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"TREES WITHOUT FRUITS": THE SOCIAL CONSTRUCTION OF INFERTILITY, SOCIAL STIGMA, AND FERTILITY-SEEKING BEHAVIOR IN RURAL BANGLADESH

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Apart from its medical concern, infertility bears significant socio-cultural consequences. This paper examines the social sufferings of infertile women, their fertility-seeking behavior, and the strategies adopted to cope-up with everyday social discrimination and stigmatization due to infertility. Drawing on ethnographic examples and qualitative research methods, this study has been conducted in three villages of Jessore and Satkhira districts of Southwestern Bangladesh. Findings of the study reveal that infertile women have various social sufferings, including but not limited to isolation, loneliness, fear of getting divorced, stigma, and domestic violence. Many infertile women live with their *shotin*, which is sometimes more difficult to adjust. Their everyday life becomes unbearable when in-laws and neighbors psychologically and physically abuse them. Infertility becomes a subject of social gossip, and infertile women are stereotypically identified as *bajha*, *haatkhuri*, and inauspicious. The social construction of fate or *kopal* is believed to be unavoidable in the context of explaining infertility. Their fertility-seeking behavior is mostly guided by the options available to them, such as pervasive use of *kabiraji*, homeopathy, and traditional healers. They, however, use their agency to overcome their stereotypical and stigmatized identities with their own efforts as well as supports from natal family members.

Keywords: fertility-seeking behavior; infertility; social sufferings of women; stigma; rural Bangladesh

Introduction

Apart from its medical ramification, infertility and its impact, particularly on women, have been a matter of significant social research. Social science knowledge increasingly recognizes infertility as a devastating problem for women in many parts of the world [Inhorn and Van Balen 2002; Kumar 2007]. Although the prime concern in Bangladesh is to control fertility because of increasing population, infertility as a social problem has not been prioritized at the policy level [Nahar and Geest 2014]. Besides infertility being primarily a biomedical concern, there has been a major gendered dimension of it, since

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women mostly become the first line of victim of infertility due to anxiety, frustration, insecurity and lack of self-esteem, fear of abandonment, domestic violence, and a sense of powerlessness [Nahar 2021; Nahar and Richters 2011; Nahar and Geest 2014; Humm 1992]. There are comprehensive studies globally that document how women bear the social consequences of infertility [Inhorn and Van Balen 2002; Whitehouse and Hollos 2014]. Feldman-Savelsburg reports that among the Bangangte in Cameroon, infertility results in high divorce rate, which consequently deprives a woman of accessing her husband's land [Feldman-Savelsburg 1999].

Medical science has already documented various causal factors of infertility, such as sexually transmitted diseases (STD), urinary tract infections (UTI), reproductive tract infections (RTI), unhygienic delivery, postpartum infection, and unsafe obstetric and abortion procedures [Unisa 1999; 2010; Ali et al. 2007; Prasad et al. 2005; Jejeebhoy 1998; Nahar 2012]. The increasing number of abortions and unhygienic birth practices in Bangladesh also increase susceptibility of pelvic infections and infertility. It has been reported that abortion practices have recently increased in Bangladesh. A cross-sectional study reveals that 66 % of the women reported that they had experienced at least one complication during their last pregnancy and/or childbirth [Ahmed et al. 2000]. Moreover, poverty, tuberculosis, malnutrition, anemia, and low-birth-weight also contribute to infertility [Nahar 2012].

Apart from its medical ground, infertility results in major socio-cultural consequences. In the context of rural Bangladesh, social sufferings of infertile couple know no bounds. In most of the cases, they are being stigmatized, socially excluded, and become a victim of domestic violence [Nahar & Richters 2011]. Despite its serious socio-cultural ramifications, ethnographic research has been very limited to documenting only the social sufferings of women due to infertility. At this backdrop, this paper examines:

1. How infertility is culturally understood, explained, and responded to by rural Bangladeshi women.
2. How infertile women are stigmatized, socially excluded, and marginalized.
3. The nature and extent of fertility-seeking behavior of the infertile couples.

Methodology of the Study

This study is ethnographic in nature conducted in three villages under Jessore and Satkhira districts of Southwestern Bangladesh. For collecting data, qualitative research techniques, such as in-depth interviews, Focus Group Discussions (FGDs), and Key Informant Interview (KII) have been used. Given the heterogeneity of rural Bangladeshi population, research participants have been carefully selected from diverse socioeconomic and religious backgrounds. However, reflecting on the nature of poverty in rural Bangladesh and Islam being the religion of the majority people, most of the participants come from poor socioeconomic condition and Islamic religious background. Infertile women, their husbands, and parent-in-laws were interviewed extensively to understand their views about infertility. Social exclusionary practices against infertile couples were revealed through interviewing the neighbors who disclosed how infertile couples, particularly women, are socially stigmatized and ostracized. Three FGDs and 10 KII have been conducted with representatives from infertile couples, neighbors and family members, and traditional healers to understand the various dimensions of infertility in line with the objectives of this research. Open ended questions were used for in-depth interviews, allowing respondents to freely talk about their problems and sufferings, and share everything they feel relevant to help us better understand the issue. Conducting such research on infertility, however, was not as easy as expected, since the issue at hand was highly sensitive and many respondents were shy to freely talk about this matter. Initial rapport build-up became instrumental in convincing the respondents that this research is purely an academic exercise, nothing personal would be disclosed, and anonymity would be strictly maintained.

