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RESEARCH PAPER

"If A Vine does not produce Fruits and Flowers, People throw it away" The Discursive Construction and Negotiation of Stigma related to Childlessness in rural Pakistan

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ABSTRACT

Being childless is an unbearable condition for women in the pronatalist Pakistani society and has a prominent place in community dialogues. Childless women bear the brunt of childlessness. These women face stigma expressed in community members' talks. This study presents a discourse analysis of community members' thoughts on childless women. Data were collected through in-depth interviews, focus group discussions and observations and analysed using a social-constructionist approach to discourse analyses. Four interpretative repertoires -childlessness as the will of God, childless women as worthless, or as ill-boding women and a medical repertoire are prominent in the community. These repertoires are used in different contexts to both stigmatise and destigmatise childless women. This study focused on the views of different stakeholders with both a direct and an indirect link with childlessness, such as childless women, their partners, older women, and healthcare providers in the community. We plea through this study that community members should be sensitised about possible stigmatising behaviour with childless women. More research should be conducted to find out the medical reasons of childlessness in the area.

KEYWORDS Childless Women, Discourse Analysis, Stigma

Introduction

Infertility is considered a cause of childlessness. While there is no universal definition of infertility, according to the World Health Organization (WHO), infertility is the inability of a couple to conceive after two years of unprotected intercourse (Larsen, 2005). Infertility is of two types: primary infertility- women never conceived, and secondary infertility- women do not conceive after one year of unprotected sexual activity following the previous pregnancies (Larsen, 2005). The reported prevalence of infertility is around 72 million people worldwide (Ombelet, 2014). A WHO-DHS Comparative Report (2004) stated that more than 186 million ever-married women in developing countries (excluding China) were infertile due to primary or secondary infertility.

In Pakistan, infertility is a less focused area of research. There is no national survey specifically conducted to address infertility. An exception is a Family Planning Survey conducted by the National Institute of Population Studies (NIPS) in 2004, which stated that infertility in Pakistan is 21.9% (primary infertility 3.9% and secondary infertility 18%). The point of departure of our study is slightly different as we see childlessness as one step ahead of infertility (where infertility is a part of childlessness). We define childlessness as, "childlessness is a state when a woman has no live child due to either primary infertility or secondary infertility or miscarriage(s) or stillbirth(s) or neonatal death(s)". According to

United Nations Fund for Pakistan (UNFPA) (2020) and Pakistan Demographic and Health Survey (PDHS, 2017-18), 4.3% per cent of married women of reproductive age (MWRA, 25-49 years) are childless in Pakistan. These percentages have not included the women who were divorced, separated and widowed at the time of the survey.

Furthermore, according to a situation analysis report by UNFPA (2020), voluntary childlessness does not exist in the country. There is a dearth of literature about childlessness in Pakistan. The previous studies are hospital-based and addressed the issues of infertile women who visited the hospitals (Ali et al., 2011; Sami & Ali, 2006; Sami & Ali, 2012; Naz & Batool, 2017; Ullah et al., 2021; Shaheen et al., 2010). There is a possibility that some women do not visit the hospitals, although they are facing childlessness. So, our study is considering all childless women present in the rural village under study to discuss the childlessness.

Pakistani society is pronatalist, meaning that the main purpose of marriage is procreation (Qamar, 2018; Slamat et al., 2023a). The child is considered to bring fortune, security in old age and be a source of pride for family and lineage (Ali et al., 2011) and couples are thus obligated to procreate. The absence of children after a few years of marriage becomes a source of scrutiny for the couple, especially for woman, who bears the brunt of the social devaluation and lack of status associated with childlessness (Sami & Ali, 2006). Childlessness is considered socially deviant (Remennick, 2000). Thus, childlessness subjects women to bear the consequences of childlessness in Pakistan (Mumtaz et al., 2013; Sami & Ali, 2012; Naz & Batool, 2017; Ullah et al., 2021; Slamat et al., 2023a) like some other pronatalist regions (Inhorn, 2003; Nahar & Richters, 2011; Unisa, 1999; Bayouh, 2011; Dyer et al., 2002; Donkor & Sandall, 2007). Because Pakistani society equates womanhood with motherhood, Pakistani women suffer if they are not able to adhere to this social expectation (Ali et al., 2011). Childless women are prone to low self-esteem, identity loss, physical and mental abuse, social recluse, ostracism, marital duress, divorce or abandonment and public stigma in general (Mumtaz et al., 2013; Sami & Ali, 2012; Slamat et al., 2023a). Society's displeasure and unfavourable practices represent the phenomenon of childlessness as something aberrant and a cause of stigma for women (Ullah et al., 2021)

Stigma is a mark, condition, or status which is the subject of devaluation/discredit (Goffman, 1963; Pescosolido & Martin, 2015). Stigmatisation is a social process of affecting the lives of individuals, who have mark, through social relationships (Goffman, 1963) in the given social context. Because stigma emerges/re-emerges in a particular social context. According to Crocker et al. (1998), stigma is seen as an individual attribute that is directly linked to one's identity, which is devalued in a social setting. These negatively labelled individuals then form a separate identity-based category in a given society. This sort of stigma-based categorisation increases power differentials between groups (Kleinman & Clifford, 2009). The distribution of power and its utilisation in a social setting produces a stigma (Link & Phelan, 2001).

Childlessness is unacceptable in many societies. Therefore, communities across the world try to solve the issue through treatments including formal (biomedical) and informal (traditional and complementary medicinal further abbreviated as T/CAM) treatments (Unisa, 1999; Bhatti et al., 1999). The practitioners of these respective sectors have an understanding of the phenomenon of childlessness unique to their education. The formal biomedical sector believes that both men and women can be infertile and are a possible cause of childlessness (Shaheen et al., 2010). These explanations can have a stigmatising or destigmatising effect. In Pakistan, women and families are also in contact with traditional and professional healers (Bhatti et al., 1999; Slamat et al., 2023b) to eradicate the childlessness.

