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HELP SEEKING BEHAVIOR OF INFERTILE WOMEN IN THE CONTEXT OF GENDER RELATION

SINEENARD PHATDIPHAN

With compliments
of
บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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HELP SEEKING BEHAVIOR OF INFERTILE WOMAN IN THE CONTEXT OF GENDER RELATION

....
Miss Sineenard Phatdiphan
Candidate

....
Assoc.Prof.Pimpawun Boonmongkon,Ph.D.
Major-advisor

....
Lect. Nartruedee Dendoung, M.A.
Co-advisor

....
Assoc.Prof.Rassmidara Hoonsawat, Ph.D.
Dean
Faculty of Graduate Studies

....
Asst. Prof.Veena Sirisook , Dr.P.H.
Chairman
Master of Arts Program in Medical and Health Social Sciences Faculty of Social Science and Humanities

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was submitted to the Faculty of Graduate Studies, Mahidol University for the Master of Arts (Medical and Health Social Sciences)
on
October 31 , 2002

....
Miss Sineenard Phatdiphan
Candidate

....
Assoc.Prof. Pimpawun Boonmongkon,Ph.D.
Chairman

....
Assoc. Prof. Amara Sunthorndhada,
Ph.D.
Member

....
Lect. Nartruedee Dendoung, M.A.
Member

....
Assoc.Prof.Rassmidara Hoonsawat ,
Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University

....
Assoc. Prof. Suree Kanjanawong, Ph.D.
Dean
Faculty of Social Sciences and Humanities
Mahidol University

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Sineenard Phatdiphan

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This study is a qualitative research of a specified case study. The sample groups comprised infertile women who sought treatment, and infertile women who did not seek treatment. There were 15 cases in each group. This research aimed at comparing factors affecting help seeking behavior of infertile women in the context of gender relations including feminine role, gender power relations, the context of medical discourse regarding infertility problems, and the context of daily spoken words affecting decision making to seek treatment by infertile women. Selection of the sample groups was made by snow-ball sampling and purposive sampling. In-depth interview was employed for data collection in combination with various techniques : Free Listing, Picture Code, and PRA-Participatory Rapid appraisal. The data was analyzed using content analysis and narrative analysis.

The results revealed that the perception of the female's role was not different between the group seeking infertility treatment and the group not seeking infertility treatment. Giving birth is a natural role of women, women have a role in producing the next generation to take place of the old one, producing heirs to continue family lines, family assets or the business of the men's family, and giving birth for their husband so as to build up a warm and perfect family. Regarding the meaning of infertility, those seeking infertility treatment felt that infertility is an incompleteness, deformity, and abnormality of females, and causes failure of achieving the role of good women and good wife causing, sorrow and grief. The group not seeking infertility treatment said that infertility is just a natural abnormality. With respect to gender power relations, it was found that factors determining power relations in the family were not different between the groups which included an economic productive role of infertile women, and pattern of residence after marriage. The context of daily spoken words to the infertile women was found to be relatively negative. The context of medical discourse regarding infertility is a crucial factor influencing infertile women to seek infertility treatment, i.e.. the meaning of infertility according to physical causes and examination by a doctor, and identifying treatment direction. Perception of medical discourse was made through various media, e.g., T.V, newspaper, magazines. The treatment of infertility mostly relies solely on the modern medical system. Much rarer is integrated treatment mainly by modern treatment in combination with traditional/local treatment and alternative medicine. The duration of treatment of each source is not certain, depending on the evaluation of the past treatment, i.e. 1) the success history of treatment and reliability of the doctor; 2) commuting distance; and 3) cost of treatment.

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(สังคมศาสตร์การแพทย์และสาธารณสุข)

สินีนาฏ พัทดิพันธ์: แบบแผนการแสวงหาการรักษาของหญิงมีบุตรยากในบริบทความสัมพันธ์หญิงชาย (HELP SEEKING BEHAVIOR OF INFERTILE WOMEN IN THE CONTEX OF GENDER RELATION) คณะกรรมการควบคุมวิทยานิพนธ์ : พิมพวัลย์ บุญมงคล, Ph.D., นาถฤดี เด่นดวง, M.A. 168 หน้า ISBN : 974-04-2735-9

การศึกษาครั้งนี้เป็นการวิจัยเชิงคุณภาพแบบศึกษาเฉพาะกรณีโดยเลือกกลุ่มตัวอย่างที่ศึกษา คือ กลุ่มหญิงมีบุตรยากที่แสวงหาการรักษาและกลุ่มหญิงมีบุตรยากที่ไม่แสวงหาการรักษากลุ่มละ 15 ราย มีวัตถุประสงค์เพื่อศึกษาเปรียบเทียบถึงปัจจัยที่มีผลต่อแบบแผนการตัดสินใจแสวงหาการรักษาของหญิงมีบุตรยากในบริบทความสัมพันธ์หญิงชาย ประกอบด้วย บทบาทความเป็นหญิง ความสัมพันธ์เชิงอำนาจหญิงชาย บริบทวาทกรรมทางการแพทย์เกี่ยวกับปัญหาการมีบุตรยากและบริบทภาษาคำพูดที่พบในชีวิตประจำวันที่มีผลต่อการตัดสินใจแสวงหาการรักษาของหญิงมีบุตรยาก การศึกษาใช้การคัดเลือกกลุ่มตัวอย่างแบบ snow- ball และแบบเจาะจง (Purposive Sampling) เก็บข้อมูลโดยการสัมภาษณ์ระดับลึก ตามแนวการสัมภาษณ์ร่วมกับวิธี Free listing ,Picture Code และ PRA- Participatory Rapid Appraisal ใช้การวิเคราะห์ข้อมูลแบบ Content Analysis และ Narrative Analysis

ผลการศึกษาพบว่าหญิงมีบุตรยากทั้งกลุ่มที่แสวงหาการรักษาและไม่แสวงหาการรักษามีการรับรู้บทบาทความเป็นหญิงไม่ต่างกัน คือ การให้กำเนิดบุตรเป็นเรื่องปกติธรรมชาติของผู้หญิงทั่วไป ผู้หญิงมีบทบาทหน้าที่เป็นผู้ผลิตคนรุ่นใหม่เพื่อสืบทอดแรงงานรุ่นเก่า ผลิตทายาทเพื่อสืบสกุลและสืบทอดมรดกหรือกิจการของครอบครัวฝ่ายชาย ให้กำเนิดบุตรแก่สามีเพื่อสร้างครอบครัวที่สมบูรณ์ ส่วนการให้ความหมายต่อการเป็นผู้มีบุตรยากกลุ่มที่แสวงหาการรักษาให้ความหมายว่า เป็นความไม่สมบูรณ์ บกพร่อง ผิดปกติไปจากผู้หญิงทั่วไปและล้มเหลวต่อหน้าที่การเป็นผู้หญิงและภรรยาที่ดี รู้สึกเสียใจและเป็นทุกข์ ส่วนกลุ่มที่ไม่แสวงหาการรักษาให้ความหมายว่าเป็นเพียงความผิดปกติธรรมชาติเท่านั้น สำหรับความสัมพันธ์เชิงอำนาจหญิงชายทั้งกลุ่มที่แสวงหาการรักษาและไม่แสวงหาการรักษามีปัจจัยกำหนดความสัมพันธ์เชิงอำนาจภายในครอบครัวไม่แตกต่างกันได้แก่บทบาทการผลิตเชิงเศรษฐกิจของหญิงมีบุตรยาก แบบแผนการอยู่อาศัยภายหลังการแต่งงาน ส่วนบริบทภาษาคำพูดที่พบในชีวิตประจำวัน พบว่าส่วนมากเป็นการพูดถึงหญิงมีบุตรยากในทางลบ และบริบทวาทกรรมทางการแพทย์เกี่ยวกับการมีบุตรยากมีความสำคัญต่อหญิงมีบุตรยากที่แสวงหาการรักษาได้แก่การให้ความหมายผู้มีบุตรยากตามสาเหตุทางร่างกายและการตรวจวินิจฉัยของแพทย์ และการกำหนดแนวทางการรักษา และพบว่ามีการรับรู้วาทกรรมทางการแพทย์ผ่านสื่อต่างๆ ได้แก่ โทรทัศน์ หนังสือพิมพ์ นิตยสาร ส่วนการแสวงหาการรักษาภาวะมีบุตรยากส่วนมาก เป็นการรักษาแบบการแพทย์แผนปัจจุบันอย่างเดียว พบว่าส่วนน้อย ที่เป็นการรักษาแบบผสมผสานโดยยึดการแพทย์แผนปัจจุบันเป็นหลักร่วมกับการรักษาแบบพื้นบ้าน และการแพทย์ทางเลือก ระยะเวลาของการรักษาแต่ละแหล่งไม่แน่นอนขึ้นอยู่กับการประเมินผลการรักษา ได้แก่ 1) ผลสำเร็จของการรักษา และ ความน่าเชื่อถือของแพทย์ที่ทำการรักษา 2) ระยะทางในการเดินทาง 3) ค่าใช้จ่ายในการรักษา

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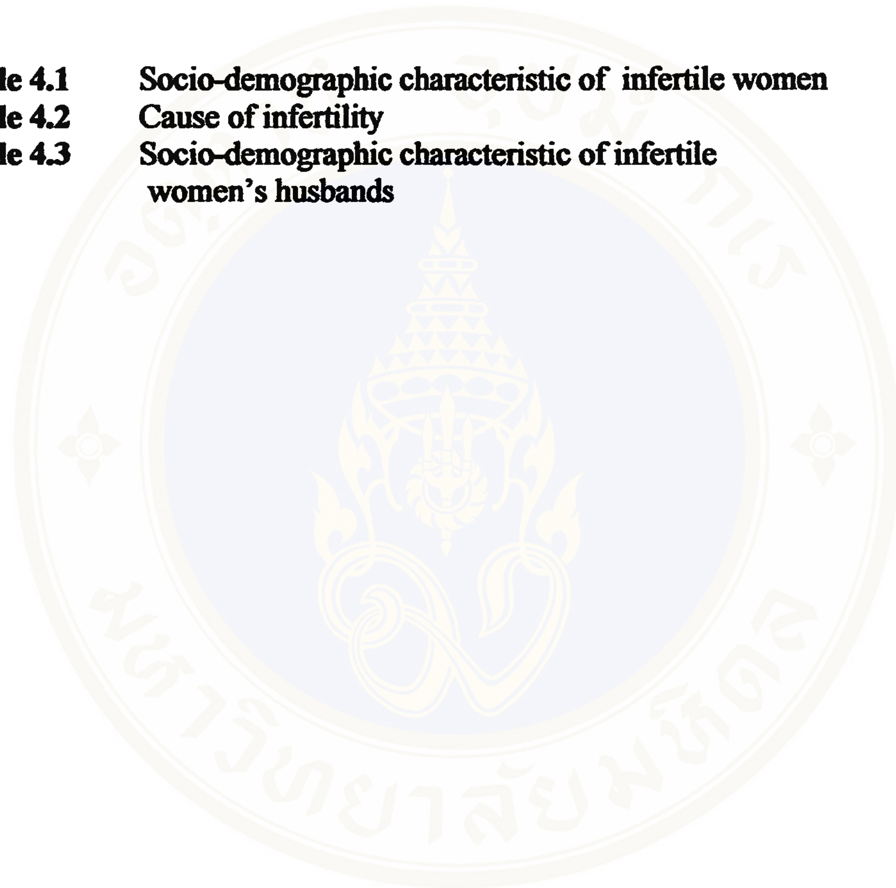

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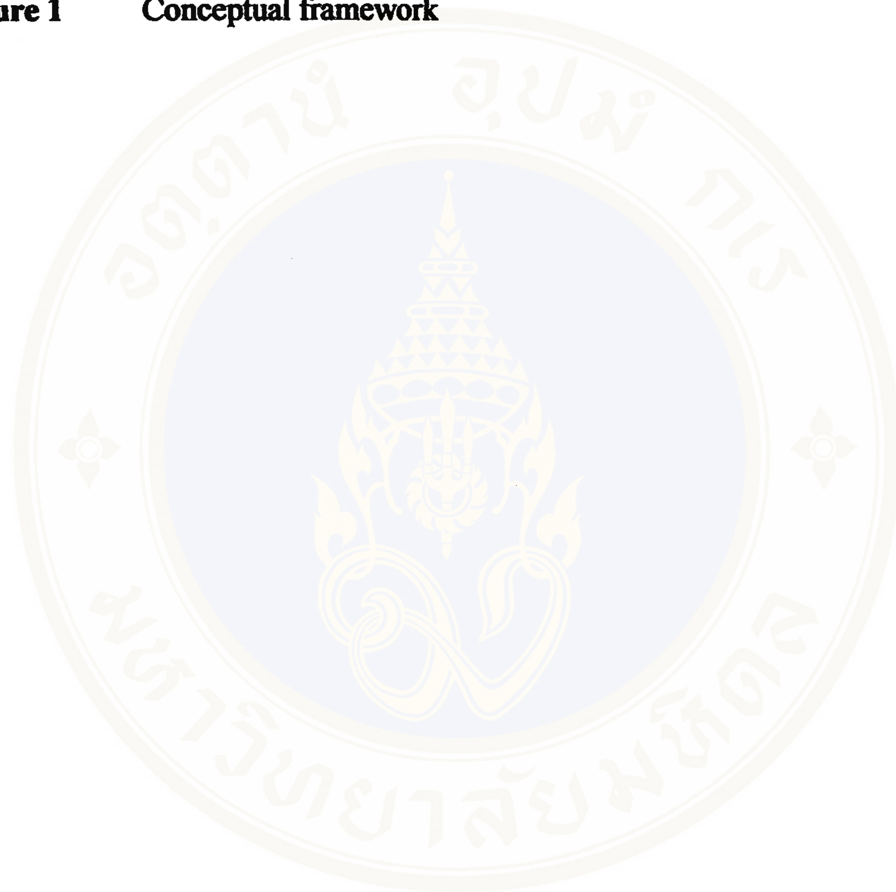

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CHAPTER I

INTRODUCTION

1.1 Background and Significance of the Problem

In the cultural society, the role and duty of men and women are defined differently by founding of gender characteristics through socialization process of both physically and psychologically. By nurturing since the childhood, male and female were defined by their specific characteristics and role. Women are valued and meant to female's role in giving birth, supported by biological characteristic of different reproductive organ of male and female. Women with ability to perceive pregnancy and give birth are expected from the society to have children. Particularly in the Thai society, marriage is to build the family and having children to continue family line. Most of the couples therefore expect to have children because they believe that children can tighten the relationship between husband and wife, continue the family line, and fulfill the role of parenthood, the expected role that valued by the society. Hence, infertility has become a critical condition of the couples in marriage life which may cause psychological problem because of inability to have children. They subsequently feel disappointment towards marriage life, become stress and suffering, and this might have cause marriage problem such as divorce (Isaranggura Na Ayuthaya, 1998:1) or extra marriage sex etc.

At present, infertility problem has become more severe. The statistics shows an increasing trend of infertility during 1980 – 1996. Koetsawang (1980) had conducted a study by interviewing 2,087 women aged between 15 – 48 years, and found that the percentage of infertile women at primary stage was 2 %, and those in the secondary stage accounted for 3.4 %.

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In comparison, the survey was conducted by the Family Planning and Population Division, Department of Health in 1996 among 6,315 married women aged 15 – 49 years who lived with their husband. The result showed 2.5 % of primary infertility, and 9.9 % of secondary infertility (Punyadilok, 1996). The incidence of infertility tends to increase. The 2.5 % of primary infertility refers to as high as 1 million married women who cannot have children (Ministry of Public Health, N.D., cited in Boonmongkol, 1999).

The incidence of infertility tends to increase partly due to changes in sexual behavior of the people, i.e. premarital sex, changing partners, free abortion, which lead to sexually transmitted diseases, infection and inflamatory in the pelvic organs, long use of contraception that effects functioning of reproductive organ, late marriage, drinking alcohol, smoking cigarette, chemical pollution from working environment which might effect the ability to have children.

Although changes in sexual behavior and exposure to chemical pollution can cause infertility but in many cases males had ignored the problems. In the Thai society, feminine identity is defined by cultural role of female, i.e. the role of producing children to continue family lines, and the social expected role and women status to give birth and being motherhood. As a consequent, the society and the women themselves viewed that infertility is the problem of women. Boonmongkol (1999) had carried out an in-dept study in 12 infertile women and found that these women thought that the infertile problem had reflected that the problem of deformity is of themselves not their husbands, and they themselves have to be responsible to seek treatment and examination (Boonmongkol, 1999:117). Similarly in India, infertility is meant the problem of women alone (Bharadwaj, 1999:2). As the Thai society had set up feminine identity and expected their role to give birth, the infertile women thus have to confront with the social and psychological problems. They usually feel that they had failure in life and afraid of being abandoned by their husbands. Moreover, they have much pressure from the husband's family, friends and

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the society, all of which affect their quality of life and living. It can be seen that in the general society, women saw infertility their own problem and abnormality.

Among most of infertile couples, women usually start seeking treatment and examination of infertility although male examination is simplier, less time and less cost. Female examination is exposure and need to use medical device which might cause pain and also takes more time. In many cases, infertility problem might be caused by men (Boonmongkol, 1999:116) since it depends equally (40 % each) on factors of both men and women sides, and the rest is the cooperated factors (Panyadilok, 1996:4).

However, infertile women have tried to seek treatment from various service facilities they expected can help them having children. The pilot project on the pattern of seeking treatment among infertile women conducted by Boonmongkol (1999) suggested that there were many service facilities that infertile women seeking treatment. Help seeking behavior among these women mostly are from government and private modern medical system together with the local and traditional treatment and religious means like praying, herbs healing, having vitamins etc. The study of Gerrit (1997) in Mozambique found that infertile women had seek treatment from both modern medicine and traditional medicine, but rather from the latter of at least 1 place or as many as 20 – 30 places.

Moreover, infertile women take risk of using modern reproductive technology in examination and treatment process, however, the successful rate is quite low, for example, only 20 % for IVF (Intrafallopian Transfer), 35 – 38 % for GIFT (Gamete Intrafallopian Transfer), but abortion rate is high too (25 %) (Vuthayavanich and Jongyusook, 1989:35), and the cost is very high. In the examination and treatment process, using reproductive technology devices has caused pain for women and the risk to side effect such as ectopic pregnancy, abortion, and hormone alergy (Charoensanti, 1996:364). However, no matter of these hardship, women continue to seek treatment. Even the USA where modern reproductive technology are available

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but costly, risky, and efficiency is limited, infertile women have tried to seek treatment by using repeated technologies (Inhorn, 1994:460).

As cultural society expects women to give birth and being motherhood, the society in general and the women themselves recognize that women have to take responsibility for infertile problem than men. Women also have much pressure from the society and their relatives than men because women is the producer to continue family lines. Women thus try to seek treatment and help. This research interested to study the pattern of decision making to seek treatment of infertile women which cover the socio-economic and cultural aspects that effect the pattern of decision making. In particular, it has to take into account the context of gender relation because the treatment is the agreement between husband and wife which is sensitive and complicated. This study employed the capitalist feminism concept of gender perspective to analyze the pattern of decision making to seek treatment of infertile women in gender relation context.

The literature review suggested that none of the studies in Thailand have been carried out on the pattern of decision making to seek treatment of infertile women especially the utilization of the femininism concept. Most of the studies employed the biological difference between men and women that effect different thought and treatment using biomedicine concept. Others focused on psychological concept aiming to explain seeking behavior for health treatment which depend on individual's decision making. Although the past concept and studies can explain the decision making to seek treatment of infertile women but at a certain level and still lack of cultural perspective particularly gender relation has not been mentioned. Therefore in this study, the researcher is interested to explore the decision making process to seek treatment of infertile women by analyzing the gender relation context in the aspects of power relation, gender role, the power and medical discourse under the reasons and point of view of women to make decision to seek treatment.

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1.2 Research objectives

1.2.1 General objective

To study the scope of pattern of decision making to seek treatment of infertile women in the context of gender relation.

1.2.2 Specific Objectives

1.2.2.1 To examine the relationship between feminine role and decision making to seek infertility treatment.

1.2.2.2 To study the gender power relation that defines the pattern of decision making to seek treatment among infertile couples.

1.2.2.3 To study the medical discourse context regarding infertility problem and the context of word being spoken in daily life that effect the pattern of decision making of infertile women.

1.3 Research question

How does the gender relation context define the pattern of decision making to seek treatment of infertile women.

1.4 Expected outcome

The result of this study will yield the pattern of seeking treatment of infertile women and gender relation that influences the decision to seek treatment as well as the knowledge and understanding about the situation of infertility problem in the aspects of cultural society in the context of gender relation. Moreover, it will be beneficial for health personnel and related public health personnel to understand more about the factors influencing decision making to seek treatment of infertile women. Moreover, women would have opportunity to choose suitable alternative for treatment and to help

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them confronting with the problem. Besides, the result will serve as baseline data for further quantitative studies.

1.5 Research Definition

Infertile Women means the group of women being in-dept interviewed who had never been pregnant after marriage without contraception and have regular sexual relation at least one year (Primary infertility) or have previous history of at least pregnancy and may terminate by abortion or delivery including ectopic gestation, and unable to conceive pregnancy again after one year of previous pregnancy (Secondary infertility).

Pattern of decision making to seek treatment means the process or pattern of decision making of infertile women regarding analysis, evaluation, and decision to choose treatment mean for themselves including the duration of treatment divided into: 1) no seeking for treatment; and 2) seeking for treatment, i.e. traditional or alternative medicines such as herbs, boiling medicine, praying etc., and western treatment from low technology like seeking advises and counseling of how to practice themselves, oral administration or injection of hormone to stimulate ovulation, to the advanced technology such as GIFT, ZIFT etc.

Gender relation means the relationship or the linkage between men and women who are husband and wife, which effect thought, belief, attitude, expression, and behavior of women and men including expression to each other, and the different impact on men and women related to infertility problem. Gender relation here is divided into feminine role, gender power relation, and medical discourse context and the use of words being spoken in daily life that attack the deformity of women's health.

Feminine role means characteristics and meaning that show the role, burden, duty, and responsibility of women defined by cultural society that effect thought,

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perception, belief, attitude, expression, and behavior of women, and subsequently affect the decision making to seek treatment of infertile women

Gender power relation means the relationship between men and women as a result of social and cultural situation, in this study, are economic productive role, pattern of residence after marriage, and negotiation power in the context of husband and wife. All that define each of husband and wife to have negotiation power or status and decision making power more than the other, or the ability to control the practice and decrease the status of the other in the family.

Medical discourse context means the medical explanation or language, words of doctor and medical personnel surrounding the infertile women including advertising media of medical institutions that influence the decision making of infertile women.

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CHAPTER II

LITERATURE REVIEW

Concepts regarding the decision to seek treatment of infertile women derived from review and analysis of related literature to answer what are the reasons behind their decision to seek treatment which include :

1. Bio-medical concept
2. Psychological concept
3. Socio-cultural concept
4. Social stigma concept
5. Feminism concept (adopted as a conceptual framework of this study)

2.1 Concepts explaining the decision to seek treatment of infertile women

2.1.1Bio-medical Concept

In the USA, medical visit for treatment of infertility has increased to become bio-medical problem in the society. In medical aspect, it was regarded as an illness called "Infertility" which can be treated by medical technology (Becker and Nachtigall, 1994 : 509). Infertility is defined as the inability to conceive a pregnancy after a year or more of regular sexual relations of 2 – 4 times a week without contraception. Infertility is classified into 2 types : primary infertility, and secondary infertility. Primary infertility refers to no previous history of pregnancy after at least one year of marriage. While secondary infertility occurs after one or more successful pregnancies and terminates by abortion or delivery including ectopic gestations, and inability to conceive pregnancy one year after previous pregnancy (Hatai and Thepisai, 1990 : 296).

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Bio-medical concept also explain the cause of human reproductive disorder, a disease that is treated by controlling and adjustment as well as eliminate and correct specific body organ according to the bio-medical concept of human body. Medical diagnosis explains that the causes of female infertility are an ovulation, endometriosis, and obstruction of the follopian tube (Boonmongkol, 1996 : 121).

Female infertility has been previously seen as psychological and family problems than medical problem until 1960 and 1970 when advanced medical science introduced synthetic drug (contraceptives) to control the functional system of follicle, and laparoscope technology to study female reproductive biology, and thus infertility problem become medical problem (Muttigo, 1996 : 8). The process never been defined as medical problem is now specified as medical problem and also need medical treatment particularly the disorder and illness for which sociologically mean medicalization (Conrad, 1992 : 139).

Moreover, technological efficacy is an important base by which medical science is trusted the best medical system with an effort to apply the knowledge and medical science technology as well as management of modern medical service organization (Sringernyuang and Upayokin, 1990 : 139). The rapid advance of medical technology makes infertility a treatable medical phenomena by medicalization. Medicalization is an industrial management in which physicians regard female body a reproductive unit that can be technically controlled under the supervision of specialist as in the industrial process (Greil, 1991; Martin, 1987; Clarke, 1998, cited in Greil, 1994 : 3).

Medical view defines f3emale infertility problem and interprets it as one among public health problems under medical concept of which infertile female body and treatment is done by controlling, adjustment and eliminate specific organ, making female accept such medical explanation regarding the nature of illness and suitable social role of the patient, that is, most of the females have to take roles of patients who need treatment although other abnormality the causes of infertility depend equally on both male's and female's factors at 40 % each, and the rest is combined factors

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(Panyadiloke, 1996 : 4). In medical aspect however views that male has limitation for treatment while female is more complex in physical limitation that needs further diagnosis. Hence female reproductive organs either uterus or follopian tube need correction. It can be then stated that medicalization is a process of social control in medical aspect by utilizing medical technology (Chantanom, เอกสารอัดสำเนา) to interpret female infertility as health problem or deviation that needs medical treatment and diagnosis.

Medical treatment can help solving infertility problem but at a certain level and not guarantee the chance of success, taking very high cost and risk of complication such as ectopic gestation (7 %), and abortion (22 – 24 %). Allergiv to hormone and some drugs such as comiphene is possible that may cause high rate of follicle cancer (Charoensanti, 1996 : 364). Treatment of infertility therefore increase the risk and many other problems through medicalization as a catalyst. In American society where medical technology has been rapidly widespread (Becker and Nachtigal, 1994 : 516), Greil stated that rapid development of medical technology had created unreal expectation to those who have no children by perceiving that infertility occurs for a period of time, but in fact they may never conceive pregnancy. It can be seen that although medical treatment has less chance of success while increasing risk of complication, however, advances in technology had created expectation among those infertile. Hence they decided to seek treatment time after time. Utilization of medical technology for infertility diagnosis and treatment has put pressure upon women to continue the treatment process when it might have succeeded or no alternatives are available (Greil, 1991).

Bio-medical concept is a declining concept that view body's functions as a separable parts as the machine of which each body's organ and its functions is separated. It also explains that infertility is the disorder of organs or a disease, while female body is a technologically controllable and correctable reproductive unit and thus forcing women to seek treatment. Although bio-medical concept can explain the decision to seek treatment of infertile women, however, the limitation occur since it

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considers infertility at a separate and specific disorder organ, hence disregards the analysis of socio-cultural, economic, and social power relationship.

2.1.2 Psychological Concept

The bio-medical concept suggested that only medical science alone is insufficient to analyze or explain the decision to seek treatment of infertile women. Therefore, psychological concept is another concept that analyze and make understanding about health related behavior particularly to understand how individual tends to practice certain behavior.

The concept of hope, a part of psychological concept, believed that hope is a crucial source of power for human living that motivates behavior or bring up certain behavior of individual to adjust to any complicated environment, stress and suffering condition (Travalbee, 1971 cited in Chuangsawang, 1997 : 5). Hope will motivate infertile women to receive continuous treatment, cooperate, and to cheer up as well as to seek treatment.

Beck et al. defined that hope means a psychological condition of desire that can be achieved or possible. Individual who has hope believes that their desire would be achieved and makes their life change, for example, having better and more meaningful life. Those with no hope find no way to solve or out of the problems (Beck, et al., 1984 :501-502). Similarly, Chuangsawang (1997) stated that hope is a psychological condition of confidence or positive future expectation, and a motivation that stimulate individual to face and adjust to overcome the problem and difficulties, so as to achieve what they expects and desires (Chuangsawang, 1997 : 35).

For infertile women, their greatest expectation or desire is to have children, hope to conceive pregnancy, and hope to take parental role (Kantarugsa, 1995 : 5). Psychological concept thus explains hope as motivation that stimulate those infertile to seek for treatment from specialized and experienced physicians, so does to seek for effective and successful method and resources to help them to have children. Besides,

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they become patient to all stress and uncomfortable during the treatment although no chance to have the baby. However, infertile women are satisfy what they have gone through for being pregnant (Blenner, 1992 : 96).

According to Myer, infertile women who are hopeless to correct infertility still have future hope without having any children. Those infertile women who have hope will try to look for positive future that their desire would be achieved and try to adjust themselves to difficult circumstances and stress. This has shown that infertile women with hope will look for the future while those with no hope become dispirited. Infertile women with hope also believe that their husband's relatives, doctors and nurses can help them. Whenever they feel hopeless to have children, they will lack of confidence in treatment and afraid to try other alternatives. On the contrary, infertile women with hope will have confidence in treatment, to accept and to try any methods they believe to help them having children. It is pointed out that hope is associated with desire, and desire is to hope for miracle (Beck, et al., 1984 : 503). Some infertile women pray before the superstitious they believe would help them having children. This has shown that infertile women have hope and try to seek ways to have children.

The psychological concept believes that expectation to have children has forced infertile women to decide or to have various help seeking behavior they believe helping them to have children. It also explains the decision to seek treatment at individual level. The decision to seek treatment thus depends on hope and desire to have children of individual. Although psychological concept can answer the reason of making decision but at a certain level and not insufficient and coverage since the problem is focussed at individual and is neglected socio-cultural reaction, hence the overall picture of problem in socio-cultural context is unclear. The reason in seeking treatment of infertile women is beyond the decision made by individual alone but need to take into account the relationship of those in the society and gender relation within the family too.