Literature Review and Conceptual Framework

There are some impressive studies that document infertility and its associated social sufferings. Nahar ethnographically examines how rural Bangladeshi women explain, experience, and respond to infertility [Nahar 2021]. She demonstrates how infertility has not just been reduced to a biological or health problem; rather, it turns out to be a serious social problem that intersects biology, culture, and society. Women in rural Bangladesh do not only submit themselves to rigid structural forces, which merely reduce their role to mother and wife, but stand against them and develop resilience to survive against stigmatization and social sufferings due to infertility [Nahar 2021, *131*]. Nahar and Richters also explore how childless women suffer from social, economic, and emotional difficulties [Nahar and Richters 2011]. They are stigmatized, and their identity is degraded as they are unable to produce children. As a result, they suffer from loss of self-respect and fear of abandonment. Infertility often results in marital disruption, stigmatization of women, and loss of dignity [Nahar and Richters 2011]. Economic consequences of infertility are explained by the fact that having no children means not having an extra-wage earning opportunity for the family and indulging into poverty. Infertility has also been reported as having emotional consequences such as feelings of emptiness, sadness, depression, guilty feeling, loss of identity, isolation, and loneliness. Rural women develop an illness because of tension, which the authors termed as *chintarog* [Nahar and Richters 2011].

Shah and Batzer examine how infertile women in the developing world are more vulnerable compared to their counterparts in the developed world due to social, cultural, political, and socioeconomic factors [Shah and Batzer 2010]. Using World Health Organization's bio-psychosocial model of disability, they argue that infertility should be considered as a disable condition in the developing world. The authors argue that women in the developing world are still primarily and predominantly regarded as child bearers, and the expectation that women will bear children shapes their social status [Bosmans et al. 2008]. Since infertility is invariably considered to be a matter of female incapability, women become the first line of social victim due to it [Shah and Batzer 2010].

The concept of "agency" as outlined by Bourdieu has appeared to be more relevant to understand actions taken by the infertile women to negotiate their everyday life [Bourdieu 1984; 1990]. Although agency has been variously explained and used in the social sciences, it can be defined as the power of individuals to think about themselves and act accordingly to shape their everyday experiences and life trajectories [Joseph 2020, *108*]. The "structure-agency" debate delineates how individuals have become part of a larger social process, "the body is in the social world but the social world is also in the body" [Bourdieu 1990, *190*]. However, rather than being overwhelmingly apathetic to the rigid social structure, individuals also use agency, their capabilities and power, to negotiate with the society outside them. In the context of rural Bangladesh, there are evidences that women are resilient and they use agency to adjust to their social context. Nahar [Nahar 2021] and Nahar and van der Geest [Nahar and van der Geest 2014] show that avoiding social gatherings is a measure taken by the middle class childless women for their mental peace. Instead of accepting their devalued social position, they continue searching for any therapy to achieve potential fertility. In order to fight against social stigma, urban women promote an alternative identity by focusing on achievements, career, or taking up a job, which keep them busy with other social activities [Nahar 2021]. Similar findings have also been reported in Rajasthan, India by Unnithan [Unnithan 2019] who argues that maternal health, infertility, and reproductive body-self have become a matter of citizenship within the broader context of power and gender politics in a patriarchal society where women continue to (re)produce and negotiate their social roles as mother and wife.

Conceptualizing Infertility: A Social Constructionist Approach

Social constructionism [Schutz 1962; 1967; Berger and Luckmann 1966] can be powerfully used to analyze infertility and its associated social behavior in rural Bangladesh. Berger and Luckmann in their book *The Social Construction of Reality* [Luckmann 1966] argue that reality is socially constructed, and the sociology of knowledge must analyze the process in which it occurs. Construction of "knowledge" is important here, which is developed, transmitted, and maintained in social situations. In other words, the everyday knowledge is concerned with the analysis of the social construction of reality, and the social "knowledge" is produced and reproduced by various social actors, where each actor might have individual knowledge construction based on their own cultural orientation to life, which Berger and Luckmann identify as the production of "multiple realities" [Berger & Luckmann 1966, *27*]. This is how a cultural knowledge is produced with specific language and meanings shared by that particular community people. This research on infertility fits into this broader framework of social constructionism, in which the common sense knowledge about infertility is constructed, produced, and maintained by the married infertile women in rural Bangladesh. Infertile women are consciously engaged with other important members of the society. Their real life is connected with these important others, such as family members, relatives, friends, neighbors, health workers etc. A vast knowledge is created among these stakeholders using specific local languages through interactions in the cultural context of Southwestern Bangladesh. The social processes through which such construction of knowledge occur is important to examine. This research is aimed at exploring such local terminologies of infertility and how the infertile women suffer in their everyday life. It is examined how the social construction of infertility is shaped by the local terminologies people use to (re)define infertility and its associated social behavior.