Healers, family, and partners are stakeholders of this study, which focuses on the views of all involved and how they formulate and reproduce discourses on the phenomenon of childlessness.

All stakeholders take on specific social positions in relation to each other within the specific social context of Punjab-Pakistan. Because stigma is produced in language and everyday speech, within common discourses, these stakeholders express their views in accordance with their positions. Discourse involves the use of vocabulary, metaphors, rhetoric, proverbs for individuals or groups. These terms are used repeatedly in social settings whenever a deviant group (childless women) is under discussion and show the "meaning, explanation(s) in the context and emotions (negative/positive) attached" with it (Yang et al., 2007). Similarly, various linguistic terms are used in a social setting to address childlessness/childless women. This study investigates local discourses on childlessness in Punjabi-Pakistani rural community.

We are taking the social constructionism stance to discuss the childlessness. Social constructionism implies a certain view of language and its role in the construction of reality. The starting point for our research is that people's understanding of world means that "how the world is represented or produced through language" (Burr & Dick, 2017). Society is seen as subjective and objective reality where realities are socially constructed and constituted through language. Language plays a bigger role than connecting people and people 'exist' in 'language'. Thus, the focus is more on the interaction where language is generated, sustained and abandoned (Gergen & Gergen, 1991). So, according to Berger and Luckman (cited in Speed, 1991 p.400), people socially construct reality by their use of agreed and shared meanings communicated through language. For this study, our focus is to understand how the community people frame the childlessness in their talk. We are using the discourse analysis (Potter & Wetherell, 1987) to investigate the childlessness through interpretative repertoires and (subject) positions by addressing following research questions:

1. Which interpretative repertoires are used to discuss the childlessness? and
2. How do these interpretative repertoires are used to stigmatise and destigmatise the childless women?

Our study adds to the body of literature that how the constructive power of language is used in (de)stigmatisation of childlessness in a rural Pakistani community? How do daily dialogues with non-verbal expressions of the community members frame childlessness and stigmatise childless women? Similarly, how childless women used the dialogues to destigmatise themselves. Further, not only women but different stakeholders who have a direct or indirect link with childlessness have been included in the study.

Theoretical Framework

To explore discourses on childlessness in the community under study, we adopted a social-psychological approach to discourse analysis, which builds on two main concepts: interpretative repertoires and positions. First, interpretative repertoires are "relatively internally consistent, bounded language units", (Wetherell & Potter, 1988 p.171) that are present in accounts about a particular phenomenon. Repertoires are like building blocks used in the discursive construction of actions, cognition, and other phenomena by the speaker(s) (Wetherell & Potter, 1988 p.172). These are culturally familiar patterns of reasoning which express and justify a social situation without discussing the whole underlying argumentation. Interpretative repertoires are socially familiar lines of reasoning, used to express the reality of the life of the individuals(s). Thus, interpretative repertoires form the 'building blocks' that speakers or listeners use to make sense of everyday life (Wetherell and Potter, 1988, p. 172). Speakers rely on repertoires in a social setting to position themselves (Wetherell, 1998; Ceuterick & Vandebroek, 2017).

The position of the speaker is framed by interpretative repertoires and related narratives, metaphors and specific language. So, interpretative repertoires are core building

blocks in positioning theory (Mckenzie, 2005). Positioning theory stipulates that a position of an individual is, how they perceive themselves concerning others and how others perceive them in the social setting (Davies & Harre, 1990) and how they linguistically express that.

Second, a position is used to express or assign a specific identity (Ceuterick & Vandebroek, 2017). The discursive act of positioning can be used to express a certain (self) identity, but it can also be used to assign a certain position to other(s). The position of the individual(s) in a social setting is expressed as the social identity of the individual(s). The individuals negotiate, communicate and express their ideas about other individual(s), keeping in view their own and other(s)'s social identity.

Subject/individual positions are fluid and can emerge from multiple interpretative repertoires depending upon the setting or context. Because within a social context, a subject's position (Davies & Harre, 1990) is constructed as a combination of knowledge and power; so a range of (diverse) identities are established (Bruni & Gherardi, 2002) with reference to each other. However, in a given social setting a limited amount of social position(s) are possible. The community people according to their limited (assigned) position use the available, (possibly limited) interpretative repertoires, to enhance or resist a situation. This study will see that how the community members placed the childlessness and position childless women in their society and make arguments verbal and non-verbal on daily basis. Similarly, the childless women position themselves in the social communal life and talk about their state of childlessness. How these stakeholders make arguments by shifting their positions during communication?

Research Methodology

Research Setting

Data were collected by the first author (RS) from a village located in a district Nankana Sahib in central Punjab. Situated on a road connecting two small cities of the area, the total population is 3004 (Record book of Basic health unit [BHU[1]], 2020). The village is religiously diverse, with two religious groups (Christian and Muslims) living together. The community is patrilineal, patrilocal, and patriarchal similar to other rural Pakistani communities (Fikree et al., 2001) where family is the smallest unit of society. Men are seen as the breadwinner, dominant, and head of the household, while women are considered dependent and mainly responsible for homemaking (MacQuarrie & Aziz, 2022). A joint extended family is seen as the ideal family system.