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2.1.3 Socio-Cultural Concept

The medical view explains infertility focusing on the disorder of female organ and interpret it as a health problem needed to be cured, while psychological concept explains and analyses the infertile women themselves that lead to seeking treatment. However both not clearly give the answer why women need to seek treatment. Socio-cultural concept is another mean trying to answer this question within socio-cultural the context.

Socio-cultural context explains that decision to seek infertility treatment is partly due to self perception of inability to take expected social role. The role is the behavior defined by the society according to social expectation and norm. foe instance, the role of wife to give birth representing good and perfect wife, and perfect family should consist of father, mother, and children, all of which are the social norm in every society (Samutpradit, 1996 : 20). In each cultural society, infertility is perceived and learned according to the belief system transferred through socialization. Once individual is unable to follow the social role, i.e. maternal role in giving birth or being good wife, it can be stated that reproductive disorder shows the failure to cultural norm that effect husband and wife relationship (Greil et al., 1988 cited in Nachtigall et al., 1992). In addition, transferring of culture from generation to generation, giving birth to offspring to further family heritage have brought familu unity. Therefore having children is the symbol that links cultural system in terms of relatives and religion. Then, having no children is regarded as a reproductive failure and deviation (Miall, 1986; Veever, 1973 cited in Nachtigall, et al., 1992).

The cultural ordering defines female's role as mother and wife, that is, taking role in giving birth to further family line, and breastfeeding the baby. Being mother and wife represent good and soft image, while on the other hand, female is of hazard if unable to have children (Wongtet, 1991 : 27). In India, for example, infertility is meant to female's problem, and inability to have children is unpropitious leading to disaster (Bharawaj, 1999 : 2). If infertility occurs to the couples no matter causes of each side, it is female's duty to eliminate the problem by seeking treatment .

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Neff (1994) revealed in his study that in India giving birth to children is to have successor to continue family line which is very important, making god family that is most important among relatives. Inability to give birth is thus against the rule and unpropitious to the family. Such problem is focused onto female not male, and hence female has to take the duty in repairing their reproductive condition and also to seek treatment so as to response the desire of continuing family line and family unity (Neff, 1994 : 475-485).

The study in the USA suggested that female is more capable to accept the risk of having infertility treatment by medical technology than male. American women tended to receive treatment and take risk just to achieve the motherhood desire as defined and forced by socio-cultural norm (Becker and Nachtigall, 1994 : 507 – 518). As in the Thai society, the unique of femininity is defined by cultural role as the child producer to continue family line (Boonmongkol, 2000 : 126).

It can be seen that decision making process to seek infertility treatment occurs within socio-cultural context that values and gives the meaning of having children as for continuing family line. Besides, the role and socio-cultural norm also specify married women to have children to represent motherhood and good wife. Therefore, female is forced by socio-culture to seek treatment to response to social expected role that may be similar or differ across societies. However, socio-cultural concept only answers how decision was made under the socio-cultural context but not mentions about gender relationship. It also did not explains the root of problems that different gender role is defined and valued, and has caused female to take reproductive burden and to face the pressure of infertility problem alone.

2.1.4 Social Stigma Concept

Infertility is an unexpected severe critical condition of life that beyond one's expectation, and may cause chronic depression among couples since it can not be specified how long they could live in such condition. Infertility is thus attacked and linked with grieve and mistake for it is against the social norm (Whiteford and

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Gonzalez, 1995 : 28). Many of those women facing infertility may sense of social stigma and shameful of having no children and thus try all means to escape from such feeling (Muttigo, 1996 : 6).

Social stigma in the concept of Goffman (1963) is regarded as a social phenomena originated since the Greek period. Social stigma is related to the badge on the body from doing a mistake, or against religious rule. Such badge has dishonored one's life by showing to the public that such individual is ignored by others. At present, social stigma concept is somewhat different from previous physical appearance, that is, the sense of losing faith from others, and specific behavior to mark unacceptability by others or disadvantage. Social stigma occurs in case of visual social identity although individual might not expected that they expect others. However, actual social identity is linked with what individual expected, thus create social stigma. Goffman had studied the social stigma in 2 dimensions : disability; and deviance. Disability is related with chronic handicapped that reduce ability to function or practice social activities, while deviance concerns with behavior that violated social norm, values and role.

Social stigma occurs in physical deformities or deviance from the group identity, and that infertility has close relation with physical deformities as stated by Goffman (Miall, 1985 cited in Whiteford and Gonzalez, 1995 : 29). For infertility, social stigma not only depends on perception and physical deformities, but also depends on the sense of destroying social norm. This is true for those women in the society where having birth supportive norm of which build up cultural structure of gender role that links with reproduction that women must have children (Muttigo, 1996 : 9).

Whiteford and Gonzalez (1995) had interviewed 25 infertile women in North America and found that infertility is shameful or a social stigma secreted in one's mind. Social stigma here in unseen like becoming paralysis or blind. Although infertility is not shown apparently as social stigma, however, women feel like being

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blamed comparing to those who have ability to conceive pregnancy and give birth, particularly in the society that values fertility (Whiteford and Gonzalez, 1995 : 28).

It can be seen that defining the meaning of female infertility is related to the sense of shameful, guilty, failure, no quality, deformity and devalue, caused by socio-cultural structure regarding gender role of female in reproduction. If women failed to reproductive function, they are socially stigmatized. Gender role created by culture reflected different role expectation between males and females towards infertility. Either male or female having reproductive deformity, female have to bear suffering trial. Although male is diagnosed having reproductive deformity, female needs to be examined for the deformity too (Boonmongkol, 1996 : 116).

The social stigma concept believes that infertile women have vision on themselves having deformity, disorder or deviance from social gender role norm. Self esteem and personality were destroyed by infertility. Hence women are struggle to overcome the infertility problem by seeking all means of treatment to help them to have children and thus escape from such stigma. Although social stigma can answer the decision to seek treatment among infertile women that motivated by socio-cultural structure of different gender role that female has to take responsibility in giving birth, however, it has yet explained the origin of problems leading to separation between couples under the gender role power relationship. Besides, this concept can answer the question on the decision to seek treatment of infertile women specifically to those accepting social stigma who feel themselves devalued and deviance from social norm or public norm, which is a one way explanation. Hence social stigma can explain at a certain level and specific to some group of women.

2.1.5 Feminism Concept

The study of women in feminism aspect is to study about females in the areas where they have interaction. It aims to present the overall truth about female as well as to explain and to make understanding regarding gender inequity. This meant to

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change disadvantage status of female by changing social power structure that currently discriminates women (Tonchaiyanon, 1997 : 11).

Feminism concept originated from western society that regards women as a main center for analysis. Attention has been paid on women status, role, and their problem in the society. It denies the belief that role separation, gender role, masculine and feminine is natural and cannot be changed, on the other hand, feminism concept explains that these conditions are brought up from social creation and nurture. Hence, masculine and feminine structure and their relationship are changeable (songsermpan, 1996 : 501 – 502). Feminism academicians have different point of views. In this study the feminism theory is categorized into 4 groups according to theoretical base and philosophy that differently explain the inequity of gender power relationship between male and female. Such different perspectives will lead to strategic means to manage gender inequity and discrimination.

Liberal Feminism This concept views that male and female are not different in term of ability but, nurturing about being feminine and masculine and gender role make them different. Definition of female role only at home by legal and traditional belief is unfair for female as a human being lacks of opportunity to be developed and seek benefit as male does. In this concept, gender inequity and discrimination caused by nurturing, education, and scope of social rules especially the unfair laws. Guidelines for solving such problems thus emphasizes on revision of the laws that promote gender bias and discrimination, providing educational and working opportunity for female as for male, including lessen female's burdens such as housework, having children and raising children.

The disadvantage of liberal feminism concept usually be pointed out is that it solves the problems without considering existing male superiority and power structure but focussing on revision of laws and promoting females to take more political and economic roles as males. As a result of this public policy, gender inequity still exists. Some groups of women take advantage and benefit by taking roles and power in formal political and economic structure, while the majority of women still faces with

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the same and increasing problems due to their increasing roles outside the house apart from their usual roles of housework, having children and raising children.

Marxist Feminism This concept tried to analyze female's problems by Marx's concept that explains the problems of gender abuse and discrimination as a social status discrimination in the capitalize economic system. Regardless of females status as bourgeoisie or proletariat, they are discriminated in different forms. While Engels stated that monogamy family in capitalize system made female become male's property, an instrument producing heirs, accepting the housework, taking care of children and husband. Thus female's works is worthless and no economic value since it relates to work and family relationship. Female labor is thus supplement with less paid, so they depend on male. Similarly, if females are unable to take duty of producing heirs, the properties and labor of family and producing system, for their husband and families, they thus turn to even lower status than males and being discriminated. To manage discrimination problem, women need to enter industrial production system, ruin capitalize system, while create social status awareness. This concept places importance on social classes contradiction than gender discrimination. It is believed to ruin capitalize system before releasing the labors from being tyrannized by the capitalists, thus change in gender relation structure is possible.

It is noted for this concept that a call of female was included in the policy and guidelines of labor process but not come into practice. It was seen that such change was just to gather to fight against the capitalization. Because the analysis and problem solving focus on social classes contradiction in the capitalized economic system than to solve female's problems, the limitation of this concept is due to utilization of economic criteria as principle for explanation and analysis, making it not widen enough to explain overall female's problems (Kaewthep, 1992 : 24).

Radical feminism This concept looks at gender relationship as a patriarchy power relationship, and believes that women discrimination causes by biological differences between male and female and defined by biological family. This has made up the power dividing structure and work separation according to biological

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characteristics. It serves as a basic concept for analysis of female's problems in various issues, for instances, reproductive and mothering. That is, since females have uterus so they have to take the childbirth duty , and if they are unable to give birth, it is their problems not male's. Thus it is difficult to eliminate female discrimination by changing other social aspects. The direction of enforcement under this concept is to separate themselves from the patriarchy power relationship, and deny their own specific social pattern and natural characteristics of feminine, including changes of natural reproductive pattern of human being to utilizing reproductive technology such as GIFT and ZIFT, and accepting sexual relation between female and female (Lesbian).

This concept was argued that the direction of enforcement had ignored the crucial natural roles of female that are valued differently across society and culture. Although male's roles are substituted by various technologies, however, male's power in other social relation is not replaced. It can be seen in several cases in which female utilized reproductive technologies but in fact it is just to accept their roles and responsibility to seek treatment and have children. It only reflects subordinate power relationship in the family. In many cases, utilizing reproductive technology is to accept female's role in seeking treatment. Females have to confront with discrimination, and no negotiation power status, while being treated with violated both in the family and society, including female commercial sex problems, etc.

Socialist Feminism This concept is a combined Marxist feminism and Radical feminism that view the discrimination structure of social classes and between social classes is overlapped and linked. The study of this concept emphasizes on capitalist analysis, and the patriarchy system, both reflects inequity between classes and genders that benefits males and capitalists. Therefore, the analysis should take into account of both systems, and female discrimination needs to be considered in socio-economic context. The enforcement against all forms of discrimination is thus to combat with respective social structure where discrimination originated. The strategic means should also consider the context and work separation condition, work separation between genders, and social reproduction (Songsermpan, 1996 : 504 – 505.)

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Various concepts of feminism differently look at the causes of gender inequity, female discrimination, with different means of enforcement. However, all concepts tend to look at female a unique characteristics with shared experiences of femininity. Hence, to select specific concept to analyze female's problems depends largely on the problem and conditions within the context of such problem. In this study on help seeking behavior of infertile female within the context of gender relation, several related factors include gender role, power relationship, family or relatives, and doctors.

This research study chose the Socialist Feminism, a combined Marxist Feminism and Radical Feminism, for analysis of female's problems, and to explain more coverage of such problems. The theorists of this concept pointed out the root of the problems regarding inequity and contradiction between social classes. They extended the study and analysis beyond the scope of economic dynamic that cover several conditions, family origins, gender characteristics and physical relation to childbirth and child-raising, analysis of patriarchy that causes various forms of female discrimination and management system that is beneficial to some group, while some might lost (Soonthornpesat, 1997:314-315). To make understanding about Socialist Feminism, it is necessary to clarify economic classes system and patriarchy system that originated capitalist patriarchy and create gender power relationship, gender inequality, sexual division of labor. The scope of analysis and understanding can be expanded to cover female discrimination as follows:

2.1.5.1 Gender classes relationship economic system

According to Marx and Engels, the analysis of female's problems had explained the oppression, exploitation and discrimination against women that such conditions were parts of classes oppression in capitalized economic system. Either women are the production factors owner or the labors, they were discriminated in different forms. Gender relation is in the social classes infrastructure especially in the social classes structure of capitalize system (Soonthornpesat, 1997 : 301). However, the analysis of Marxist is created to explain the production mean of capitalist and

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production relation including their related pattern with production mean, while gender specification, classes, and female domination concern with female's role in continuing human race which emphasizes on understanding about sex, family relation, housework, and child raising, together with understanding and analysis of female's role in economic production process (Tonchaiyanon, 1997 : 38 – 39).

Engels seems to present a more complicated analysis of patriarchy system linkage and production mean than that of Marx in terms of analysis of social status of women that subordinated to men. This issue appears in the book "The Origin of Family, Private Property and the State", written by Engels in 1884. The book pointed that economic development and social production power lead to changes in family structure which effects family relationship including sexual abuse against women. "Defeat is a women's history" occurred when production power was developed until human learned how to hunt and grow plants and the production efficiency was well advanced to make a social's surplus. Men as the owner of production inputs for hunting thus need to control the surplus. This has brought about the personal property ownership that originated social classes inequality. Women need to change from being social members with productive equality and freedom to take subordinate role to become dependent wife under their husband's rule.

Property is the cause of change of the relationship between men and women in the family for it absolutely changes the political and economic relation oriented over time. Exchanged products owned by men had been expanded to substitute the production for household use, the family and women's products, making changes in women's status. Women today need to work for their husbands and families instead of their society although their labor s are needed. However, the social regards women's labor as a part of subordinate exchanged production (Wongthet, 1991: 92 – 97).

Engels stated that the pattern of social classes is the classification of males and females of which males take social work while females are kept for the housework not for working outside. Social classes defines women to work at home for the family,

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whereas men take social productive role for exchange. Men are more utilized than women either as social labors or in public administration. Having superior economic power, men are able to control women's body and sex through marriage of monogamy type that strict only to women. This is to make sure that their properties will further to their heirs. At the same time, women's body and labor are under the control of their husbands while they were hindered from social shared production (Tonchaiyanon, 1997 : 42). Besides, women were promoted to stick with traditional value and roles in the family and raising children, and finally take whole responsibilities in family's consumption, producing family members, nurturing and raising children, then become the new generation of exchanged labors in the future, which is deemed necessary in the capitalized society. Marx defined the word for continuing life in social aspect to be substitute labor as "social reproduction". Hence, women are important producer in reproduction, making women a gender dominated and controlled in various forms by society. Development of production means had brought about gender classes differences.

As mentioned earlier, women have subordinate role and status to men especially in the family. Women have to take burden in all family matter, from the housework with no production, no economic value, and no recognition, to the childbearing burden.

Although Engels had clarified the relationship that link and support each other between genders and classes that the origin of personal property effects the need to control and to become ownership of women whose having reproduction role. However, the concepts of Marx and Engels still have limitation since they focus and utilize only on economic criteria as the principle for analysis. It is not that broad to explain female's problems depending largely on cultural dimension. The concepts of Marx and Engels such as production inputs and surplus value can only explain some points. Regarding personal ownership mentioned by Engels, although such ownership does not exist, female oppression might still remain. If such properties are to be public properties, it is one among other necessary conditions to release women (Kaewthep, 1992 : 24 – 25). Because women's problems at all times not only caused

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by capitalist society, but also dominated by patriarchy system, the gender power relationship that males are superior than females. The capitalist women thought that this issue should be mentioned so as to combat with the patriarchy capitalized system in the present society.

2.1.5.2 Patriarchy gender role system

Patriarchy is a pattern of power relationship and domination between men and women. Domination of males over females is of most important pattern for its long history (Tingsapat, 1981 : 18). As mentioned before, economic relation system is not the main problem of female oppression, but it is because of the patriarchy. Therefore, social reproduction is not the labor product for the capitalist but the product of patriarchy that males have the power to control sexual relationship and childbirth, i.e. the power of domination on biological differences. Prioritization of power that put women at the lowest is regardless of economic classes that women depend on men, but because of social power structure that put men on the superior level of power to dominate gender relationship at every level.

In the modern industrial society where women have education, income and have increased social and political rights, patriarchy however still exists. Crucial mechanism brought up patriarchy is social nurturing process started since the childhood, making women accept the defined female role, and also accept the unequal power pattern between men and women (Millet, 1970 cited in Tonchaiyanun, 1997 : 32 – 33). Gender is the social expected role of appropriate behavior of men and women. Boys and girls are taught and treat to have different behavioral role, life expectation, emotional and intellectual development. Gender role defined by socio-culture is not specific but changeable and can be developed (Boonmongkol, 1999 : 23). Specification of gender role since the childhood allows boys to learn how to be family leaders and learn to dominate and occupy political and socio-economic role, while girls are nurtured to take role in the housework, taking care of family members, being good mothers and wives. It is apparent that gender role definition cannot excuse

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to mention biological characteristic of female as the child-bearer and to give birth. Their natural biological characteristic has led them to take unavoidable social role.

Gender differences support the patriarchy system and lead to oppression. It can be said that oppression is specific experience of women. It is the relationship originated from specific biological characteristic "reproductive" of women that allow them to be oppressed. Similarly, biological family is the sub-unit for continuing human race, and is the family of unequal power dividing (Firstone, 1970 cited in Eisenstein, 1979 : 18). Firstone's concept suggested that understanding the background of gender oppression is to understand the function of "biological family". The biological family is specified by power, duty and prestige according to biological characteristics. The origin of biological family based on the 3 biological facts : 1) women are to give birth and take main responsibility; 2) infants are to depend on mothers longer than animals; 3) psychological dependence between mother and child. Based on the 3 facts, work pattern at the early stage in the society was defined by gender differences of natural reproduction, which is continued to the present time (Wongthet, 1992 : 22); Tonchaiyanun, 1997 : 37). As for Firstone, imbalance of power between gender based on biological factors since males and females have different biological characteristics. Thus, they have unequal rights as seen by the superior power of men over women divided by their biological characteristics (Firstone, 1970, cited in Eisenstein, 1978 : 18).

It is the fact that men and women are created with natural differences. Although women have to give birth and raise the child as a motherhood role defined by biological fact with no excuse, the biological difference has been mentioned as principle for inequality, and thus becoming a simple sign of difference for dividing social labor. The reason why women need to concentrate with the housework is their motherhood role and be hindered from socio-economic and political activities. Women have to depend on their husbands. As women are limited to the housework, they are unable to access to power and reputation. Cultural value is thus belongs to men only. It can be seen that biological differences had supported the social classes system and the patriarchy system through the biological family process. As men are

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excused from natural commitment, women and children are oppressed by men in both the family and the society.

The biological claim for analysis of women oppression provided some understanding about how the oppression power was brought but at a certain level. However, it did not link to how men pursue such power. The discussion is carrying on if the patriarchy is stopped and women are released by technological change and substitution or biological technology such as GIFT and ZIFT as Firstone's concept, can actually solve the problem of women. It might just release women from natural burden than change the relationship of gender discrimination in the society.

The oppression of men over women might not defined only by biological difference as a tool to make women take reproductive role to continue the family line, but the oppression is also made by men to force women to give birth to continue the family line instead of themselves. Therefore, the origin of biological family might not be the outcome of gender classes that men dominate women. It might be the oppression created by political system and human culture regarding sexual relationship through heterosexuality, supported by family institution and marriage, and controlled by cultural, traditional and legal system. These phenomenon are the political power base that men treat women (Atkinson cited in Eisenstine, 1979 : 44).

The power of men over women not only be used through biological difference, but also through various forms of social relation system of political benefit that men treat women to secure such power. Therefore, the analysis of the problems of oppression over women is not scoped only in biological difference but should be extended to cover other aspects of social relation structure including politic, culture, and economy, all that put women on disadvantage status.

2.1.5.3 Patriarchy capitalist system

Patriarchy capitalist system has brought to the analysis of economic classes power relationship and the patriarchy gender relationship. It originated the analysis of

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social classes system and the patriarchy system including the oppression over women, based on race, age, gender discrimination, and social ordering.

Women of capitalist group pointed that understanding the overall facts of life is necessary to mention about the economic classes system and the patriarchy system. Actually, the relationship between human and the nature as well as others is the activities for living and continuing human race, covering 2 aspects. The first is producing inputs for living such as food and cloths, and the second is producing human being to continue human race of the next generation. Women have shared equal role as men in this social process through social relation system between men and women.

This group of women stressed on the analysis of the issue on oppression against women in the patriarchy power system in the society. Exploitation against women through the social classes relation is in the form of wage and social power ordering, while oppression is made through unpaid housework at home including sexual relation and being motherhood. In developed society, women play increasing role in education and socio-economic aspects, but they still not escape from the patriarchy, exploitation and oppression. It is yet a complex issue in the passive role structure of women. Therefore, the analysis of women's experience in the capitalist system cannot be separated.

Juliat Mitchell is another one who believed in socialist mean and tried to create the new socialist theory with respect to oppression against women and family problems. She criticized the past socialist process that it totally failed to understand the problem of oppression against women. She saw that the Marist's concept alone is not sufficient to analyze such problem, but we could not deny its concept, instead wand need to broaden the analysis. The importance of socialist's analysis is not only to give up personal ownership and patriarchy family, but also broaden to cover the production, reproduction (production to continue the human race), sexual relation, and child rearing. These have caused women become powerless today. Mitchell saw that economic, capitalist, family and patriarchy issues have to simultaneously process and

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analysis has to be made at every level of social life and individual life. Mitchell (1989 : 297 – 313) had explained about the following 4 structures:

*1. **Production function*** Biological difference between men and women defines work separation. Smaller and weaker body of women is meant to less work and labor, and thus production ability of women is less than men. This make women subordinate to men. Society also influence work separation according to biological production ability of what should be men's and women's works. Women are forced to accept the housework as their own job including having children and child rearing, while men's work related to labor, ability and productivity. These confirm the oppression against women under the work separation condition as women have disadvantage biological characteristics. In some cases women's anatomy is not defined only for the housework, but women shared their labor as men or more than men in production and agricultural works. However, women labor in production is seen as supplement labor since their main responsibility is the housework, while men are the main labor because they own production inputs.

*2. **Reproduction function*** Women disappeared from the part of production in the history not because they have weaker anatomy than men in the oppression context, but because they take reproductive role as mother. Being motherhood, women need to leave their work to breastfeed and take care of their babies, but not always the case. Taking reproductive role in the capitalist society, being motherhood is to fulfill women's role as the producers. To give birth, taking care of children, and the housework are natural role of women. Motherhood is a biological production, and children are the labor product of the society. Being parenthood is thus regarded as a job and to childbirth activity is one of the achievement of mother as creating labor product. To give birth is to own the most important thing. Creating society's members, women are treated and intervened by the government by implementing the national family planning programmed aiming to control population size. In doing this, women have no right to control their body and reproductive function. The productive ability as mother is to define mother not only physically but women are to accept to represent the activities and to create activities within the housing area.

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3. Sexuality function Regarding sexuality, there are many traditional restricted dimensions for women, and women are controlled about their sex. This is partly to control women sexual behavior as a mechanism to control the society based on the image of honor and shame. If women had practice sexual behavior against the goodness rule, such behavior brought about the loss of honor and shame to the family. To avoid this, women are to be kept to live within their house and strictly follow the rules such as dressing, manner, and behavior. The image of good women is set up including virginity, respectability and regarded as a sexual behavioral pattern that women are forced to practice. Moreover, men can control women's body and sex through monogamy marriage which actually be practiced only by women especially in case of extramarital sex that is common for men, but women are to be blamed. This point of view supports the control of women's behavior by men who takes role in defining women's role, status, and behavior, including punishment if women behave against the rules and tradition. Women' sexual relation as a mechanism to control women's behavior obviously affects their lower social status than men.

4. Socialization of Children Feminine and masculine are natural and social roles that define work separate role in the family. Male is defined to be strong as leader, and earn income for the family. Female's role is stick to the child since the fetus and to raise the children. Children will be nurtured and have similar characteristic and behavior like their mother during the early childhood. Girl in particular will be transferred the role from her mother's experience in being a girl and a wife. This makes women belief that having children is women's burden and responsibility. Boy is less likely to be close with his father because the father has to work, so he has learnt freely. Boy will be transferred the masculine image, learn how to be the leader and pursuing power through family and social systems.

The analysis of the above 4 structures revealed that to destroy the capitalist system is not only to eliminate the prestige of classes, but also to eliminate the classes differences. In addition, women have to destroy the patriarchy system by controlling the reproductive inputs of women in both the power and equity to control their body and sex, and the control child rearing institution as men do (Kaewthep, 1992 : 28). In

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conclusion, the women's rights commission will have to eliminate the power of men including to eliminate gender difference in the economic, political, and socio-cultural system.

In this study, the researcher has chosen the socialist feminism concept for the analysis of related factors within the gender relation context in the decision making pattern to seek treatment of infertile women which is similar and consistent to the problem issues in this study.

2.2 Study factors within the gender relation context in decision making pattern to seek treatment of infertile women

The decision to seek treatment of infertile women has different dimensions that reflect through their roles in various institutions linked between family and society, thus making different decisions. This study within the gender relation context has separately considered related factors that are likely to effect the decision making to seek treatment of infertile women.

2.2.1 Gender role

Gender role is defined by socio-culture. It is not such a specific role and can be changed or developed. Gender was differently defined and reflects the concept of the people in each society. The process of founding characteristic and gender role is made through socio-cultural process of both physical and mental appearances starting from childhood nurturing during which specific characteristic, meaning and gender role were defined.

2.2.2.1 The meaning of infertile women

Gender difference is not defined by physical only but socialization process had created more different role between men and women. Nurturing since the childhood

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through transferring and socialization process are all the mechanism that nurtures gender role and differentiates men and women.

In general women are seen having kindness, gratitude, well-behave, sweet and gentle, being housewife, while men are strong, patient, and being leader. Moreover, it has long been recognized that the major role of women is to take care of their families, children, husbands, and relatives, in providing food and keeping house. Women are taught to bear these burden. Another role of women n the family is to support and assist men.

Such a different role is partly defined by gender or biological difference as it is known that male and female has different biological characteristic, i.e. reproductive organ. So, it is female's natural duty to be responsible for childbearing and breastfeeding. Women have to be responsible for unavoidable reproductive duty particularly women are meant to take the main role of reproduction. Women's role in reproduction and family are defined by biological factors, making women a main labor in producing children, raising children, and to be responsible for other jobs in the household such as cooking and keeping the house (Assawes, 1992 ; 41).

Feminine and masculine defined by the natural and socio-cultural roles have separate job and gender role in the family. Men are expected to be strong, leadership, and earn income for the family, whereas women, regardless of socio-economic background and different reproductive status, are specified and founded by the society to basically mean living to be married and to have children, being motherhood and wife (Rungauga, Sandby, and Aggleton, 1999 : 19 – 20), as well as to raise children and take care of the family including keeping the house. At this point, women are meant to have children as women's role and responsibility. Although women currently have increasing role and responsibility such as economic role in earning income, however, nurturing and transferring belief in gender role of being motherhood and wife cannot be wipe away from women's mind and the society.

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Furthering thought, and nurturing thought, ideology, and belief of gender role through socialization have been reproduced and promoted by various institutes such as family, education, and medical institutions. This has become a part of social awareness and principle of social ordering, building values and norm that define roles, duty, and image of female's body that women have the duty to give birth or produce new social members. It is believed that having children has shown identity of womanhood, the role that women are meant to be responsible for. Ability to conceive and give birth are the most fundamental duties of women, but having children for men is just a chance to secure their male status in the society (Bharadwaj, 1999 : 10). Regarding reproductive health, women's role is just "the receiver of men's semen" and it is just a media that makes the potential of being fatherhood of every man become perfect (Sontasombat, 1996 : 50).

The meaning of identity and women's role under the patriarchy structure system has made the infertile women become unhappy and uncomfortable about social expectation regarding having children. In particular, expectation of the motherhood role is what women can prove their role and is necessary to support their self value. Infertile women usually feel losing their identity of childbearing and childbirth roles. The thought that they had physical deformities with inefficient function, and thus lost social status. This is because the social value accepts and recognizes the parenthood as important and valuable role in giving birth and protecting children (Isarangura Na Ayuthaya, 1998 : 19; Chuangsawang, 1997 : 42). This is consistent with the study of Gerrits (1991) that the infertile women had given the meaning of their infertility that it is because they have physical deformities, and they feel failure of being motherhood, they are bad because of inability to have children, all that spoiled their identities. Gerrits had conducted interviews among infertile couples and found that all of these wives felt that infertile experience had tremendous effect upon them, but most of the husbands felt disappointment but not effect themselves or destroy other experiences. A little number of husbands had felt their identities were destruyed (Gerrits, 1991 : 51 – 57).

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It can be seen that the socio-cultural had separated different gender role by specifying women than men to take role of giving birth. If the couples are unable to have children, the meaning of infertility is thus different between men and women. The society especially the women themselves mostly gave the meaning of infertility that it was their own abnormality and failure to take motherhood role and maintain their female identities which is against social expectation. Most of these women felt unhappy and worry than men. And because infertility was defined by the society and the women themselves, women perceived such role and responsibility, and try to seek treatment to have children to fulfill their duty.

2.2.1.2 Perception of women in reproduction

In the past agricultural society, production and the housework were not absolutely separated. The advances of production technology especially the machine had increased efficiency and productivity. This had reduced the producing role of women although they maintain such role in the field. Men usually control the producing machine and distribute the product and have the actual power in the society. Apart of these roles, men are likely to have son to continue their family line and to be the main labor of the family, and thus reducing the importance of women's role and status to be just "the son producer" with the main activities of childbearing, child raising, and keeping house. And because of these burden, women are unable to spend time and labor in economic activities, allowing men to take absolute role in production system. The importance of women's role is just "reproductive" in the family, i.e. doing the housework, giving birth and raising children (Sontasombat, 1991 : 66).