Conceptualizing Fertility-seeking Behavior

Fertility-seeking behavior can be understood as a sub-set of broader health-seeking behavior, which refers to the sequence of remedial actions that individuals undertake to rectify perceived ill health [Chrisman 1977; Ward, Mertens & Thomas 1997; Ahmed et al. 2000]. In any social context, there exist medical plural settings where different therapeutic options are available and sought after by the community people. Arthur Kleinman suggests that there are at least three major healing options available in any social setting, namely popular sector, folk sector and professional sector [Kleinman 1984]. Popular healing option refers to self-care, including self-medication and self-help groups, whereas folk sector comprises of non-professional healing options, such as alternative therapies and traditional healers. Professional sector includes scientific biomedical healthcare services. One important feature of Bangladeshi healthcare system is the coexistence of all these three sectors, including but not limited to biomedicine, homeopathy, ayurveda, unani and traditional healing systems [Ahmed et al. 2000, *362*]. In such a medical plural context, how people make a decision which healthcare services are to be used is a major point of interest in medical sociology. Janzen's "therapy management group" [Janzen 1978] plays a significant role in shaping health-seeking behavior of an individual in a medical plural setting. Therapy management groups comprises of various kinsmen, friends, neighbors, and others who give moral support and information about appropriate and efficient healing services when someone becomes ill. Thus, therapy management group works like a 'brokerage function' between the patients and health service providers.

Such health-seeking behavior with the help of therapy management group provides useful framework to understand fertility-seeking behavior of the infertile couples in the context of rural Bangladesh. This paper examines how therapy management group in the form of family members, friends, relatives, and neighbors play a significant role in

shaping fertility-seeking behavior of the infertile couples. They provide information where to get effective healing services to achieve fertility. Infertile women continue to use different healing services with the assistance of the therapy management group. They strategically combine different healing options to optimize success in achieving fertility. This study is an ethnographic examination of such strategies adopted by the infertile couples in the context of rural Bangladesh.

Findings and Analysis

Infertility poses significant challenges on the everyday life of the infertile couples, particularly on women. This article focuses on the lay understanding of infertility, its associated social stigma, and fertility-seeking behavior in rural Bangladesh. Findings of this research have been presented in three broad areas in line with the objectives of the study. The lay knowledge about infertility will be presented at the outset followed by the social sufferings of the infertile women, and thirdly, the ways women seek healthcare services to achieve fertility.

The Social Construction of Infertility: The Lay Knowledge

During the very first day of fieldwork at a village in Satkhira, when villagers were asked to show us the house of a particular infertile couple we knew, they immediately said "*ohh you are looking for the house of the hatkhuri*". It became very evident at the beginning of the study that the local people use specific terminologies to identify infertile couples. Gradually, we found that the villagers use different local terminologies to denote infertile couples, such as *hatkhuri* (lorn/forsaken), *bajha* (barren), *olukkhune* (inauspicious), and *nagin* (serpent). These vernacular terms often come with derogative and stigmatized connotations. In the local context of southwestern Bangladesh, infertility invariably refers to "*baccha na houa*" or not having any children. Coming across an infertile woman on the way, going somewhere with the infertile women, or crossing the path of an infertile woman in the early morning are considered ominous by the villagers. Furthermore, an infertile woman is considered to be an indication of bad luck, hardship, or failure. The social construction [Berger & Luckmann 1966; Greil, McQuillan, & Slauson-Blevins 2011] of infertility in southwestern Bangladesh has been reflected with vernacular terms that are often associated with stigma and negative undertone. The local terms used to refer to infertile women, such as *hatkhuri*, *bajha or olukkhune* etc. appear to be the reality of everyday life for the infertile women. In fact, the "reality" about infertility in rural areas is constructed with the shared knowledge of the local people to symbolize infertile women.

Language has been the most crucial sign system of the human culture. In order to socially construct any reality, local language is used to symbolize this [Berger & Luckmann 1966]. In the context of southwestern Bangladesh, infertility has been symbolized with specific local languages. In their everyday social life, infertile women are surrounded by many other social actors, such as family members, relatives, friends, neighbors, healers and so on. In their everyday interactions, each of these actors creates different realities and knowledge on infertility. Infertile couples themselves feel a sense of loneliness and social exclusion, as significant others identify them as *olukkhune*, *bajha*, barren or inauspicious; whereas, traditional healers develop a specific knowledge to treat infertility using indigenous knowledge and techniques. These vast stocks of local knowledge have been (re)produced by different actors to delineate the sufferings of the infertile women and their fertility-seeking behavior. The everyday knowledge regarding infertility has thus been appeared as the social construction of reality in the context of southwestern Bangladesh. Such a lay knowledge base of infertility is developed, shared, and maintained by the local people living in a particular socio-cultural context. Thus, "multiple realities" as defined by Berger and Luckmann [Berger and Luckmann 1966] provide a powerful

cultural framework to analyze how social reality of infertility has been variously defined, explained, and experienced by different social actors in their everyday life in southwestern Bangladesh.

