and social expectations about having children to carry on the family lineage.

II. Psychological Impact of Infertility:

A study by Cwikel, Gidron & Sheiner (2003) entitled 'Psychological interactions with infertility among women' reflects that a couple attempting to conceive feels frustrated and disappointed if a pregnancy is not easily obtained. However, if the difficulties worsen the couple is branded as infertile devastating one's self-esteem, body image, and self-assessed masculinity/femininity. It is more so among couples with primary infertility. Women experiencing primary infertility are subjected to face emotional difficulties such as stress, worry, and low self-esteem. The desire to have a child is often profoundly rooted, and inability to conceive can result in feelings of guilt, regret, and loss. In many Indian households, in-laws and extended

family members have a significant influence on a couple's decision-making processes. These family members put greater pressure and scrutiny on infertile women leading to severe psychological distress and despair among them.

III. Cultural and Religious Beliefs and Infertility:

Perceptions and attitudes about infertility are also influenced by cultural and religious beliefs. Some people may use alternative or traditional cures, rituals, or religious practices that may or may not be successful. Individuals may be discouraged from obtaining evidence-based medical interventions as a result of these beliefs. A study by Sewpaul (1999) on culture religion and infertility in South Africa among the African and Indian communities confirms that cultural beliefs provide significance to the infertile experience of a couple. Couples with infertility approach treatment based on their cultural backgrounds and life experiences. For instance, the couples from Hindu religion linked infertility to the Karmic life cycle. They attached infertility to their past misdeeds and sins overburdening themselves with regret and guilt. As mentioned earlier in the paper, tribal societies too have a cultural lens to see infertility and the treatment adopted is driven by nature cure based on traditional medicinal practices guided by a traditional healer (Guntupalli & Chenchelgudem, 2004; Kumar, 2007).

IV. Socio-Economic Impact of Infertility:

According to Patel (2016), children are a reliable source of manpower in many rural and developing countries and provide economic security in old age; infertility frequently leads to marital instability and the possibility of divorce or abandonment, resulting in financial insecurity. Certain customary laws and cultural customs encourage discrimination against infertile women and may exacerbate the scourge of gender inequality. Women with infertility are often mistreated and ostracized resulting

into the loss of their property and material wealth. In many cases, a husband remarries and disowns his first wife owing to infertility. As per Nahar (2012), infertility may lead to abandonment and more economic hardship if women have to pay back their bride wealth or pay bride wealth for husbands to enter into new unions. The major financial crisis arises when a couple wishes to go for Assisted Reproductive Technology (ART) such as In-vitro Fertilization (IVF) or Surrogacy. The cost of treatment is too expensive for a couple from meek financial background. A study by Dyer & Patel (2012) on the economic impact of infertility on women in developing countries suggests that infertility can result in impoverishing health costs as well as economic instability or hardship as a result of societal implications. The health systems of the developing countries too fail to meet the expectations of couples with infertility from lower social strata.

Infertility has a significant impact on women's mental well-being, social positioning, social relationships and financial stability. In developing countries like India, the socio-cultural stigma surrounding infertility exacerbates women's difficulties, leading to blame, shame, and social marginalization. Inability to conceive can create severe psychological pain damaging marital harmony and disagreements with extended family members leading to isolation and discrimination.

Government Policies and Programmes

There are several government policies implemented to support couples and women with infertility in India. These policies and programmes include:

1. The Assisted Reproductive Technology Regulation Bill 2020

The most current in a series of legislations passed by the Union Cabinet to defend and safeguard women's reproductive rights is the Assisted Reproductive Technology Regulation Bill 2020. The bill establishes guidelines

for the safe and ethical use of assisted reproductive technology services in the country. The measure establishes the National Board, State Boards, the National Registry, and the State Registration Authorities to regulate and supervise assisted reproductive technology clinics and banks. The Bill also provides for National Registry and Registration Authority to maintain a Central database and assist the National Board in its functioning. Moreover, the Bill proposes for a stringent punishment for practising sex selection, sale of human embryos or gametes, running agencies/rackets/organizations for such unlawful practices.

