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Infertile women's survival strategies in rural Bangladesh: A qualitative study

Md. Mostafizur Rahman[a] ✉ | **Tohmina Nasrin Mitu**[a] | **Md. Sazzad Hossen**[a]

[a]Department of Anthropology, University of Rajshahi, Rajshahi, Bangladesh.

Abstract This study focused on the experiences of infertile women in rural Bangladesh. Infertility is not a new phenomenon in Bangladesh. In fact, the infertility rate in Bangladesh is the highest among all South Asian countries. Infertile women face many challenges in society regarding their new uncertain identity. The aim of this study was to explore infertile women's survival strategies by considering sociocultural factors in the rural community in Bangladesh. Additionally, this article explains infertile women's new identities and portrays their experiences in the family and society. As the nature of this research is qualitative, we conducted 20 in-depth interviews with infertile women in Godagari Upazila, a rural area situated in the Rajshahi district in Bangladesh. All the respondents were selected through purposive sampling. The criterion for sample selection was a married woman who had no child within five years and whose doctor decided about her infertility. The results suggest that there is a gender dimension to infertility in research, as only women are framed as infertile. This makes women socially isolated and sometimes results in abandonment. For survival strategies in families and society, women use coping strategies such as paying the entire cost of treatment by their family, avoiding social gatherings, accepting their infertile identity, and demonstrating resilience in marriage. The study also suggests that more discussion should be from government and nongovernmental organizations to improve the situation and stop blaming women.

Keywords: infertility, infertile women, social isolation, survival strategy, gender discrimination, resilience

1. Introduction

Infertility is an important social and biomedical phenomenon. Millions of women worldwide are infertile. Infertility is a disease of the male or female reproductive system and is defined as the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse (World Health Organization, 2021). It is estimated that approximately 10–25% of couples aged 48–180 million are of reproductive age worldwide (Thoma et al., 2021). A number of sustainable development goals, including objectives 3, 5, 6, 8, 10, and 16, are closely related to infertility, which is essential to reproduction and human rights.

A global analysis of infertility from the World Fertility Survey and others assessed infertility rates in South Asian countries at 4% in Bangladesh, even though no epidemiological inquiry has been conducted at the national level to estimate the prevalence rate of infertility in Bangladesh (Gm et al., 2018). Among women aged 15–49 years who are approaching the end of their reproductive life, another estimate of primary and secondary infertility in South Asia indicates that Bangladesh has the highest infertility rate of any South Asian nation, at approximately 15% (Nahar, 2012). According to a prospective study in Dhaka city, the capital of Bangladesh, primary infertility was reported in 90 (81%) patients, and secondary infertility was reported in 21 (18.9%) patients. Among the direct risk factors for female infertility, ovulation failure accounted for the majority of cases (74 (35.1%)), and ovulation failure was mainly observed in infertile women (58 (33.9%)) (Magdum et al., 2022). On the basis of data available through the Bangladesh Demographic and Health Survey (BDHS) 2014, 12.7% of married women in Bangladesh are infertile (Khatun et al., 2022). However, infertility is an increasingly prevalent issue in Bangladesh, affecting approximately 10–15% of couples who struggle to conceive naturally (Arikadkins2004, 2025).

Infertility is often understood as a phenomenon with medical, ethical or mental aspects (Hocaoglu, 2018). Therefore, little attention is given to the sociocultural context of Infertility (Bos et al., 2009). Studying Infertility provides an ideal vantage point from which to study such features of health care as inter-societal and cross-cultural disparities in health care, the relationship between identity and health, gender roles, and social and cultural variations in the process of medicalization (Greil et al., 2011). Infertility, though a global reproductive problem, is uniquely constructed within different sociocultural contexts. In Bangladesh, some researches are conducted on Infertility. However, the majority of the research examined and described knowledge, attitude and practice of infertile women. Very few studies have been conducted about the life experiences of infertile women. On the other hand, considering the study's methodology, the study design is mostly quantitative. Knowing the life experiences of infertile women is obviously important; at the same time, it is also important to address the cultural survival

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strategy of these women as patterns of coping with infertility could also contribute to strong marital relationship. The study suggested that infertile women should be empowered by effective coping strategies (Hasanpoor-Azghady et al., 2019). Therefore, this article aims to understand the identity formation of infertile women and their different surviving strategies in the narratives of their experiences. By understanding these coping strategies, we can gain insight into the unique experiences of infertile women, which will help both academicians and policymakers.