Another important concept that is invariably used to explain infertility is *kopal*, fate or destiny. Almost all the respondents unhesitantly mentioned that infertility was written in their *kopal* and, therefore, unavoidable. One of the respondents said that, “*Most of the couples have children after marriage. They are happy. But look at me, even though I’m married for 12 years I’m not blessed with any child. Baccha houa na houa sob kopaler likhon (having children or not is all about destiny)*”. Another respondent mentioned that, “*kopale na thakle baccha hoi na (there will be no child if it is not written in kopal)*”. The local people use *kopal* as a broader framework to explain any misfortune, illness, or any sort of loss. Many respondents strongly believed that *kopal* is a key factor to determine who will be affected by infertility. Such an understanding of *kopal* is strongly based on the fatalistic explanations and logic of divine agency. Many infertile women often ask this question: “Why is infertility on me?” To answer this question, they frequently said that *baccha houa na houa* is fated and, as such, this factor is completely beyond the control of human being. It is a predominant belief among the respondents that infertility is an examination of patience from the God. While others believe that the sufferings inflicted due to infertility is a mechanism through which past transgressions and bad deeds would be washed away. The social construction of fate appears to be crucial here to explain the process through which infertile couples rationalize their pain and distress.

Many infertile couples accept that without the willing of God none can have children. When asked why infertility was on her and not on others, one respondent said that, “*Infertility is an examination from the God who tests you through different examinations. Infertility is one of such examinations. We must keep patience and pray to God to overcome infertility*”. Another female respondent said that infertility might be due to her any past bad deeds (*paap kaz*), which she did knowingly or unknowingly, that need to be abolished first before any pregnancy is expected. Solemn pray to God is the only way to abolish such past bad deeds. The framework of *karma* has been instrumental in explaining infertility in rural Bangladesh. Stone [Stone 1976] and Zvosec [Zvosec 1996] have used *karma* in the Nepalese context to explain how inauspiciously misaligned planet (*graha bigrayo*) may inflict misfortune, illness, or even death to someone. Respondents in rural Bangladesh also believe in similar divine consequences of infertility. It is believed that having children is eternally divine and the will of God. Such an understanding of infertility logically shapes fertility-seeking behavior of the subjects, whereby they prefer religious healings over other methods, which has been described in the subsequent section.

Social Sufferings of Infertility

Infertility comes with a range of social sufferings for the infertile couple, particularly women, in their everyday life. While conducting fieldwork it became very evident that most of the respondents experience loneliness and a deep sense of social exclusion due to their infertile condition. Women usually do not go out of their house unless there is a real necessity as people often talk behind about their childlessness. They prefer staying at home for avoiding any sort of stigmatization. Similar findings have been reported by Nahar and Richters that infertile couples in rural Bangladesh suffer from loneliness, stigma, fear of divorce, and guilty feeling [Nahar and Richters 2011]. The following discussion illustrates the socio-emotional sufferings of the infertile couples.

- **Infertility and Stigmatization**

In the context of rural Bangladesh, infertile women are severely stigmatized and marginalized. The local stereotypical language, such as *hatkhuri* and *bajha* are used to refer

to infertile women. They are also identified as "witches" who bring sufferings, defamation, and shame to the in-law's family. As a new born child is believed to bring happiness and joy for the family, an infertile women, who is blamed for her inability to give birth, is often targeted as an agent who brings unhappiness and disturbance in the family. The common local saying "*poribar e santi more gese*" (peace has died in the family) denotes the condition of "*oshanti*" in the family to stigmatize the infertile couples.

Findings of this study corroborate with the argument of Shah and Batzer who demonstrate that infertility is popularly believed to be a disabling condition [Shah and Batzer 2010]. Disability can be explained using two models: the medical model and the social model. The medical model of disability views infertility as a condition whereby individuals suffer from deficit, abnormality, and a defect [Scully 2008, *23*]. By contrast, the social model of disability demonstrates the specific socio-cultural and political arrangements that render a person to be disabled [Reindal 2000, *93*; Newell 1999]. Social models of disability therefore vary across cultures, spaces, and historical contexts. In this study, the social model of disability appears to be a powerful analytical framework that helps better understand how the local people identify, label, and define infertile couples as disabled in producing offspring. In rural Bangladesh, local people often stigmatize infertile couples, particularly the women, as *bajha* or barren who are not considered to be "normal" like other women. They are marginalized and excluded from most of the public spaces, as their physical presence is believed to be ominous. "*Tader mukh dekhlei omongol*" is a popular saying, which refers to the stigmatization process whereby infertile couples are identified as ominous if their faces are seen. Such a stigmatized identity severely restricts their social life, bonding, and networking in the family and society.

In the context of rural Bangladesh, infertility has been explained with specific gendered dimension whereby women are invariably seen incapable in producing children. Compared to male counterpart, women are convincingly targeted as responsible for infertility, which consequently allows men to remarry with a hope to save the family with a child. In a Bangladeshi patriarchal society, remarriage for the male is often justified as it may help sustain the family name, in case remarriage helps in reproduction, as one of the infertile male mentioned that, "*What else to do except remarriage? How to survive the family if there is no children? My current wife cannot give me any child so remarriage is the only option for me. People around me always ask me why I am not remarrying. I have to save my family*". Thus, women are mostly the victim of infertility, they are ostracized as incapable and disable. Everyday life of an infertile women in rural Bangladesh is like "*beche more thaka* (living like a dead)" as mentioned by one of the respondents.