2. The Assisted Reproductive Technology (Regulation) [ART] Act 2021

The act defines ART as any treatment that seeks to obtain a pregnancy by handling sperm or oocytes (immature egg cells) outside the human body and transferring the gamete or embryo into a woman's reproductive system. The act allows for married heterosexual couples and a woman above the age of marriage to use ARTs. However, it excludes single men, cohabiting heterosexual couples, and LGBTQ+ individuals and couples from accessing ARTs which raises a serious concern regarding the gender spectrum. The act is often blamed as homophobic promoting gender stereotyping (Jamwal & Yadav, 2023).

3. The Surrogacy (Regulation) Act 2021

Until 2008, the commercialization of surrogacy was rapid in India. There was no statutory legislation to regulate this. Surrogacy was not socially accepted in the country, but unethical commercialization was rampant, in ignorance of certain guidelines provided by the Indian Council for Medical Research (ICMR). During that time women involved in surrogacy faced several hardships, such as exploitation, poor living conditions, low-cost fertility clinics, and unethical treatment.

Surrogacy has grown in popularity in the country in recent years. With the country's infertile couples numbering 20-25 million, this Assisted Reproductive Technology has proved a major benefit to childless couples. In order to safeguard the reproductive rights of the childless couples and human rights of surrogate mothers the Surrogacy Regulation Act 2021 was passed. According to the Surrogacy (Regulation) Act, 2021 any couple involved in commercial surrogacy shall be punished for first offence with an imprisonment up to 5 years and fine up to INR 50,000; and for subsequent offence, imprisonment shall be up to 10 years and fine up to INR 1 lakhs. Any person, organization or clinic involved in exploitation of surrogate mothers or children born through surrogacy shall be punished with imprisonment for a term which may extend to 10 years and fine which may extend to INR 10 lakhs (Ministry of Law & Justice, 2021). Nonetheless, major barrier to surrogacy in India is balancing the diverse interests of both parties. On the one hand, it is the state's responsibility to defend the rights of surrogate mothers and the unborn child; while on the other hand, it is the right of women to make their own reproductive choices and the rights of intended parents. Surrogacy law in India is still attempting to strike a balance between these competing interests (Kashyap & Tripathi, 2022).

CONCLUSION AND RECOMMENDATION

According to WHO (2019), most of the developing countries continue to struggle with the availability, accessibility, and quality of the treatments for infertility. The diagnosis and treatment of infertility are frequently overlooked by the development policies and reproductive health strategies, and are rarely covered under the public health funding. Furthermore, even in nations that are actively addressing the needs of

people with infertility, a shortage of skilled professionals and the essential equipment and infrastructure, as well as the current high costs of treatment medicines, are substantial impediments. While assisted reproduction technologies (ART) have been available for more than three decades, with more than 5 million children born worldwide from ART interventions such as in vitro fertilization (IVF), these technologies are still largely unavailable, inaccessible and unaffordable in many parts of the world, particularly in the developing world.

Efforts should be made to raise awareness, minimize stigma, and enhance access to infertility treatments among couples. Addressing the complex impact of infertility, on the other hand, necessitates a holistic approach that includes comprehensive reproductive health education, destigmatization campaigns, accessible and affordable healthcare services, and psychological support. It is feasible to ease the emotional, social, and financial pressures encountered by women with infertility and promote their overall well-being by giving the required support and care. In order to support women with infertility in India and other developing countries, the following policies must be implemented:

There should be a provision of infertility coverage in healthcare systems: Integrating infertility treatments, including diagnostic tests, medications, and assisted reproductive technologies (ART), into public and private healthcare coverage. This will ensure access to affordable and comprehensive infertility care to the women with infertility. Secondly, the integration of counseling services into infertility clinics and healthcare facilities to provide emotional support, coping skills, and guidance to individuals and couples dealing with infertility issues. Infertile women's psychological well-being needs to be addressed by trained counselors. Thirdly, comprehensive reproductive health education must be introduced for implementing comprehensive reproductive

health education programmes in schools and communities. To improve early knowledge and comprehension of reproductive health, these programmes should cover themes such as fertility awareness, family planning, and the variables impacting fertility. Fourthly, enhancing international cooperation and collaboration should be initiated to encourage cooperation between developed and developing countries in infertility research, treatment, and knowledge sharing. This can make it easier to gain access to experts, transfer technology, and increase capacity in infertility care. Lastly, empowering infertile women through lobbying for their rights is an essential step needed for supporting their involvement in society, and establishing support networks. Encouraging the creation of patient advocacy groups to advocate for policy changes and to strengthen the entire support system for infertile women is a pressing need of the day.