1.1. Theoretical framework

The study's theoretical framework was framed by Labeling Theory Gove, W. R. (1975). Labeling theory enhances our understanding of the sociocultural construction of stigma through language and power dynamics. This theory provides critical insights into how societal labels shape individuals' identities and experiences. Labeling theory holds that when individuals are characterized by negative terms, they often adopt these labels, leading to self-stigma and transformed behavior (Berk, 2015). In pronatalist societies where childbearing is central to women, the label of infertility has profound social consequences for them. Women experience exclusion, diminished status, and feelings of shame, as they are perceived as failing to play expected gender roles. This theory helps in understanding how cultural labels contribute to the social isolation process.

In addition, the transactional model of stress and coping (Lazarus & Folkman, 1984) introduces a dynamic, cognitive appraisal process that individuals use when facing social pressure such as infertility. The transactional model provides deeper insight into the cognitive and emotional processes underlying coping strategies. The theory distinguishes between primary appraisal, where women evaluate infertility as either a threat, harm, or challenge, and secondary appraisal, where they assess their available coping strategy. Unlike traditional coping approaches that focus primarily on behavioral responses, this model emphasizes the critical role of perception in shaping coping strategies. Some women view infertility as an insoluble crisis (threat appraisal), leading to distress and withdrawal from social events to some extent, whereas others perceive it as a manageable challenge, motivating proactive problem solving. The model also identifies meaning-based coping, where individuals find new purposes through spiritual understanding or alternative family-building options. By incorporating this theoretical perspective, a more nuanced understanding of why women adopt particular coping mechanisms and how cognitive interpretations influence their resilience paths can be achieved.

2. Methods and Materials

2.1. Research design and location

Our qualitative research adopted a phenomenological approach to explore and describe the lived experiences and coping strategies of infertile women. This approach is well suited for understanding subjective human experience. It allows researchers to delve into the personal meaning and coping mechanism of infertile women without imposing preconceived perceptions on a specific societal context (Fetterman, 2010). By attempting to put aside preconceived notions about the phenomenon, the researcher classifies it as an epoch. This enables the researcher to identify the substance of a phenomenon (Sadala & Adorno, 2002). The present study was conducted in Godagari Upazila, Rajshahi district, a rural area situated in the northwestern part of Bangladesh where motherhood is closely tied to social identity and marital stability. The choice of this location is deliberate, as rural communities often lack access to treatments and emotional support systems, making coping strategies even more critical for survival in such environments.

2.2. Data collection process and sampling

This qualitative phenomenological study involved infertile women aged 18--49 years who had never been parents in their marital relationship. The sampling procedure was performed via a purposive sampling strategy. This study employed 20 in-depth interviews (IDIs) with infertile women. Our study deployed semistructured guidelines to gather data from infertile women. The interview aims to explain collective meanings among the study participants by allowing them to share a real picture of their live experiences. The participants explained the specifics and backgrounds that influenced their experiences throughout the interviews (Sorrell & Redmond, 1995). It has two main centers of attention, one being infertility and the other being women. Next, informed consent was obtained from all the participants after the research objectives were clarified and the requirement to record the interviews was met. Each interview took approximately 50 minutes. Face–to-face interviews were conducted depending on the participant's preference at a convenient location agreed upon by both the participant and the researcher. Data collection was stopped by applying triangulation approaches to ensure data saturation.

2.3. Data quality assurance

The study ensured high-quality data collection by contextualizing semi structured IDI guidelines in Bengali, adapting them to the local sociocultural setting, and pretesting the tools. The interviews were conducted by researchers fluent in local dialects to interpret the responses accurately. All audio-recorded interviews were transcribed in Bengali and translated into English, with rigorous quality checks at each step. Inconsistencies were resolved by revisiting original recordings, and

translations were cross-checked among translators for contextual accuracy. Field notes and interviewer observations supplemented the data. The research supervisors closely supervised the interviews, holding regular debriefing sessions to identify information gaps after completing the interviews every day.