Wedlock executes the new family formation, sanctions sexual partners, and adds the responsibility of procreation and fulfilment of social duties (by the couple) like other communities in the country (Naz & Batool, 2017; Shaheen et al., 2010). A bride lives with her in-law's family after marriage and takes on the identity of the husband. Children of the couple are considered part of the husband's lineage. As couples are socially responsible to procreate children, a couple with no children is a threat for the family and lineage. Being a "mother" is the most important status for the women in the community. When she becomes a mother, a woman moves upward in the hierarchy of power; she can use and regulate power at a certain time in her life and also play a role in the decision making in the family

[1] Pakistani healthcare system consists of public and private healthcare service(s). Public healthcare system is a three layered-structure (Hassan et al., 2017). Primary healthcare (PHC) comprises Basic Heath Units (BHUs) and Rural Health Centers (RHCs) serving rural areas. Secondary-level healthcare provides technical, therapeutic and referral services through Tehsil Headquarter Hospital (THQs) and District Headquarter Hospitals (DHQs). Tertiary level healthcare institutes serve in metropolitan cities.

(MacQuarrie & Aziz, 2022). Thus, procreation and childbearing are the most important norms for women in Pakistani society (Qamar, 2018; Slamat et al., 2023a, 2023b).

Economically, the subsistence of the community is primarily agriculture, including farming and livestock. Men are also engaged in government and private jobs, driving, factory workers, and labouring. Although women are primarily responsible for homemaking, some women also perform other jobs. Christian females are more (in percentage) than Muslim women in the community as working women. The infrastructure of the village has cemented streets, a semi-developed sewerage system, two high schools, one BHU, Churches, and Mosques. The housing pattern is mixed.

Data Collection

Data for this article were collected by the primary author from January to June 2020. Ethical approval was granted by the Ethical Committee the Faculty of Political and Social Sciences of Ghent University, Belgium. Permission to work in the community was obtained from the responsible authorities through the Health Services Academy, Pakistan (host institution). Target women, partners, and older women were contacted through lady health workers (LHWs) (WHO, 2008) and staff of BHU was approached directly. The aim of the study was discussed with research participants and their consent was obtained, either written (from literate participants) or orally (from illiterate participants). A cover letter, was prepared by consensus of all authors, read aloud (by first author) in front of the participants before conducting the interviews and focus group discussions (FGDs).

The data for this article is based on 12 semi-structured in-depth interviews with childless women (primary and secondary infertility and with one woman conceived after many years of fertility treatments) and six FGDs with 12 partners, four healers, and 16 older women. In total 17 childless women were present in the community. All women were contacted but two women refused, three women agreed but were not present in the community due to lockdown restrictions (Covid-19 pandemic) imposed by the Pakistani Government, and one woman was pregnant at the time of the interview. Therefore, eventually 12 childless women in the community were interviewed. The participants of the interviews (Table 1) and FGDs (Table 2) were diverse.

Table1
Childless women's demographics

Characteristics	Number
Total women	12
Primary infertile	8
Secondary infertile	3
Pregnant (after 9 years)	1
Age	
20-25	1
26-30	3
31-35	4
36-40	4
Marital duration	
0-4	1
5—9	4
10—14	4
15—19	3
Religion	
Christian	9
Muslim	3
Family type	

Nuclear	6
Joint/extended joint	6
Education	
Illiterate	6
Primary	0
Middle	3
Matric	3
Higher secondary	0
Husbands' profession	
Labour	4
Shopkeeper	2
Farmer	2
Rikshaw driver	1
Serving in an organisation	3
Women's profession	
Home maker	10
Teacher (private school)	1
Volunteer teacher	1
(Church)	
Type of marriage	
Endogamous	5
Exogamous	7

Table 2
Characteristics of respondents of FGDs

Types of FGDs (on basis of respondents)	**Number**
Healers	1
Older females	3
Partners/Husbands	2

Characteristics of respondents' in FGDs

Characteristics	**Number**
1. Healers	
LHV	3
LHW	1
Age (years)	
25—35	3
35—45	0
46—55	1
Christian	2
Muslim	2
2. Older Females	
Age (years)	
45—54	6
55—64	8
65—74	3
75+	1
Christen	8
Muslim	8
Illiterate	6
Literate	12
1—5	6
6—8	3

9—10	3
10+	0
3. Partners	
Age (years)	
31—40	5
41—50	4
51+	1
Muslim	4
Christian	6
Farmers	4
Labourers	6
Mill workers	2

All interviews and FGDs were conducted/moderated by the first author (RS) of Pakistani origin herself. This allowed (RS) to explore themes in a culturally appropriate way as she could contact women easily. Moreover, being a mother of two children herself, she could more easily address the sensitive topics of motherhood, sexual life and health matters. RS introduced herself as a researcher (not a health practitioner/gynaecologist) several times but women perceived her as a woman (having knowledge of health matters) who may help them by giving advice. Women were interested in participation and gave detailed answers to questions.

All interviews were conducted in a separate room at participants' homes to avoid external pressure from family members. The interviews lasted between 35-45 minutes. The interviews and FGDs were conducted in the local language (Punjabi) and some in the national language (Urdu), according to the respondent's preference. RS is fluent in both languages.

All interviews and FGDs were recorded after obtaining consent from the respondents. RS transcribed the interviews and FGDs in local/national language and then translated these into English entirely (Al-amer et al., 2016). Important terms and proverbs were transcribed following Al-amer et al. (2016). All transcriptions were rechecked by two language experts (local, national and English) following Al-amer et al. (2016).

Data Analysis

In a first round, data were analysed following the steps outlined by Braun and Clarke (2006). Excerpts about childlessness were scrutinised from the interviews and FGDs (by the first and third authors). The statements relating to, the concept of childlessness (in the community), role/status of childless women, behaviour of family and community with childless woman, reasons of childlessness, were coded and organised. RS analysed the transcripts in the original language by reading and rereading to assign codes. Then I inductively organised the merging codes to discover the themes surrounding the childlessness phenomenon in the community. Secondly, following guidelines developed by Potter and Reicher (1987) excerpts were analysed by focusing on argument development, the use of arguments in different situations, grammatical structures, proverbs, narratives, and use of repeated words to identify interpretative repertoires. As such, four interpretative repertoires were identified. The emerging repertoires were then refined in an iterative process (in which translated excerpts were used) between all authors until consensus was reached.