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REFERENCES

1. Allen, C., & Browne, R. (2010). Selective salpingography and recanalisation of blocked fallopian tubes.
2. Anderson, K., Nisenblat, V., & Norman, R. (2010). Lifestyle factors in people seeking infertility treatment—a review. *Australian and New Zealand journal of obstetrics and gynaecology*, 50(1), 8-20.
3. ASRM (American Society for Reproductive Medicine). (2021). Definitions of infertility and recurrent pregnancy loss: A committee opinion. *Fertility and Sterility*, 116(1), 35-41. doi: 10.1016/j.fertnstert.2021.04.040.
4. Bala, R., Singh, V., Rajender, S., & Singh, K. (2021). Environment, lifestyle, and female infertility. *Reproductive sciences*, 28, 617-638.
5. Balasch, J. (2010). Ageing and infertility: an overview. *Gynecological Endocrinology*, 26(12), 855-860.
6. Bharali, M. D., Rajendran, R., Goswami, J., Singal, K., & Rajendran, V. (2022). Prevalence of polycystic ovarian syndrome in india: a systematic review and meta-analysis. *Cureus*, 14(12), e32351. <https://doi.org/10.7759/cureus.32351>
7. Bornstein, M. J. (2021). Perceptions and experiences of (in) fertility, contraception, and reproductive health outcomes: A mixed methods study among women and men in Malawi. University of California, Los Angeles.
8. Brase, G. L., & Brase, S. L. (2012). Emotional regulation of fertility decision making: What is the nature and structure of “baby fever”? *Emotion*, 12(5), 1141.
9. Buck, G. M., Sever, L. E., Batt, R. E., & Mendola, P. (1997). Life-style factors and female infertility. *Epidemiology*, 435-441.
10. Collins, J. A., Rand, C. A., Wilson, E. H., Wrixon, W., & Casper, R. F. (1986). The better prognosis in secondary infertility is associated with a higher proportion of ovulation disorders. *Fertility and sterility*, 45(5), 611-616.
11. Cwikel, J., Gidron, Y., & Sheiner, E. (2004). Psychological interactions with infertility among women. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 117(2), 126-131.
12. Dyer, S. J., & Patel, M. (2012). The economic impact of infertility on women in developing countries a systematic review. *Facts, views & vision in ObGyn*, 4(2), 102.
13. Edelmann, R. J., & Connolly, K. J. (1986). Psychological aspects of infertility. *British Journal of Medical Psychology*, 59(3), 209-219.
14. Greenwood, E. A., Cedars, M. I., Santoro, N., Eisenberg, E., Kao, C. N., Haisenleder, D. J., ... & National Institutes of Health. (2017). Antimüllerian hormone levels and antral follicle counts are not reduced compared with community controls in patients with rigorously defined unexplained infertility. *Fertility and sterility*, 108(6), 1070-1077.
15. Gupta, N. (2002). Infertility: planning a prototype action plan in the existing health care system. *Journal of the Indian Medical Association*, 100(6), 391-2.
16. Guntupalli, A., & Chenchelgudem, P. (2004). Perceptions, causes and consequences of infertility among the Chenchu tribe of India. *Journal of*