2.4. Data management and analysis

We analyzed the data by organizing categories to capture both homogeneous and heterogeneous patterns within the study subjects, following a thematic framework analysis approach. Codes were then derived from meaningful units of participants' narratives and grouped according to similarities and differences on the basis of themes identified within the paradigm. The analysis process involved reviewing, identifying, and coding recurring themes for each participant, as well as recognizing common themes across participants. To develop a comprehensive understanding of the key elements of the events, the identified themes were meaningfully interconnected (Bernard, 2006). The purpose of this study was to explore the experiences of childless married couples and the diverse strategies they adopt for survival.

2.5. Ethical consideration and approval

In this study, all participants were informed about the background of the research, the rationale for their selection, and the expectations of their participation while being assured that they would face no risk of harm. Written consent was obtained prior to conducting any interviews, and participants were interviewed only after providing consent. They retained full freedom to withdraw or stop the interview at any point without any obligation if they felt uncomfortable. Privacy, anonymity, and confidentiality were strictly maintained. The interviewer clearly communicated that participants would not receive any direct benefits from the study. The interviews or discussion venues were arranged according to the participants' preferences to ensure a private and comfortable environment for open conversation. This research received approval from the Department of Anthropology under Social Science, Rajshahi University, which is regarded as an ethical and institutional review board.

3. Results and Discussion

3.1. Infertile identity is framed only for women

There is evidence that Bangladesh also has many possible causes of infertility. According to research, sepsis and pelvic infections are linked to infertility in South Asia. These disorders include sexually transmitted diseases (STDs), urinary tract infections (UTIs), reproductive tract infections (rTis), unclean deliveries, postpartum infections, and unsafe obstetric and abortion procedures (Saha et al., 2015). Furthermore, there are different indirect causal factors for infertility, such as poverty, tuberculosis, malnutrition, anemia, and low birth weight. For example, poverty increases the risk of infertility in several ways, and women are more susceptible to rTi due to water scarcity, lack of access to nutrition, and lack of health care, which may result in secondars (Unnithan, 2010). Therefore, a comprehensive discussion outlines that many factors must be considered to understand infertility. However, female gender factors are still likely responsible for suppressing an individual's identity.

One of the participants, Nita, whose marriage has reached 7 years but is not yet conceived, said that

'I like kids. They are cute, but after marriage, my initial plan was not to have kids for around 3 years as I was completing my studies and also wanted to give time to our marriage. But after one year, everyone started to ask about children, and at a point, they tried to blame me for not being conceived. And even then, they started to call me infertile. I feel very irritated, frustrated, and depressed. I could not make them understand that I will have babies in the future, as we are now not even trying. My husband was very supportive, but...you can understand that...'

People always impose an identity regarding one's credibility. In addition, women are usually the primary victims. They are always told to act as ideal women and are kept under surveillance.

Infertility is a condition of the reproductive system that affects both men and women at almost the same rate (Iktidar et al., 2022). Although men and women are both affected by infertility, women are especially likely to perceive it as a substantial threat to their gender identity and sense of self (Andrews et al., 1992). Women experience more distress and less well-being when they perceive their infertility as central to their identity (Neter & Goren, 2017). Women who are confronted with infertility must rethink core aspects of their identity and adopt new ways of understanding their sense of self (Peterson et al., 2006).

Women in Bangladesh are predominantly blamed for childlessness in marriage. Even if the husband is the cause of infertility, the woman will always be held "responsible", and he will never be publicly held accountable. One of the participants, Anika, said,

'The problem is not mine but my husband's. We did not tell anyone about this except our family. As a result, people think the problem should be in me and taunt me negatively.'

This deep-seated view persists even when medical evidence indicates male infertility. Like Anika's case, it highlighted the unfair cultural treatment that married women face and the intricate scenario of the silence surrounding male infertility.

3.2. Survival strategy for infertile women in society

For rural married women in Bangladesh, motherhood is the most desirable status (Papreen et al., 2000a). There is hardly a place for a nonmother in Bangladeshi society. Children are central to the social world; if there are no children, nothing can compensate for their absence in a woman's life. Being childless has a wide range of negative consequences for rural Rajshahi women, be they personal, psychological, economic, or social, with the essence of these consequences being 'suffering.' Rural childless women experience strong stigma, as their identity is devalued for not being able to produce children; they are blamed for their childlessness and, as a result, develop a sense of guilt. They are also socially isolated and sometimes suffer from abandonment by their families. As a result, many women who want to become pregnant and create a family find that infertility is an arduous and emotionally draining journey. We discuss different coping mechanisms that infertile women might use to address the difficulties of infertility. When coping with challenges related to infertility, these strategies include a range of psychological, emotional, and practical approaches that help increase resilience, enhance overall well-being, and provide a sense of empowerment and control. On the basis of our data, we highlight some of the key components of their strategy.