Results

In what follows it will be shown how the four identified interpretative repertoires are used to label the childless women and how childless women subtly renegotiate the

negative labels that are assigned to them to discursively form a positive identity outcome nonetheless.

"Will of God"

This repertoire expresses the belief of community members in their God. Both religious groups believe in God and relate their wishes, success and failures to the will of God. Community members believe their God is almighty, sovereign and merciful; He blesses humans with provisions. Children are considered a major blessing from God, so the childlessness of a couple or woman is attributed to God's will. A participant stated in older female FGD.

"The decision to bear children or not, is controlled by God. He knows very well to whom He should give what". (Christian, 56 years)

The vocabulary that distinguishes this repertoire refers to God as supreme power and all human beings are helpless against him. The vocabulary associated (Punjabi language) is *rab jane* (God knows), *rab di marzi* (will of God), *qismat and muqaddar* (fate), *majboor* (helpless) and similar words. Community members believe in fate/destiny designed by God. It helps the childless couple to reduce the grief and blame of childlessness. All respondents stated a belief in God, but women expressed their relationship with God in different ways. One woman (who serves in the Sunday School of Church on a voluntary basis) shared her views:

"I don't have a child. God is testing me. Sometimes, God tests our belief, how firmly we believe in Him (God)". (Childless woman, Christian, 34 years)

Another woman shared:

"I pray to God to give me a baby, sometimes I become and speaks to God, he is our God and He can listen to our voice". (Childless woman, Muslim, 36 years)

The respondents consider their childlessness as part of their intimate relationship with God. In the first case, the woman takes childlessness as a test for her love with God. By believing in him and bearing the childlessness, she attempts to make her link stronger with him and satisfy herself. In the second case, the woman takes God as a close being, with whom she can share her feelings and feels satisfaction.

The women in the community also present the "will of God" as a major reason of childlessness. They conceal their situation of childlessness in the belief and express themselves as an obedient person by accepting the current state. Similarly, family members of the couple also use their belief, as a reason, to answer the community members when someone asks about the childlessness of the couple(s). Because the family of the couple is also pointed out by the community and they feel pressurised (stigmatised). Most of the time, family members reply using phrases such as: *"It is the will of God" and "We are helpless in front of His will"*. They use the notion of belief for their face-saving.

The women by adhering to this belief seek treatments and families help them in searching and following various treatments. When women do not conceive despite a healer's treatment, they attribute this to the will of God. Similarly, healers also put the will of God in case of treatment failure.

During an interview, one woman stated:

"The lady doctor treated me for eight-nine months and after completion, she said: Oh girl, trust on God, He will bless you with a baby". (Childless woman, Muslim, 36 years)

This repertoire is used by women, family members and healers but all stakeholders agree at one point "helplessness against the creator/authority".

"Worthless"

The second repertoire considers childless women as worthless as the child directly contributes to the devalued status of a woman. This expression is discussed in an FGD the older females discussed:

"It is common in our communities that if a vine does not produce fruits or flowers, people throw it away. [……] A child is like a fruit or a flower for a female". (Muslim, 61 years)

This repertoire is used to stigmatised childless women. The associated vocabulary is (Urdu language): *be-olad* (childless), *bad naseeb* (having bad-fate) and (Punjabi language): *wicharyan* (pity), *sada* (we), *assi* (we). Furthermore, participants and interviewed women both refer to childless women in plural form which is a discursive mechanism that takes away part of the burden/culprit. Discussions about childless women always started with sighs and non-verbal expressions such as "hi", "hah,haa", "cheh cheh". These are local ways of expressing pity and sorrow.

In older female FGD the respondents discussed:

"When we enter our home and see our children, we feel happy. So I always pray for these women to have a child". (Christian, 44 years)

"If we did not have any children, we would not know how to spend the day. We spend all our time with our children and are busy taking care of them". (Christian, 63 years)

This participant's words show that having a child directly affects a woman's value. Children increase a woman's value. A woman without biological child feels worthless. The childless woman is not considered equal to other women who do have children.

Further, the community assumes that the couple is not enjoying life due to lack of a child. Childless couples, especially women, are considered having no goal in life. The close kin and community members show pity for them, whenever they meet them. These expressions enhance the tension for women. Furthermore, the grief of childlessness extends to the woman's family, especially to her mother. Because most of the time the in-laws and community blame women for their childlessness. This point was shared by the respondents of the (male) partners FGD:

"Community mainly blames women for childlessness, cheh,cheh". (Christian, 44 years)

"Women are not responsible for childlessness alone, but men behave arrogantly towards their wives. Women endure this behaviour". (Christian, 39 years)

"Hah,ha…She thinks that maybe her husband might leave her or break the wedlock and decide to have a second marriage". (Christian, 36 years)

The discussion above revealed several points about women's life. First, the woman holds the blame of childlessness. Both community and family consider childlessness as a personal failing for woman. Secondly, childlessness disturbs the couple's relationship and women bear the consequences in form of physical and mental violence. The husband uses his power, behaves aggressively and his behaviour puts his wife in a difficult situation where she bears the consequences alone. Sometimes, women feel childlessness as a threat for wedlock. Thirdly, the woman faces consequences at the family level. The in-law's family

taunts her and uses negative words which put her in tension and regret. One childless woman shared her experience:

"*My life was really tough because my husband spent more time away from home.[.....]hah..... It was really difficult for me to stay at home because my mother- and sisters-in-law made comments. I wept for the whole day*". (Childless woman, Christian, 38 years)

One important point to mention here is that the behaviour of family (with woman) and behaviour of husband (with wife/woman) support/regulate each other. Sometimes, family pushes the husband to behave arrogantly with the woman. Sometimes, the bad/aggressive behaviour of the husband with the woman triggers the family's negative behaviour.