- **Encountering Family Members, Neighbors, and Relatives**

Infertility in rural Bangladesh often comes with deep family crisis, particularly in the joint families where infertile women live with their parents-in-law. While interviewing women about their everyday experiences of being infertile, most of them said that they are much more distressed and ostracized by their own family members, especially mother-in-law and the neighbors. Mothers-in-law appear as a strong counterpart who routinely ostracize their infertile daughters-in-law as *nagin* or ill-omened, and consistently persuade their sons to get remarried. They routinely and publicly speak ill of their daughters-in-law and mentally torture them by blaming them as infertile. One of the mothers-in-law thus said that, "*My son does not listen to me because of this nagin. My son has become distorted because of her*". Many respondents said that their mother-in-law secretly brings *pani pora* (sacred water) and *tabij* (amulets) from the local *hujur* (religious healers) to protect sons from their inauspicious wives. It is also believed that such traditional healings would work to motivate sons to abandon their wives and encourage them to remarry. Another mother-in-law mentioned that, "*What is the benefit of keeping the tree which does not give any fruit. We should cut the tree and plant another one. He must*

remarry to have children and protect the family". Thus, everyday life is full of quarrels between in-laws and their daughters-in-law, which most of the time irritate their sons who consequently physically torture their wives. One of the respondents said that one day her husband beat her severely while she was sleeping because her mother-in-law said something ill about her to the husband.

Besides her own family members, an infertile woman also becomes routinely ostracized by her relatives and neighbors. Deliberate avoidance is one of the ways of excluding her from the social life. She is unlikely to be invited in the social gatherings, as she is considered to be ill-omened. It is popularly believed that the day would be ruined if her face is seen in the morning. People cancel their travel if they accidently meet her on their way. One of the respondents mentioned that, "*One day I went to a neighbor's house and I saw a woman chewing betel leaf. She immediately spilt out betel from her mouth saying that she is impure for her childlessness*". Infertile women become subject of 'social gossip' of the neighbors on the matter of why she is not having children. Many respondents we interviewed mentioned that neighbors used to talk about the purpose of keeping a wife who is not capable of begetting a child. Why she has not been divorced yet and he is not getting remarried become a subject of routine social gossip in the everyday life of the neighbors.

- **Fear of Divorce and Uncertain Future**

Another important aspect of the everyday life of the infertile women is the constant fear of divorce and unsecured life after that. In the patriarchal context of rural Bangladesh, infertility often results into remarriage of the husband. Wives are either divorced or permitted to stay with co-wives. Since most women in rural Bangladesh are economically dependent on their husbands, divorces often come with miserable life condition and unsecured future of the women. They have nothing to do but to accept the decision of the husband. One of the respondents thus said that her husband wanted to remarry but conditionally permitted her to stay in the family, "*I want to get married again. But you should come to a contract. I will not divorce you and you cannot leave me. Do you agree with this contract?*" The respondent did not agree with this condition and argued that if her husband gets remarried, the second wife will occupy all the resources and authority of the house. The first wife will be subjugated and deprived of her rights.

Everyday life of the infertile women in rural Bangladesh often comes up with the fear of divorce. Family members and neighbors continually provoke men to remarry with a hope to have a child. Women who choose not to stay with co-wives often endure a miserable life condition. Many of them return to their natal families and try to survive by doing small entrepreneur activities. One of the respondents with the blurred eyes full of tears stated that:

> "I did not opt for staying with shotin (co-wives) but when I went out of the house there was no one to take care of me. People blamed me why I left. If I had a child, I would not have to face this depressed life. There is no one to call me 'ma' (mother), no one to say, 'mother feed me please'. Just to hear the word 'ma' I took the adoption of my sister's child".

- ***Shotiner ghor*: Miserable Life with Co-wives**

Considering that there is no place to return, many women choose to stay with their husband and co-wives (*shotin*). *Shotiner ghor* in local language is often symbolized as the "life in the hell". Infertile women have to endure endless deprivation and subjugation when living with co-wives. Some respondents shared their bitter experiences of *shotiner ghor* and said that their husbands could not do justice to them. Both wives often engage in quarrels over everyday issues including cooking, cleaning utensils, and clothes as well as maintaining authority and control in the family. Some respondents refused to publicly

disclose their sufferings whereas others privately shared their pains. One of the respondents shared how she was ostracized by her *shotin* even when her husband's dying wish was to see her first wife, she mentioned that:

> "My husband remarried after seven years of our marriage when he became assured that I am not capable of producing a child. After his second marriage the co-wife did not want that I talk to my husband. She told me not to talk to my husband. As I had no child, there was no right to meet and talk to my husband. Even at time of my husband's death, she (co-wife) did not allow him to meet me. He (husband) said repeatedly that he wanted to talk to me; he wanted to talk to his boro bou (first wife) before his death. But she (co-wife) was so cruel that she did not inform me about this".

Respondents broke into tears when sharing their experiences. Infertility did not only shatter their life but also forced them to endure the pain of living and sharing homestead with co-wives. Many women in rural Bangladesh do not have any earnings and mostly depend on their husband. Therefore, remarriage of their husband forced them to share household with co-wives. They have nothing but to endure quarrels and misbehavior of the co-wife. Many respondents told that they do not have any future since they do not have any children.