Gender role separation has made women perceived their role as "reproductive" who produce the new generation or labors to substitute the old ones. In agricultural society, producing heirs as the producing labors has long been the main purpose of marriage among the Thai agricultural society (Sontasombat, 1992 : 50). This is not different from the industrial society in the capitalist society where social classes separation and discrimination existed. The superior class had controlled the labor to produce the surplus products, the sources of their wealth. Therefore, having and

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producing labors to substitute the old ones is necessary for production (Tonchaiyanun, 1999 : 45). Having children is thus effect the continuation and substitution of labors in production process of the capitalist system. Marriage and having children is the reproduction of the new generation to substitute the labors and to continue the properties (Chowdorow, 1979 : 95). The ability of women as the producer of the new generation is thus very important. In the Thai society, the mechanism to control the behavior, body, and sex of women is built, for example, setting up the image of virginity and the monogamy family that is practiced only by women. The control of women's sexuality has put women in a lower status than men.

Moreover, the reproductive role of women in the family is to produce heirs to continue family line and properties of men. In particular, women in the upper social class are separated from the production work but taking role in giving children. This is the mechanism of continuing properties from father to children, and also supports perfect fatherhood. Besides, it creates unity within the family (Sontasombat, 1991 : 71). Women has taken important role in reproduction. Social expectation on women as the reproductive and motherhood under the patriarchy structure has made women subordinate to men and become the wives who serve and take care of their husbands and children. Such expectation has forced women's nature and to accept the motherhood status (Muttigo, 1999 : 63). Since the society defined women's role as the producer of the new generation, women have to perceive their own reproductive role. If they are unable to have children, they subsequently feel unhappy and anxiety, and thus try by all means to escape from the suffering status by seeking treatment to have children.

The study of Oyekan (1999) among infertile couples suggested that the families were unhappy if they have no children to continue their family line and properties, to take care of family business and to be labors. Women were more unhappy than men for having no children because the society regards it women's mistake. Having perceived their reproductive role, women thus accept that infertility is their own problem and try to seek treatment than men (Inhorn, 1999 : 9).

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It can be stated that the defined role of women as the producer of the new generation to continue labors and family line has forced women to accept such role as reproductive which subsequently effect their decision to seek treatment.

Gender role has originated from the socio-cultural structure that found the separate and different gender roles and responsibilities. This has brought about work separation, social classes, power and prestige that effect the pattern of life of women in the society. In general, femininity is just a reflection of men discrimination against women in certain society (Ryan, 1979 : 151). Women's duty and value are defined either under the consent and non-consent of women, however, such duty has long been continues.

2.2.2 Gender power relation within the family

The root of gender discrimination is resulted directly from the gender power relationship in which males take advantage to control, utilize, and discriminate women. This condition is integrated as social organization of patriarchy infrastructure, which is described in the followings.

2.2.2.1 Economic productive role

In the Thai society, male and female take different roles and duties in separated areas of private and public spheres (Songsermpan, 1996 : 497). Men take role outside the house in public sphere with respect to socio-economic matters. Their work require power and competitive ability. Working outside belongs to men to earn income for the family. In contrast, women take roles in domestic sphere within the house, and their works are those of the housework, cooking, facilitating family members, giving birth and raising children.

Women are specified to take care of the housework which is not regarded as a job since it is outside the social production sphere, but produces use value not the exchange value. Women who do the housework are included in "laborforce

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outsiders". Housework is an unpaid work because it is done with love and satisfaction between family members. Women who do the housework produce nothing that is important for maintaining the public sphere and economic role of men. This unpaid work hence having no economic value, and women thus depend on their husband.

Changes in economic situation of the current society had forced women to work outside to earn income for the family, so women have increasing economic role. However, the society still regards women not the main income earner of the family but having reproductive, childbirth, child rearing and the housework roles. All of which overlook women's role in productive activities. Although women have to work outside, but they are also responsible for the housework and raising children, while men take very less role in these activities. Since gender role specified men to work outside, women therefore have to be responsible more inside and outside the house. Nonetheless, women still are regarded as supplementary labor to assist men's productive work, i.e. the housework, while men become family leader and important social producers (Assawes, 1992 : 13).

The social value and belief had specified men to be family leader and pursue power in the family partly because women earn less income than men, and the value of women and men were justified by men's work (Chodorow, 1997 : 84 – 86). Economic power, domestic role and the role outside the house are divided under the influence of socio-cultural value. It seems that women have only domestic power but still less than that of men outside the house which is recognized as men's work (Laiskul, 1994 : 12).

In a number of societies where women have equal role as men in working outside, women have more decision making power. Boonmongkol (1999 : 24-25) conducted a study on gender relation in the northern villages of Chiengrai, and found that the role inside and outside the house between men and women were not absolutely separated, and women were able to work outside as their husbands. In addition women were the ones who collect money and decide the spending for family like buying food, but not other major matter. Since women work and earn for the family,

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thus having a certain level of social status and decision making power, and subsequently having negotiation power with their husbands.

It is obvious that economic power and gender bias had close reasonable relationship, i.e. women have increase involvement in production and distribution of resources, while gender discrimination and bias become less. On the contrary, the less the women have role in production or involve only in production activity, the more the gender discrimination and bias (Sontasombat, 1991 : 36 – 37). This effects women's decision making power. Decision making is the measurement that mostly reflect the power aspects, however, the accurate measurement that who has most decision making power in the family is not that easy for it is quite sensitive and complicated. As mention earlier, it is understandable that women's role in economic production and earning income for the family as well as being recognized and valued from by socio-culture that equal to men have partly brought about an increase in their negotiation power and decision making power in the family, especially between men and women. Contrarily, if women's role is regarded subordinate to men, their power within the family including decision making power become less too.

The decision making to seek treatment of infertility of the couple is a part of the decision making in family, which is generally discussed and decided between men and women. However, under such sensitive and complicated decision making process, it is partly bias with unequal power relation. In many cases, the desire to seek treatment to have children was not come from the desire of women but from the lower decision making power and negotiation power of women due to the bias in economic productive role, that force women have to seek treatment.

2.2.2.2 The pattern of living after marriage

Partly, the origin of power in the family can be considered in the issue of the pattern of living after marriage which links to the relatives and family system greatly effecting the family life and the status of women. Therefore, the study of power

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relation between men and women need to understand the criteria of living after marriage.

In selecting residence after marriage, the Thai society did not set up the criteria for selecting residences. As found in the Thai society, after marriage the Thai people may chose to live with their parents, move in to the wife's family (matrilocality), move in to the husband's family (patriolocality), and live separately (neolocality). The study of Limanonda (1983) found that, in all regions, the most popular residence after marriage is living with parents and matrilocality, except in the urban area that living separately is more popular.

Regarding family system, choosing living places after marriage is much important for marriage life and women's role as wife. For instance, in the society with rules and regulations, patrilocal residence after marriage is that women move in their husbands' home. As in Chinese society, women or daughter-in-law are subordinate to the mother, father, relatives and family of their husband. Beside, they are not accepted as family member until they give birth to the son. Women is thus valued for their ability to have son, although they take equal or more productive role than men. This limits the social status and life of women at home. Women are under the command of the relative system of men's power.

For the matrilocal residence as in the rural Thai society, men mostly move to women's house after marriage. In this society, women usually have more role and higher social status. Living among their relatives, women feel more protected from being discriminated by their husbands. This living arrangement allows women themselves to manage the household and play more family role. Men, on the contrary, become the outsiders or strangers with somewhat less influence. However, it does not mean that women in this society have higher economic and political power than men because decision making power actually belongs to men than women (Sontasombat, 1991 : 64 – 67; 1994 : 112 – 113). In particular, formal decision making is expected to be men's responsibility who are family's leaders.

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The case of neolocality was mostly found in urban area such as Bangkok or among the upper class society. It was also found in this type of family that both husband and wife have to work outside due to overall changes in socio-economic condition, and the families need to adjust with such situation. Women have to work outside because the family cannot rely on men's earning alone. Women thus have increasing family role both productive role and reproductive role, i.e. income earner's role and motherhood role (Pongsapich, 1990 : 25 – 26). The neolocaity residence keeps away the relative environment context of both woman's and men's sides, providing them to make decision freely and manage the problems themselves. Moreover, women have a chance to play more role in public sphere especially working outside as economic producers in the family, thus increasing their social status, negotiation and decision making power in the family. However, the society still views woman's income as supplement income to their husbands, making their decision making power subordinate to men.

It is obvious that the pattern of residence after marriage had effected the power status of women in the family. The study of Pongsapich (1990) revealed that changes in family pattern affected changes of role and status of both men and women in the family including management and decision making between husband and wife. Therefore, women who move in to their husband's house had fallen into disadvantage position and had to adjust themselves to the new environment, living under control of husband's relatives, bear a lot of burden, without any attention of the husband's parents to sooth them during troublesome. They also lacked of supportive people and negotiation power in case of having contradiction (Sontasombat, 1997 : 123). The problem of infertility usually effect women than men. Infertile women who lived in their husband's family have much pressure because the husband's family has paid much attention on having children, apart from having less decision making power and negotiation power. Therefore, infertile women need to seek treatment to have children. Having children will support their status and being accepted in the husband's family (Sermsri, 1996 : 50).

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In case men live in their wives' family after marriage, women will have less pressure because they have lived among their own relatives with support and advises. In this case, women can share the decision making with their husbands in various matters including the diagnosis and treatment of infertility. However, most important and formal decision making power still belong to men.

The pattern of residence after marriage has an effect to some extent on the status and decision making power of women in the family depending on the type of living arrangement. In case of infertility, the pattern of residence after marriage has effected on the decision to seek treatment.

2.2.2.3 Power relation in the context of husband and wife sexual relationship

It was known that pregnancy can occur from fertilization of sperm and ovum without contraception. It can be stated that the cause of inability to conceive pregnancy in some couples may due to having sexual relation during the inducive timing to fertilization apart from other causes such as health and physical problems or other related factors.

With respect to the problem of sexual relation between husband and wife, it is usually overlooked on sexual desire and the women's need and timing to have sexual relation. In the Thai culture and society, it is seen that the nature creates men to have sexual desire and want to release it. Men's sexual desire is apart of masculine and is mostly accepted that it is the nature of men to express it when they want it or specify when to have it. On the other hand, women are seen having less sexual desire than men and have to control it. In some couples, women have never shown to their husbands whether they have sexual desire or not, or never start having sex with their husband for it because they thought it is shameful for women.

Sexual activity in women's thought is to response their husband's desire and make their husband happy while they feel the same. Most women believe that sexual

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response is the duty of good wives and good women should never express their sexual desire. Boonmongkok (1999) had carried out a study on beliefs and behavior of sexual relation and male-female relationship in family system in the northern village of Thailand. In her study, with respect to sex negotiation of women when having sexual desire, it was found that most women thought that women also have sexual desire as men, whereas some thought that it is not women's role to start having sex with their husbands. Some women thus never start having sex with their husbands (Boonmongkok, 1999 : 33).

It can be seen that the belief about sex and sexual relation in the Thai society and culture had defined different sexual expression role of men and women that support men to have control of sexual relation over women, and may partly relatively effect infertility condition.

The timing for fertilization and conception is during the ovulation period and the ovum had fertilized with sperm. The hormone in female's body has changed which effect various changes. For example, the endrometrium becomes thicker to prepared for implantation of eggs if fertilization occurred. During this period, the hormone level is higher and women may have increased sexual desire (Limlomwong et al., 1993 : 286 – 287). This is an important period for fertilization. Because women are subordinate to men, when women have sexual desire during the ovulation period, they have to wait if their husband want it too. They cannot starting sexual activity as they want. During this time the ovum with no fertilized will withered and discharge with the uterus linings as menstruation. The healthy ovum suitable for fertilization may live only one and half day (Jivanuntaprawat, 2000 : 42). The next timing for conception is on the next ovulation period of the subsequent month.

In case of infertile women, they might have ovulation disfunctioning. Each ovulation period means so much for conception opportunity. Women is subordinate to men in sexual status while men take advantage in the control of sexual relation over women. This is resulted from the belief, opinion, and socialization that found thinking system of some women in the Thai society, and thus may brought about infertility

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problem. Moreover, it might partly show the social status and sex negotiation power of women in the family.

2.2.3 The context of medical discourse in fertility and the use of language and wording in daily life that repeat women's health problem or deformities

2.2.3.1 The use of language and wording in the relatives system and family

Consideration of gender relation in the family by separation of relatives system might cause misunderstanding. Family is not a free and complete unit within itself but family is a part of relatives system and relatives group is an always important base of social relation network within the community. The members of relatives group usually support, assist, and take care of each other.

In the present Thai society, the family structure composed of nuclear family and extended family. Members of relatives may live nearby or away in case they separate to live on their own, but they always come to visit each other especially on special occasion such as the wedding, funeral, or when family member is sick. These relatives often come and visit to assist and advise each other (Sontasombat, 2000 : 109 – 111). The member of neighboring family will help identifying whether someone is sick, and advise how to take care of them, or to see the doctor. The decision depends on others who are important and have superior power, i.e. family members, relatives, and neighbors. Expectation and power of relatives has an influence on the lifestyle of the couples (Changpok, 1992 : 3 – 4). Similarly, if the couples have infertility problem, their relatives usually give women advises how to have children, for instances, having vitamins or herbs to build health and enhance ability to conceive pregnancy including suggestion of treatment facilities, or even to manage ceremony and pray for pregnancy. Those advises and discourses may encourage women to seek treatment. The study of Changpok (1986) suggested that the opinion of the seniors about contraceptive use and the advises of relatives and neighbors about contraception are associated with the decision to use contraceptive service of the reproductive women (Changpok, 1986 : 22).

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In many cases, these advises from relatives and family had supported the women, however, some words had hurt the women because the infertile women felt that the infertility problem is personal problem related with sex, and it was not suitable to let other know, criticize, and sympathy. These women usually keep this secret and did not want others to know. An infertile woman said that *"I do not want to be sympathized by others" "I am afraid to be asked or to receive advises like How many children you have ?, Why do you have no children ?, You have to release from stress., Why don't you have a second honeymoon? etc. Sometimes I can't find the answer, and some advises I've already done"* It can be seen that these advises had put pressure onto the infertile women, and they easily be sensitive on such condition, position, and words of the surrounding people (Changsawang, 1996: 45).

Boonmongkol (199) found that in the context of family, relatives, neighboring people of the infertile women, these people often talk about the infertile women in negative, blaming their deformity of feminine qualification. One infertile women told that *"The society look at us as sin persons. My neighbors said my husband will have other girl. Some said I am inability"* This has made women feel like a handicapped or deficiency of being wife, separated and unaccepted by the society, family an relatives. Besides, some said that they are not serious to do something to have children such as "Why don't you go and see the doctor? Why don't you ask for the children? When someone asked about it, they felt bad. Some might have caused broken between couples. Some relatives said that their husband might have another girl if they have no children. These women are afraid and worry about it. So these words and discourses have put pressure onto infertile women.

Infertility problem is usually an issue of divorce. Although no divorce, the couples have much pressure from their family and relatives (Inhorn, 1999:9-10). Particularly in the extended family where relatives are very close, they are serious about the reproductive failure and expect that women must have children after marriage. If infertility problem occurred, the women have to accept the blame from the society and their relatives such as mother-in-law, sister-in-law. Among such

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context, women have to bear the blaming burden. Besides, men are encourage to have new wives or extramarital sex (Rungunga, Sanby, and Aggleton, 1999:28-30).

Under the patriarchy socio-cultural structure that defined the major role of women as mother to give birth or heir to continue family line, the relatives surrounding the infertile women usually focus onto the deformities of women than onto men. Infertile women thus have much pressure especially the words that repeat about their inability or their husband will have another wife including the advises, blaming. The infertile women took these seriously in life and always indulge about it and try to seek means to overcome the problem and decide to seek treatment (Changsawang, 1996:46) to reduce such pressure.

The context of wording within the family and relatives is therefore one among power pattern that put women in the subordinate status to men, and probably force women to mange the infertility problem by making decision to seek treatment by all means to have children.

2.2.3.2 Medical discourse about infertility problem

With respect to the power relationship of infertility problem, the use of power is of various form either explicitly or implicitly in words such as the advise of doctor about infertility problem. The power in Foucault's opinion did not mention about the power of oppression or enforcement but the refine power of "knowledge" of certain thing or specialty such as science, biology, medicine, economy etc. The existence of the power in the society is accepted because there is an important mechanism of the power process, i.e. rules, tradition, and practice in the society especially the practice rule of specialists in the form of "discourse" specifically to certain thing.

The meaning of "Discourse" by Foucault is more than a language, words or interpretation, but it is about the power and violence expressed in the form of discourse practices. It may be the expression of inequality power relationship or giving identity and labeling, all that specify rules of status, roles, duty and power of

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certain thing such as developed and developing country. It is the unequal separation of power and duty or categorization of people in the society as children, women, men, patient, handicapped, the infertile, mother, father. In each category, specific role, duty, and status are defined differently (Parker, 1992 cited in Lupton, 1994:8). Therefore discourse is a wise mean of power. The actual practice of discourse that interest Foucault is not the practice of speech acts in daily life but a serious speech acts, i.e. the discourse of specialists of various profession.

The practice of discourse will specify the scope of speech or study of how to speak, what to speak and who speaks to be meaningful, communicable, and acceptable in the society. Moreover, the actual practice of discourse has established the speaker to be powerful, equitable in specific thing. For instance, the doctor has power, equity in saying about illness and health of the patient and be accepted by the people in the society since it is the discourse of traditional practice of specialist who have special knowledge. It can be stated that the knowledge effect powerful. And the discourse can specify rules and regulations that who should speak, what to speak, and when to speak. The same sentence if said by individuals with different social status, different occasions and places, the meaning is thus different too. For example, the doctor says to the patient in the context of examination and treatment that "Your body is abnormal and need treatment" , it's meaning is trusted and accepted than said with the same words by the relatives of the patient. It can be seen that discourse is a form of power domination (Foucault, 1965-1988 cited in Charoensinchai-oran, 1999:1-23; Muttigo, 1999:16-18; Soonthornpesuch, 1997:369-373).

The concept and knowledge base of Foucault on the power built from the discourse and knowledge can explain the decision making to seek treatment of infertile women in the context of medical treatment. That is, medical knowledge effects powerful. Foucault had mentioned about Bio-power that it is the power from examination. Women is the first one who are examined by the doctor to find reproductive disorder (Boonmongkol, 1999:130). The examination of infertility is usually done in women no matter its cause is in males or females such as ovulation test and GIFT etc. (Isaranggura Na Ayuthaya, 1998:20). To be examined by the doctor

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making women become powerless. The inner environment of women needs to be corrected or changed and women themselves usually accept and cooperate with this power domination through suspicious and agreement with their own health or reproductive health. In addition, medical production industry utilized the problem of infertility to produce advance medical technology to solve the infertility problem of women under the support of political and economic factors as well as medical institution. This has brought about new research and development in reproductive technology that conducive to the growth of this aspect, the medical achievement and advance. Hence, explanation, words, and medical treatment of technological and research base have increased the power and influence of medical discourse over women.

Moreover, domination of power over women through medical discourse usually links with different biological condition of men and women especially on reproduction. Such discourse reflects the role of men and women. The discourse that mention about the fertilization of female's eggs and male's sperms that the egg have to wait for sperm that passes through obstructed environment in female's body to meet the egg and fertilize. Sperm belongs to male that takes role in producing life, while female's egg stays still but the environment in female's body had obstructed the sperm to meet with the egg to fertilize (Martin, 1994:29-34). Such discourse reflects the role of men and women and the power of discourse that dominates women. Therefore, several medical discourse about infertility problem usually focuses on women. The doctors usually explain about the abnormality of female's body such as obstructed follopian tube, disfunctioning of the uterus to allow the fertilized egg to grow up, all of which enforce women to be responsible for it. Most importantly is that it is explained about the deformity of inner environment of female's body than the reduced quality of semen or the sperms. The issue of meaning or explanation of both doctors and the women themselves is that although the male's sperm is not strong but it can be developed to the new life within the perfect inner environment (uterus and follopian tube) of female. Besides, the advise for the couples usually focus on women and how to practice , while the advise for men is simply nothing but only teasing them to have the new wife so they can have children. Regarding seeking the treatment, women are

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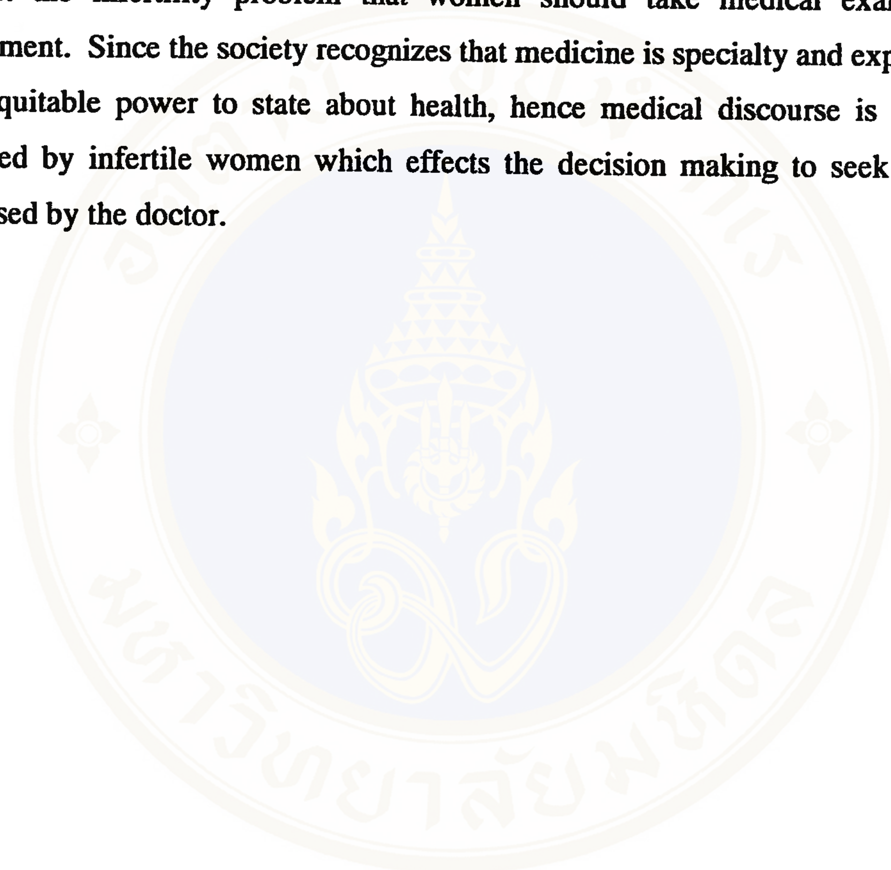
to be blamed if the treatment is failed, and are suspected of their behavior, ability and quality (Boonmongkol, 1999:131).

It is obvious that the power of medical discourse has focused onto women than men Women themselves accepted such medical explanation and discourse that noted about the infertility problem that women should take medical examination and treatment. Since the society recognizes that medicine is specialty and expertise as well as equitable power to state about health, hence medical discourse is accepted and trusted by infertile women which effects the decision making to seek treatment as advised by the doctor.



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2.3 Conceptual Framework

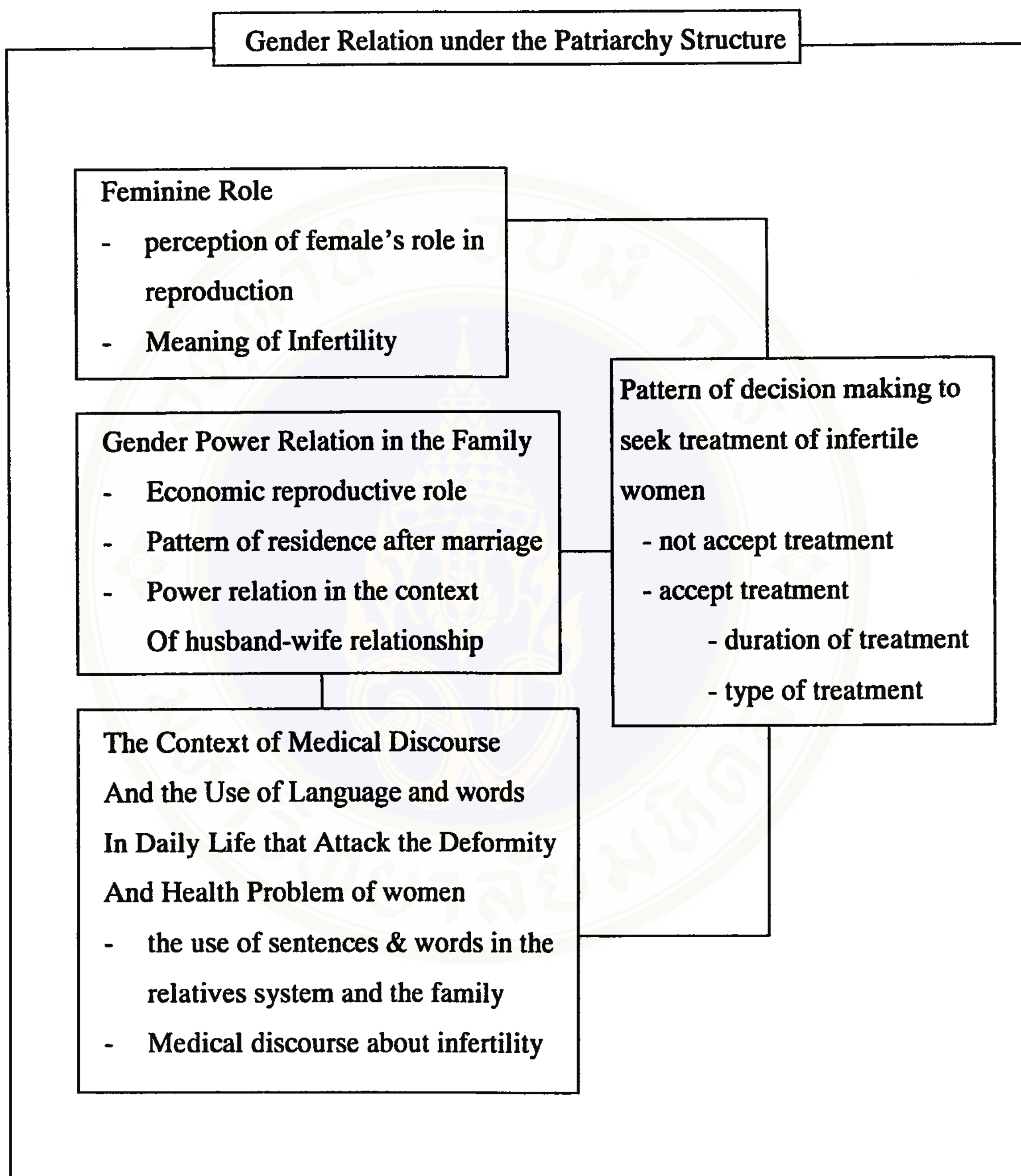

Figure 1 Conceptual Framework

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CHAPTER III

METHODOLOGY

3.1 Research design

This research aimed at examining factors influencing decision making to seek treatment of infertile women under the condition context of gender relation related to the thought to make decision of infertile women which is sensitive and complicated issue. The information derived from in-dept study to obtain information consistent to the issues and cover the objectives. Quantitative research design of retrospective was employed, and the details are presented in the subsequent parts.

3.2 Sample population

The sample population in this study is divided into 2 groups :

Group 1 : 15 infertile women who had no experience of seeking treatment

Group 2 : 15 infertile women currently receiving treatment or had experience of seeking treatment for at least 1 years prior to this study, by either western treatment or traditional treatment or alternative medicine

The researcher specified the group of infertile women who had experience in seeking treatment at least 1 year prior to this research to avoid the problem of recall past memory.

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3.3 Sample selection

The samples are purposively sampling and snowball sampling, starting from asking and introducing from one to another through the researcher's network such as friends, colleagues, and relatives of the researcher, including observation by the researcher.

The purposive sampling was made under the following criteria:

1. The seeking treatment group is the infertile women who currently receiving the treatment or had experience in seeking treatment at least one year prior to this study. The treatment includes traditional healing or alternative medicines, and western treatment using low technology such as giving advise and counseling, administration of hormone to advanced technology such as GIFT, ZIFT etc.
2. The non-seeking treatment group are infertile women who had no experience in seeking treatment aged less than 35 years. If over 35 years of age, the chance of pregnancy is less. The age factor may be the reason of not seeking treatment.
3. The purposive sampling was made under dimension sampling by considering the demographic factors including occupation, education, income, residential area (rural and urban), to obtain variety of samples that most represent and coverage the infertile women.
4. The sample group consent to voluntary cooperate in data collection.

The researcher had asked the samples about the detail of primary information before proceeding the selection under the above criteria.

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3.4 Data Collection Methods

To obtain information consistent and covering the research objectives, data collection in this study was undertaken by 4 methods:

*1. **In-dept interview*** Interview guidelines was used to obtain detail information which includes family context of the samples regarding the decision to seek infertility treatment in the gender relation context of various issues that are sensitive and complicate. The answer cannot be obtained from formal interview but through telling and explaining the feeling and thoughts of the samples.

2. ***Free listing*** This method is to obtain information about way of thinking of the samples related to women's role, gender relation, and the context of spoken words, medical discourse about infertility problem. The data from in-dept interview of each sample was collected.

3. ***Picture code*** This is to obtain information about thinking, feeling of the samples towards infertility problem by presenting pictures of the situation that women confronted about infertility.

4. ***PRA – Participatory Rapid Appraisal*** Information about the priority of women's role according to the sample's perception was collected.

3.5 Quality of Research Instrument

The researcher had constructed the interview form by studying the textbook and related research in order to obtain the interview guide of content validity. The interview form was tested with the infertile women of similar characteristic of both sample groups, 3 cases each. Then the interview form was reviewed to yield content validity, understandable language and wording which is consistent to the research objectives. After that the researcher had consulted about the instructed interview form with the supervisor who are thesis control committee. Then the interview form was corrected and improved, and used for data collection.