Similarly, community members treat childless women badly/negatively. Most of the time community members' advise the elders of the couple to take action as the woman fails to conceive. The simplest solution suggested is to have the husband remarry, which means replacing his wife. If a body fails to reproduce, the suggestion is (simply) to find a new one. As such, the female body is seen as a commodity that can be replaced.

Community members in gatherings point out these women. One woman shared:

"Sometimes women ask me about a pregnancy. When some people taunt me that I have no children, I become tense and I cannot answer". (Childless woman, Christian, 28 years)

These women feel sorrow and regret due to scrutiny of the community. They consider it that community members discuss their childlessness to degrade them. Women feel helpless, not in a position to answer them and remain silent. Most of the time, they endure the harsh words and feel lonely even in gatherings.

Perhaps contradictorily, childless women experience the deficiency in their lives, even more when relatives show sympathy, as this makes them realise that they are missing something in life, as illustrated in this quote:

"One daughter of my maternal aunt delivered a baby yesterday. My uncle phoned me first to tell me the good news (…) They also asked me, why do you feel that you are different from us, when we do not feel that you are different". (Childless woman, Muslim, 36 years)

This illustrates that women themselves perceive that others are looking into their deficiency. They suppose community members would not treat them equally. They have feelings of self-pity for themselves.

In this repertoire, women are submissive/passive while husbands, family and the community at large are active agents.

"Ill-boding"

In this repertoire, childless women in the community are strongly stigmatised. In addition to seeing childless women as worthless, respondents also stated viewing childless women as ill-boding or *manhoos*, i.e. 'as having bad luck and affecting the community members around them strongly with it'. This is a social concept which is used as an epithet for childless women. A woman's inability to conceive or give birth makes community members question her body and attach negative forces to it, particularly bad luck. As such, childless women are framed as inauspicious and ill-boding, which affects them the most. This repertoire is mentioned by older women, partners and the childless women themselves.

This repertoire enhanced the intensity of stigma for childless women. The vocabulary associated with this repertoire expressed metaphors used such as *manhoos/nehas* (ill-boding), *banjh* (barren), sand (ox), *heejra* (intermediate sex/she-male), *kaala mounh* (having black face) and similar epithets. Childless women are considered non-beneficial persons for the community. Both the community and the family regard them as the cause of their own childlessness. Some community members consider them even as ill-boding personalities who bring bad luck, as discussed by one respondent in the older female FGD:

"Mostly people say that this woman could not produce children. [……..] They say that she is manhoos". (Muslim, 54 years*)*

One woman shared:

"My mother and sister-in-law abused me many times. I fought with them and after that, they said 'look the manhoos woman is coming. Stay away from her (……). Sometimes they said that I brought bad luck to their home". (Childless woman, Christian, 38 years)

Mostly, in-laws and women from the community use this word during jibing and quarrelling. These words are used to point out women, treat them as outcaste and devalue them. The family member used these words to blame her for the stigma they shared as family.

Some childless women suffering from *athra* (a maternal folk illness) are considered dangerous to other women since the community believes that they can transfer their illness to other young women. So, in the views of community, *athra* is a contagious disease. These women are therefore discouraged from attending social events such as marriage and visiting an infant. They receive indirect messages not to attend the ceremony. The excerpt from an older women's FGD is given below:

"Women should stay away from women having athra". (Muslim, 54 years)

"It can cause childlessness". (Muslim, 78 years)

This repertoire positions women with *athra* as a danger for other women (reproductive age group) and indirectly for lineage. Older women and folk healers firmly believe in the existence of folk illness and exclusion of ill women from social gatherings (especially at birth and marriage) as a preventive measure. Older females' position makes them responsible for safe the other women (reproductive age) directly and lineage indirectly. This term *athra* is used by older women and folk healers. An important point to mention here is, no childless woman relates herself with this condition or *athra*.

Further, some childless women also think that they may have a physical problem/illness (which may transfer to others) and avoid embracing or sitting with female relatives. These women perceive themselves as faulty (fallible bodies) and position themselves as a possible danger for others and behave accordingly. On the whole, this repertoire shows the placement that community and family are active and women are passive in the social setting.

"Medical Causes"

The last repertoire frames childlessness as a medical issue (in both women and men). This repertoire is shared by healers, lady health visitors (LHVs) who serve in the community's health centre and by childless women who visit LHVs/gynaecologists in the city to have them treat the medical causes of their childlessness.

Moderator: "What kind of (medical) issues childless women have"?

"Sometimes, some women have issues and some men have issues". (Lady health visitor, Muslim, 46 years)

"Some women have problems with their periods/menses and some have hormonal problems. ….Women have cysts in their uterus". (Midwife, Christian, 31 years)

The discussion reveals that there are several medical reasons (in females) which hamper pregnancy. Male factor infertility is a possible cause of childlessness.

The associated vocabulary contains medical language such as diagnoses and treatments for childlessness. Examples include: *sehatmand* (healthy), *kamzoori* (weakness), *bemari* (illness), *bara masla* (major illness), *mard da masla* (male factor), *kamzoor jaraseem* (weak sperms) and similar terms.

The older females also stated male factor infertility in the FGD.