3.2.1. Paying the entire treatment cost by the woman's family

In our study, one coping strategy that infertile women and their families adopted was taking on the responsibility of covering the entire cost of fertility treatments. This mirrors findings from (Inhorn & Patrizio, 2015), who reported that in most low- and middle-income countries (LMICs), infertility treatments are largely out-of-pocket expenses. The similarity lies in the economic burden disproportionately borne by women and their families. However, a partial difference exists: while in some contexts, families provide support, in others, women themselves must independently finance treatment, leading to further economic vulnerability (Dyer et al., 2004).

In terms of intimacy, our findings participants felt that infertility contributed to a lack of intimacy in the marital relationship since sexual relations were focused on becoming pregnant rather than being an expression of love. This aligns with (Greil et al., 2010), who reported that couples often perceive sex primarily as a means to conceive. However, a contradiction emerges in some Western contexts where infertility was also reported to strengthen marital intimacy, as couples united emotionally against the shared struggle (Greil et al., 2011). Thus, while reduced intimacy is a dominant theme, cultural differences shape whether infertility distances or unites partners.

When they discussed their inability to bear their spouse's children, feelings of shame surfaced. One wife said, "You will be affected by seeing your husband play with other people's children." You get the impression that he wants to have a child as well. You experience guilt".

This resonates with findings from (Hollos et al., 2009) in Nigeria and (Dyer et al., 2004) in South Africa, where infertility directly threatened women's social identity and marital stability. However, a partial difference is evident in high-income countries, where stigma still exists but is less tied to a woman's identity as a wife and more framed as a medical or biological challenge (Cui, 2010).

In this approach, the woman's family bears most of the financial burden. Context of a couple's relationship and the notion that a couple's identity influences one's identity of self-influences.

Gita said, "I was very depressed and sad. I felt particularly sad for my husband and the in-laws. It is because my husband is the only child of his parents. I felt guilty, as it seemed that the family would not have any offspring because of me. Although my in-laws did not blame me, I still felt guilty. My family also felt guilty about it. That is the reason that my father paid the entire treatment cost."

Additionally, a feeling of failure resulted from the participant's response to treatment failure and inability to reach the optimum goal, which was considered a stressor. Paying for the treatment costs themselves can give infertile women a greater sense of ownership over their fertility journey. This can contribute to a greater sense of autonomy and self-reliance during the infertility treatment process.

Finally, our participants emphasized the role of parental families in covering treatment costs. This finding aligns with relation-based societies, where families often step in to manage health-related challenges (Hollos et al., 2009). In contrast, in modern contexts, infertility tends to be regarded as a private matter, with couples relying on loans, insurance (where available), or delaying treatment owing to costs (Inhorn & Patrizio, 2015).

3.2.2. Self-exclusion from social gatherings

Another coping strategy is that infertile women avoid social gatherings, especially those that revolve around pregnancy, childbirth, or children. This strategy allows them to protect their emotional well-being and create a safe space for themselves during challenging times. For some infertile women, being in social settings where pregnancy and children are the main topics of conversation can exacerbate feelings of isolation and disconnection. By avoiding these gatherings, they can create a more supportive and understanding environment for themselves. Similar findings are also reported in Nahar and Richters's study in Bangladesh. According to their research, because they are perceived as wicked individuals, rural childless women are usually

forbidden from attending social gatherings by their community. Women are verbally abused if they participate in a ceremony (Nahar & Richters, 2011).

Anika said that when someone met her, they would ask her how many children she had. It was an automatic assumption that she should have children. She explained,

After six months of my marriage, everyone started to ask, ‘When are you going to have those babies? Time's running out. You aren't going to have those babies yet? You are getting old!

She went on to say that she often asked why she did not have children yet. Thus, I have struggled with that, mainly because it is a sore point sometimes, and I have felt so much pressure over the years.