It has been quite evident in the discussion that infertility is often associated with endless sufferings and exclusions. Infertile women are believed to have no use for the community as they are unable to produce children. The social construction of infertility reveals the specific languages and local knowledge that people use to delineate the specific condition of infertility. These languages are often derogatory, as infertile women are generally looked down upon when they are referred to as *bajha* (barren), *hatkhuri*, *olukkhone*, and *nagin*. They are socially excluded, marginalized and become a subject of social gossip. Infertile couple, however, tries all sorts of available healing methods in order to treat the condition of infertility.

Fertility-seeking Behavior

Fertility-seeking behavior is one of the most significant tasks in the process of achieving pregnancy. It is believed that all sorts of discrimination, anxiety and stigmatization associated with infertility could be over, if pregnancy is achieved. Therefore, infertile couples try all sorts of healing methods possible to achieve pregnancy. Given the medically plural context of rural Bangladesh, there co-exist various healing methods, including but not limited to allopathic, homeopathy, faith based traditional healing, *kobiraj* (who treats with herbs), and religious healers. When asked which healing services they mostly prefer, almost all respondents invariably said that they would seek any method that work for them. They would not mind spending any amount possible or travel anywhere to gain fertility. However, among the healing methods, all respondents informed that they tried *kabiraj* (healing mostly based on herbs) and *hujur* or religious healers who provide amulets and sacred water. They also went to *majar* (grave of a religious figure) to seek his blessings in order to gain pregnancy. As discussed earlier, the social construction of fate or *kopal* predominantly determines fertility-seeking behavior of the subjects. Since infertility is believed to be caused due to *karma* and *kopal*, the most effective healing is believed to be celestial by praying to God or religious healing by going to a *hujur* or religious person. Thus, most respondents prefer visiting a religious healer who uses *tabij* (amulets) or *pani pora* (sacred water) to treat infertility. One of the respondents thus said:

> "It depends on the will of Allah whether we have children or not. There is no other alternative but trying in this case. Also it takes a lot of money for the treatment. We visit the hujur regularly but not yet successful. We are happy with the adopted child from my sister-in-law. We are unhappy, but this is life".

Besides seeking healing services from the religious *hujur*, many other respondents seek services from the local *kobiraj, a local traditional healer* who treats with *gachra* medicine mostly herbs from the roots and leaves of trees. The local *kobiraj* is a trusted person in the village who is believed to be reputed in treating infertility. *Gachra* medicine provided by the *kobiraj* is believed to be strong enough in removing underlying causes of infertility and inflicting pregnancy. One major reason why people prefer *kobiraj* healing is the reassurance provided by him. Unlike allopathic treatment, the *kobiraj* continually reassures that pregnancy is possible. Patients also feel comfortable while discussing with him the personal matters such as infertility. While comparing *kobiraj* and allopathic medicine, one respondent said that:

> “We cannot properly talk to the doctors in the hospital or clinic. They do not have time to listen to our problem. If he does not allow us to share our problem, how can we get the solution? The kobiraj is personally known to us, he listens to us, and more importantly he reassures us that pregnancy is possible. Such reassurance helps us keep patience and continue his healing service”.

Allopathic medicine has been another very important resort for the infertile couple. Most of the respondents simultaneously used allopathic and *kobiraji* medicine. In most cases, allopathic medicine is considered to be the last resort for treating infertility. However, considering the cost of allopathic treatment, many couples think twice before seeking professional medical services. Affordability is an important issue here. Many couples even discontinue treatment when it goes beyond their affordability, as one of the respondents said that, “*My husband and I went to a clinic and the doctor gave some tests. Doctor said that I accumulated cholesterol in the uterus. So, a wash up is required which I did. Every week I spend 500 taka for medicine. Till now, the overall costs have crossed over one lac. The doctor finally said that the chances are very low and we discontinued the treatment*”. Another woman said that she was having trouble in conceiving and went to see the *kabiraj*. She was treated with *gachra* medicine which did not work. They went to consult an allopathic doctor and diagnosed as having a tumor in the uterus, which was operated. Now she is 45 and will never be a mother again.

Kleinman suggests that local healthcare system may consist of three major healing services such as popular, folk and professionals [Kleinman 1978; 1980]. This constitutes a plural medical system where patients seek services according to their preference. Rural Bangladesh is also characterized by such a plural medical system where different medical systems co-exist. Janzen’s therapy management group help us better understand fertility-seeking behavior of the infertile couples in a medical plural setting [Janzen’s 1978]. By “therapy management group”, Janzen refers to the process by which family members, relatives, and neighbors play a significant role in shaping health-seeking behavior of the patients. In the context of rural Bangladesh, such a kin network appears to be instrumental in assisting infertile couples in finding a suitable and effective healing service. Infertile couples routinely consult with such “therapy management group” in search of effective healers to treat infertility.