"There is one more point, a male could be sterile [……] Both should be fit to produce kids". (Muslim, 58 years)

In this repertoire, childlessness is attributed to medical problems that both males and females can experience. These medical issues hamper pregnancy and cause childlessness. Not only the LHVs relied on the medical cause repertoire, many childless women equally referred to medical causes in their responses. The medical causes referred by women are swelling in the uterus, irregular periods, small size of uterus, and blockage in fallopian tubes. Women mentioned several subsequent issues in their journey to have a child. One woman said:

"I have visited many doctors but every doctor told me a different problem. One doctor said, swelling (in uterus) problem. Another told, I have PCOs[2] in my womb, Another said, my (fallopian) tubes are blocked". (Childless woman, Muslim, 36 years)

One more woman stated:

" I have the problem of irregular menses….It is not my fault.. I am taking medicine. The doctor said, I can conceive after treatment". (Childless woman, Christian, 38 years)

The above mentioned quotes show that women present their medical problem(s) as a cause(s) of childlessness and try to motivate others to believe in it. They believe that medical issue is treatable and after treatment, they will give birth to a child. Women use medical cause(s) as an agency and hope.

Male infertility is discussed by the LHVs, older females and women

"hah….my husband has low germs than normal". (Childless woman, Christian, 38 years)

Male infertility helps to remove the burden to some extent from women, but because of the community's patriarchal structure, family cannot usually argue with the man about his condition, and they blame the woman instead. Furthermore, if a man has a medical issue, it is not discussed publicly but some relatives can find out by talking with (childless) women in private. At the community level, the woman is identified as a childless woman.

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[2] Polycystic Ovary Syndrome

Discussion

Stigmatisation of Childlessness

The community under study is pronatalist like other communities of Pakistan. Every couple and especially the woman is considered responsible to procreate. Women who cannot bear this role are known as "childless women". The position of childless women in the Pakistani social context is illustrated in some studies (Mumtaz et al., 2013; Winkvist & Akhtar, 2000; Sami & Ali, 2006; Qamar, 2018; Naz & Batool, 2017; Ullah et al., 2021; Slamat et al., 2023a). Childless women are positioned differently from and are attributed a lower status than women who do have children. The four identified interpretative repertoires exhibit the positioning of childless women and other stakeholders in the social setting (community).

The repertoire in which childless women are considered worthless focuses on the idea that their value as a woman is reduced; they are presented as incomplete beings. It is a common belief that children complete womanhood (Qamar, 2018; Slamat et al., 2023a). Childless women are relegated to a low social status and subject to stigmatisation. The worthless and ill-boding repertoires show how stigmatisation operates in family and at community level. At home, in-laws especially the mother- and sister-in-law, often jibe at childless women (Bhatti et al., 1999) and they also taunt them in public gatherings. Similarly, other females from the community single them out by asking them publicly about a possible pregnancy. As such, these women face public stigma (Remennick, 2000; Mumtaz et al., 2013; Donkor & Sandall, 2007).

In line with other studies, the present results demonstrate that in the studied community people use different epithets to highlight the stigma (Bhatti et al., 1999; Nahar & Van der Geest, 2014), in local language such as *saande* 'ox', *baanjh* 'barren or infertile'. Women being overtly stigmatised as worthless suffer from mental and physical abuse (Nahar & Richters, 2011), privacy loss (Mumtaz et al., 2013), low self-esteem and sometimes social isolation.

The ill-boding repertoire in specific contains an enhanced version of stigma where women's bodies are considered harmful and leads to social isolation. Here, childlessness reduce women to 'their bodies'. The related folk illness *athra* is considered a dangerous condition; women who are believed to suffer from *athra* are discouraged from attending social events like birth, touching new-borns and performing certain rituals in weddings (Slamat et al., 2023a), as has been documented in some other communities as well (Qamar, 2018; Donkor & Sandall, 2007; Unisa, 1999). The village culture thus positions these women as a possible danger to other women in the reproductive age group. So, a rule of absence was created for them, to keep them away from events following the belief that childless female bodies have a negative energy attached to them, which could cause harm/transfer to other bodies. The bad luck of childlessness is believed to be symbolically contagious. So, these women are directly targeted and physically excluded from certain social events (see also, Mumtaz et al., 2013). This condition is considered so dangerous or unacceptable that childless women are afraid to openly position themselves in this category known as *athra*.

Furthermore, childless women perceive themselves as weak women who are unable to follow their required social role. These women reframe the positive behaviour(s) of family and relatives as pity for themselves. Because in Pakistani society, people often feel pity for childless women (Naz & Batool, 2017). These perceptions of childless women show the internalisation of stigma, their position as a weak agent which makes the situation worse for them. As has been shown before, these processes have negative health consequences, as women who perceive stigma, show increased stress levels (Donkor & Sandall, 2007).

Diverting Stigma in a Highly Religious Community

The religious repertoire 'will of God' documents attitudes of the community towards childlessness that are connected with the belief that God (both in Catholicism and Islam) is almighty, sovereign and merciful. The underlying idea is that children are a blessing of God (Remmenick, 2000; Bayouh, 2011) and community members believe that God decides about whether a woman or a couple will have/have not a child. Furthermore, childless women/couples pray, follow religious teachings to attain His will (Unisa, 1999) and become close to God (Batool & De Visser, 2016). Healers, being part of the community, also believe in the will of God while providing treatment to infertile couples. In sum, the repertoire also functions to destigmatise childless women by showing that no one has authority over the will of God.

This repertoire positions all stakeholders (not only the childless women) as passive and God as the active agent. The human beings are helpless against his will. Community members take him as authoritative and decision maker. They take childlessness as a test (test of patience, love and intimacy), hope, punishment and fate. Women and families rely on this repertoire to avert being blamed for the couple's childlessness because in the community no one can challenge the authority of God. They reframe the shame as helplessness against him.

The last, repertoire focuses on possible medical causes of childlessness. It argues that male and female can both be equally responsible for childlessness. Several studies illustrate the medical reasons in males and females and treatment seeking in other pronatalist societies like Pakistan (Nahar et al., 2000; Inhorn, 2003; Shaheen et al., 2010).