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Regarding reliability of the interview, the researcher had examined the information for reliability by triangulation method, i.e. using freelisting to obtain primary information to be used for in-dept interview of each sample, and to be used for in-dept asking to specific important issue. During the interview, the researcher had made a certain level of acquaintance and trust with the interviewees. During the in-dept interview, the researcher had observed the reaction and position of the samples during their answering the questions, i.e. their body language such as delightful, sorry, anxiety etc. The researcher also repeated the question in the issue that receiving unclear information. Besides, the researcher had utilized the picture code and PRA in collecting the data, so as to help recheck the information.

Each topic of data collection by free listing, the researcher had consulted with the supervisor who are the thesis control committee before collecting data.

In selection of picture for picture code method, it was considered and improved by the thesis control committee. The pictures presenting the issue of situation confronted by infertile women is presented , only in single issue in 4A paper type with no detail and color. The researcher had tried out the picture with 3 women of similar characteristic of the samples before using for the actual data collection.

The PRA was tested with 3 women of similar characteristic with the sample, describing the detail of women's role prioritized from the most to the least important according to their own thought. The 4 prioritized roles of women are having children, taking care of the husband, earning for the family, and doing the housework. The researcher then using these information to construct the tool for data collection.

3.6 Data collection

This research employed an in-dept interview. The interview was made strictly to the issues in the interview guideline together with the free listing, Picture code, and PRA methods, as well as observation of behavior and emotion. The interview and

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observation were recorded in writing, and tape recording by consent. The interviewees were explained and clarified about the objective of the research, and were asked for their consent to be voluntary samples and to be interviewed. The interviewer guaranteed to keep confidential of the interview and information obtained which has to be taken into account during the interview as the research ethic :

- the rights of the samples to answer or not answer the questions or consent to be studied at what extent, and the right to stop the interview as desire. The researcher need to give respect to the humanitarian rights
- Keeping confidential of the samples without showing their real name and address

3.6.1 Data collection steps

1. Selection of samples using snowball technique, starting from asking and introducing from one to another through the researcher's networks such as friends, colleagues, relatives, and observation of the researcher, and by purposive sampling as stated in the criteria.

2. Making good acquaintance and relationship with the samples in order to access information. Since the sample was made by snowball technique through the relative network of the researcher, it is thus easy to make acquaintance at a certain level. In some group of the samples, of which the convenient commuting is allowed, the researcher will pay occasional visit and ask for interview, making relationship prior to the actual interview.

3. The researcher started to collect the data by freelisting, after that the information were used as guidelines for asking interested issues in the subsequent in-dept interview.

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4. The in-dept interview was made strictly to the constructed interview form combined with guidelines of interesting issues derived from the freelisting. Interested and important information were recorded, so as to facilitate the examination of data accuracy and validity. The record was made according to the thinking and feeling of the sample respondents.

5. The information from picture code was collected during the interviewees were telling, discussing, answering the questions. The picture code is tape recorded continuously following the in-dept interview.

6. The PRA was collected by asking the sample to choose the role of women in prioritized order from most to least important according to the sample's thought and perception of the samples. The researcher has prepared the word cards for choosing, them recording in writing the information obtained.

7. Fieldwork note After finishing the daily field work, the researcher completely transformed the tape record word by word of the whole interview in written note to obtain accurate information. The information from free listing, picture code, and the PRA were also recorded, then compiled the whole information classifying in sections for convenient search, analysis. The information were checked for its validity continuously each day.

8. Additional interview was made in case the interviewee had given unclear information. The researcher had to follow the case on the next day to make additional interview depending on the availability of the respondents and the interviewer. Additional interview not only clarify the information but also to rechecked the validity of information of the last interview in combination with other methods.

The study duration took 5 months altogether.

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3.7 Data analysis

Information obtained from free listing, picture code, PRA and in-dept interview in each day were classified and categorized in files for further overall analysis and to examine the relationship and linkage of information according to the concepts employed. Information from in-dept interview of each case was checked for its accuracy and consistent to the reason of each issue so as to obtain conclusion base on the information received. Content analysis and Narrative analysis were applied to analyze the feminine role, gender power relation, and the context of spoken language and words used in daily life that attack the deformity of women's health, as well as the medical discourse context about infertility. The researcher had analyzed the data all through the research duration to obtain most complete and reliable information

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CHAPTER IV

RESULT

This research aimed at examining the pattern of decision making to seek infertility treatment under the condition and context of gender relation. This is a qualitative research design carried out by collecting data from an in-dept interview in combination with free listing, picture code, and participatory rapid appraisal. The data was processed and the result was presented as follows:

4.1 Socio-demographic characteristics

4.2 Infertile women seeking treatment

4.2.1 The context of gender relation effecting decision making to seek infertility treatment

4.2.2 Seeking infertility treatment

4.2.3 Evaluation of seeking infertility treatment

4.2.4 Feminine role

4.2.5 Gender power relationship

4.2.6 The context of daily spoken words attacking the deformity of women's health and medical discourse context

4.3 Infertile women not seeking treatment

4.3.1 The context of gender relation effecting decision making to seek infertile treatment

4.3.2 Feminine role

4.3.3 Gender power relation

4.3.4 The context of spoken words in daily life attack the deformity of women's health and medical discourse context

4.4 Conclusion

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4.1 Socio-demographic characteristics

This research presented background information on socio-demographic characteristics of infertile women seeking infertility treatment, and not seeking infertility treatment. Background information of their husband was also partly presented which was derived from interviewing the infertile women. This is to present the picture of the context of family relation of infertile women. This study has selected the samples with different demographic characteristic in terms of education, occupation, income and current residential area in both rural and urban in order to obtain the most representing samples of infertile women.

Table 4.1 Socio-demographic characteristic of infertile women

Demographic characteristic of the samples	Seeking treatment group (Number)	Non-seeking treatment group (Number)
Age		
25-29 years	3	2
30-34 years	8	11
35-39 years	4	2
40-44 years	-	-
> 45 years	-	-
Total	15	15
Education		
< grade 4	1	-
Grade 4 – Grade 6	4	5
Junior secondary school	1	2
Senior secondary school or equivalence	1	1
Diploma	1	3
Bachelor degree	7	3
>Bachelor degree	-	1
Total	15	15
Occupation		
Labor/employee	3	4
personal business	2	2
housewife	5	4
government service/business employee	5	5
Total	15	15

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Table 4.1 Socio-demographic characteristic of infertile women (continued)

Demographic characteristic of the samples	Seeking treatment group (Number)	Non-seeking treatment group (Number)
Income		
< 3,000 Baht	5	4
3,000 – 5,000 Baht	4	4
5,000 – 10,000 Baht	3	3
10,000 – 15,000 Baht	1	3
> 15,000 Baht	2	1
Total	15	15
Residential area		
urban	7	8
rural/peripheral	8	7
total	15	15
Marriage duration or living with husbands		
3 – 5 years	5	3
6 – 8 years	8	9
8 – 10 years	2	3
total	15	15
Contraceptive use after marriage		
No	4	7
Yes		
- oral pills	7	6
- injection	2	-
- condoms	1	-
- rhythm/withdrawal	1	2
total	15	15

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Table 4.2 Causes of Infertility

Demographic characteristic of the samples	Seeking treatment group (Number)	Non-seeking treatment group (Number)
Causes of infertility		
Wife's causes		
- malformation of uterus	3	-
- fybrotic covering and follicular cysts	5	1
- Ovulation disorder	3	-
- frequent abortion with unknown cause	1	-
- poor health	1	-
- had induce abortion history	-	2
husband's causes		
- sterilize	2	2
other (not check for the causes)	-	10
Total	15	15

To show the family context of infertile women, the background information of husband derived from interviewing infertile women was also presented here.

Table 4.3 Socio-demographic characteristic of infertile women's husbands

Demographic characteristic of the samples	Seeking treatment group (husband)	Non-seeking treatment group (husband)
Age		
25-29 years	1	1
30-34 years	5	5
35-39 years	7	6
40-44 years	1	3
> 45 years	1	-
Total	15	15
Education		
< grade 4	1	-
Grade 4 – Grade 6	3	4
Junior secondary school	-	1
Senior secondary school	1	2
Diploma	-	4
Bachelor degree	10	4
Total	15	15

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Table 4.3 Socio-demographic characteristic of infertile women's husbands (continued)

Demographic characteristic of the samples	Seeking treatment group (husband)	Non-seeking treatment group (husband)
Occupation		
Labor/employee	3	4
Personal business	3	3
housewife	-	-
government service/business employee	9	11
total;	15	15
Income		
3,000- 5,000 Baht	2	3
5,000- 10,000 Baht	3	2
10,000 – 15,000 Baht	4	4
> 15,000 Baht	6	6
Total	15	15

The result revealed that age of infertile women and their husbands were varied and different among those seeking ad non-seeking treatment. Among the seeking treatment group, their husbands had average age of 35 years, ranged from 29 to 50 years, while their wife aged 32 years on average, ranged from 25 to 38 years. On average, the husbands is 4 years older than their wives. Only 1 couple that the husband is 15 years older than his wife, followed by the same age, and 1 couple that the wife is 1 year older than her husband. For the non-seeking treatment group, the average age of husbands and wives are 35 years and 32 years respectively. The age was ranged between 27 – 43 years for husbands, and 29 – 35 years for wives. Most of the husbands are older than their wives but not much different, followed by equal age, and the wives are 2 – 4 years older than their husbands.

Educational level of the infertile women and their husbands in both seeking and non-seeking treatment groups were not different. That is the majority had compulsory education at grade 4 or grade 6, and higher (junior and senior secondary schools), and mostly had bachelor degree of education. Among those seeking treatment, only one couples, both husband and wife, was found uneducated for they

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were Vietnamese migrants living in Nongkai province, but having very little literate through self study. Whereas, among those non-seeking treatment, one wife had highest level of education (a Master Degree). In comparison of education between husbands and wives in both groups, it was found that the majority of husbands and wives in the seeking treatment group (10 cases) and non seeking treatment group (7 cases) had same level of education. There are 4 cases of each group that the husbands have higher level of education than their wives. There were 1 wife and 4 wives in the seeking treatment and non-seeking treatment groups had higher education than their husbands.

Occupation is likely to have close relation with income. Occupation engagement of both groups is not different. The majority of wives engaged in government service such as teachers, working for the Department of Land, and being dental officer, secure professions with permanent salary of about 10,000 – 15,000 Baht per month. Some worked for private business earning more than 15,000 Baht per month. In both groups, 5 cases of each had worked for the government, followed by being housewives (5 cases in the first group and 4 cases in the latter group). Only 2 cases in each group owned business such as selling food, second-hand stuffs and miscellaneous. There are 3 and 4 cases in both groups respectively were hired labors and employees. The labor work like agricultural work was found among infertile women in rural area whose having low income which depends on their production, and the size of land area. Those who have very small hired agricultural land are mostly in debt. However, when harvest season was over they earned as hired labors or selling veggies or fish stuffs at the market with average income of 3,000 – 5,000 Baht per month. For those labor work in the hospital, restaurants, or cleaning service, some had extra income from washing cloths with permanent monthly salary about 5,000 – 10,000 Baht.

Their occupation of their husbands in both groups is not different. The majority is government officers level 6 – 7 (9 cases), private company's officers (11 cases). They rather had high income of more than 15,000 Baht a month, followed by the labor work and employees (3 cases, and 4 cases in both groups). For those in

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agricultural work with shared labors between husbands and wives, the average monthly income is about 3,000 – 5,000 Baht . Those who own business (3 cases in each group) such as hired motorcycle, fruits stall/vender, their income is about 5,000 – 10,000 Baht per month.

Comparison of income between husband and wife, it was found among those seeking treatment that about 10 out of 15 cases engaged in various occupations and earned about the same income as their husbands. Seven cases are shared earning. Two husbands have earned more than their wives, but only one wife have earned more than her husband. Out of 15 cases, 5 cases are housewives the are dependant on their husbands. Two cases came from the well-off family with better financial status than their husbands. Among the non-seeking treatment group, 11 out of 15 cases had occupation, 5 cases earned equal income as their husbands, 4 cases earned higher than their husbands and become major source of income in the family. There were 2 cases of husbands earned higher income than their wives. And 4 out of 15 cases are the housewives with no income.

Among the infertile samples resided in the urban area, there are 7 cases seeking treatment, and 8 cases non-seeking treatment, all of them lived in Bangkok. In this group, some have provincial domicile and the majority were from the north-eastern part to seek better job in Bangkok. However, it was found that they have moved to Bangkok about 3 – 5 years before getting married. For those rural residents, there were 8 cases seeking treatment and 7 cases non-seeking treatment, mostly lived in the peripheral area of provincial city of Udornthani, Nongkai, Sakonnakorn, (the domicile area of the researcher), and Nakokpatom. Those rural residents mostly live in their own domicile or nearby provinces of their husbands or wives.

Regarding the duration of marriage or living with the husbands, there is no difference between both groups. There are 8 cases in the first group having been married for 6 – 8 years, followed by 3 – years (5 cases), and 8 – 12 years (2 cases). Among the latter group, the majority has been married for 6 – 8 years (9 cases), 3 – 5 years (3 cases), and 8 – 10 years (3 cases). The relationship between husband and

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wife is mostly smooth because they were married for a period of time and living together with understanding. They said "It's OK" "It's common like tongue and teeth but not that serious" "It's OK but not sweet as just married"

With respect to contraceptive use among couples in both groups, it was found no difference. Most of them use contraception after marriage or living together, 11 couples in the first group and 8 couples in the second group. The methods were mostly used by women. The most popular one is oral pills, followed by inject able. The reason for using contraception among women themselves is because it is female's responsibility and men did not pay attention or know about it. Other popular methods are natural methods such as withdrawal and rhythm for which both husband and wife had shared decision. The least use is male's method. Among infertile women ever used contraceptive method, only 1 cases in the seeking treatment group have her husband using condom because she can negotiate with her husband and she needs not to take pills. It can be seen that contraceptive use among couples was practiced by women since they perceived it as their responsibility not their husband. Among those never used contraception after marriage, the first group said that they were allergic to the pills, have nausea after taking 2 –3 pills, so they gave up. Others said they do not need contraception because they prepared to raising a child. However, among those of both group who had contraception after marriage, they gave up contraception because they want children.

Regarding causes of infertility, it was found among those seeking treatment that as high as 13 cases identified female's cause, and it is the reason for seeking treatment. For those not seeking treatment, only 3 cases identified female's cause, and they thought it was the sin because they had induce abortion, and decided not to seek treatment. There were 2 infertile husbands in each group. The rest of those not seeking treatment did not pay attention on physical checkup to find what is wrong or causes infertility.

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4.2 Infertile women seeking treatment

4.2.1 The context of gender relation effecting decision making to seek treatment

The result suggested that in the context of gender relation of various aspects, those infertile women seeking treatment had perceived reproductive role as a natural role and duty of female to give birth because female has an organ to give birth. Therefore, infertile women seeking treatment had perceived their role and burden to bear a child without any excuse. They stop contraception after being married for some time or never practiced any contraception. The infertile women seeking treatment thus expected themselves to have children to show their feminine role and the duty of being good wife who have to give birth and please their husband, especially in case they know their husband want to have children. Moreover, infertile women seeking treatment had perceived themselves the role to build up warm and perfect family by giving birth to children as a bond between husband and wife. Some have to give birth to continue family lines and husband's properties.

In addition, infertile women who seek treatment usually suspect themselves having deformality in their body, that might cause infertility than in their husbands. Their surrounding people usually blame about their inability to have children, or the delay of having children. This partly forced them to see the doctor to find out what is wrong in their body. It was mostly found that infertile women who seek treatment has meant themselves infertile, failure, disfunctioning of women's role and wife's role, and differ from other who can have children. They felt so sorry, and unhappy about inability to have children. In case their husband are infertile, they meant themselves functioning but different from other women. It was also found that infertile women seeking treatment wanted to perfectly pursue their duty and role as other women, especially when they were expected from their family and relatives to have children after marriage. The husband's family usually pay attention to women to have children for continuing family lines and properties. If women did not have children, they are to be blamed or forced to have children by seeking treatment. For

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those living with their husband's family or living separately, they have been put much pressure by the expectation of their husband's family. Moreover, those surrounding them always talk about their inability to have children than talking about their husbands. Besides, their husbands were teased to have another wife so they can have children, making infertile women become more stress for their disability since these word had attacked their feeling and failure to have children. The findings of this study suggested that infertile women who seek treatment were more suffering, anxiety, under depressant, and stress from the infertility problem, so they tried to escape from such situation by seeking treatment.

4.2.2 Seeking infertility treatment

According to the result, most infertile women seeking treatment are the main decision makers in seeking treatment for either source and type of service or place of service, because they perceived and meant themselves their role and responsibility to have children. Mostly their husbands would support and follow their decision making. They start seeking treatment from seeking information about the treatment from various media such as T.V programmed, newspaper, leaflets advertising about service efficacy by advanced technology. Since most of the infertile women have separated family, their relatives have thus less influence, but on the contrary, their surrounding people like friends, neighbors, and the infertile networks would have more influence on their decision to seek treatment. The advises of these people had attacked their feeling and disfunctioning. After receive advises, they seem not to satisfy with the advises, particularly the advises from the experienced infertile networks.

The infertile women believed and accept the modern medicine for it is the best ever to treat infertility. Every of them start seeing doctors for physical check up, and mostly they were investigated having body's organ disfunctioning the caused infertility. They were advised to make correction of disfunctioned organ. Every of them decided to choose modern medicine since they believe it can help them having the children. Some have furthered the treatment with the doctor, while some seek to

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consult with information on service sources. Regarding the decision making about types and sources of treatment, it was found that social networks and relatives had high influences in convincing them to receive treatment, considering treatment skill and expertise. They evaluate the expertise and success of the doctor before deciding to choose treatment. In case receiving treatment for some time, the infertile women will evaluate the efficacy of treatment. If the result is not satisfied, or no explanation from the doctor about the failure, or they found it inconvenient, they would shift to other service facilities. Some received modern treatment in combination with traditional or alternative medicines, just for a trial and psychological reason. Prolong treatment cases were found because of the past failure that make them feel unhappy. The social network's roles in providing advises and counseling in combination with information about new technology have encouraged these infertile women to start seeking treatment again.

Types of infertility treatment

The result showed that most of the infertile women seeking treatment emphasizes and relied solely on modern medicine system or western treatment because they feel confident, accepting, and trust the modern medicine that it can help them to achieve the desire of having children. Only 4 out of 15 infertile women seek integrated treatment of modern medicine in combination with traditional and alternative medicines, just for psychological support or trial. Traditional healing of infertility found include praying, having boiling herbs or blessing water etc. The treatment was performed integratedly of places and types, continuously or uncontinuously, however the modern medicine is the main type. Here are examples:

> *"I have boiling herbs, my sister told me that it is good for menstruation, if the mens is normal, it's easy to have children. I have taken the herbs but not yet having the children. Actually I don't believe it so I quit the herbs, just try it. I believe in modern medicine, the doctor is reliable, he is an expert. But I pray too, every places I can, just for a flook, better than do nothing, many alternatives should be better" (Pueng)*

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"My mother took me to see the nun at the temple in Korat. They perform the ceremony and make blessing water. They said it's good, then I drink up 2 bottles of blessing water. I have no children yet. Actually I don't trust it, just try, no loss" (Nok)

"Some ever advised me to take Chinese boiled herbs but I don't believe it'll work. I used to pray Phra Bhromme. It has mental effect, so I tried asking him, but I don't hope for it' (Nuch)

"My neighbors advised me pray asking to the land spirit. I did it for 2 – 3 places where they said good. I have treatment with the doctor but not work yet, so I tried the spirit. I believe it will work because others were successful" (Koi)

Most infertile women who seek treatment believe in modern medicine system or western medicine than the traditional one. This group received only modern medicinal treatment but they usually receive advise about traditional treatment from the surrounding people. However, they did not believe about the traditional medicine, so they do not pay attention on it

"I think boiling herbs and praying cannot work, no confirm. I thought this is the best way (modern medicine). It depends on the doctor whether successful or not. We tried this hard but not successful yet, so forget others, I don't believe praying will work, it's the elder's beliefs." (Eew)

"Never believe and never ask the monk or God, only advises. We already know that children come from egg and sperm. I never ask for it, I pray with faith not for children, but never disparage it" (Pai)

I believe in modern medicine, I think it would help us having children, I have studied that it works" (Sai)

Duration of treatment

The infertile women took at least one year receiving modern treatment from each service facility because there are many details in each step of treatment with

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frequent appointment dates or special examination such as Ultrasound. So it rather take much time for the infertile women to evaluate each step of treatment. The traditional treatment have no complicated steps, no fixed time, usually finish in one time depending on the infertile women. However, they usually change to other place without evaluating the result. They pray here and there and other places without waiting for the result of the first pray. However, the duration at each place varies, no fixed time. The duration of treatment depended on the evaluation of the result at each place. The details will be presented in the subsequent section.

4.2.3 Evaluation of the seeking the treatment

Evaluation of the result All of the infertile women evaluate the treatment mainly from the success of the treatment of the doctor. Mostly they consider from the duration of treatment, 1 – 2 years on average by each place, in combination with the method and step, number of failure, and explanation of the doctor. When the samples made evaluation from the result and the duration of treatment at a certain time, and found no progress or failure of 1 – 2 times on average, they decline to trust that source of treatment and the doctor, similarly if they did not have reasonable explanation from the doctor. Such evaluation effects the decision making to seek the new source of treatment.

> *"I know the doctor cannot do any better, they just do the same routine measuring temperature, and observing ovulation for 2 years" (Pai)*

> *"I have treatment with him for a long time, last time he said just taking out the fibrolic covering then you can have the baby, but it failed, so I change the doctor" (Poo)*

> *"He told me to have hormone shots for 6 month, still not having the baby. Then taking hormone to discharge the fibrolic covering for 9 month, nothing happen. He want to try the GIFT, but I quit, not impressive" (Maew)*

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Evaluation of the distance It is obvious that the infertile women took much time and trouble to reach the hospital. In addition, it has too many steps to meet the doctor. The doctor usually make frequent and continuous appointment, so they found it inconvenient and took much time to see the doctor.

> *"I had been there twice but no chance to receive check up, just to make appointment, so many steps. I have to take one day off and wasted too much time traveling to the hospital. Spending half a day just to make an appointment, so I quit" (Pai) the 1st source of treatment*

> *"Very complicated, I understand it took steps but I live upcountry and took much time to reach the hospital. Sometime the doctor asked to come back tomorrow, he do not care whether you work or not, so I quit" (Pai) the 2nd source of treatment*

> *"I thought the large hospital have the same instrument, we better choose the one nearby, it's convenient to commuting because we have to work. If we go there we wasted all day" (Poo)*

Evaluation the cost of treatment High cost of treatment has no effect on those with high income. But among the moderate and low level of income, they are able to pay for a certain level. The advance technological treatment is very costly and no guarantee of success. The treatment cost is the obstacle among the samples, effecting their effort to seek treatment from other place with less cost. However they said that if they can afford it they are pleased to pay for it no matter of the cost if they can help them having children

> *"I am not sorry for the cost but sorry for not coming. It's costly but worthy for the baby" (Maew)*

> *"We'll pay for it if they are good in examination and explain why, we are pleased to pay" (Eew)*

> *"I have paid for many ten thousands Baht, if it works, I'll pay" (Koi)*

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"The doctor asks if I had problem, it cost a hundred thousands each visit, and the doctor cannot guarantee if it works for only 1 time, so I give up (GIFT), better keep the money" (Pueng)

"The doctor told me to have GIFT, they ask if I was ready. If it fails we lost and pay again, many ten thousands, no guarantee, so I give up" (Pai)

After evaluation is made for each place, it was found that the infertile women have delay behavior for treatment to rest their mind. Since each failure make them feel sorry and stress, not ready for the next try. Some start to seek information of the new source immediately. The social networks play advisory role about the source of treatment, and thus stimulating the infertile women to seek the new treatment

In this research, the researcher studied the context of gender relation effecting decision making to seek infertility treatment

4.2.4 Feminine role

4.2.4.1 Perception of women's reproductive role

It was found that every infertile woman perceived their role of reproduction and the duty to give birth as natural role. They also perceived being good wife by giving baby to their husband, pleasing the husband, and build up warm an perfect family. This help create good relationship between husband and wife and to avoid family broken due to extramarital sex. There are 4 out of 15 cases perceived their role in producing heir to continue family lines and properties of their husband's family .

According to the result, every infertile women perceived their natural role of giving birth since they perceived the biological difference between men and women. Female is the gender with ability to conceive pregnancy and give birth that links to the natural role of female without any excuse. Women who are married and infertile women perceived and expect that they generally should have children.

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"I think having children is women's matter. Every women is pregnant, it's a common thing" (Jom)

"Being born a women without children, better born being a man. After marriage it's women who have to become pregnant, it's our duty to have children" (Pu)

"Human must have children, after married, women must have children" (Poo)

In this study, it was found 2 infertility couples caused by men from being sterilized. Although infertile women knew that it caused from their husbands, but they still perceive and expect their own role to have children and still want to have children.

"Woman who were married must be pregnant and have children. They actually should have children, I'd like to have too" (Eew - sterilized husband)

Every infertile women perceived their natural role of giving birth that links with reproductive role in he family, that is the role in building warm and perfect family including father, mother, and children. Having children is a part of building perfect family, pleasing husbands, and bonding family relationship especially relationship between husband and wife. In addition, every infertile women seeking treatment perceived that it is their duty and role to be good wife by having children especially if they know their husbands want to have children. The study showed that the majority of these infertile women never heard their husband said they want children, and never blame about it, or mention about infertility in negative way. Most of them interpreted from the behavior and position of their husbands when they expressed love and care by hugging or holding children that they may like to have children. They thus have the duty to satisfy their husband. In this study one of the infertile women with sterilized husband perceived that it is wife's duty to please and satisfy the husband by having children and allow sterilized husband to have new wife

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just to have children. This has shown that women have to be responsible for the problem of infertility in all cases, even their husbands are sterilized.

> *"Married women should have children. Having father, mother, and children. We are women, it's us who make warm family" (Toi)*

> *"Married women have family. Family means father, mother, and children. No children make on perfect family. We are women we must have children for them (husbands), and men should take care of us" (Jom)*

> *"I've seen him playing with the child of that house, I rather had a child for him, I am his wife, I want to have children and make him happy" (Pai)*

> *"My husband never show he want children, he said why hurt yourself by treatment, never mind if we don't have one. But I saw him loving and holding children, I feel pity, I know he wants one, I 'd like to make him happy" (Pueng)*

> *"Honestly, I like to have children cause my husband love children. He like to hold children. I feel it's my duty to have children for him, he must be glad, our family must be happy with every body. But he said never mind, why not stop seeing doctors" (Pu)*

> *"My husband love children. When we went the Department store. He saw baby's cloths and liked to touch it cause he had no children. I am his wife, I want to have one for him, but he can't. I told him to find someone else, perhaps he might have one" (Koi – sterilized husband)*

Moreover, the infertile women had perceived the role of good wife to have children for their husband. This is to place importance and meaning to giving birth which effect relationship between husband and wife. Most of them perceived the negative impact of inability to have children that might upset their husbands, and

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cannot keep their husband to stay taking care of them and the family because of having no children. The infertile women thought that having children create the bond between husband and wife. Inability to be good wife may lead to broken family and extramarital sex. They might claim that because their wives are defective to wife's duty in giving birth. In case the husband want children, the situation might cause anxiety and stress among infertile women.

> *"Having children is very important because children make perfect family and bond between me and my husband. If I don't have children, he might find someone else and claim that because I can't have children for him, he wants children" (Jom)*

> *"I'm afraid my husband have someone else. He wants children because children create bond between husband and wife. Some cannot have children, then her husband has someone else. I'm afraid so, it's possible, because I am his wife but cannot have children for him" (Nuch)*

> *"If having no children, when we make quarrel we might make decision for ourselves without thinking about our children. We might be easily broken up. Only 2 people living together for 2 – 3 years, it's boring. He starts boring being home. Having children make us closer and share activities, hardly have family problems" (Amphorn)*

Moreover, the infertile women also perceived their reproductive role in terms of continuing human race, that is, perceived female's role in giving birth to continue family lines and properties of husband's family. There are 4 out of 15 cases perceived their role in producing heirs to continue family lines, and only 1 case want heir only for furthering properties of them and their husbands. There are 3 cases that their husband's family are wealthy. Every infertile women came from families with much less economic status than their husbands' families. This study revealed that among the infertile women whose husbands' family are wealthy, they were paid attention and put pressure as daughter-in-law who produce heir than for their husband and their own property. Besides, the level of perception on the role of giving birth to heir depends

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on the status of their husbands or the ordering of husband as children of the family. For example, if being the eldest son or the youngest one, or the only son, or being the first son who married, then the daughter-in-law is of importance in giving birth to the heir, and be paid special attention as well as be expected to have children, especially from the husband's mother who always force their daughter-in-law to have children, or being upset. This has put much pressure onto the infertile women to become stress from bearing the burden and expectation in giving birth , so they try to seek infertility treatment.

> *"My husband's parents want children to further their properties because they did not have one. They had 3 children ,and my husband is the only one who married, the youngest is daughter, the oldest is heterosexual, so they want children to further their properties and continue their family lines. I want to please them, so they stop forcing me, sometimes I feel uncomfortable, annoy able, I think I'll do my best to have children for them" (Sai)*

> *"I'm afraid my husband's parent are upset because my husband is their only son, and I have no children yet, they have no one to continue family lines, it's very important for them, they have much properties and business, but they never blame me, just keep calm like freezing on me, it makes me feel bad if they are angry with me, I am uncomfortable, It'll be better if I have children" (nun)*

> *"My husband is the oldest son, they have no grandchildren, they blame me a lot for I have no children for them, it's serious, I am so depress, my husband's mother told me that if I have no children to continue family lines, she won't accept me" (Nuch)*

In case the couple want to have children to further their properties, it was found that they become wealthy by their own, not by their parents, so they just want children to continue their properties, they thus have no pressure.