- Reproductive and Infant Psychology, 22(4), 249-259.
17. Inhorn, M. C. (2015). *Cosmopolitan conceptions: IVF sojourns in global Dubai*. Duke University Press.
 18. Inhorn, M. C. (2005). Fatwas and ARTs: IVF and gamete donation in Sunni v. Shi'a Islam. *J. Gender Race & Just.*, 9, 291.
 19. Jamwal, V. D. S., & Yadav, A. K. (2023). The Assisted Reproductive Technology (Regulation) Act, 2021: A Step in the Right Direction. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, 48(1), 4.
 20. Jejeebhoy, S. J. (1998). Infertility in India: Levels, patterns and consequences-Priorities for social science research. *Journal of family welfare*, 44, 15-24.
 21. Kashyap, S., Tripathi, P. The Surrogacy (Regulation) Act, 2021: A Critique. *ABR* 15, 5-18 (2023). <https://doi.org/10.1007/s41649-022-00222-5>
 22. Kumar, D. (2007). Prevalence of female infertility and its socioeconomic factors in tribal communities of Central India. *Rural and Remote health*, 7(2), 1-5.
 23. Larsen, U. (2000). Primary and secondary infertility in sub-Saharan Africa. *International journal of epidemiology*, 29(2), 285-291.
 24. Letterie, G. S. (2011). Management of congenital uterine abnormalities. *Reproductive biomedicine online*, 23(1), 40-52.
 25. Lindemann, K. (2018). I'm a feminist. So why does infertility make me feel like a failure. *The Guardian*, November, 2.
 26. Lunefeld, B., & Van Steirteghem, A. (2004). Infertility in the third millennium: implications for the individual, family and society: condensed meeting report from the Bertarelli Foundation's second global conference. *Human reproduction update*, 10(4), 317-326.
 27. Martin, L. J. (2010). Anticipating infertility: Egg freezing, genetic preservation, and risk. *Gender & Society*, 24(4), 526-545.
 28. Ministry of Law and Justice. 2021. The Surrogacy (Regulation) Act, 2021. *The Gazette of India*, 25 December 2021. <https://egazette.nic.in/WriteReadData/2021/232118.pdf>.
 29. McKinnon, A. O. (2011). Uterine abnormalities. *Reproducción equina III*, 78.
 30. Mohammad, K., & Ardalán, A. (2009). An overview of the epidemiology of primary infertility in Iran. *Journal of reproduction & infertility*, 10(3), 213.
 31. Nahar, P. (2012). Invisible women in Bangladesh: stakeholders' views on infertility services. *Facts, views & vision in ObGyn*, 4(3), 149.
 32. Nasser, A., & Grifo, J. A. (1998). Genetics, age, and infertility. *Maturitas*, 30(2), 189-192.
 33. Olooto, W. E., Amballi, A. A., & Banjo, T. A. (2012). A review of Female Infertility; important etiological factors and management. *J Microbiol Biotech Res*, 2(3), 379-385.
 34. Ombelet, W. (2020). WHO fact sheet on infertility gives hope to millions of infertile couples worldwide. *Facts, views & vision in ObGyn*, 12(4), 249.
 35. Patel, M. (2016). The socioeconomic impact of infertility on women in developing countries. *Facts, views & vision in ObGyn*, 8(1), 59.
 36. Persson, S., Elenis, E., Turkmen, S., Kramer, M. S., Yong, E. L., & Sundström-Poromaa, I. (2019). Fecundity among women with polycystic ovary syndrome (PCOS)—a population-based study. *Human Reproduction*, 34(10), 2052-2060.
 37. Poulpunitha, S., Manimekalai, K., & Veeramani, P. (2020). Strategies to prevent and control of cybercrime against women and girls. *Mental*, 81, 81-0.
 38. Practice Committee of the American Society for Reproductive Medicine. (2004). Endometriosis and infertility. *Fertility and sterility*, 82, 40-45.
 39. Ray, A., Shah, A., Gudi, A., & Homburg, R. (2012). Unexplained infertility: an update and review of practice. *Reproductive biomedicine online*, 24(6), 591-602.
 40. Rouchou, B. (2013). Consequences of infertility in developing countries. *Perspectives in public health*, 133(3), 174-179.
 41. Rowland, R. (1992). *Living laboratories: women and reproductive technology*. London: Cedar.
 42. Sewpaul, V. (1999). Culture religion and infertility: A South African perspective. *The British Journal of Social Work*, 29(5), 741-754.

43. Shadap, A. (2015). Causes of infertility among married women-a review. *SMU Med J*, 2, 347-56.
44. Shattuck, J. C., & Schwarz, K. K. (1991). Walking the line between feminism and infertility: Implications for nursing, medicine, and patient care. *Health Care for Women International*, 12(3), 331-339.
45. Ulrich, M., & Weatherall, A. (2000). Motherhood and infertility: Viewing motherhood through the lens of infertility. *Feminism & Psychology*, 10(3), 323-336.
46. Weaver, L. T., & Beckerleg, S. (1993). Is health a sustainable state? A village study in The Gambia. *The Lancet*, 341(8856), 1327-1330.
47. World Health Organization. (2019). Infertility definitions and terminology: Interim glossary. Retrieved from <https://www.who.int/reproductivehealth/topics/infertility/definitions-terminology/en>

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