Traditional healers and certified practitioners both agree that (childless) women or men can have medical issues that do not allow women to conceive. The difference is that medical reasons lying with the male are visible only at the family level and at the healers' level while a woman's childlessness is displayed within the broader community level. This repertoire helps childless women to reduce the stigma as it provides not only the idea that they might not be the sole responsible for the couples' childlessness, by exploring possible medical causes of childlessness that may (possibly) be treated, the repertoire also creates hope for women and helps them to deal with the culpability induced by others. Similarly, the idea that the male body too could be faulty or not functioning properly also diverges the patterns of thinking of family and community.

The repertoires discussed above are distinct but also coexist simultaneously. At certain points, these repertoires merged within participants' accounts, to either enhance or reduce each other. For example, the repertoire will of God is the most dominant one and it dilutes the effects of other repertoires. It reduces the intensity of (verbally) violent behaviour of husbands, family and community to some extent. The ideas expressed in this repertoire provide a continuous hope and agency to childless women. The medical repertoire is different as it brings the man into the debate by focusing on male infertility. The focus is diverted from female towards both partners. On the one hand this repertoire establishes the harmonious relationship between couples and enhance the responses of in-laws. If the couple's infertility is due to the woman, it multiplies the reactions of the family but if the infertility is due to the man, it reduces the harshness of behaviour. Women use this repertoire as a form of agency to resist and not accept the label of childless women. This is a different finding that in Pakistani rural society childless women use the medical repertoire as a form of agency in their everyday life to reduce the resistance, although they cannot change the situation entirely. Studies by Riessman (2000) and Nahar & Van der Geest (2014) documented that childless women use their agency against stigma in their everyday life.

Conclusion

Community discourses show that childless women in rural Pakistan bear the burden of childlessness and are seen as main culprit. Consequently, childless women are stigmatised both privately and publicly. Our study explains how different interpretative repertoires (worthless, ill-boding) are used to stigmatise childless women. The religious (will of God) on the other hand serves to reduce the stigma; especially women use this as a source of agency and position themselves differently in a social context. The medical repertoire brings the man in the debate of childlessness. This repertoire reduces the burden of childlessness from women and serves as a source of coping mechanism in their everyday life. Although women themselves do not believe that they are the culprit of their childlessness, they do not succeed in defying their community's thoughts due to the prevailing social norms of a pronatalist patriarchal society.

Firstly, the novelty of this study lies in using a discourse approach to explore the phenomenon of childlessness in a rural Pakistani community. However, there are some limitations to the study. In addressing the "childless women", the study focused on one gender only, while there is a dire need to know more about the life experiences of childless men in patrilineal and patriarchal societies too.

Recommendations

We plea through this study that community members should be sensitised about potentially stigmatising behaviour that is painful for childless women. The advocacy can be done through involving the LHWs and media. Because LHWs have the opportunity to talk to community people (male and female). Television can play a role in advocacy because most of the community watch it as it is the main source of entertainment in country. The bio-medical causes of childlessness/infertility should be explored through research in the area.

Disclosure statement

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References

Al-Amer, R., Ramjan, L., Glew, P., Darwish, M., & Salamonson, Y. (2016). Language translation challenges with Arabic speakers participating in qualitative research studies. *International journal of nursing studies*, *54*, 150-157.

Ali, S., Sophie, R., Imam, A. M., Khan, F. I., Ali, S. F., Shaikh, A., & Farid-ul-Hasnain, S. (2011). Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross-sectional study. *BMC public health*, *11*(1), 1-7.

Batool, S. S., & de Visser, R. O. (2016). Experiences of infertility in British and Pakistani women: A cross-cultural qualitative analysis. *Health Care for Women International*, *37*(2), 180-196.

Bayouh, F. A. (2011). *Socio-cultural perceptions of infertility and their implications: a study of women experiencing childlessness in South Gondar, Ethiopia* (Master's thesis, The University of Bergen).

Bhatti, L. I., Fikree, F. F., & Khan, A. (1999). The quest of infertile women in squatter settlements of Karachi, Pakistan: a qualitative study. *Social science & medicine*, *49*(5), 637-649.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bruni, A., & Gherardi, S. (2002). En-gendering differences, trans-gressing the boundaries, coping with the dual presence. In I. Aaltio & A. J. Mills (Eds.), Gender, identity and the culture of organizations (pp. 21-38). London: Routledge.

Burr, V., & Dick, P. (2017). Key features of Social Constructionism. Routledge.

Ceuterick, M., & Vandebroek, I. (2017). Identity in a medicine cabinet: discursive positions of Andean migrants towards their use of herbal remedies in the United Kingdom. *Social Science & Medicine*, *177*, 43-51.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In S. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology* (pp. 504-553). Boston: McGraw-Hill.

Davies, B., & Harré, R. (1990). Positioning: The social construction of selves. *Journal for the Theory of Social Behaviour*, *20*(1), 43-63.

Donkor, E. S., & Sandall, J. (2007). The impact of perceived stigma and mediating social factors on infertility-related stress among women seeking infertility treatment in Southern Ghana. *Social science & medicine*, *65*(8), 1683-1694.

Dyer, S. J., Abrahams, N., Hoffman, M., & van der Spuy, Z. M. (2002). Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human reproduction*, *17*(6), 1663-1668.

Fikree, F. F., Khan, A., Kadir, M. M., Sajan, F., & Rahbar, M. H. (2001). What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan?. *International family planning perspectives*, 130-136.

Gergen, K. J. (1991). *The Saturated Self.* New York: Basic Books.

Goffman, E. (1963). "Stigma and social identity." *Understanding deviance: Connecting classical and contemporary perspectives,* 265. Routledge.

Hassan, Ahmad, Khalid Mahmood, and Hudebia Allah Bukhsh. (2017). "Healthcare system of Pakistan." *IJARP,* 1(4), 170-173.