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"I want children, I have much properties but no one to further it, it's pity to give it to someone else, I want to give it to our children, houses and money, it's better to give to our children" (Eew)

Regarding receiving infertility treatment, about half of infertile women thought that both husband and wife need to see the doctor together to receive examination because having children concerning both husband and wife, so both need to be check up. Another half thought that they should go check up together but the one who is the cause of infertility should take main responsible to receive treatment. However, the infertile women usually perceive the abnormality and have suspect in themselves than the husband, so they are eager to seek treatment.

"We both have to see the doctor, the doctor said we both must have a check up, not only each, but my period is not normal, I'm afraid it is me" (Pueng)

"We both have to go first, if we know who is infertile, then receiving treatment, I have to be responsible because it's me, not my husband" (Nuch)

4.2.4.2 Meaning of infertility

Infertile women is likely to pay attention on perception bout changes or abnormality in themselves than their husbands such as stop using contraceptive, or stop for sometime but never get pregnant, because they perceived that married women should normally have children. They also perceive the abnormality of their body such as irregular menstruation or other physical health problem, including those sharing the meaning including the social networks, colleagues, and relatives so as to caution the abnormality of infertility of women. So the infertile women start noticing and suspecting themselves about infertility, so they confirm such abnormality by seeing doctor for physical examination and to investigate the cause of infertility. The diagnosis shows it's women 's problem for 13 out of 15 cases, of which 11 case had

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malformation of reproductive organs, the other 2 cases had personal disease and frequent abortion with unknown cause. There were 2 out of 15 cases of men's problems which is sterilized. The infertile women were meant from the medical explanation according to the cause of infertility, and link it to the role of giving birth. So infertile women has meant the infertility as abnormality, incomplete, disfunctioning, and abnormal from general women. They usually feel sorry, unhappy, inferior, etc. In case having sterilized husbands, infertile women has meant themselves that they are not disfunctioning or have abnormality because they can conceive pregnancy but their husbands are disfunctioning , so they do not feel depress or anxiety.

Every infertile women has meant about the perception of physical changes and abnormality, for example, stop taking contraception but not become pregnant, the average duration that infertile women felt of abnormality is 2 – 4 years, irregular menstruation, poor health, and other causes, for example,

> *"I thought it was my body, I am weak, having anemia, having less mens, sometime having only one day" (Poo)*

> *"I now I am not OK, I have irregular mens, it's the problem I cannot have children" (Amporn)*

> *"I let it for 4 years, others may already have children, I have regular sexual activities but not pregnant like others" (Pu)*

> *"Let it for 2 years, I doubted why I am not pregnant because we are together every day, I am afraid I am disfunctioning, why I don't have children" (Pueng)*

> *"It's not my husband's problem, he is polite and calm, it's must be me, I always lose temper, being stress, sometimes I have a headache for 3 – 4 days, I thought it was stress that I can't have children" (Toi)*

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Among these infertile women, one case ever become pregnant but experience frequent abortion for 5 – 6 times. She meant herself disfuntioning because her husband can make her become pregnant, so it's not her husband's problem but it is herself.

> *"I thought it is me because I become pregnant abut turn aborted many times, I fell abnormal, the uterus is malformation, he is OK, I am the one who is pregnant but aborted" (Nuch)*

The social networks of infertile women also co-meant or express their opinion about the abnormality of having children. Being cautioned by friends, colleagues, and relatives, the infertile women usually agree with them when hearing often about it because it attack their feeling and doubt about their abnormality.

> *"My friend said why having no children yet, it's too hard. I thought it is real, I heard very often and unsure what happen to me or having abnormality" (Pueng)*

> *"They caution I was married for long why have no children, am I sterilized, I start thinking it's true, or I have something wrong" (Maew)*

The infertile women who seek treatment, together with the social networks, has meant themselves about perception on changes and abnormality of themselves, they thus become suspicious that it might cause infertility. They confirmed themselves by seeing the doctor for physical check up and investigated for any abnormality and causes of infertility. It was found that every infertile women believe and meant the diagnosis and explanation of the doctor. The doctor is likely to explain about the abnormality of inner body organ. They also link the causes of infertility from the medical concept and the perception of the role to give birth. It was found that most of the infertile women who were examined by the doctor that they have physical abnormality that cause infertility, had meant fertility that it is the imperfect, and malformation of the body, making women failed to practice women's duty as good

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wife, and disfunctioning in family life, differentiate from other women. They thus feel inferior, sorry, unhappy, and stress, etc.

> *"As other, it's my weak point, I am a wife who failed to my duty. I have cyst, it's my inferior, I know I am not OK" (Amporn)*

> *"Married with no children is an unusually feeling. I should have children like others. Married women should have children. No children is unnatural" (Pai)*

> *"I thought if having no children my family would fail. I though a lot I am disfunctioning, I have to be responsible. Am I wrong? I really have no children, I'm sorry for myself, I suffer a lot" (Pueng)*

> *"I feel sorry for myself why I have no children like others. I feel so sorry, I am different from others, like I am disfunctioning, it's a heartbreak" (Poo)*

> *"I don't want to talk about it, its an inferior, It's me having abnormality. I want to have family"*
> *"I'm sorry, I like to have children like others. Sometimes I feel so sorry why I don't have children for him (my husband), because I am not OK, so stress" (Maew)*

For those (2 cases) experienced pregnancy but aborted had meant themselves much disfunctioning, and accept the situation alone because their husbands can make them pregnant. They feel so stress and under pressure

> *"I feel I am disfunctioning and having inferior, I feel so bad when I am ready but not pregnant, I have no children, I have no complete family, I want children so much like crazy, I thought I was pregnant when having delay mens, I have urinate test every month, I am so stress because I use to be pregnant, It makes me feel I am disfunctioning, not him" (Jom)*

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"It's my fault not him, because my uterus is not good. He can make me pregnant but I am aborted, I am sorry for myself why I am abnormal" (Nuch)

There are 2 out of 15 husband cases were sterilized. The infertile women had meant the cases that they themselves are not abnormal or have physical malformation because they can conceive pregnancy but their husband cannot make them pregnant. So they are not depress or under pressure. But because they perceived women's role, so they perceived responsibility of having children and they still want to have children.

"In fact it's wrong that I have trouble with having children because I am not abnormal but my husband has weak sperm so we cannot have children, not because I cannot become pregnant. I want to have children so much" (Eew-sterilized husband)

"I want to have children for him but he cannot have it. He went to see doctor but still can't have it. I am OK but what can I do" (Koi-sterilized husband)

4.2.5 Gender power relation in the family

4.2.5.1 Pattern of residence after marriage

Most of infertile women seeking treatment have nuclear family type, found in both urban and rural areas. There are 2 characteristics of nuclear family : 1) single family with close relationship with relatives, usually separated family but living near their relatives, mostly visited by husband's relatives who pay attention on the couple, and usually caution about infertility problem. The couples often get advises from the husband' relatives, making them feel much uncomfortable and depress. 2) single family with less communication with relatives or separate family and living far from their relatives, less chance to talk or consult with relatives, receiving less cautions about having children, hence less pressure from their relatives of both sides. Living in a nuclear family allows couples to make decision freely, and manage their family on their own without intervention from relatives.

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Extended families were less found in this study. It can also divided into 2 characteristics : 1) infertile women move in to their husband's family; and 2) infertile women live with their own family. It was found that living in extended family with husband's family have been paid much attention from the husband's parents because they live among the context of husband's family, especially in the family that needs children to continue family lines. The infertile women might feel much pressure and depress with the daily environment. Moreover, they rather have less power and low status in the family because they usually give respect to husband's parents, and not feel free to live in other's house. The decision making in family matter depends on the husband's parents. In contrast, living with their own family making the infertile women feel warm, have higher status and negotiation power. The study shows that there is no difference of both nuclear and extended families between rural and urban areas.

Living in nuclear family

Living in nuclear family but have regular communication and visit by both husband's relatives and wife's relatives, mostly separated to live not far from their relatives. It was found that the infertile women feel uncomfortable because the husband's relatives pay much attention on the ability to have children. These relative usually have cautions, or force them to have children, or give advises about the treatment. The situation has put much pressure on infertile women.

> *"I separate to live together. When we visit his parents, every time they said why not have children, they thought we used contraception. I am not satisfy with that I try to explain but they didn't listen. So I stop visiting them. I feel much pressure. Or when O go home at Supanburi, it's convenient, I go there about every week. I met my relative they usually ask why not have children. I feel they don't understand us, so I don't want to go home" (Nuch)*

> *"My home is near my husband's home. We need to see each other because we live near. I am in-law, I have to visit his relatives. When I went having dinner at his house I feel inferia. His sister works at the*

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hospital, she suggests me to go to the hospital, I have to pay attention to it but in fact I feel uncomfortable, I don't like to go to his house" (Nun)

Most of the infertile women living in the nuclear family but far from relatives of both sides, hence less communication and visit by relatives. The infertile women said that they are satisfy with it because of the privacy, freedom, and no bothering from relatives. The samples seldom visit their relatives which have no effect on them. The decision making depends on the couples themselves

"We live only 2 in the house. If we stay with the husband's family, it must be hard and uncomfortable because of too many people. This is very privacy. No relatives bothering our private life because we seldom meet" (Pu)

"I go back home once a year. They asked when I will I have children. Both my mother and his mother ask me. I feel uncomfortable. We seldom meet, I go back home only a few day. If they ask me everyday I feel bad. Living like this is better" (Me)

"We separated from the family. We seldom meet with our parents, so they don't know much about us, I won't tell them, and they don't pay attention too, they ask about the living" (Pueng)

Living in extended family

The infertile women who live with the husband's family usually receive attention from the husband's parents who expect them to have children to continue their family lines. They have less negotiation power and have to be responsible for family expectation. So they feel under pressure and uncomfortable with the cautions to have children in the daily life.

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"Today I live with him seeing his parents everyday. In 30 days they said they want to have grandchildren, they said about the properties, family name. It's no problem but I feel uncomfortable and annoy able. If we can stay separately, it's better. It's nothing, not like mother-in-law and daughter-in-law in the drama. But I feel uncomfortable like this everyday" (Sai)

Moreover, living in the husband's house did not allow them to make much decision making because they give respect to the husband's parents, and they are afraid of expression the idea, usually stay quiet and let them make decision because every family matters depends on the husband's parents.

"His parents make decision in family matters, I can't bother it, it's their business. If complicated matters I dare not to bother it. Sometimes I am afraid to speak out" (Sai)

However, husband and wife can discuss their own business but still ask for opinion from the husband's family. This makes the infertile women have low status and less negotiation power in the husband's family.

"Mostly he asks my opinion, and I ask him too. For important matter we have to ask his parents. Sometime I do not argue with him, if his parents know they will think I am hard" (Sai)

In case the husbands cause infertility because they are sterilized. Although the infertile women is surrounded with their husband's relative, but they do not feel much pressure because the husband's family did not ask or force them to have children because they know that their son has the problem and causes infertility. The situation that women are not the cause of infertility, they will not have pressure from relatives of their husband.

"I feel reluctant because I do not belong to here, I am afraid they won't like what I said, and their parent would blame me. I do all the housework, but they still blame me when they were upset. If possible I prefer to stay only 2 of us" (Koi)

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Living in extended family where husband move in to the wife's house surrounded by parents and relatives of the wives makes the infertile women feel warm with mental support from their own parents when having problems including the infertility problem.

> *"My parents aare very supportive. If I cannot have children, it's OK. I feel satisfy and happy. I feel warm living together with many people. He never say anything to make me feel bad. He knows I want children, he always support me and said it's OK if we don't have children" (Pai)*

Living with their own family allows infertile women having higher status and high negotiation power. Discussion can be made between husband and wife, and wife can express idea in various matters. For important matter such as changing work, they have to consult with the parents of women. However, the main decision making belongs to men.

> *"We share decision making in personal matter. If important matter we consult with my parents, sometime just ask for their opinion, we do not follow them, we have our reason. For important matter, I leave it to my husband" (Pai)*

4.2.5.2 Economic productive role

There are 10 infertile women who have occupation and earn income, and 5 are housewives. Among those working they have equal economic productive role as men. That is, infertile women can earn income about the same as their husband. For instance, those who engage cleaning work in the hospital can earn about 3,200 Baht per month, while the husband work as hired driver earns 3,500 Baht a month. Both husband and wife in government service at the same level of 5 can earn about 9,000 – 10,000 Baht per month.

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Having job and income, the infertile women thought they help each other to earn for the family, no main earner or sub-earner, they thus not depend on their husbands but have equal economic reproductive role as men. This effects their equal status and negotiation power as their husband from family matter to formal decision making. They can also discuss important matter with their husband. As they can earn equal income as their husband, the infertile women seems not to be reluctant to their husbands but feel free to express opinion especially on financial management in the family or when spending a large amount of money.

> *"We told each other, we discuss important matter without reluctance, we share decision making" (Maew)*

> *"Mostly we share decision making in every matter, we discuss first" (Pu)*

> *"WE discuss family matters for what to do" (Poo)*

> *"For little thing I can make decision. For important matter we discuss first. We talk first for family matter" (Jom)*

The infertile women can earn more income than men and being the main earner for the family. For example an infertile women work with their husband selling the used stuffs. She also take other job to earn more income. She thus earn more income than her husband so she take main economic productive role for the family. She does not depend on her husband. This group of infertile women mostly take deicing making role in all family matter especially in important matter such as making decision to buy a car or management of financial matter. They may consult with their husband for some matter, but in fact just to inform and give respect to the husband. However, main decision maker belongs to the infertile women.

> *"I manage everything, my husband did not know about it. He never ask if I had money to pay installment for a car. I manage*

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> *it alone. For household matter, never discuss with him , de doesn't know at all. Even financial matter, he never bother me but let me decide how much to give him"(Koi)*

> *"I earn more income. I manage all household expense, but I have to consult him sometimes because he is my husband, but finally I take care of it" (Nok)*

Infertile women who are housewives , did not engage other job, and did not have income, mostly come from the family with better economic status than the husbands. For instance, one infertile woman came from the family own sugar cane factory, while her husband work for a private business and came from the middle income family. He married with this woman who become a housewife but have a land heritage not in a money form. Although she does not take productive role but she own more productive input than her husband. This has shown her status that is not dependent on her husband. She also had high decision making power in the family. Her husband is reluctant to her. She manage the household expense. She collect and control the expense of her husband. She also share formal decision making with her husband. She can make own decision making in many things.

> *"He mainly earn income, but I collect the money. I am the front legs of elephant, I manage everything. His duty is to make money. I make decision all other matters. He has to ask me everything in the family" (Mee)*

> *"He mainly earn income and give them all the money. He leave me manage everything in the house. We discuss everything but mostly I make decision. We discuss first. He let me manage everything" (Amporn)*

> *"He let me collect all the money and give him a monthly allowance. I make decision and order. If I want something, he will find it for me. For important matter like improving house, we discuss, but I make decision" (Eew)*

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Both husband and wife discuss about the infertility problem, but the wife make decision because the infertile women realize it is her problem. Whereas her husband just support and agree with her.

> *"The decision to seek treatment is mine. It's up to me. He will take me for the treatment" (Pu/equal economic role to the husband)*

> *"I mostly make decision alone but talk to my husband first. I told him about the doctor and where to receive treatment. He never argue" (Eew/no economic role)*

> *"We discuss all the time where to have treatment, but mostly I make decision. He is OK" (Poo/ equal economic role to the husband)*

Similarly, the infertile women who have no economic role, i.e. being housewives have to depend on their husbands. The husband is the main earner. These infertile women are subordinate to their husbands. They seek treatment and want to have children to maintain their status in the family. They want to have children for their husband, to please their husband, and to build up self-value as well.

4.2.5.3 Sex negotiation power within the context of husband and wife relationship

The sex negotiation power in the context of husband and wife relationship is divided into 2 types :negotiation power to have sexual relation; and negotiation power to refuse sexual relation.

About half of infertile women seeking treatment can start having sex with their husband, while another half have never done that. Among the first group, they begin with body communication such as using sexy dress, teasing him. However, they thought that it is not suitable for women to over express their sexual feeling or desire.

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Using body language or words is possible such as "Today please" or "Today is special" the words known between husband and wife. With this women can communicate about sex with their husbands, it is not shameful because it is a personal matter between 2 people. In case having sex to conceive pregnancy, during the ovulation, women can persuade their husband by mention about doctor's advuses. However, men generally start sexual activities. For those infertile women who never start having sexual activities with men for any reasons, they thought it is not women's role, it is shameful, unsuitable. Regarding sex negotiation power, almost all infertile women never refuse having sex with their husbands except having menstrual cycle. Very few ever refuse gently using health reason such as headache, stomachache, but very rare because they perceive their role and it is her duty to response to sexual desire of their husbands, and also to have children.

Negotiation power to have sexual relation

Infertile women thought that women can express their sexual desire without words but communication through body language such as teasing, use sexy dress, using fragrance. Their husbands can understand it. They thought that over expression is not suitable.

> *"I used to ask him but not often. Mostly man starts first because they have more sexual desire and sensitive. Sometime I just kiss him, it's OK" (Jom)*

> *"We didn't say directly but use sexy dress and fragrance. Usually my bed dress is pants and T-shirt, but if I wear nightgown, he may know" (Pueng)*

The infertile women thought that in the current society, women can have sexual expression as men do. Word persuasion is possible not shameful because it is personal matter between husband and wife. When having sex for children, they may claim doctor's advise for having sex.

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"We can talk about this matter because we are husband and wife. Not shameful. I just told him "you spends too little time with me". "Today I'd like" or (laughing) just grasp him but seldom (Nun)

"It's husband and wife matter, no one know, I ask him, I know the ovulation, I just grasp him cause I want to become pregnant" (Nok)

"I ask him, when it is the exact date (ovulation), I told him today is special, we know each other, I thought it's OK for todays, It doesn't matter who starts first" (Toi)

"We just tell him when the ovulation due, I just feel embarrass at the very first time, but it's doctor's advise, so I feel OK" (Pu)

The infertile women who had never start having sex with their husband thought that it is not suitable, and shameful

"I never ask him for it, I just stay still, it is not woman's matter, no one know but I feel embarrass" (Koi)

"I thought today we can ask for it but I never (laugh) I am afraid" (Sai)

"He always start, I never, we can do so but I am embarrass. If I want it I just stay still. It's no big deal for women, not like men, never mind" (Mee)

Negotiation power to refuse sexual relation

Most of infertile women never refuse having sex because they thought it is the duty of good wife to response to sexual desire of their husbands, to please them . Because they thought it is a part of having children, so they do not refuse.

"I married him, I am his wife, if he wants it, I should give him, make him happy" (Amporn)

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"I never refuse cause it is a part of having children. Sometimes I am so tired from work, but It's OK it's the duty to make him happy" (Jom)

"Never refuse, except during the period, mostly I let him do that" (Mee)

"I never refuse, no reason to do that except during the period. I am his wifer, if he wants but I refuse, then I am not his wife, it is my duty too" (Sai)

It was found that very few had ever refuse their husbands, or refuse gently, or claim health reason such as headache, stomachache, tired, but rarely found because they realized it is the duty of wife, refuse often is not suitable.

"I ask him I am not ready today, tired, he is OK, then we sleep" (Toi)

"Mostly I am evasive than telling him directly, I have stomachache, something like this" (Pu)

"I am his wife, I have to response, it's not good to refuse very often, sometime just postpone or tell him I am tired, headache, stomachache, too full, sleepy, etc" (Nuch)

4.2.6 The context of daily spoken words attacking the deformity of women's health and medical discourse context

Most of the language spoken to the infertile women is to give advised and ask about having children. It was found that most of the samples live in nuclear family so they have less chance to talk with other or consult with their relatives, hence it has no effect on their decision making to seek treatment. The language used by their relatives has an effect on their decision making to seek treatment usually force the infertile women to have children. This has made them become stress and uncomfortable

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especially if it was from the parents of their husbands. And because the infertile women have low status and decision making power in their husband's family, they hence try to escape from the infertility problems. Moreover, they have to confront with the social networks and friend who tried to tease them about their husband to find the new wife or the disability to have children. The infertile women are likely to be sensitive to these words, so they feel so sorry, suffering about their inferior. Even the simple word to say hello or asking about having children can make them upset, stress, and do not want to listen to the advise.

Language and words spoken by relatives

One of the infertile women lived with her husband's family with low status and negotiation power in this family. The family of her husband had high expectation about her to have children, and she had to listen to the words from her husband's mother everyday that forced her to have children and have treatment, or take all mean to have children. This has made her become stress and uncomfortable.

> *"She just say she likes to have children, just a few words "want grandchildren", and ask me to go check up. She said like that very often that I feel annoy and uncomfortable to answer, and she said that every time we met, so I went for examination, just to tell her that I already have check up. I have to receive treatment until I can have the grandchildren for her" (Sa)*

Some sample lived in a nuclear family but very closed to their relatives that always pay a visit to them. The context of words about infertility had much effect on the women especially from the mother of their husband that always blame about the inability to have children but never mention about her son. In addition they support their son to have new wife because the infertile women cannot have grandchildren for them as expected. All these words have the power that put these infertile women subordinate to their husbands and accept the blame.

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"She (husband's mother) thought I had contraception but I tried to explain that I don't use it. I am pregnant but aborted. She doesn't believe me or listen to me. She said my uterus will dry out if it is not used. So I told her to ask his son, he know very well. Then she said she like her son to have the new wife and see if she can have children. She said like this every time we met. It put me much pressure, and I thought that I must have the children" (Nuch)

"I met his relatives and they said "why don't you have children or you are incapable to have children. Look ! others can have children, is it shameful ?" They rather satire, I don't like it. His relatives make me and my husband misunderstand each other. I think a lot about it and so much worry. They try to force me" (Nuch)

Language and words from the social networks

Most of the infertile women live in the nuclear family away from their relatives. Therefore the context of words and language about having children were received from the surrounding people like friend, colleagues, neighbors they regularly met. These people put much pressure on these women because their words are rather negative and these women are sensitive to such words because they already feel bad for inability to have children. It just attack their inferia when someone make cautions. They become easily upset, unhappy, unsatisfactorily and did not want others to talk about it.

"I feel like having inferia when someone ask me about it, why asking me, they already know that I can't have children, I am upset, I don't want to here about it. Mostly my friends said "others already overtake you, you are left behind, you can't catch them" These words are not too serious. But I am serious when someone said why I didn't have children. Actually I want to have, when they said, I just really want to have, it is my inferiority, I don't want others to talk about my inferiority" (Pai)

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> *"Some friend are good, but some are... (about to cry). I can sense it, they always satire when we met, I don't want to listen to their words. Sometime I feel like ask them to stop forcing me (cry)just ask about living it's OK but I don't want to hear about having children. If possible I want them to not talking about it" (Maew)*

Their friends or neighbors like to tease or say something sarcastic such as let the husband has new wife or someone else who can have children. These words caused stress, pressure and anxiety to the infertile women. Some said such deride word for their inability to give birth but no one mentioned about the deficiency of their husbands. These word context obviously shows that women are subordinate to men regarding gender that force women to accept their disfunctioning of infertility than that of men.

> *"Mostly my colleagues like to say something sarcastic. During the lunchtime we eat together and they like teasing me that my husband might have found someone else. I am inferior. Sometimes my husband's friend said to my husband to have the new wife, and if so, his children might have grown up already. They don't know how I feel, it's too bad. Sometimes I cried, I am worry my husband will have other, although he is so good to me. Such teasing make me worry and stress. I don't want to hear that, it hurts me so bad" (Jom)*

> *'Mostly my neighbor ask me why I have no children yet, or am I afraid my husband has someone else. I seriously thought about it and feel unsafe and insecure, I am afraid he really has someone else (Nun)*

> *"My colleague said that if I cannot have children for him, I may be abandoned. The Chinese strict to this. I am nervous and I must try to have children. I am not happy today, sometimes I can't sleep at all" (nok)*

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The word and language context of those surrounding the sample has attacked their feeling and deficiency This make them feel themselves differ from others who can have children, and thus feel inferior, unhappy, having psychological problem.

> *"I am sensitive and heartbroken when I saw others talk about their children. I don't have any, I feel so sorry. I can't sit there anymore, and I have to keep away from there" (Maew)*

4.2.6.2 Medical discourse about infertility problem

Medical discourse had an influence both directly and indirectly on decision making to seek treatment of the infertile women which includes how to mean the cause of infertility, examination and diagnosis, and treatment direction. The direct influence is the explanation of the doctor. The infertile women had seen the doctor for medical examination and to investigate what causes infertility, e.g., malformation of physical organs or disfunctioning of the reproductive system such as irregular ovulation, fibrotic covering and cysts etc. The doctor usually advise that infertility can be cure by correcting the disfunctioned organ by administration of injection of hormone to catalyst the ovulation or surgery of fibrotic covering and cysts. The medical discourse or explanation by the doctor had a power to influence the infertile women to accept and trust them since doctors had the knowledge and expertise especially if the explanation was made by subspecialty doctors. The infertile women accept and agree and has some hope to eliminate the causes of infertility. The indirect influence of medical discourse is the perception of various media, for example, through television programme presented by the doctor on the knowledge about infertility and the treatment steps. Similarly, the media like newspaper presents the advances of medical technology and innovation. The infertile women can perceive such information and expect the opportunity to fulfill their hope that their infertility can be eliminated.

The direct influence of medical discourse begins when infertile women come to see the doctor for physical examination and the doctors explain the causes of

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infertility that might cause by the malformation or disfunction of reproductive organs. The doctor usually advise that the causes of infertility can be controlled or eliminated by make correction or adjustment of the disfunctioned organs, making the infertile women hope that they can conceive pregnancy if following the doctor's advise.

> *"The doctor said it is just the stress and an ovulation, he advises me to take hormone pills, I still have some hope and opportunity" (Toi) "He is a subspecialty doctor, he said I have fibrolic covering, I have to cut it out (curette), after that I can have sex with my husband. He said it should be better" (Mee)*

> *"I have a check up, the doctor said I have cysts and it obstructed the conception, he advise me to see specialized doctor. The doctor also advises me to cut the cysts" (Amporn)*

Indirect influence of medical discourse was made through various media, for example, the health programme on T.V presented by medical doctor on the health knowledge, infertility, including the presentation of advance medical technology on infertility treatment. The media like newspaper also presents the potential of efficacy, and success of infertility treatment. The infertile audience who perceived the media may have some hope and more alternatives to cure their infertility.

> *"The A hospital publicized that they were successful in GIFT, I have tried it immediately" (Pai)*

> *"I have seen in T.V. a doctor from hospital B presented in the programmed about infertility. He is well-known, then I go to see him" (Amporn)*

> *"I've seen the "House No.5" the doctor talked about the blastosis, it's better than GIFT, it causes no pain, not like GIFT. I am interested. It is Dr. Somchai from hospital C" (Maew)*

> *"Health programme is on every channel in the morning, I can't remember which channel I saw but it is in the newspaper too. They said the doctors are successful in their methods. To days tie technology is advanced. The doctors is excellent and can help those who have no*

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children, nothing like this before" (Amporn)

The cut-out and leaflets presented the place and time that infertility service is available. In such places, specialists are available for counseling and treatment. Infertile women can perceive such information.

> *"I took my relative to hospital D and I have seen a leaflet saying that there is a specific facility for infertility treatment. I showed it to my husband and talk about it. Then 2 days later I go for a check up" (poo)*

> *"I drove pass a clinic saying infertility counseling. I thought it should be goo, so I decide to step in for counseling" (Eew)*

Infertile women who seek treatment believe and accept the modern treatment and try the medical procedure. Medical discourse had influenced the decision to seek treatment in every step. As a result, infertile women have long continued receiving treatment in the medical system from the power and trust of doctor.

1. Medical discourse in diagnostic step The infertile women has meant the abnormality of infertility according to the concept of modern medicine that they believed and accepted. Hence every of them enter the entire process of treatment . As has been told by the samples, the doctor started with asking about the history and physical checkup, e.g., PV test, blood test, semen test test, x-ray, ultrasound, and check up reproductive organs which was mostly started and done in women than in men. The doctors said male checkup is simplier and not complicated as female's that is likely to cause infertility than male's, so they focused on female abnormality. There was only one case that started checking up in male, however if abnormality was not found, no repeated checkup was undertaken. The doctor then started checking up female's physical organs to investigate the abnormality and causes of infertility. The infertile women perceived that the examination is bias to women. And in many cases they feel themselves being the cause of infertility because the doctors paid attention to checkup females than males.

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However every infertile women who seek treatment believed and accepted the examination step done by doctors from the medical-base description about the different of male's and female's organs. Besides, they are likely to noted and agreed with the doctors especially those with high level of education because the doctor's description is consistent to what they had studied and known. Hence, the doctor finally concluded that the abnormality was found in women than in men

> *"At first, we two went there but I had a checkup, not my husband because the doctor said check up the man is simple just examine the semen, but it's difficult for woman so he checkup woman first, I did not feel anything" (Pai)*

> *"The doctor started checking up my husband, if it's normal, then he suspected me. He checked up many things not as simple as men" (Pu)*

> *"This hospital focused on women. They said female checkup first, if nothing is found, then have male' checkup for just a semen test. I agreed with the doctor because he said women had many characteristic factors that cause infertility because female's physical organs are more complicated than male's, and the examination steps are more complicated, i.e. just a semen test for men, and if the sperm counts is normal and strong, it's OK. But the sperm might have died after entering the female body because the cervix is obstructed. It's complicated so the doctor checkup women first." (Pai)*

> *"I had studied I know female's organs are more complicated, so they checkup female first, no big deal" (Sai)*

2. Medical discourse in identifying treatment direction The doctor identifies the steps and direction of infertility treatment of all cases. That is, the doctors considered the treatment direction suitable for each case. Mostly the treatment process was undertaken for women for which the women themselves did not involve in identifying the treatment direction, but only listen to the description and the reasons made by the doctor, however, every of them agreed with it.