Conclusion

Drawing on ethnographic evidences and narratives from rural Bangladesh, this paper illustrates how infertility has been socially constructed by focusing on local knowledge, social sufferings, and fertility-seeking behavior of the infertile couples. It has been quite evident in the preceding discussion that infertility is not just a medical condition; rather, it has deep-rooted socio-cultural implications. Infertility is often explained and associated with a local knowledge system, which has been developed over time by the local people. The social construction of infertility refers to the specific languages people use to signify infertility such as *bajha*, *olukkhone*, *hatkhuri*, *nagin* etc., which invariably denotes a

derogative and stigmatized identity construction for the infertile couples. Women feel a deep sense of loneliness, isolation, and insecurity. They are socially stigmatized and excluded from much of the public life. In a patriarchal context of rural Bangladesh, women become the first line of victim as they become a subject of social gossip who are blamed for their infertile condition. Everyday life of the infertile women is full of struggle where they have to fight against severe social stigmatization. People do not consider them as normal, since they are believed to be incapable of producing a child and thereby inauspicious. There are some evidences of resilience among the infertile couples. Some women take job outside home so that they feel involved in work and bypass psychological trauma. Other couples have adopted children from their relatives or neighbors. As far as fertility-seeking behavior is concerned, infertile couples seek different healing options in a medically plural context in rural Bangladesh. Fate or *kopal* appears as indispensable in explaining infertility. Since infertility has been understood as celestial, religious healings are preferred followed by *kobiraji* healing and professional doctors. "Therapy management group" as illustrated by Janzen [Janzen 1978] plays a significant role in shaping fertility-seeking behavior of the infertile couples. Despite being highly ostracized, infertile couples strategize their agency to have a better living in the family and society.

REFERENCES

Ahmed S. M., Adams A. M., Chowdhury M. and Bhuiya A. (2000), "Gender, socioeconomic development and health-seeking behaviour in Bangladesh", *Social Science & Medicine*, Vol. 51, Issue 3, pp. 361–371. DOI: https://doi.org/10.1016/S0277-9536(99)00461-X

Ali T. S., Sami N. and Khuwaja A. K. (2007), "Are unhygienic practices during the menstrual, partum and postpartum periods risk factors for secondary infertility?", *Journal of Health, Population, and Nutrition*, Vol. 25, No. 2, pp. 189–194.

Berger P. L. and Luckmann T. (1966), *The Social Construction of Reality*, Penguin Books, Harmondsworth.

Bosmans M., Nasser D., Khammash U., Claeys P. and Temmerman M. (2008), "Palestinian women's sexual and reproductive health rights in a longstanding humanitarian crisis", *Reproductive Health Matters*, Vol. 16, No. 31, pp. 103–111. DOI: https://doi.org/10.1016/S0968-8080-(08)31343-3

Bourdieu P. (1984), *Distinction: A Social Critique of the Judgment of Taste*, Routledge and Kegan Paul, London.

Bourdieu P. (1990), *The logic of practice*, Stanford University Press, Stanford, CA.

Chrisman N. J. (1977), "The health seeking process", *Culture, Medicine and Psychiatry*, Vol. 1, No. 4, pp. 1357–1368. DOI: https://doi.org/10.1007/BF00116243

Feldman-Savelsberg P. (1999), *Plundered kitchens, empty wombs: Threatened reproduction and identity in the Cameroon grassfields*, University of Michigan Press, Ann Arbor. DOI: https://doi.org/10.3998/mpub.16324

Greil A., McQuillan J. and Slauson-Blevins K. (2011), "The social construction of infertility", *Sociology Compass*, Vol. 5, No. 8, pp. 736–746. DOI: https://doi.org/10.1111/j.1751-9020.2011.00397.x

Humm M. (1992), *Modern feminisms: Political, literary, cultural*, Columbia University Press, New York.

Inhorn M. C. and Balen F. V. (2002), *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*, University of California Press, Berkeley.

Janzen J. M. (1978), *The quest for therapy: Medical pluralism in Lower Zaire*, University of California Press, Berkeley.

Jejeebhoy S. J. (1998), "Infertility in India: Levels, patterns, and consequences. Priorities for social science research", *Journal of family Welfare*, Vol. 44, No. 2, pp. 15–24.

Kleinman A. (1978), "What kind of model for the anthropology of medical systems?", *American Anthropologist*, Vol. 80, No. 3, pp. 661–665. DOI: https://doi.org/10.1525/aa.1978.80.3.02a00170

Kleinman A. (1980), *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry*, University of California Press, Berkeley.

Kleinman A. (1984), "Indigenous systems of healing: questions for professional, popular and folk care", in *Alternative Medicines: Popular and Policy Perspectives*, Routledge, London, 27 p.

Kumar D. (2007), "Prevalence of female infertility and its socio-economic factors in Tribal communities of Central India", *Rural and Remote Health*, Vol. 7, p. 456. DOI: https://doi.org/10.22605/RRH456

Nahar P. (2012), "Invisible women in Bangladesh: Stakeholders' views on infertility services", *Facts, Views & Vision in ObGyn*, Vol. 4, pp. 149–156.

Nahar P. (2021), *Childlessness in Bangladesh: intersectionality, suffering and resilience*, Routledge, Abingdon, Oxon. DOI: https://doi.org/10.4324/9781003050285

Nahar P. and Richters A. (2011), "Suffering of childless women in Bangladesh: The intersection of social identities of gender and class", *Anthropology & Medicine*, Vol. 18, Issue 3, pp. 327–338. DOI: https://doi.org/10.1080/13648470.2011.615911

Nahar P. and van der Geest S. (2014), "How women in Bangladesh confront the stigma of childlessness: Agency, resilience, and resistance", *Medical Anthropology Quarterly*, Vol. 28, No. 3, pp. 381–398. DOI: https://doi.org/10.1111/maq.12094

Newell C. (1999), "The social nature of disability, disease and genetics: A response to Gillam, Persson, Holtug, Draper and Chadwick", *Journal of Medical Ethics*, Vol. 25, No. 2, pp. 172–175.