Hakim, A., Sultan, M., & Ahmad, F. (2001). *Pakistan Reproductive Health and Family Planning Survey (2000-01): Preliminary report*. Islamabad, National Institute of Population Studies.

Inhorn, M. C. (2003). "The worms are weak" male infertility and patriarchal paradoxes in Egypt. *Men and masculinities*, *5*(3), 236-256.

Kleinman, A., & Hall-Clifford, R. (2009). Stigma: a social, cultural and moral process. *Journal of Epidemeology & Community Health,* 63(6), 418-419.

Kurji, Z., Premani, Z. S., & Mithani, Y. (2016). Analysis of the health care system of Pakistan: lessons learnt and way forward. *J Ayub Med Coll Abbottabad*, *28*(3), 601.

Larsen, U. (2005). Research on infertility: which definition should we use?. *Fertility and sterility*, *83*(4), 846-852.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, *27*(1), 363-385.

McKenzie, P. J. (2005). *Interpretive repertoires*. FIMS publication. 45.

MacQuarrie, K. L., & Aziz, A. (2022). Women's decision-making and contraceptive use in Pakistan: an analysis of Demographic and Health Survey data. *Sexual and Reproductive Health Matters*, *29*(2), 2020953.

Mumtaz, Z., Shahid, U., & Levay, A. (2013). Understanding the impact of gendered roles on the experiences of infertility amongst men and women in Punjab. *Reproductive health*, *10*(1), 1-10.

Nahar, P., Sharma, A., Sabin, K., Begum, L., Ahsan, S. K., & Baqui, A. H. (2000). Living with infertility: experiences among urban slum populations in Bangladesh. *Reproductive health matters*, *8*(15), 33-44.

Nahar, P., & Richters, A. (2011). Suffering of childless women in Bangladesh: the intersection of social identities of gender and class. *Anthropology & medicine*, *18*(3), 327-338.

Nahar, P., & Van Der Geest, S. (2014). How women in Bangladesh confront the stigma of childlessness: Agency, resilience, and resistance. *Medical anthropology quarterly*, *28*(3), 381-398.

Naz, B., & Batool, S. S. (2017). Infertility related issues and challenges: perspectives of patients, spouses, and infertility experts. *Pakistan Journal of Social and Clinical Psychology*, *15*(2), 3-11.

Ombelet, W. (2014). Is global access to infertility care realistic? The Walking Egg Project. *Reproductive biomedicine online*, *28*(3), 267-272.

Pescosolido, B. A., & Martin, J. K. (2015). The stigma complex. *Annual review of sociology*, *41*, 87-116.

Potter, J., & Reicher, S. (1987). Discourses of community and conflict: The organization of social categories in accounts of a 'riot'. *British journal of social psychology*, *26*(1), 25-40.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage.

Qamar, A. H. (2018). The social value of the child and fear of childlessness among rural Punjabi women in Pakistan. *Asian Journal of Social Science*, *46*(6), 638-667.

Remennick, L. (2000). Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex roles*, *43*(11), 821-841.

Riessman, C. K. (2000). Stigma and everyday resistance practices: Childless women in South India. *Gender & Society*, *14*(1), 111-135.

Rutstein, S. O., & Shah, I. H. (2004). Infecundity, infertility, and childlessness in developing countries. In *Infecundity, infertility, and childlessness in developing countries,* 56-56.

Sami, N., & Ali, T. S. (2006). Psycho-social consequences of secondary infertility in Karachi. *JPMA. The Journal of the Pakistan Medical Association*, *56*(1), 19.

Sami, N., & Ali, T. S. (2012). Domestic violence against infertile women in Karachi, Pakistan. *Asian Review of Social Sciences*, *1*(1), 15.

Shaheen, R., Subhan, F., Sultan, S., Subhan, K., & Tahir, F. (2010). Prevalence of infertility in a cross section of Pakistani population. *Pakistan Journal of Zoology*, *42*(4), 389-393.

Slamat, R., Bracke, P., & Ceuterick, M. (2023a). "*"Athra",* a maternal illness in rural Punjabi-Pakistan, as a source of stigma", working paper at Ghent University.

Slamat, R., Bracke, P., & Ceuterick, M. (2023b). Childlessness management in a rural Pakistani community, working paper at Ghent University.

Speed, B. (1991). Reality exists OK? An argument against constructivism and social constructionism. *Journal of Family Therapy*, *13*(4), 395-409.

Ullah, A., Ashraf, H., Tariq, M., Aziz, S. Z., Zubair, S., Sikandar, K. U. R., Ali, N., Shakoor, A. & Nisar, M. (2021). Battling the Invisible Infertility Agony: A Case Study of Infertile Women in Khyber Pakhtunkhwa-Pakistan. *Journal of Ethnic and Cultural Studies*, *8*(2), 89-105.

United Nations Fund for Pakistan (UNFPA), (2020). *Pakistan Population Situation Analysis*. Ministry of Planning Development and Special Initiatives.

Unisa, S. (1999). Childlessness in Andhra Pradesh, India: treatment-seeking and consequences. *Reproductive health matters*, *7*(13), 54-64.

Wetherell, M., & Potter, J. (1988). Discourse analysis and the identification of interpretative repertoires. *Analysing everyday explanation: A casebook of methods*, *1688183*.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse & society*, *9*(3), 387-412.

Winkvist, A., & Akhtar, H. Z. (2000). God should give daughters to rich families only: attitudes towards childbearing among low-income women in Punjab, Pakistan. *Social Science & Medicine*, *51*(1), 73-81.

World Health Organization. (2008). *Global health workforce alliance. Pakistan's lady health worker Programme: Global Health workforce alliance.* World Health Organization

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social science & medicine*, *64*(7), 1524-1535.