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If the first try was not successful, the doctor decided to adjust the treatment by applying new technologies. The doctors explain to the client that such technology increased the chance of success. Partly, the infertile women accepted the new treatment because they trusted in modern medical system and the description of specialized doctors. In addition medical change usually come with new technology. So the infertile women is hopefully to try the new methods and sometimes the doctor gave the clients hope of success. A number of infertile women said that the doctors also explain about the chance of failure and unsuccessful. However, because of the medical-base explanation of the doctor, the infertile women accepted to try treatment options prescribed by the doctors.

> *"The doctor asked about the personal history and gave \some medicines, then make an appointment for ultrasound examination to inspect the size of ovum. He suggested I try having sex for 3 month, but it did not work. So he tried another method by injecting the sperm and take medicines. I followed the appointment dates for 6 times but still failed. I have an X-ray to investigate the uterus and follicle status, the film result showed I had fiber and cysts, then I have an operation. The doctor said it should be OK now. Three months after that, it still doesn't work. The doctor told me to come back again and try another method" (Eea)*

> *"I firstly hope 100 % because the doctor told me it's surely effective, and he experienced the success in many cases. He also treat the Laos cases. I tried GIFT twice, but not successful. The doctor said once try is not enough, but should try for many times. If the doctor said so, T thought it must work. Although my hope decline but I still hope I can, so I continue the tries" (Eew)*

> *The doctor said I hope for 70 % but it might not work. It depends on many factors such as the hormone, stress. But I rather feel confident because of there are successful cases and he is specialize in this field. His explanation make me understand that one try might not be successful depending on various factors. I failed in the past because maybe I am too stress" (Eew)*

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> *I feel good because the doctor did not give me a 100 % guarantee,, he said some may succeed and some may fail. Before starting the procedure, he said I'd like to try for 3 times. I failed for the first time but I still have confidence in this doctor, so I go back and try again, and because he is an expert. Now I am trying the Plastosia for the second time" (Maew)*

The result of this study showed that when the infertile women have received the treatment for a period of time, and the treatment was not successful, a number of them were referred through the medical system to another doctor. They were advised that the new doctor is a specialist and is better. Every of them accepted to enter the referral system because it just give them new hope, so they remain in a long period of the treatment process.

> *"After trying the GIFT twice, I still can't conceive pregnancy. Dr. Sumwong referred me to Dr. Somsak. Dr. Sumwong told be that Dr. Somsak is expert in this Plastisis. I thought it is good, he must be better, and I must succeed this time" (Nuch)*

> *"Firstly I consulted the doctor at the hospital, he is an obstetrician. He told me I have cyst, he advised me to see specialized and experienced doctor. Now I have the treatment with Dr. Ruengwut" (Amporn)*

> *"The doctor, obstetrician, give me hormone to stimulate ovulation, but it failed. He then transfer me to Hospital G, a private hospital, he said, the equipment is available as well as specialize doctor. I want to have children so I try" (Maew)*

Most of the infertile women feel suffering with the treatment such as the daily routine blood and hormone test, observing the exact ovulation date and having sex on that day. Some take hormone everyday so they are smelled hormone. Some said that they are much stress and anxiety. Because each treatment give them hope and chance, so they become worrying if it failed and affected the daily fife. Some were worry that the commutation might effect the treatment. If it failed they would be sad and

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disappointment. But for every visit the doctor usually sooths them, gives some hope, cheers them up, and tell them to try again and again.

> *"It's boring taking pills everyday, measuring temperature, observing exact date of ovulation and having sex on that day. It's boring because sometimes I don't feel like having sex on that day, but I have to, because I want the baby. After that measuring temperature again, if the temperature is stable, it means I have chance. Sometimes the temperature make me so delighted that I am going to have a baby. I am so glad, I'm afraid to move and do anything because I thought I was pregnant. Suddenly the Mens come. Oh. I failed again. I feel so stress. I have to start over again taking pills and measuring the temperature" (Pueng).*

> *"I showed the doctor my temperature, he said I am pregnant, I am so glad because the doctor told me so. I'm glad and I can't sleep. But then I have Mens. The doctor told me to try again, the temperature is well. It gives me hope. Sometimes when the temperature is OK, the doctor congratulates me I am pregnant, but he suspect why I have Mens. He told me to try again, so I try" (Pueng)*

> *"I have a blood test to investigate the ovulation, if the ovulation took place, then have a hormone test. I have a blood test everyday, and take much pills, I am suffering. The doctor give me full dose, I was smelled. If the doctor said I was pregnant, I have to be careful, never use Tuk-Tuk or motorcycle, but use taxi. I have injections. But still I miscarried. Nevertheless, I still have hope, I am confident with this doctor, he is a specialist in infertility. He told me he try to find what is wrong with me, he said at least I can conceive, I have to take step by step, I feel better because the doctor never stop trying" (Nuch)*

4.3 Non-seeking treatment infertile women

4.3.1 The context of gender relation effecting decision making to seek Infertility treatment

It was found that the non-seeking treatment infertile women had perceived their reproductive role that the role in giving birth is natural especially for the married

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women, similarly to those seeking treatment. They also perceived the role to build up warm and perfect family, being good wives who have children for their husbands, pleasing the husbands, allowing their husbands to take good fatherhood role. For those in agricultural work, they perceived the female's role as the producers of new generation of labors to substitute the old ones. Perceiving such roles, infertile women with no children thus define the meaning of infertility that it is the abnormality of women because women naturally have to give birth. They are different from others who can have children, but they did not feel much worry about it. Some who ever had abortion history defined fertility that it's the faith and the sin they did (abortion) in the past, and having no children is to repay that sin. They accept the result of what they did in the past. So they did not struggle to have treatment.

Although the non-seeking treatment group had perceived their roles of giving birth as in the seeing treatment group, they were not serious with the problems of infertility. This is because they perceived that their husbands did not pay attention whether having children or not. In almost all cases, their husbands were not eager to manage the infertile problem. In addition, the infertile women can discuss and negotiate to accept their fertility problem. Besides, some of them who have low and uncertain monthly income had perceived that having children is to increase economic burden. They rather become worry about surviving than having children. They have not much pressure or expectation from the family or relatives to have children. Hence, they are not worry or become stress with the infertility problem. Because of the above reasons, all of the non-seeking treatment group had evaluate the situation and thought that having no children is not the problem of the family and themselves because they are happy with it and no problems. Hence, it is not necessary to be struggle seeking infertility treatment.

4.3.2 Feminine role

4.3.2.1 Perception of female's reproductive role

Among the 15 infertile women not seeking treatment, the study reveal that all had perceived female's reproductive role that giving birth is their natural role

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especially for the married women. They have the role to build up warm and perfect family, as perceived by those seeking treatment group. In addition all had perceived that giving birth is to produce the ones who have to take care of the dependent elderly parents. About half on this group perceived that giving birth is the mechanism of helping men to take good fatherhood role. Two out of 15 cases perceived that giving birth is to produce the new generation of labors in the family, which was found among those in rural agricultural work. The finding found no case of perceived the role of giving birth to continue the family assets. There are 13 out of 15 cases explained that having no problems created no problem to themselves and the family, but the still can live their life happily. One important reason is that they can negotiate and discuss to accept the infertility condition, and mostly their husband did not pay attention to it. For those whose husbands are sterilized (2 cases), their husband did not show they want children. Besides, some perceived negative impact of having children, e.g., 4 cases with low income said that having children is a big burden for the current social situation, and with this reason another 13 out of 15 cases decided not to seek treatment. However, 2 cases had perceived the role of giving birth of wife because they thought their husbands want children as in the following details.

All of the non-seeking treatment group had perceived that giving birth is natural role. Different gender anatomy allows females to conceive pregnancy, and it is female's natural role to have children especially those married women having sex with their husband normally expect to have children.

> *"It's natural, if having sex, then become pregnant, and have a baby. Woman but man can conceive pregnancy" (A)*

> *"What to say, women must be pregnant and have children, it's just natural, if married then have children" (Ning)*

> *"Normally, married women must have children to make perfect family, father, mother, and children" (Joy)*

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In addition, every in the seeking treatment group had perceived that having children is important because the children will take role in taking care of the dependent elderly parents who cannot earn for their own living, and also being companionship.

> *"Having children so they can take care of dependent elderly parents" (Jiab)*

> *"When we are old we must have someone to take care of us, not the same as in foreign countries that the government provide the old age welfare" (Jee)*

> *"I have children to take care of myself when I am old and dependent and be my companion" (Nui)*

According to the result, the non-seeking treatment group with agricultural engagement or own farmland had perceived female role in giving birth as the producer of the new general of labor to help working for the family.

> *"I have a family, if don't have children, who will take care of the farm work and helping parent to wok. My friends have children to help them. How long can we work, if we have no children who will take care of and continue our work" (Ning)*

> *"Children can help us working in the farm, because we are getting older" (Poom)*

About half on those non-seeking treatment had perceived their role in giving birth that it can help their husbands pursue their good fatherhood role and responsibility for family, become mature, behave good, and being good model for the children.

> *"I thought having children help the father be more responsible. I want my husband to have responsibility. He is just like childish for sometime*

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in making decision. If we have children, the father will become more mature" (Poom)

"If I had children, my husband be a father, he has to take the children to school, staying with them, raising them, being good role model, be more responsible, being good father" (Jee)

"My husband is an easy man. We have to discus about having children, we should not only focus on it, because they will separate from us when the get married, leave us two living together. They thus cannot help much because they do not stay with us. I thought we should not take that serious, not to be too struggle and take it easy. My husband agrees with it, we have the same idea, we can negotiate, not that serious like others" (Ann)

"My husband did not pay much attention about having children, so do I, not serous" (Koong – infertile husband)

Some of the non-seeking treatment who can accept infertility problem had given additional reason that having children is to increase economic burden. The reason of family impact reduced the pressure and shifted their interest from this issue to the survival of themselves and their family. Most are those who are hired labors or business employees with low income and almost all are in debt, relatively poor, and poor living condition. Hence they are not eager to have children or seeking any treatment.

"I thought I won't do anything (treatment) because I still have to earn for living. If I would have children, I'll take care of them. But if not, I won't do anything to have them. It's a big burden, just to survive ourselves is difficult, I am not eager about it" (A)

"Children is burden, what to feed them, if we have them we need to take care of them. Now I can just live to survive each day. Having children is about surviving too" (Ning)

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"I like to have children but life will be more difficult, I am not ready for it, I am just an employee with very little income, children is a big burden" (Nai)

Some, but very less, of the non-seeking infertile women gave additional reason that having children is a big burden and difficult, especially raising them to be a good one in the current social situation. This is the reason why they can accept the situation and live with the infertility problem. One of them is a university teacher, finished a master degree, and expose to adolescent problem said that they are worry about raising children.

"I thought perhaps we are better than those who have children. It's not the same as before that we listen to our parents, but todays if we want to have children we have to seriously think about it. I am a teacher, I have seen a lot, they are misbehave, and cause problems to the parents. Raising children today is very difficult, big burden, too much worry they were failed, making the parents heartbroken. It's better not having any children" (Tik)

Perception of women's role in combination with the above reason had effected the decision making not to seek treatment for 13 out 15 cases. Two out of 15 cases had perceived the role of giving birth and pay attention to it because their husbands wanted to have children but the husband and wife had blamed each other, and the husband mentioned about infertility problem, so they thought that their husbands want children, it is the expectation of the husband that the wife must have children. This has put pressure on women. The two cases need to seek treatment but are afraid and worry that they have caused infertility. If their husbands know, they might have problem, but they never suspected their husbands. One of them was worry that her husband have someone else because she cannot has children for him, and she is older than him. The expectation of children of both husband and wife cause mental problem to the women, they just kept that feeling inside, never express it out because they do not want to take risk of being broken family due to inability to have children which is the expectation of their husbands.

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"He want to have children, he always ask me when to have children, he wants it, but I don't know what to do. He said it's me who is infertile, but not too serious. I am afraid if the checkup shows I am infertile. I am afraid we have problem and have someone else. I am older than him, he might have other who can have children for him" (Too – 4 years older than husband)

"He wants children, he told me why I don't have, he loves children, I also want him to have one. Women should have children but I am afraid of the result showed I am abnormal, I don't how to tell him, I feel so bad" (Mod – same age as husband)

4.3.2.2 Meaning of infertility

Among those non-seeking treatment, they firstly had meant infertility as same as those seeking treatment. They meant fertility from perception of abnormality of themselves than of their husbands, for example, sfter stop contraception for a while, they cannot conceived, but others who married later already have children, or because they are older than their husbands. The social networks also involve in meaning infertility by make cautions about abnormality of not having children. This has made the infertile women perceived the problem of having children that links to the perception of reproductive role. However, they perceived that having no children caused no problems, so they meant infertility as a natural abnormality of women that differ from other who can have children. Thus, they are not sad or feel sorry. Only 3 cases meant infertility as a sin. They accept infertility problem and the faith, and never thought seeking treatment.

The infertile women had meant the perception of abnormality, for example, after stop using contraception for about 2 – 4 years on average, they have not conceived, while other who get married later can have children, they may have health problem, or maybe because they are older than their husbands.

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"It's about 3 years after stop using contraception, I have not conceived yet, I thought I have difficulty in having children. Others just stop birth control for a while, they can have children (Poom)

"After marriage I just let to have children, but it's 4 – 5 years now I have no children yet, or should I have difficulty, but I have let to have children for a long time, I am not strong" (Jee)

"I have let for 3 years but not have children yet. My friends can have children after marriage. Or it's me who have problem" (A)

"I saw other couples having children but why I don't have any. I frequently have sex, no contraception, but I still can't have one. It's 3 years now" (A)

"May be I am too old and have more physical problems than men" (Toom – 4 years older than husband)

In combination of the social networks that meant infertility by making cautions about inability of women to give birth or their abnormality, these infertile women had agreed to them especially those who often received such cautions.

"My friends usually ask me why I have no children after being married for many years, or have I seen the doctor. I start thinking....do I really have problem having children" (Joy)

"After being married for 2 – 3 years, I have been asked very often why I have no children, why not seeing doctors. Now I start thinking why I do not have one" (Jiab)

"My neighbors always ask why I have no children, who is infertile, other already have children" (Tuk)

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Perception of self abnormality and change in combination of the meaning of social networks towards infertility, the non-seeking infertile woman had meant themselves having unnatural physical abnormality and that against the expectation that married women should have children, having physically diference from other who can have children. However, they are not serious or sad about having no children because they had perceived their reproductive role and had evaluate to accept the infertility problem.

> *"It is like we are unnatural, women generally are able to have children, but I am not that serious" (Jee)*

> *"It's different from other women that they can have children. It's abnormal, but I just cant have it, what can I do?"(A)*

> *"Actually woman should have children after marriage, but never mind if we don't have" (Ann)*

> *"Naturally women should have children, I am different from other that I have never been pregnant, I don't know how it feel bearing a child" (Jiab)*

A few number of those non-seeking treatment group had meant infertility as a sin, being unlucky, having no future. It was found among this group that they had experienced induce abortion because they were not ready to have children. They accepted they what they have done is wrong or a sin. Hence they just meant themselves a sin people, and having no children is to repay a sin. Some of them had experienced fallopian tube operation reducing chances of pregnancy, they thus meant infertility a sin and unlucky because they must have an operation. Because they accepted their faith, so they did not seek treatment. It is another way to find reason for themselves to accept infertility problem.

> *"I thought the sin had followed us like the older said can do no good, the children may not want to be born with us, the sin stick*

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to us all the time, even doctor can't help, it depends on faith, just try to accept it"(Kung-experienced induced abortion)

"It's my sin having an abortion so they've just all gone, no one want to be born by us, I may need to repay it, if it's paid, they might come born with us" (Nai-experience induce abortion)

"I am the one , I had an fallopian tube operation that makes it difficult to have children, it depends on faith now. I am unlucky, no future" (Poom)

4.3.3 Gender relation within the family

4.3.3.1 Pattern of residence after marriage

The pattern of residence of the non-seeking treatment group is similar to those seeking treatment group. That is, most of them have nuclear family type of 2 categories. The first is single family with close communication to relatives and frequent visits, but these relative did not expect or pay attention to infertility problem, just giving some advises and cautions but not often. The infertile women are satisfy with this living arrangement allowing privacy. In general, they did not like others topay attention on their infertility problems even giving advises. Another is single family away from relatives and with seldom contacts with relatives of both sides, seldom talks and occasionally receiving advises. The problem of infertility is less paid attention from relatives. Hence their relative have caused no pressure on the infertile women to seek treatment, and thus no effect upon women status and family relation.

Living in extended family types are divided into 2 categories. The first is living with the husband's family. The infertile women feel uncomfortable with it because lacking of privacy, and reducing status and decision making power in the family. They have to seek advises from those superior in the husband's family of

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which the decision making depends upon. However the infertility problem has not been paid much attention or receiving less cautions and advises because other family members are busy with their work. Another category is living with their own family surrounded by relatives, providing warm feeling and mental support. However, their relatives did not pay attention about infertility problem because they thought it is personal matter. The decision making in the family depends on the most seniors of the wives, but decision making of husband and wife matters depends on shared decision making of both.

Nuclear family residence

For those infertile women living in single family with regular contacts with relatives living nearby in the same area or provinces, they are satisfy with it because of the privacy condition. Their relatives did not pay much attention on having children although have regular contacts and talks. It was found that regular contacts between the couples and their relatives has no effect on decision making in their family.

> *"My husband is a Bangkokian. We have contacts and visits with his relatives once a month to give the money to his mother and have meal together. Normally his relatives did not come or bother us" (Joy)*

> *"We live together in a separate house but near his mother's house. It's convenient and privacy. His mother did not bother us, we make our own decision. Sometimes we went having meals with his mother's house, sometimes they brought us foo, just that" (Toom)*

> *"It's convenient living like this. It's uncomfortable if having others with us. Our relatives just live around here, sharing some foods they are not interested in our business" (Ning)*

For those living in single family away from relatives with seldom contacts, visits, and talks, they lived separately and made occasional visits such as on the New Year Day, Songkran's Day. Those in this group did not seek treatment, they are

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satisfy living like this, feel privacy, and their relatives never pay attention on their infertility problem. Besides, their relative had no effect on their decision making.

> *"We live only two of us, although not that convenient, but we are happy not being disturbed from other or relatives. We seldom go home, just once a year" (Kung)*

> *"We live in military flat, rather privacy. Our home is in Rachaburi. His parents had passes away. He has a few relatives. We seldom see our relatives" (Jiab)*

> *"My home is in Nakonpanom, I seldom go back home, only for religious occasion because it is not convenience, like we are apart. Now we live in the hospital's residence, it's better for us to live separately from relatives. We manage everything ourselves" (Nai)*

Extended family residence

For those living with the husband's family, it was found that the non-seeking treatment group feel uncomfortable and did not like this living arrangement because they lack of privacy, lack of freedom to live their life or to behave since they have to give respect to others in their husband's family. Besides, they have lower status and less decision making power because the decision making in the family depends on the most superior or senior in the family.

> *"I feel uncomfortable. No other places like home that we can do anything we wants, but here is others', nothing convenient, everything is under controlled of my husband's mother. For every family matters like buying stuffs, improving house, we have to consult his mother, all depends on his mother, except for our personal stuffs that I bought myself. But his mother did not bother us, she is busy at work, she did not pay attention whether we have children or not" (Poom)*

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"We get along very well, his family is different from other extended family, we live on ourselves, I feel OK, except for privacy. If living only 2 of us, it's more privacy. It's better living with my mother's house. Most of the decision making in the family depends on his sister, we have to tell them first. She sometimes asks when will we have children, but not serious. Infertility treatment is our own matter, we do not need to consult other in the house"(Mod)

For those living with their own family, the infertile women are satisfy and happy with this living arrangement. Decision making power depends on the most superior or senior in the house. They have higher status and decision making power than that of their husbands because they were among their own relatives.

"I thought it is good and convenient living with my own relatives suporting us. It's quite lonely living with others. But my husband feel uncomfortable because it's not his house, I don't care I live here long before. My mother is the superior of the house, making decision of all matters, everyone have to listen to her. My husband is OK, he is easy"(Dao)

It can be seen that the pattern of living arrangement has an effect on status and decision making power of the infertile women. That is, those living with their own house, surrounded with relatives had better status and decision making power than their husbands although the major decision making depends on the superior of the house. On the contrary, those living in their husband's house feel uncomfortable and unprivacy. The decision making power depends on the superior of the husband's house. Living in single family separate from relative has no effect on the status and decision making power of infertile women. The decision making in the family relies on the couple themselves.

4.3.3.2 Economic productive role

Among the non-seeking treatment infertile women, 11 cases have occupation and earn income and 4 cases are the housewives. For those having job and earning

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income, most of them have equal economic productive role as their husbands, i.e. they can earn as same or similar income as their husbands. One case is the hotel P.R earning 12,000 Baht a month, while her husband working for the state enterprise earns 13,500 Baht a month. One couple both husband and wife work as university teachers earn the same amount. They said the couples helping each other working for their family, hence neither are the major or minor earners of the family. These infertile women are thus not economic dependant on their husbands, but economically supportive to each other, hence having equal decision making power as their husbands. Every family matters depends on their shared decision especially on spending a large amount of money. Other household matters like buying food, living stuffs depends on the decision of the infertile women alone.

> *"I decided and buying for the living stuffs, I manage the household spending. But for the expensive things, I have to consult my husband, give him an honor" (Tuk)*

> *"I manage financial matter and collect the money for the family, but we share decision making for family matter" (Jee)*

> *"I collect the money, but sometimes we cannot meet the expense. We discus every family matter, we are democratic. We talk before buying big stuff. But for small stuff, I take care of it" (Nai)*

> *"We both collect money but I manage the account. I can decide buying things because I hold the money. But for the big stuff I have to consult him first and make decision together" (Ann)*

Among those non-seeking treatment samples having more economic productive role than their husbands, i.e. earning more income to support family spending, they thus become major earner of the family. For example, one among this group has worked as a cleaning maid in an apartment with permanent monthly salary, and have another job cleaning and ironing cloths for the apartment's tenants. Her husband is a hired motorcycle with uncertain income. This woman has higher income

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than her husband, so she is the major earner of the family. Another woman sells fast-food earning around 3 – 4 thousands baht per month, whereas her husband earn uncertain income from selling preserve fruits (fruits stall), and help her selling food in the evening. It can be seen that some of them have more economic productive role than their husband, hence having economic independent on their husbands. These women have become major decision maker in almost all family matter especially on financial management and spending. Besides, their status and negotiation power in the family are higher too.

> *"He mostly asks me before buying things, but I don't tell him when I bought things, he did not say anything" (Kung)*

> *"I manage the money, he will ask for money if he wants something. I hold every Baht, I give him the money for what he wants" (Dao)*

> *"Man is not cautious especially my husband is not good at it, I have to make decision on money matter. I work hard for money, I have to be cautions. I am not reluctant to him because I am better about it. I mostly make decision. He always believe me." (A)*

For those infertile women with no economic productive role, i.e. being housewives, cooking and taking care of their husbands, all are non-income, their husbands are solely the major earner of the family. As their husbands take all economic productive role in the family, the decision making power thus belongs to them. Every matter including financial matter depend on their husband, the infertile women are just the followers. They regards their husbands family leaders. They are economically dependants on their husbands. Therefore, they had low status and less decision making power. They are reluctant to their husbands especially on financial matter.

> *"I collect the money, he gave me the money every payday to deposit at the Bank, I spare some for necessary family expense. We talk before spending money, mostly depend on him" (Joy)*

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"He earns to support family, he make decision on household matter, he has the rights, all spending depend on his decision because he earn the money" (Ning)

The infertile women can talk and discuss infertility problem with their husbands, and make solution together. They both decide not to seek treatment , but women are the main decision maker because they are responsible for giving birth.

"We both decide not to seek treatment, but I first suggest we won't have children, we accept it, and try to look at the good point, he agreed with me" (Joy/ equal economic productive role as her husband)

"We talk first, sharing reason. He is OK, no problem" (Ann/ equal economic productive role as her husband)

"We talk we like to have children but not serious, so we let go, doing nothing" (Poom/ no economic productive role)

4.3.3.3 Sex negotiation power within the context of husband and wife relationship

Those non-seeing treatment samples had similar pattern of sex negotiation power as those seeking treatment group. Two-thirds of the samples never ask their husbands for sex because they thought it is not suitable for women. One-third had ever use body language to persuade their husband but they thought women should not over express their sexual desire. No oral communication was found. Regarding negotiation power to refuse sex, the pattern is similar among both groups, That is, the majority never refuse their husband's sexual desire because they thought it is the role of good wife. Some seldom refuse because they were not ready at a time due to physical health.

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Negotiation power to have sex

Most of the non-seeking behavior infertile women thought that sexual desire is similar for both sex, but it is not women's role to start having sex, it is shameful, good women never did so. Therefore, most of them never start having sex with their husbands

"Men should start first, I never did so, women should not do that, we should stay calm" (A)

"I don't know, I never did so, I don't know how it is, But I thought women should not do that, it is shameful, I never did that" (Ning)

"I thought women should not do that, I don't know but it's not good" (Tuk)

Some among this group had ever express their sexual desire by start persuading their husband mostly using body language such as hugging, and lying against their husband, teasing etc. but not using direct oral communication.

"Mostly he asked me, Sometimes I just hug him, he knew that" (Dao)

"Just lie against him, he knew, usually we lie separately" (Joy)

"He knew when I lie against him, usually he starts first" (Jiab)

"Mostly, he asked first, I did it sometimes when I am in the mood, just teasing him, but seldomly" (Mod)

Most of the non-seeking treatment samples never refuse having sex with their husbands except during the period or being exhaust or sick, but very least that they refuse because they thought having sex is to please their husbands so they should

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response whenever their husbands wants it, most of them perceived it is the role of good wife.

> *"I refuse for sometime when I was sick or exhausted, but if he really wanted it I give him. If I am not OK I can tell him" (Toom)*

> *"I have to give him, I seldom refuse, If I am tired I told him, he understand. Sometimes I thought if I refuse, I am not good on my duty"(Dao)*

> *"Sometimes I am too tired. He asked to sleep with me, but I said I am tired, then he gave up. If he wanted it, I have to response, it's my duty" (Mod)*

Very few cases among the non-seeking treatment group never refuse their husbands except during the period. They thought it is the duty of good wife to please their husbands.

> *"I thought I have to please him because I am his wife. If I don't do that he might have gone with someone else. But he will not do that. I have to do my best" (Joy)*

> *I thought we should not refuse, it's our duty except when er have a period" (Ann)*

> *"I am his wife so I have to please him, I never refuse if he wants except when I have mens" (Nui)*

4.3.4 The context of daily spoken words attacking the deformity of women's health and medical discourse context

4.3.4.1 Spoken words in the relatives and family system regarding Infertility

Among those non-seeking treatment group, the spoken words used by their family and relatives mostly are the words asking about having children and advises or

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alternatives in solving infertility problem. The result suggested that those living in single family had received some advises because they live separately with less contacts or visits from their relatives. For those living in extended family surrounded with their relatives, they usually receive advised and were asked about having children. However, both types of residence have no effect upon decision making to seek treatment since they decided to accept their infertility condition, and do not believe such advise that could help them having children. Besides, all of them positively perceived the words and advises from their family and relatives that they all concern for their problems and have good wish, so they do not feel pressure or worry from those words.

The in-dept interviews revealed that apart from those spoken words received from their family and relatives, the sample groups also receive such words from friends, neighbors, and colleagues. These are mostly criticize words about the infertility problems of the samples and asking about having children but not blaming for the deformity of infertile women, and no words mentioning about the deformity of men. However, because of frequent listening of these words, it had caused annoy, stress and unhappy among these infertile women but not that worse to effect their decision making to seek treatment. For those seldom perceived those words, they feel alright and pay no attention on it.

Spoken words from relatives Most of infertile women not seeking treatment perceived positively on those words that their relatives concern with their problems and have good wish, so they do not feel stress or thought about it

> *"They concern why we have no children. They are afraid nobody will take care of the children if having children very late, and they will not have grown enough to help us. They are good to me. Sometimes they asked why I have no children for we married for many years. But I do not care, we seldom met. They say good things, they concern, I am not upset" (A)*

> *"Others in the family did not pressure me, just asking when I will have children, they just concern, that's all, I'm OK"(Tuk)*

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> *"Mostly my relatives just ask when I will have children, we seldom met, I do not feel anything" (Jee)*

> *"They never said anything, not ask. My husband's sister said when I will have children. I am to have children but no one comes, some are not ready for it but they have children. She likes to say this. I am not serious"(Mod)*

Spoken words from social networks The words from friends, colleague, and neighbors usually are asking about having children or health problem, no words mentioning about the infertility problem of women that caused annoy, so they did not have pressure from those words.

> *"They said I am getting older why I have no children, or, am I good at it. I don't care , just let them said, but a bit annoy" (A)*

> *"My colleagues asked me when will I have a baby, when I will hold a baby, but never a bad word. I just feel if I am guilty having no children. Why asking, but I am not that serious" (Nui)*

> *"They talk often why I do not have a baby. Others' babies have grown up, but mine has not come yet. Some said sarcastic like I am weak to make children, because I have allergy, always getting cold. I heard them said very often I can't help thinking, they didn't understand our feeling, but I know they are just kidding"(Jee)*

> *"Most of them know I have no children but they didn't say any words. I went to the market, they say hello where are Mae Mun (infertile) going. I am not angry, what can I do, we the rural people did not take such words seriously. It's not a shame or something abnormal" (Ning)*

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4.3.4.1 Medical discourse regarding infertility problem

The study found that medical discourse had an influence on those non-seeking treatment infertile women in terms of belief and acceptance of medical treatment and the potential of the doctor. However, they do not seek treatment partly because they can accept their infertility problem, so they do not try any treatment. They indirectly perceived medical discourse from media because they did not see the doctor. Most of the media they perceived are television through the health programmed or talk show presenting the story of evolution and potential of infertility treatment presented by specialize doctors. However such media did not have any influence on decision making to seek treatment of these infertile women.