There are two sides to every coin. Anika, for example, stated that she had no set response and that her parents had even urged her to inform people who she was unable to conceive. Most participants reported that their relatives supported them in identifying as infertile. However, some of the participants described comments that family members made that indicated disappointment. According to Gillespie (2003), women’s perceptions of motherhood are associated with sacrifice and loss, and women who choose to remain childless are associated with motherhood with a loss of identity. Maria said,

‘Nowadays, I avoid meeting all my relatives. I avoid people who have children. I also avoid children because I think their company makes me sad, and I hate to talk about the situation I am through and possible treatments, as I have tried hard on that part. As a result, where there is the slightest possibility of facing the question about my pregnancy, I totally avoid that place. It is natural for people to ask about one's health, job, or children as well. However, I feel embarrassed, sad, and uneasy when someone asks me questions regarding children.’

Family planning-related inquiries and remarks about social events are frequently well-intentioned but may be offensive. Women who are infertile may be asked about their reproductive options or unwittingly remind themselves of their infertility. They can reduce the number of these interactions and keep clear of awkward or bothersome chats by staying away from social events.

3.2.3. Accepting the infertile identity

One coping strategy that infertile women may adopt is accepting their infertile identity. This process involves acknowledging and embracing their fertility challenges, finding ways to redefine their sense of self and happiness, and seeking emotional and psychological wellbeing in the face of infertility. Accepting an infertile identity involves recognizing and acknowledging the reality of infertility. It involves coming to terms with the fact that conceiving a child naturally may not be possible.

Sonia’s opinion about her identity-

"Initially, I felt insulted by the fact that I was not able to be a mother. Now I don't feel that way. Now I am fine. I may not have a child, but I am not sick either. I am cheerful. I feel, why shouldn't I enjoy my life? Other people in this society get upset about my cheerfulness. They say, "You don't look like a childless woman." I have accepted that I am not having a baby."

Vinita (pseudonym) had someone tell her, "You know, you should have kids. Having an adopted child does not mean as much as having children of your own." She indicated that she could not move freely, and if she saw any neighbor, she just turned and walked away, ‘because I just…. It just, it irritated me.’ How badly people want you to have kids and be a good mother... 'It did not make me feel sad or anything like that. It was unbearable because I am glad you want kids, but that does not mean everyone else does." Vinita described,

My nonad (husband's sister) tried to pinch me, saying that we needed to have children so I would not always be by myself. My mother-in-law has said, 'Oh, you're supposed to have kids and give us grandchildren.'

A woman is considered infertile if she is unable to conceive or carry a child to term, regardless of the cause. Thus, the woman becomes the center of the issue even if she is not the source of the condition. They reported rarely attending family and other social gatherings to avoid people's curiosity about their childlessness. Most participants mentioned that this situation is God’s will, so they accepted it and paid no attention to people's comments, which gave them the courage to move through each day.

Gender inequality, which is ingrained in Bangladesh's patriarchal social structure, is confirmed by women's social status (Greil et al., 2011a). Importantly, Islamic practice is very flexible in Bangladesh, where the state does not enforce Islamic theology. Islam influences people on a personal and societal level in regard to seeking infertility treatment, but it is not a state-organized policy (Nahar, 2010). The ultimate power of Allah's will is emphasized in local beliefs among rural and urban women for treating infertility (Nahar, 2010).

Mili expressed,

‘We tried our best, but not everything we can control in our lives. Allah knows best; we can pray if he wants us to have kids. We left everything in Allah’s hands.’

Furthermore, infertility is not considered a reproductive health concern under existing health policies, which further restricts access to biomedical treatments (Nahar & Van Der Geest, 2014).

Acceptance does not mean denying the pain and grief associated with infertility. It involves allowing oneself to experience and process these emotions fully. It can provide an opportunity for self-exploration and redefining one's identity beyond motherhood. Infertile women may focus on other aspects of their lives, such as personal growth, career development, hobbies, or relationships. By redirecting their energy toward fulfilling experiences and goals, they can find a renewed sense of purpose and fulfillment.

Mili is a 37-year-old woman trying to conceive. She describes,

‘Having a baby is good. But it is not something that, for your whole life, will be shattered. Look at me I love babies, but I don’t have any. That doesn't mean that I, as a woman, am worthless. Without children, I can spend my whole life with my husband. It's a god's wish to know whom he wants to give children and whom not. At least children can be adopted too.’