Prasad J. H., George V., Lalitha M. K., John R., Jayapaul M. N., Shetty N., Joseph A., Abraham S. and Kurz K. M. (2005), "Reproductive tract infections among young married women in Tamil Nadu, India", *International Family Planning Perspectives*, Vol. 31, No. 2, pp. 73–82. DOI: 10.1363/3107305

Reindal S. M. (2000), "Disability, gene therapy and eugenics – a challenge to John Harris", *Journal of Medical Ethics*, Vol. 26, No. 2, pp. 89–94. DOI: https://doi.org/10.1136/jme.26.2.89

Schutz A. (1962), *Collected Papers*, Vol. 1: *The problem of Social Reality*, Martinus Nijhoff, Hague.

Schutz A. (1967), *The Phenomenology of the Social World*, Heineman Educational Books, London.

Scully J. L. (2008), *Disability bioethics: Moral bodies, moral difference*, Rowman and Littlefield, Lanham and Toronto.

Shah K. and Batzer F. (2010), "Infertility in the developing world: The combined role for feminists and disability rights proponents", *International Journal of Feminist Approaches to Bioethics*, Vol. 3, No. 2, pp. 109–125. DOI: https://doi.org/10.2979/fab.2010.3.2.109

Stone L. (1976), "Concepts of Illness and Curing in a Central Nepal Village", *Contributions to Nepalese studies*, Vol. 3, pp. 55–80.

Unisa S. (1999), "Childlessness in Andhra Pradesh, India: Treatment seeking and consequences", *Reproductive Health Matters*, Vol. 7, No. 13, pp. 54–64. DOI: https://doi.org/10.1016/S0968-8080(99)90112-X

Unisa S. (2010), "Infertility and treatment seeking in India: Findings from district level household survey", *Social Aspects of Accessible Infertility Care in Developing Countries*, Vol. 59, p. 65.

Unnithan M. (2019), *Fertility, Health and Reproductive Politics: Re-imagining Rights in India*, Routledge, London. DOI: https://doi.org/10.4324/9780429465482

Ward H., Mertens T. E. and Thomas C. (1997), "Health seeking behaviour and the control of sexually transmitted disease", *Health Policy and Planning*, Vol. 12, Issue 1, pp. 19–28. DOI: https://doi.org/10.1093/heapol/12.1.19

Whitehouse B. and Hollos M. (2014), "Definitions and the experience of fertility problems: Infertile and sub-fertile women, childless mothers, and honorary mothers in two Southern Nigerian communities", *Medical Anthropology Quarterly*, Vol. 28, No. 1, pp. 122–139. DOI: 10.1111/maq.12075

Joseph J. E. (2020), "The agency of habitus: Bourdieu and language at the conjunction of Marxism, phenomenology and structuralism", *Language & Communication*, Vol. 71, pp. 108–122. DOI: https://doi.org/10.1016/j.langcom.2020.01.004

Zvosec D. L. (1996), *Perceptions and Experiences of Tuberculosis in Nepal: A Biobehavioural Perspective*, Unpublished Doctoral Dissertation, University of Hawaii.

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“Дерева без плодів”: соціальний конструкт безпліддя, соціальна стигма та дії, скеровані на відновлення фертильності в сільських регіонах Бангладеш

Крім того, що безпліддя є медичною проблемою, воно також має значні соціально-культурні наслідки. У пропонованій статті досліджуються соціальні страждання безплідних жінок, їхні дії, скеровані на відновлення фертильності, та стратегії подолання щоденної соціальної дискримінації і стигматизації, спричинених безпліддям. Це дослідження проводилося на основі етнографічних прикладів і якісних методів у трьох селах районів Джессор і Саткхіра на південному заході Бангладеш. Результати дослідження свідчать, що безплідні жінки потерпають від різноманітних соціальних страждань, поміж яких ізоляція, самотність, страх розлучення, стигма, домашнє насильство тощо. Багатьом безплідним жінкам доводиться жити разом з іншою дружиною (shotin) свого чоловіка, і цим іноді ще більше ускладнюється їхнє життя. Повсякденність стає нестерпною, коли родичі їхнього чоловіка та сусіди психологічно й фізично знущаються з них. У суспільстві безпліддя стає об’єктом пліток, і жінки без дітей стереотипно ідентифікуються як безплідні (bajha), “закайдовані” (haatkhuri) і зловісні. У контексті пояснення безпліддя соціальний конструкт “доля” (kopal) видається неминучим. Дії жінок, скеровані на відновлення фертильності, здебільшого продиктовані доступними їм варіантами, як-от вельми поширене звернення до аюрведичних засобів (kabiraji), гомеопатії і знахарок. Однак, користуючись своєю свободою волі, вони власними зусиллями, а також за підтримки членів батьківської сім’ї намагаються протидіяти стигматизації і навішуванню на них стереотипних ярликів.

Ключові слова: безпліддя; дії задля відновлення фертильності; сільські регіони Бангладеш; страждання жінок у соціумі; стигма

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