> *"I have seen in TV, the doctor presented the knowledge how infertile woman take care of themselves. I watch TV a lot because I stay home all day. The programme is presented in early morning. I thought today the doctor is good, the instruments is advanced. The well-off can afford it. If asking me, I think never mind if I had no children, no matter how good the doctor is" (Joy)*

> *"I have seen an advertisement saying infertility treatment in front of the clinic, but I did not pay attention on it, just know it is available in any places" (Jiab)*

There are 2 cases in the non-seeking treatment group believed and accepted medical explanation. Both have not received medical checkup but they believed if the result showed her abnormality, it is actually their mistake according to the doctor's words, and they would become stress and worry about the result that they have deformity, hence having family broken. Because of this reason, the sample group are afraid to see the doctor. It can be seen that medical discourse has an effect on decision making to seek treatment.

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"If the doctor examined and said I am infertile, and my husband know about it, what can I do if the doctors found I have deformity and cannot have children. If my husband wants children, I am afraid we have problems, and find someone else. I am not ready for that if the doctor said I am infertile"(Tum)

I hesitate to see the doctor, I am worry if the doctor said I am abnormal. Perhaps I try a checkup if the doctor said I have something wrong, I have to compose myself for a while, then tell my husband"(Mod)

4.4 Conclusion of the result

4.4.1 Feminine role

It was found that the perception of women's role on reproduction and giving birth is not different between those seeking treatment and non-seeking treatment groups. That is, both groups perceived that the role of reproduction and giving birth belong to women because naturally females have different physical organs from males that conducive to conceive pregnancy and to give birth. Therefore married women and have family normally have children. Both groups also perceived that their role to give birth is to build up warm and perfect family, and thus prevent family broken, or the husband have extra marriage partner because their wives cannot have children. The first group had much worry about family problem because they perceived their husband's position of wanting children. While the latter group thought that having no children caused no problem to themselves and family because they knew that their husbands did not pay attention or are eager to have children. In addition, the first group had perceived the reproductive role to continue offspring, while the latter perceived such role for continue family line and assets to their husbands' family which was found among those whose their husbands' family are wealthy or own large business. It was also found that the first group is expected from their husbands that they have to take role in producing heir, and such expectation had put pressure on these women. For the second group, producing offspring is to reproduce the new labors to substitute the old ones and to assist parent's burden in the

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farm which was found among those in agricultural work. However this group are aware of economic burden from having children because they have low income.

Regarding the meaning of infertility, both groups perceived reproductive role as natural duty of women, therefore, most of them had noted it is her abnormality not their husbands'. For the second group, they had meant their infertility problems as a natural abnormality, and that they are different from others who can conceive pregnancy, but they are not sad or sorry for having no children because they thought that having no children did not cause any problem to themselves and their family, and importantly their husbands did not pay attention on it. They can negotiate with their husband to accept the infertility problem. Besides, the infertile women who have low income gave the reason that having children increased economic burden to the family. Whereas the first group noted that infertility is their own problem than od their husbands'. They are serious about perception of reproductive role and expectation or their family and relatives especially their husbands than that of the second group. Hence they become more anxiety pressure. They have medical checkup and found that they were investigated by the doctor that they are abnormal. The infertile women thus meant themselves according to the checkup result that their body is abnormal, incomplete, conformity, and failure to take women's and mother's role, and are different from general women. So they feel sad, sorry, stress, and inferior that they are inability to have children. However, in case that the doctor investigated that their husbands are infertile, they meant themselves no deformity.

4.4.2 Gender power relation within the family

With respect to the pattern of residence after marriage, _both groups have similar pattern of living arrangement . Most of them have single family type separately from their own family, away from relatives, and have less contacts and visits from their relatives, hence have less involvement much in their fertility problem. For single family with regular contacts and visit from relatives, the infertile women often received cautions and advises about solving infertility problems and alternatives which was found among the first group than the second group. This type of living has put much pressure on these women. For those living in extended family with their

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husband's family, the first group was not paid attention about infertility problem from their husband's family. In contrast, the latter group have received much attention from their husband's family especially from their husband's mother who want grandchildren to continue family line. They are stimulated to have children of have infertility treatment. This group have low status and less decision making power because all decision making depends on the seniors in the husband's family. They lack of privacy and freedom. This living arrangement put them in serious pressure. For those seeking and non-seeking treatment who live with their own family, they feel warm and supportive, and have high status in the family.

Economic productive role There is no different between both group regarding economic reproductive role. Such role has an effect on decision making and negotiation power with their husbands. Women with equal economic productive role as their husbands can express their idea, make agreement, and share decision with their husbands in various family matters, and make own decision in some matters. For those having more economic productive role than their husbands, main decision making belongs to the women from small subjects to big stuffs such as household spending to large spending. Similarly, infertile women with no economic productive role at all but depend solely on their husband to earn income, have to be reluctant to their husbands, give them honor as family leaders who earn for the family. Therefore, the decision making depends on their husbands especially the important matters. However, those with no economic role, being housewife, but came from the richer family than their husbands, they are regarded as the owner of production inputs than that or their husbands, and thus receiving love and reluctance from their husbands. Therefore, they can share have decision making with their husbands in various matters, while some may have more decision making power than their husbands particularly on financial matter.

In consideration of sex negotiation power in the context of gender relation, both groups have similar pattern of sex negotiation power, i.e. they have sex negotiation power at a certain level. They can start having sex by using body language such as lying against their husbands, hugging, or dressing sexy pajama, very few used

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oral communication when wanting to have sex, while some who wanted to have children and know their own ovulation date may claim the doctor's advise to have sex with their husbands. A number of these women never start having sex with their husbands whether they have sexual desire or not. Regarding negotiation to refuse sex, almost all never refuse having sex with their husbands, very few seldom refuse having sex gently with health problems like having headache. Every of them perceived that it is their role being good wife, pleasing their husband by sexual response, and to have children.

4.4.3 The context of daily spoken words attacking the deformity of women's health and medical discourse regarding infertility

With respect to the context of spoken words in family and relative system, it was found that those who live in single family with regular contacts with relatives and extended family surrounded with relatives have received advises about solving infertility problem, although they meant to support and assist infertile women but they did not want others to bother or criticize or giving opinion about their infertility problem. For those living in extended family of with their husbands or living in single family closed to the relatives of their husbands, they are expected to have children after marriage, and have been paid attention about having no children, and seeking treatment or alternative to have children. In particular their husband's mother mentioned about having heir to continue family lines and assets, and suggested their husband to have the new wife. These women have to accept and become tolerate with such blaming and pressure from those words of their husband's family. Besides, the their relatives who visit them always ask about having children or using the words to blame the infertile women who have not proceed to solve the problem, for example, "Why having no children yet ?", "Do you have children ?", "Why not seeing the doctor ?. these words put much pressure on these women. However, the word of those relatives seldom met did not put pressure on them. The words from social networks like friends and colleagues who regularly met are rather negative such as teasing their husbands to find the new one, or talking about the deformity to have children without mentioning men's disfunctioning. Although those words are not that serious but

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making the infertile women feel like attacking their deformity and disfunctioning role as wife, feeling anxiety, stress, and afraid that their husbands might have the new wife. The words like "not pregnant yet?" is also have much pressure because they meant their infertility a deformity, incomplete, abnormality, and inferiority. They thus become sensitive towards words and position of those surrounding. The context of spoken word, questions, advises from others have put much pressure on them and subsequently influenced their decision making to seek treatment to reduce such pressure from the context of spoken words. For those non-seeking treatment , the words and advises from relatives had no influence on decision making to seek treatment because they already perceived that their relatives concern about them and have good wish for them. In addition, they have not been paid attention from their relatives about the issue of having no children, hence having no pressure or worry. However, the word from social networks which mostly and often criticized negatively on infertility problem have caused some annoyance and upset but had no pressure to decision making to seek treatment.

Medical discourse regarding infertility problem It was found that medical discourse had much effect on decision making to seek treatment on the those who seek treatment caused by meaning of fertility, medical examination and treatment direction. Those having physical checkup were explained about their abnormality and deformity of female organs, and received advises that the treatment can be made by correction or adjustment of such organs. Every of them believed and accept such description and investigation of the doctor that they have something wrong with their body which caused infertility. The doctor identified the direction of treatment of each case and that the infertile women can just perceive the explanation and reason from the doctor. All had agreed with the methods suggested by the doctor although not succeeded. However, they are explained about the new methods that increases chances of success, hence making these women accept the new procedure because they trust the doctor who are expert in health particularly on infertility issue. They also perceived the knowledge from various media such as TV programmed, newspaper's column presenting the potential, efficacy, and ability of the doctor and advance technologies that increase chances of success. Such an image convinced their trust and acceptance

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as found among those seeking treatment but have no decision making power since they already decided to accept the situation with their husbands.

According to the above conclusion of the main 3 issues, the pattern of decision making to seek treatment of the infertile woman can be summarized in the next part.

4.4.4 Pattern of decision making to seek treatment

Classifying by the group of seeking and non-seeking treatment, the stage of pattern of seeking treatment is as follows: 1) Perception on the role of giving birth and meaning of infertility when those seeking treatment perceived that the normal role of women is to have children, and the role of good wife is to have children for their husbands so as to build up warm and perfect family, as well as to give birth to heirs to continue family line. Most of them perceived that they themselves have caused infertility. When they have no children, they just meant themselves failure to their duty, incomplete, deformity, abnormal, hence being sad, anxiety, worry about having no children. For those non-seeking treatment, the have meant themselves having natural abnormality, and differ from other women but they do not feel sorry or anxiety. 2) The infertile women have evaluated the infertility problem. They feel guilty of deformity and inability to give birth. They received pressure from many sides including expectation of having children from family and relatives and surrounding society especially their perception of their husband's position of wanting children. They are afraid their husbands having someone else because they cannot have children for him. They received regular negative spoken words about infertility problem of women that make them become stress, under pressure, and anxiety. They evaluated the problem and found that having no children have much impact upon them, so they try to find alternative by seeking treatment. For those non-seeking treatment, they meant themselves having something wrong from other women who can conceive pregnancy, but they are not serious at it because they knew their husbands neither pay attention on it nor eager to have children. In addition they can discuss and share decision making with their husbands to accept the infertility problem. Besides, they perceived the impact of having children, i.e. those having low income perceived that

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having children increases economic burden to the family. However, they did not receive much pressure or expectation of having children from their family and relatives. Hence they evaluated that having no children creates no problem to themselves and their family especially to their husbands, so they are not struggle to have children, hence decided not to seek treatment. 3) Seeking treatment – Every of infertile women is the main decision maker to seek treatment since they perceived their responsibility to their deformity under the agreement and support of their husbands. They started with follow up information on infertility from various media such as T.V., newspapers etc. Their family and relatives involved in giving advises about alternatives for having children, but because they separated from their own family so their relatives had less influence on their decision making. However, social networks such ad friends, colleagues, and neighbors especially infertility networks with infertility experience had much influence on decision making, and that these women always receive advises from the social networks. 4) Seeking types and places of treatment. It was found that every of infertile women most trusted and accepted the modern treatment methods. Every case started with seeing the doctor for physical examination to investigate any abnormality that cause infertility. Most of them are diagnosed having physically deformity that caused infertility. The doctor then advised them that such condition can be treated by correcting the deformity. All decided to have modern medical treatment because they believed it can help them having children. Some of them received treatment from the doctor who performed physical examination, while some seek additional information about sources of treatment they thought effective before making decision on type and source of treatment. It was found that social networks and infertility networks played much influential role on decision making about sources and expertise in infertility including advises and what has been told from mouth to mouth. The decision making depends on their evaluation about medical expertise, successful performance. In case receiving treatment for a period of time, evaluation of the result was undertaken. If the evaluation showed inefficacy, or no description from the doctor about its failure, or inconvenient commuting, they may seek treatment from other sources. Some had integrated treatment, but found less, between the modern methods and traditional methods/alternative medicines such as praying, drinking blessing water, taking boiled

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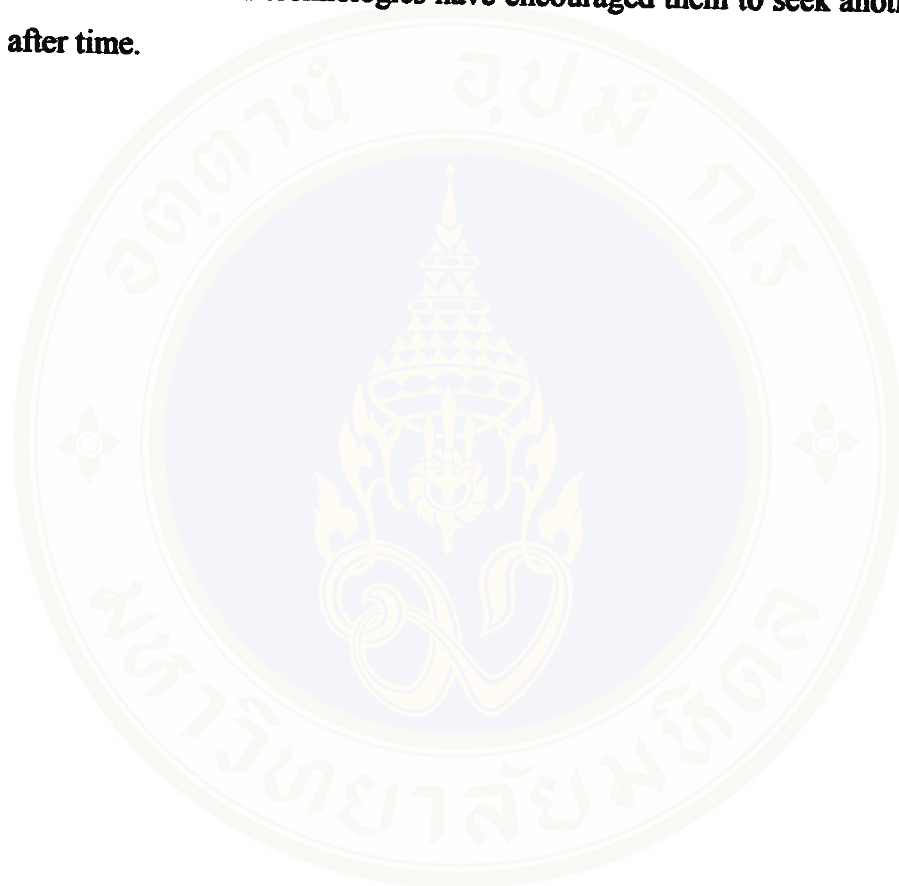
herbs etc. but just a trial for psychological reason, not expecting the success because they rather trust in modern treatment. It was also found that infertile women had prolong treatment behavior because of the failure that make them feel disappointment and pain, thus they need sometimes to compose their physical and mental preparedness. The stimulation of social networks through information on sources of treatment and advanced technologies have encouraged them to seek another treatment time after time.



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CHAPTER V

DISCUSSION AND RECOMMENDATION

This study is a qualitative research of specified case study. The sample groups comprises infertile women who seek treatment, and infertile women who do not seek treatment. Selection of the sample groups was made by snow-ball sampling and purposive sampling, totally 15 cases in each group. In-dept interview was employed for data collection, in combination with various techniques : Free Listing, Picture Code, and PRA-Participatory Rapid appraisal. This research aimed at identifying help seeking behavior of infertile women in the context of gender relations including feminine role, gender power relations, the context of medical discourse regarding infertility problem, and the context of daily spoken words effecting decision making to seek treatment of infertile women. The result of this study is served for making understanding the factors effecting the decision making to seek treatment of infertile women.

5.1 Discussion

As described earlier, decision making to seek treatment of infertile women Is influenced by various factors, but the most important influences that found thinking process of the women are feminine role, perception of reproductive role, meaning of infertility, all that are defined by cultural society through socialization which is a complex process. Individuals are tighten with existing social structure. This type of relationship is shown as individual need to take various duties and roles in, for example, working, ruling, education, religion, family. The foundation of characteristic, personality, and gender role through nurturing process since childhood had defined characteristics and meaning that specific to gender role. Such role is

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expected by the society what men and women should practice. Boys and girls are taught and nurtured to take different role and behavior. Boys learn how to be strong, brave, leadership, while girls are taught to bear household burden, being good mother and good wife. The definition of social role is specified since the childhood an that female have to accept their feminine role especially the role of childbearing, giving birth which is consistent to biological characteristics of female that differ from male. Females are able to conceive pregnancy and give birth, therefore, they have be responsible for their natural role without any excuse.

In addition, furthering idea and nurturing ideology, norms and belief in gender role through socialization are promoted by various institution such as family institution, academic institution, and medical institution. All thus become a part of social awareness to build social norms and measurements that meant the role of women in giving birth, and believe that having children is identity of womanhood, the role that is expected by woman themselves, family, relatives, and society. Attention has been paid to women as producer of the new generation, or substitute labors for production which is the main target of marriage in Thai agricultural society (Sontasombat, 1992:50). It is found that infertile women in agricultural family want to have children to be the labor in agricultural work. Giving birth to children is to produce labors to assist the farm work of the family. In addition, the reproductive role means continuing human race and family lines, furthering family assets. Marriage or having children is to reproduce new generation as labors to furthering properties (Chowdorow, 1979 : 95). In this study such norm was found among those infertile women living in the wealthy family because the mother of their husbands want to have grandchildren to continuing family lines, and they are expected to have children as family labor to furthering family business and properties. Some expected to have children for continuing family line. This has shown that the society had defined women's duty for producing offspring for the benefit of capitalist, family labors especially their husband's family. This it to tighten family unity and continuing family lines. This is devalued women if they are unable to have children, they might

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have been put on pressure from such expectation, without negotiation power in the family. The cultural society had defined gender role differently. Females have identity and role to give birth with supportive biological factor. When couples are unable to have children, the definition of infertility if different. As mentioned earlier, nurturing of sexual norm and biologic factors, the society has criticized and meant infertility the abnormality of female than males, even women themselves had perceived it. It can be seen that infertile women had noted their abnormality than their husbands. The social networks also meant infertility as women's mistake. Importantly, medical discourse investigated women have caused infertility. All of these attacked women's role in having children and correcting the problem. According to the result, women had meant themselves about physical abnormality, incomplete, deformity, failure to pursue the duty and identity of giving birth which is against themselves and social expectation. Infertile women become stress, unhappy and under pressure and anxiety, and inferiority. In case their husband are infertile, they still feel they are failed to being mother, although it is not their mistake, while men did not pay attention to it or eager to have children. This is consistent with the study of Gerrits interviewing infertile couples and found that all of them felt that infertility experience had much effect on themselves, while their husbands thought they are just disappointed in having no children but not effect other experience, only a few thought their identity was destroyed (Gerrits, 1991:51-57). As the cultural society defined gender role and that women perceived their duty and responsibility in combination with expectation of their family and relatives regarding the role of having children, it has increasingly attacked women's role and responsibility.

Besides, the result suggested that infertile women are worry about the problem of family broken because their husbands have extra marriage sex, or might lead to the divorce because they cannot have children for their husbands, and might be claimed by their husbands. This is may be due to the cultural society that contribute to men's power to control over female's body and sexual relation through the monogamy marriage. In particular, extra marriage sex practiced by males is viewed by the society

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as a common things, while female may be seriously blamed or stigmatized. This has made female become subordinate to male. The perception on good wife role that women have to take care of their husband, thus having children is a part of fulfilling male's potential of being fatherhood. Because the patriarchy society had define female role as reproductive that support masculinity, and as a wife, woman has to support her husband. Although their husband never mentioned about wanting children, but women can notice from their position such as holding and hugging children that reflects their need of having children. Being infertile, women are worry and afraid that their husbands might have someone else who can have children by claiming inability to have children of their wife. And women cannot even call for it because it is meant to be their mistake.

Regarding economic productive role, most of women have equal economic productive role as their husbands. They both shared income earning for the family, while some had better economic role than their husbands. Women who take major economic role than their husband usually have status and decision making power in the family at a certain level. This is because formerly males take roles in public sphere, i.e. earning for family, using power and ability, while female take role in domestic sphere, taking care of the housework. Today, due to changes in socio-economic situation, the family could not rely sole on men's earning, but women also have to work outside. An because women now have higher education, they are able to engage in the high skill work that require knowledge and ability as same as men do. They thus earn higher income and have equal economic role as men, and even become the main producer in the family. Women are not dependent on their husband anymore. They take increasing role and share decision making with men, while some have higher economic role and decision making power than men. The result is consistent with the study of Boonmongkol who conducted a study on gender relation in a village and found that the role of men and women inside and outside the house are not defined separately, and women can also work outside as men. Women take role in collecting money and make decision on family spending for miscellaneous things such as buying

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food, but not the main decision maker of the family. Women who can earn for the family become a main factor that increase their status and decision making power in the family at a certain level. Therefore, women dare to talk and negotiate with their husband in various matters (Boonmongkok, 1999:24 – 25). Women who have no economic role, and not the housewife, but come from a wealthier family than their husband would have decision making power as well because they own most of the assets which reflects their economic role similar to productive inputs, providing them status and decision making power at a certain level. For those having neither income nor economic productive role, they have low status and decision making power. Hence decision making power in the family depends on men and they are economically dependent on their husbands. Because men takes productive role, they have higher status and more power than women. Although infertile women is responsible for the housework but it create no income, no compensation so it is not counted as production in capitalist view, as for the men's work outside. However, in overall, economic productive role of infertile women is equal to men, providing them higher status and increase negotiation power. Regarding infertility problem, their family, society, and infertile women themselves still aware that it is female's responsibility. The study showed that women make decision to seek types and sources of treatment, and men are to support and follow, or stay calm. This is likely rooted from nurturing social norm and socialization regarding gender role in the patriarchy society.

The study of power relations in the context of sexual relation between husband and wife revealed that a number of infertile women are able to identify their sexual relation at a certain level, i.e. starting sex by using body language such as lying against their husbands and teasing. Most of women thought that it is not suitable to over express sexual desire. Very few used words because they wanted to have sex at the ovulation date so they can conceive pregnant. Some of them never starting sex with their husbands, mostly their husbands start first. It can be explain that cultural social controls sexual behavior of women by set up image of honor, and shame if women

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have sexual behavior against the rule. For example, over expression of sexual desire is shameful, women should behave. The Thai society regards sex as men's matter, i.e. male defines, controls, and decides, female is to response. It was found that most of infertile women never refuse having sex with their husbands. It showed that sexual role of female in the family is subordinate to male. As women cannot express their sexual desire to their husbands, it directly effects chances to conceive pregnancy. In case if they want to have children, women need to tell their husband because women knew their ovulation date and that sexual intercourse must occur on that date. Because of being subordinate status, women may be afraid to talk or negotiate with their husband about sex in other aspects, as in case on infertility problem.

The pattern of residence after marriage effects status and decision making power of female in the family. It was reported that infertile women live in nuclear family. Separate living without the surrounding context by their relatives of both sides allowing the couples are free in making decision and manage problem in their family. Increasing economic role of women providing better status and more decision making power in the family, sometimes women can share decision making with their husbands. Infertile women living in extended family with their husband's family would have lower status and less decision making power. This is because women have to adjust themselves in the new environment, and become reluctant with their husband's mother. They dare not ague with their husbands. They have no support of negotiation power in the family. Living with relatives of their husbands allow their husband's mother to pay attention on having children by forcing them to have children . This finding is conform to Gerrits that infertile women, as daughter, who live with their husband's family or in the context of family and relative of their husbands have been paid attention on infertility (Gerrits, 1997:43). This has put much pressure on the infertile women, making them in a lower status and having less negotiation power in the family. Having children might help increasing their status and be more accepted in the family. In contrast, infertile women feel warm living with their own family and relatives, and have higher status as well as negotiation power because their husband

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have to adjust themselves living with women's family. In addition infertile women feel more supportive from their relative and play important role in their own family. It can be seen that the pattern of residence after marriage has an effect on negotiation power in the family, and may influence negotiation power in management of infertility problem.

Pattern of residence after marriage is associated with the context of spoken language used in family and relative system. Living in extended family with the husband's family or closed to their relatives allows them to pay a visit, give advise and empathy, or asking about the children, similarly the social network including friends, neighbors, and colleagues. Women working outside have a chance to meet other close friends other than their relatives, thus exposure to the context of spoken language used by the social networks which has more influence to the infertile women than their close relatives. This is partly because living in the nuclear family have less contacts with relatives. The study showed that the infertile women do not want other to criticize or being sympathy or give advise because they thought that those words although just to show their wished but it attacks their feeling and their deformity and inferior, particularly the teasing words from friends but somewhat blaming the deformity of infertile women, including words that encourage their husband to have the new wife. All these words have put much pressure on the infertile women and feel stress and worry that their husband will have extra marriage partners. The words like "When will you have children" or when their husband' mother forces her to have children or seek treatment because they are waiting to have grandchildren to continue their family lines, sometimes blaming about their abnormality and infertility, or told their son to have new wife, or not accept them as daughter-in-law. The influence of the mother of their family is that the infertile women have to live with husband's family among the context of talking, cautioning, blaming, teasing. Being in such condition make the infertile women feel inferior but have to accept the condition. This is consistent with the study of Boonmongkol (1999:120) that in the context of family and relative with infertility problem, their relatives and those in the family always say

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negative words or blaming the infertile women that they cannot take female role (Boonmongkol, 1999:120). It is obvious that in the patriarchy cultural society that define the role of women as mother or giving birth to continue family line, making the context of relatives surrounding the infertile women become subordinate to men, and have to be responsible for it, and put much pressure on the infertile women especially the words related to infertility that force infertile women to seek treatment to reduce the pressure from the context of spoken words.

Perceiving their own problem, the infertile women have received physical examination to investigate the cause of infertility. Infertile women chose to have the checkup with the doctor because the modern or western medical system are widely accepted. Infertile women might have experienced the public health system from other illness, when they have problem they thus seek treatment form modern medicine, and because the doctor is specialize in this field. The study showed that infertile women seeking treatment believed the description of the doctor after being investigated, and meant their own abnormality according to the doctor. Mostly, infertile women were investigated having some abnormality that caused infertility. Th result has made these women to meant themselves incomplete, deformity, feel sorry and unhappy. It can be said the description of the doctor had the power in identifying the status of infertility of women, and that they accepted and trust the medical discourse. The result confirmed the statement of Foucault about the discourse and power that the special discourse of specialist defined the scope of words and discourse that is accepted in the society, and it is also established those who stated it such as the doctor that have the power to state about the illness or health problem and is likely to be accepted form the people in the society (Foucault, 1972 cited in Charoensinoran, 1999: 3 - 13).

Medical discourse had influenced decision making to seek treatment of infertile women that occurred in the context of treatment at every step, from physical examination. It was found that women were examined to investigate the cause of

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infertility, which was undertaken in female than male. The doctor explained that females have complicated physical organs than males so they should be examined. Some case felt that they were abnormal not their husbands. Males were not examine, but if done, just only have semen test. Besides, the advise and treatment are mostly for females although the abnormality was for males, for instances, injection or administration of hormone, to stimulate ovulation, and GIFT etc. The treatment is rarely for men but to be advised to quit drinking and smoking cigarettes, or taking medicines. The medical discourse that explain, examine, advise, and treat focus on females than males, have put female in the position that have to accept the correction and change. It might be the medical discourse of specialize doctors that make women accept and cooperate with the doctor and agreed to the doctor that it was female's abnormality that caused infertility and need to be corrected. It might be influenced by the medical discourse that mentioned about the innovation of advance medical technology to solve the infertility problem of female, crate the image of medical success and medical advances, through various media including TV, and newspapers. As Rowland said medical discourse about the success of IVF technology widely disseminated through TV and newspapers, and female magazine presented the scientist or doctor about chances and hope of infertile women to pursue motherhood role (Rowland, 1992 cited in Lupton, 1994 : 157). Therefore, explanation of the doctor as well as the medical knowledge base treatment and supportive technology and media, and partly because of advances in communication technology, that had an influence of perception of information about infertility are disseminated by both government and non-government sectors. Medical words had power and influence on infertile women. It was also found that medical discourse is consistent with what women have learnt so women are likely to accept it.

It can be stated that medical discourse is the reflection of women' s role that the power of medical discourse had dominated and that female need to bear the whole infertility problems starting from explanation of female's physical abnormality and the step of treatment. This attacked infertile women to be responsible to solve the

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problem. Under the patriarchy cultural society structure, nurturing of norms and ideology on gender role defined female to take main responsible role to give birth. It founded belief in gender role through socialization and through various institutions such as family institution, academic institution, and medical institution. It turns to be social norm and measures that meant the role of women on giving birth and gender role to be absorbed in every space of the society including the infertile women themselves, medical personnel, and doctors. Being specialize doctor is absolute power to state about women's health. Medical discourse is thus accepted and trusted by infertile women and the people in the society, which effect decision making to seek treatment according to the doctor's advise.

5.2 Recommendations

5.2.1 Equal gender norms should be promoted. The research result suggested that infertile women had perceived and meant gender role that stick to biological or gender characteristics and linked with the past role such as being good wife by having children and raising children. This has an effect on women to be responsible to take role of having or not having children than male although it is a shared problem. In addition, it should also promotes the value of women in other ability aspect than focussing on ability to give birth. It is thus necessary to create knowledge and understanding in academic institution and family institution through nurturing, medical institution, as well as other institution regarding attitude and perception of equal and proper gender role without gender bias. Health education on gender role in giving birth is introduced as a shared responsibility. Social norms and ideology are created from the family level through nurturing children which will be transferred to the society in other aspects especially individually and medical aspect.

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5.2.2 The husband should take role start discussing with their wives if they are not serious and did not pay attention about having children instead of stay calm, making infertile women feel anxiety. The study found that the husband did not mention about wanting children but infertile women had meant from observing the position of husband that they want children. The pattern of relationship of no discussion between husband and wife has made infertile women become stress an worry about their failure to pursue the role of good wife which might cause their husband upset. Therefore the husband should take role to make understanding with their wives to ensure that having no children is not a problem.

5.3.3 Medical and health facilities should provide basic information about the treatment process or steps, duration of treatment, and evaluation, suitability of each method, and its side effect especially on women's physical and mental health in which the husband should involve in every step and process of treatment, chance of success and failure, as well as the cost of treatment. Such information is necessary for women to help making decision on suitable method for themselves.