Oakley believed that biological motherhood was a myth founded on the threefold belief that “all women need to be mothers, all mothers need their children, and all children need their mothers” (Tong, 2009). According to Oakley, the first claim—that all women need to be mothers—receives legitimacy from how girls are socialized and popular psychoanalytic theory, which offers "pseudoscientific backing" for the socialization procedure (Acien, 1997).

Importantly, acceptance is a profoundly personal and individual process, and there is no timeline or "right" way to achieve it. Each person's journey toward acceptance will be unique and may take time and effort. However, accepting an infertile identity can lead to a sense of peace, self-compassion, and the ability to find joy and fulfillment in life, regardless of the fertility challenges faced.

3.2.4. Resilience in marriage

Motherhood is considered a power for the new bride, and lacking it makes her vulnerable (Greil et al., 2011b). For men, remarriage is the most commonly mentioned solution on the basis of the belief that women are the source of infertility. Although most participants shared having a supportive husband, they also expressed constant fear of their husband's remarriage under social pressure.

“My spouse may decide to get married again in the future, but his current way of thinking is acceptable. But you can never predict what the future holds. As no one can predict that, everything changes with time. He will not change 99 percent of the time, but he may.

Women with infertility are considered less likely than others are, as they are not able to fulfill the predesigned role of females as approved by society. The participants reported being second citizens in comparison to those who enjoy fertility, as expressed by one:

"There are girls who cannot cook, they do not have anything special to mention.... even do not respect their husbands… but just because they have babies, they are respected... and for us, our good qualities are sidelined…. we might have everything, but that is not visible to people. They are not able to see those…"

One of the participants even mentioned that infertility at present is the result of bad karma performed by her in the past. Some participants experienced stigmatization; women believed that they were a waste of resources and that their families and communities saw them as enemies and problems. Most women stated that they avoided social events, particularly those related to children. Some women, however, would be abandoned by their husbands and others by their relatives. Many women considered that they were embarrassing to their families.

4. Conclusion

The paper addresses the problem of stigmatization, which many women face because of their infertility. Overall, the study highlights the difficulties faced by infertile women in Bangladesh, their coping strategies, and their marginalization. Society judges women's worth only on the basis of their ability to give birth children. The stigma around childlessness manifests through constant questioning about conceiving, blaming, and cruelling stigmatizing, which biasedly targets women, even when the reason for infertility lies with men. This stigma pushes women into loneliness, depression, and regret and makes them feel ashamed, resulting in social isolation.

In Bangladeshi society, infertility is considered a woman’s problem, and she is blamed for not being able to procreate. A woman's sense of identity can be severely disrupted by infertility, which can affect her duties and self-perception while also questioning social norms. This inability to conceive can lead to a range of feelings, such as despair, regret, guilt, and failure. Infertile women employ a range of coping strategies to manage this disruption and related social pressures.

Infertile women employ a range of coping strategies to manage social pressures. The experiences of infertile women in Bangladesh are reviewed, along with the different coping strategies they use. The first coping strategy identified was the willingness of the woman's family to pay for the entire cost of her infertility treatment. The second coping approach is to avoid social gatherings that can make them feel guilty or inadequate. Some find solace in faith, acceptance, or redefining self-worth

beyond motherhood. However, while these strategies help individuals endure, they are not sustainable solutions. However, infertility affects women more profoundly than men do. Therefore, identifying these coping strategies in women is very important. Governments should initiate programs for community sensitization through empathetic counseling and unbiased medical guidance for infertile couples. The media can play a pivotal role by disseminating accurate information and sharing success stories. Together, these actions can normalize infertility as a medical condition and reduce societal discrimination toward women.

Ethical Considerations

The research results were obtained on the basis of the answers of the respondents collected via interviews. Each person who was initially interviewed was given the following information: "I hereby would like to ask you to provide your responses on the basis of your feelings, knowledge, and experience. The results will be used exclusively for scientific purposes in the form of a summary". The study was performed in line with the principles of the Department of Anthropology, University of Rajshahi, and according to local legislation and guidelines on research involving human subjects, ethical approval was not needed.

Conflict of Interest

The authors declare that they have no conflicts of interest.

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