5.3 Recommendation for further studies

1.The study on decision making to seek infertility treatment should be undertaken focussing on the husband regarding perception of gender role towards infertility problem, particularly on men as a cause of infertility or sterilization, to obtain additional and coverage information

2. Further studies should be carried out on decision making to seek infertility treatment under the medical management process since the modern medical system had considerable influence on thinking and decision making of infertile women. Further studies can increase understanding the environmental context of infertile women.

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การปรับตัวของสตรีที่มีบุตรยาก. วิทยานิพนธ์ปริญญาพยาบาลศาสตร์มหาบัณฑิต,สาขาการพยาบาลแม่และเด็ก บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

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APPENDIXES

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แนวการสัมภาษณ์ระดับลึก

1. ข้อมูลพื้นฐาน

1. ชื่อ ที่อยู่ อายุ
2. ประวัติของท่านตั้งแต่เด็กจนถึงปัจจุบันเกิดที่ไหน เป็นลูกคนที่เท่าไร พ่อแม่มีลูกกี่คน เรียนหนังสือชั้นอะไร หลังจากเรียนจบมาแล้วทำอะไร ย้ายถิ่นไปเรียนที่อื่นหรือไม่ เจอกับแฟนเมื่อไร
3. ลักษณะอาชีพ รายได้ จำนวนที่ดินและทรัพย์สินต่างๆ ที่ได้เปรียบเทียบระหว่างสามีภรรยา
4. สมาชิกในครัวเรือนมีกี่คนใครบ้าง
5. ท่านแต่งงานหรืออยู่กับสามีมานานเพียงใด
6. อายุ ขณะแต่งงาน หรือเริ่มอยู่กินด้วยกันกับสามีและภรรยา
7. จำนวนปีในการสมรส หรืออยู่กินด้วยกัน
8. ความสัมพันธ์ระหว่างท่านและสามีเป็นอย่างไร (รักกันดี/งั้นๆ/ทะเลาะกันตลอด)
9. ท่านกับสามีรู้จักเป็นแฟนกันมาเป็นเวลานานเท่าไรจึงตัดสินใจแต่งงาน
10. การตัดสินใจแต่งงานของท่านได้รับการเห็นชอบจากผู้ใหญ่ฝ่ายตนเองและสามีหรือไม่อย่างไร
    10.1 เห็นชอบ
    10.2 งั้นๆยังไงก็ได้
    10.3 ไม่เห็นด้วย
11. ระหว่างที่ท่านอยู่กินกับสามีและยังไม่ต้องการมีบุตรท่านคุมกำเนิดด้วยวิธีใดบ้าง ใครเป็นคนเลือก / ใช้เป็นระยะเวลานานเท่าไร

2. บทบาทหญิงชายในประเด็นการให้ความหมายต่อการเป็นผู้มีบุตรยาก การรับรู้บทบาทเพศหญิงในการผลิตซ้ำ

1. ทำไมท่านจึงคิดว่าตนเองเป็นผู้มีบุตรยาก
2. เป็นเวลานานเท่าไรหลังจากที่ท่านตัดสินใจที่จะมีลูกหรือพยายามที่จะมีลูกแล้วจึงตัดสินใจคิดว่าตนเองมีปัญหาการมีบุตรยาก
3. ท่านคิดว่าผู้หญิงไทยในปัจจุบัน (ถ้าแต่งงานแล้ว) ควรต้องมีลูกไหมเพราะเหตุใด
4. ท่านคิดอย่างไรบ้างกับการที่ท่านไม่สามารถตั้งท้องมีลูกได้
5. ท่านรู้สึกอย่างไรกับการไม่มีลูกของตนเองเพราะเหตุใดจึงรู้สึกอย่างนั้น
6. ท่านคิดว่าการมีลูกมีความสำคัญ ต่อ

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- ตัวท่านเอง หรือไม่ มากน้อยเพียงใด เพราะอะไร
- ต่อสามี หรือไม่ มากน้อยเพียงใดเพราะอะไร
- ต่อครอบครัวและวงศ์ตระกูลของท่านหรือสามีท่าน หรือไม่ มากน้อยเพียงใด และเพราะอะไร

7. เมื่อท่านไม่มีลูกท่านได้รับการปฏิบัติจาก ครอบครัว / เครือญาติ และสามี อย่างไรบ้าง ท่านรู้สึกอย่างไรกับการได้รับการปฏิบัติเช่นนั้น
8. ระหว่างท่านและสามี มีการกล่าวโทษซึ่งกันและกันบ้างหรือไม่ ถ้ามี มีการกล่าวโทษ / อธิบาย / วิจารณ์ว่าอย่างไรบ้าง
9. โดยทั่วไปในปัญหาการไม่มีบุตรของคู่สามีภรรยาท่านคิดว่าใครน่าจะโดนวิพากษ์วิจารณ์มากกว่ากันเพราะเหตุใดจึงคิดเช่นนั้น
10. ระหว่างท่านและสามีได้รับการ วิพากย์วิจารณ์หรือกดดันบ้างหรือไม่ ถ้าได้รับใครได้รับผลกระทบมากกว่ากัน และได้รับการวิพากย์วิจารณ์หรือกดดันจากใครบ้าง
11. ถ้าจะต้องไปเยียวยารักษาปัญหาการมีบุตรยาก ท่านคิดว่าใครจะเป็นผู้ที่จะต้องไปรับการตรวจวินิจฉัยรักษาเพราะเหตุใด
12. และในทางปฏิบัติระหว่างท่านกับสามีเป็นอย่างไร

3. <u>บริบททางภาษาคำพูดที่ใช้ในระบบครอบครัวเครือญาติ</u>

คนรอบข้างเช่น เครือญาติ พ่อแม่ พี่น้อง เพื่อน พูดถึงการไม่มีลูกของท่านอย่างไรบ้าง ท่านรู้สึกอย่างไร

4. ความสัมพันธ์เชิงอำนาจ ในประเด็นคำถามบทบาทการผลิตเชิงเศรษฐกิจและแบบแผนการอยู่อาศัยภายหลังการแต่งงาน

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1. ภายหลังจากที่ท่านแต่งงานแล้ว ท่านอาศัยอยู่ที่ใด อยู่ที่นั่นจนถึงปัจจุบันหรือไม่ มีใครอยู่ในบ้านบ้าง (ตั้งแต่อดีตจนถึงปัจจุบัน) เป็นบ้านของใคร ถ้าเป็นบ้านของตนเอง สร้างหรือเช่า (ใครเป็นคนออกค่าเช่าบ้าน)
2. ท่านรู้สึกอย่างไรกับการอยู่อาศัยในปัจจุบัน

   2.1 ชอบ เพราะ...........................

   2.2 ไม่ชอบ เพราะ...........................

   2.3 ยังไงก็ได้ เฉยๆ

   2.4 อื่นๆ.......................................

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3. ถ้าท่านเลือกได้ ท่านต้องการอาศัยอยู่ครอบครัวแบบใด เพราะอะไร
4. การอยู่อาศัยในปัจจุบัน มีผลต่อการตัดสินใจดำเนินชีวิตในเรื่องต่างๆของท่านและสามีหรือไม่ อย่างไร
5. ครอบครัวหรือสมาชิกในครอบครัวมีหน้าที่และกิจกรรมอะไรบ้างและใครเป็นผู้รับผิดชอบหน้าที่เหล่านั้น
    5.1 บทบาททางเศรษฐกิจ การทำงาน ค้าขายหารายได้เข้าบ้าน
    5.2 การทำความสะอาดบ้านเรือน การซ่อมแซมบ้าน
    5.3 การซื้อของ สะสมเงิน
    5.4 การดูแลสมาชิกครอบครัวยามเจ็บป่วย
    5.5 งานบ้านต่างๆ เช่น การทำอาหาร ล้างจาน ซักรีดเสื้อผ้า เป็นต้น
6. ใครเป็นผู้หารายได้หลักของครอบครัว สามีหรือภรรยา
7. มีการตกลงกันในการจัดสรรเงินสำหรับเก็บ ใช้จ่ายในครอบครัวอย่างไร ใครทำหน้าที่ในการเก็บเงิน
8. อำนาจการตัดสินใจในการดำเนินชีวิตของครอบครัวด้านต่างๆได้แก่ การใช้จ่ายภายในครอบครัว การหารายได้มาจุนเจือครอบครัว การรักษาพยาบาลในครอบครัว การออกสังคม เป็นการตัดสินใจของใคร สามีหรือภรรยา เพราะเหตุใด และในทางปฏิบัติใครเป็นผู้ตัดสินใจในเรื่องต่างๆในครอบครัวของท่าน
9. การตัดสินใจเรื่องอื่นๆ ภายในครอบครัวมีการปรึกษากันก่อนหรือไม่ ส่วนใหญ่ใครเป็นผู้ตัดสินใจ สมาชิกในครอบครัวคนใดที่เกี่ยวข้องกับการตัดสินใจเรื่องในครอบครัวด้วย ท่านคิดว่าเป็นเพราะเหตุใด
10. ท่านคิดว่าการที่สามีภรรยา ได้รับรายได้ที่แตกต่างกันมีผลต่ออำนาจการตัดสินใจเรื่องต่างๆภายในครอบครัวของท่านหรือไม่
11. ปัญหาการไม่มีบุตรได้มีการปรึกษาวิธีการรักษาเยียวยาระหว่างสามีภรรยาหรือไม่ ใครเป็นผู้ตัดสินใจที่จะทำการรักษา

<u>5. ประเด็นความสัมพันธ์เชิงอำนาจในบริบทเพศสัมพันธ์ระหว่างสามีภรรยา</u>

1. ท่านคิดว่าเรื่องการมีเพศสัมพันธ์เป็นสิ่งสำคัญสำหรับชีวิตแต่งงานหรือไม่อย่างไร
2. ท่านคิดว่าผู้หญิงควรพูดเรื่องเพศกับสามีของตนหรือไม่ เพราะเหตุใด
3. หลังแต่งงานแล้วท่านเคยพูดคุยกับสามีของท่านเกี่ยวกับความสัมพันธ์ทางเพศของท่านกับสามีหรือไม่ ถ้าเคย พูดเรื่องใดบ้าง และในโอกาสเวลาใด (เช่น ความต้องการทางเพศของท่านฯ)

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4. ในกรณีที่ฝ่ายหญิงมีความต้องการทางเพศ ท่านคิดว่าเธอควรที่จะเป็นฝ่ายชักชวนให้สามีเป็นฝ่ายร่วมเพศกับเธอหรือไม่
5. ท่านเคยเป็นฝ่ายเริ่มต้นชักชวนสามีของท่านให้มีเพศสัมพันธ์กับท่านก่อนหรือไม่ บ่อยครั้งแค่ไหนและท่านใช้วิธีการอย่างไร
6. ตั้งแต่ท่านอยู่กินกับสามี ถ้าท่านไม่ต้องการมีเพศสัมพันธ์กับสามี แต่สามีของท่านมีความต้องการ ท่านเคยปฏิเสธความต้องการของสามีหรือไม่ ในกรณีใด เพราะเหตุใด และท่านใช้วิธีการใดในการปฏิเสธ ประสบความสำเร็จหรือไม่ เพราะเหตุใด วิธีการใดที่ทำสำเร็จ
7. การมีเพศสัมพันธ์ของท่านกับสามี ส่วนใหญ่ใครเป็นฝ่ายชักชวน
8. ท่านมีเพศสัมพันธ์กับสามีของท่านบ่อยครั้งแค่ไหน
9. ท่านคิดว่าภรรยาควรมีบทบาททางเพศต่อสามีอย่างไรและในความเป็นจริง ท่านปฏิบัติกับสามีอย่างไรบ้าง

6. ประเด็นแบบแผนการตัดสินใจแสวงหาการักษาภาวะมีบุตรยาก

1. ท่านทำอย่างไรเป็นอย่างแรกเมื่อท่านคิดว่าท่านมีปัญหาการมีบุตรยาก
   - ใครเป็นผู้แนะนำวิธีการนี้
   - เพราะเหตุใดท่านจึงเลือกวิธีการนี้
   - ถ้าเป็นวิธีที่รักษาเยียวยาท่านรักษาที่ใด และเพราะเหตุใดท่านจึงเลือกการรักษาที่แห่งนี้
   - ผลเป็นอย่างไร ทั้งด้านความหวัง / จิตใจ / การตั้งครรภ์
   - ใช้วิธีนี้อยู่เป็นระยะเวลานานเท่าใด
   - เสียค่าใช้จ่ายเท่าใด
   - ท่านเชื่อมั่นวิธีการนี้มากน้อยแค่ไหน เพราะอะไร
2. ท่านได้แสวงหาการรักษาเยียวยาแบบพื้นบ้านหรือการแพทย์ทางเลือกบ้างหรือไม่ เช่น ยาสมุนไพร การบนบานศาลกล่าว พิธีทางไสยศาสตร์ เป็นต้น (ถ้ามีการแสวงหาการเยียวยา ให้ถามแนวคำถามเดียวกับข้อ 1)
3. แล้วท่านทำอะไรต่อไปอีก(ถ้ามีการแสวงหาการเยียวยาแบบอื่นๆหรือแหล่งอื่นๆให้ถามแนวคำถามเดียวกับข้อ 1.)

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4. ท่านพอใจกับการรักษาแบบไหนมากที่สุดที่เคยได้รับมาเพราะเหตุใด ท่านจะเลือกวิธีการหรือแหล่งการรักษาเยียวยาสักแห่ง ด้วยเหตุผลใดบ้าง

    4.1 ค่าใช้จ่าย

    4.2 ระยะทาง ความสะดวกสบายในการเดินทาง

    4.3 คุณภาพ

7. ประเด็นบริบทวาทกรรมทางการแพทย์เกี่ยวกับปัญหาการมีบุตรยาก

1. เพราะเหตุใดท่านจึงเลือกมารับการรักษาที่คลินิกแห่งนี้

- คำบอกเล่า จากใคร......... ว่าอย่างไร.........
- คำโฆษณา / สื่อต่าง คือ............... ว่าอย่างไร......... รับรู้จากที่ใด/ ได้ย่างไร.......
- เทคโนโลยีทางการแพทย์ เช่น................

2. ระหว่างท่านและสามีใครเป็นผู้ตัดสินใจ เพราะอะไร และท่านรู้สึกเช่นไรกับการตัดสินใจนั้น
3. ท่านและสามีได้รับการตรวจรักษาอย่างไรบ้าง ช่วยเล่าอย่างละเอียดตั้งแต่ต้น
4. ให้ช่วยเล่าการพูดคุยสนทนา และคำอธิบายของแพทย์ที่พูดกับท่านตั้งแต่ครั้งแรกที่ได้รับการรักษาจนถึงครั้งสุดท้าย
5. ท่านรู้สึกอย่างไรกับการตรวจวินิจฉัยรักษาที่ท่านได้รับ
6. ท่านคาดหวังความสำเร็จจากการรักษาที่คลินิกแห่งนี้หรือไม่ ถ้าท่านคาดหวัง มากน้อยเพียงใด มีสิ่งใดที่สร้างความเชื่อมั่นเพราะอะไร
    - เทคโนโลยีทางการแพทย์ เช่น...............................
    - คำบอกเล่า ว่าอย่างไรบ้าง..................
    - การอธิบายจากแพทย์ ว่าอย่างไรบ้าง................
    - คำโฆษณา ว่าอย่างไรบ้าง..................
7. ท่านรับทราบข้อมูลหรือได้ยินได้ ได้ฟังได้อย่างไร จากที่ใด
8. ค่าใช้จ่ายในการรักษาของท่านประมาณเท่าไร
    - ทั้งหมดโดยประมาณ
    - รายละเอียดในค่าใช้จ่าย อะไรบ้าง / แต่ละรายการเท่าไร (ถ้าทราบ)
9. ท่านมีความคิดเห็นอย่างไรกับค่าใช้จ่ายในการรักษา

(ถ้าได้รับการรักษาจากการแพทย์แผนปัจจุบันแหล่งอื่น ให้ถามคำถามแบบเดิมตั้งแต่ข้อ 1)

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FREE LISTING

ผู้หญิงแตกต่างกับชายตรงไหนอย่างไร

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บทบาทของผู้หญิงไทยมีอะไรบ้าง

ผู้หญิงไม่มีลูกจะรู้สึกอย่างไร

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ในฐานะที่ท่านเป็นผู้หญิงมีบุตรยากท่านรู้สึกอย่างไรบ้าง

คำพูดที่ท่านได้ยิน เพื่อนบ้าน ญาติผู้ใหญ่ ญาติพี่น้อง พูดถึงปัญหาการมีบุตรยากของท่านมีว่าอย่างไรบ้าง

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คำโฆษณาของแพทย์ หรือโรงพยาบาลที่เกี่ยวกับปัญหาการมีบุตรยากเท่าที่ท่านได้ยินมา มีอะไรบ้าง

PRA – Participatory Rapid Appraisal

1. การมีลูก
2. หาเงิน/รายได้เข้าบ้าน
3. ปรนนิบัติสามี
4. ทำงานบ้าน

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ผลการศึกษาจากการเก็บข้อมูลแบบ Picture code ในกลุ่มหญิงมีบุตรยากที่แสวงหาการรักษา

จากการที่ผู้วิจัยได้ให้กลุ่มตัวอย่างที่แสวงหาการรักษา ทั้ง 15 ราย ดูรูปภาพที่ผู้วิจัยเตรียมไว้ เพื่อให้กลุ่มตัวอย่างได้สะท้อนความคิดความรู้สึก ประสบการณ์ โดยการตอบคำถามจากรูปภาพทั้งหมด 6 ข้อคือ

1. จากรูปภาพเกิดอะไรขึ้น
2. ทำไมจึงเกิดขึ้น
3. เกิดขึ้นในชีวิต/สถานการณ์จริงหรือไม่
4. เหตุการณ์จากรูปนำไปสู่ปัญหาอะไร
5. อะไรคือสาเหตุพื้นฐานของปัญหา
6. จะหาวิธีแก้ไขอย่างไร

จากการศึกษาพบว่า เกือบทั้งหมดของกลุ่มตัวอย่างหรือมากกว่า 2 ใน 3 ของกลุ่มตัวอย่างทั้งหมดได้อธิบายภาพและตอบคำถามได้อย่างต่อเนื่องมีควาามสำพันธ์กับปัญหาการมีบุตรยาก

ข้อที่ 1 เมื่อให้กลุ่มตัวอย่างดูรูปภาพแล้วให้บอกถึงเหตุการณ์ในภาพเกิดอะไรขึ้นบ้าง พบว่ากลุ่มตัวอย่างบรรยายภาพในลักษณะความหมายใกล้เคียงกันคือมีผู้หญิงกำลังมองอีกครอบครัวหนึ่งที่อยู่กันอย่างพร้อม พ่อ แม่ ลูก ตัวอย่างเช่น

" ผู้หญิงคนหนึ่งยืนที่หน้าบ้านครอบครัวบ้านนั้นมี พ่อ แม่ ลูก"

"ผู้หญิงยืนดูครอบครัวที่อยู่กันพร้อมหน้าอย่างมีความสุข"

"ผู้หญิงคนหนึ่งยืนอยู่บริเวณหน้าบ้าน มองดูเด็กที่อยู่ในบ้านกับพ่อแม่"

ข้อ 2 กลุ่มตัวอย่างส่วนมาก ให้เหตุผลของการที่ผู้หญิงในภาพยืนดูครอบครัวอื่นว่า มีความสัมพันธ์กับความต้องการมีบุตร เช่น

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"คงอยากได้ลูก แต่ไม่มี ขอแค่เห็นก็เอา"

"อยากจะมีลูก อยากมีครอบครัวที่ครบเหมือนบ้านนั้น"

"ผู้หญิงคนนี้คงไม่มีลูก ไปยืนดูครอบครัวอื่นที่มีลูกเพราะตัวเองอยากมี"

ข้อ 3 กลุ่มตัวอย่างส่วนมากบอกเล่าว่า เคยเกิดเหตการณ์เช่นนี้กับตัวเองแต่เป็นสถานการณ์ที่ใกล้เคียงกันเช่น

"ที่เป็นบ่อย แต่ไม่ได้ไปยืนดูหน้าบ้านอย่างนี้หรอกนะ เห็นโดยบังเอิญ เวลาซื้อของ กินข้าวตามร้านอาหาร หรือว่าไปเที่ยวเห็นเขาพร้อมหน้าครอบครัว พ่อ แม่ ลูก เราก็แอบมองคิดคล้อยตามว่า ถ้าเรามีลูกคงมีความสุขแบบนี้ คงมีลูกหน้ารักแบบเขา เห็นเขาซื้อเสื้อผ้าเด็กพี่ก็อยากซื้อ ให้ลูกได้ใส่เสื้อผ้าน่ารัก ๆ แบบเขา อิจฉา"

"ที่เคย บ่อยเลย ชอบมองครอบครัวที่มีพ่อ แม่ ลูก เป็นภาพที่มีความสุข น่ารักดี"

"เคยบ่อย เวลาดูทีวีเป็นเห็นเด็ก ๆ หรือ พ่อ แม่ ลูก หรือคนท้องก็รู้สึกอิจฉา ไม่ไม่ได้อิจฉาตาร้อน อิจฉาแค่ทำไมเราถึงไม่มี"

ข้อ 4 กลุ่มตัวอย่างทุกรายให้เหตุผลว่า จากเหตุการณ์ในรูปจะทำให้ผู้มีบุตรยาก รู้สึกไม่สบายใจ น้อยใจ เสียใจที่ตัวเองไม่สามารถมีบุตรได้ และมีความต้องการอยากมีบุตรมากขึ้น

"ทำให้เกิดความอยาก อยากจะเป็น อยากจะมีเหมือนเขาเราก็น่าจะดิ้นรนมากขึ้น"

"อยากมีความสุขเหมือนเขา อยากมีลูกน่ารักเหมือนเขา ต้องทำให้เป็นเหมือนเขา"

"น้อยใจตัวเอง มีไม่ได้เหมือนคนอื่น

ข้อ 5 กลุ่มตัวอย่างส่วนมากอธิบายถึงสาเหตุของเหตุการณ์ในภาพว่าเกิดจากความผิดปกติของตนเอง ทำให้ไม่สามารถมีลูกได้เหมือนคนอื่น ส่วนน้อยที่ให้เหตุผลเกี่ยวกับการทำใจยอมรับกับปัญหา

- สาเหตุจากความผิดปกติของร่างกาย

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"มีความผิดปกติของร่างกาย ทำให้ไม่มีลูก"

"เราไม่สามารถมีลูกได้ตามต้องการ"

"ตัวเราเองผิดปกติทำให้มีลูกไม่ได้"

- สาเหตุจากการทำใจยอมรับปัญหา

"ทำใจยอมรับกับสภาพของตัวเองไม่ได้"

"ทำใจไม่ได้ยังอยากมีลูกอยู่"

ข้อ 6 กลุ่มตัวอย่างทุกรายบอกถึงวิธีแก้ปัญหาว่า ต้อทำการรักษา เพื่อให้มีบุตร ตัวอย่างเช่น

"ไปหาหมอเก่ง ๆ ที่ทำให้มีลูกได้"

"ปรึกษาหมอที่เชี่ยวชาญที่ทำให้มีลูก"

"เราต้องรักษาทุกวิถีทาง"

ผลการศึกษาจากการเก็บข้อมูลแบบ PICTURE CODE ในกลุ่มหญิงมีบุตรยากที่ไม่แสวงหาการรักษา

จากการที่ผู้วิจัยได้ให้กลุ่มตัวอย่างที่ไม่แสวงหาการรักษาทั้ง 15 รายดูรูปภาพ เพื่อให้กลุ่มตัวอย่างได้สะท้อนความคิดความรู้สึกประสบการณ์ โดยการตอบคำถามจากรูปภาพทั้งหมด 6 ข้อ คือ

1. จากรูปเกิดอะไรขึ้น
2. ทำไมจึงเกิดขึ้น
3. เกิดขึ้นในชีวิต / สถานการณ์จริงหรือไม่
4. เหตุการณ์จากรูปภาพนำไปสู่ปัญหาอะไร

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5. อะไรคือสาเหตุพื้นฐานของปัญหา
6. จะหาวิธีแก้ไขอย่างไง

จากการศึกษาพบว่า เกือบทั้งหมดของกลุ่มตัวอย่าง หรือ มากกว่า 2 ใน 3 ราย ของกลุ่มตัวอย่างทั้งหมด ได้อธิบายภาพ และตอบคำถามได้ต่อเนื่องมีความสัมพันธ์กับปัญหาการมีบุตรยาก

1. เมื่อให้กลุ่มตัวอย่างดูรูปภาพแล้วให้ บอกเล่าว่าในรูปภาพเกิดอะไรขึ้น ส่วนมากกลุ่มตัวอย่างบรรยายภาพในลักษณะ ความหมายใกล้เคียงกันคือ มีผู้หญิงยืนดูครอบครัวอื่นที่อยู่ด้วยกันอย่างพร้อมหน้าพร้อมตา เช่น

" ผู้หญิงคนนี้ (ชี้ในรูปภาพ) ยืนอยู่หน้าบ้านครอบครัวที่มีพ่อแม่ลูกนั่งอยู่หน้าบ้าน"

" มีบ้านในบ้านมีพ่อแม่ลูกนั่งอยู่หน้าบ้าน มีผู้หญิงยืนอยู่หน้าบ้าน"

" ผู้หญิงมาหาบ้านนี้ เขากำลังเล่นกันอยู่ชานหน้าบ้าน"

2.กลุ่มตัวอย่างส่วนมากให้เหตุผล ของการที่ผู้หญิงในภาพยืนดู ครอบครัวอื่นว่า มีความสัมพันธ์กับความต้องการที่จะมีบุตร เช่น

" เขาคงอยากมีลูกก็เลยไปแอบดูลูกบ้านอื่น"

" เห็นเขาเล่นกับลูกคงอยากไปขอเล่นกับลูกเขา คงอยากเล่นกับเด็ก"

" คงไปธุระ หรืออาจจะดูว่าบ้านโน้นทำอะไรกัน ไปดูลูกเขา คงอยากมีบ้าง"

3.กลุ่มตัวอย่างส่วนใหญ่บอกเล่าว่า ไม่เคยเกิดเหตุการณ์เช่นในภาพกับตนเอง แต่มีสถานการณ์ที่ใกล้เคียงเช่น

" ไม่ถึงกับยืนดู เห็นโดยบังเอิญก็แอบมองเล็กน้อยเท่านั้นเอง"

" มีบ้างที่มอง เห็นพ่อแม่ลูก น่ารักดี ที่ว่าคนอื่นๆคงเป็นเหมือนกัน"

" เคยเป็นบ้างเหมือนกัน แต่ที่จะเข้าไปขออุ้มเลยนะ เด็กๆมันน่ารักดี"

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" บางที่แค่มองแว่บๆ ไม่ได้ตั้งใจมองแบบนี้ (แบบในภาพ) หรอก"

4.กลุ่มตัวอย่างเกือบทั้งหมดมีความเห็นว่าผลจากเหตุการณ์ ในภาพที่เห็นครอบครัวอื่นพร้อมหน้าพ่อแม่ลูก การนำสู่ปัญหาที่ทำให้ ผู้หญิงที่อยู่ในภาพนั้นรู้สึก อยากมีลูก หรืออยากมีครอบครัวที่พร้อมเหมือนคนอื่นๆ บางรายคิดว่า ทำให้รู้สึกน้อยใจตัวเอง อิจฉาคนอื่น เช่น

" เกิดความน้อยเนื้อต่ำใจมีลูกไม่ได้ ทำให้อยากมีมากขึ้น"

" ผู้หญิงคนนี้ (ชี้ในภาพ) ก็จะไม่มีความสุข เพราะไปดูก็จะคิดมากอยากมีเหมือนเขา"

" ถ้าไปยืนดูลูกเขา ก็เกิดความอยากได้ลูกเขา หรืออยากมีลูกเหมือนเขา"

" อยากเป็นอยากมีเหมือนเขา ทำให้คิดมาก ไม่มีความสุข ปลงไม่ได้"

5.กลุ่มตัวอย่างได้อธิบายถึงสาเหตุของปัญหาว่า สาเหตุเนื่องจาก หญิงในภาพไม่มีลูก ทำให้ไม่สบายใจ ไม่ปลง หรือยอมรับกับปัญหาไม่ได้ เช่น

" คือปัญหาเนี่ย มันมาจากคนเรามันอยากมีลูกมาก แต่ไม่มีซักที ไม่รู้จะทำอย่างไร"

" อยากมีลูกแต่ทำใจยอมรับกับปัญหาของตัวเองไม่ได้"

" ปลงไม่ได้ ทำใจยอมรับสภาพของตนเองไม่ได้ เอาใจไปผูกติดกับปัญหามากเกินไป"

" คงอยากมี (มีลูก) แต่ไม่ได้"

6.ในการแก้ไขปัญหา กลุ่มตัวอย่างมีความคิดเห็นว่า ควรแก้ไข โดยการทำใจยอมรับกับปัญหาให้ได้ เช่น

" ต้องทำใจ มองโลกในแง่ดี มองในด้านที่ดีของการไม่มีลูก คนอื่นที่ไม่มีลูกก็เยอะแยะไป"

" ปลงอย่างเดียวเลย ถ้าปลงได้ก็หายอยาก"

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" ต้องทำใจ ไม่มีก็คือไม่มีต้องยอมรับ"

" ต้องทำใจรับสภาพให้ได้ แล้หันไปหาความสุขด้านอื่นทดแทน ให้คุณค่ากับตัวเราเอง หาอะไรทำจะได้ไม่ฟุ้งซ่าน"

"ทำใจอย่างเดียวต้องคิดว่าถ้าไม่มีคือไม่มี จะทำอะไรได้ เป็นเวรเป็นกรรมคิดอย่างนี้ก็มีความสุขได้ แต่ต้องคุยกับแฟนด้วยนะ ถ้าทำไม่ได้ทั้ง 2 คน ก็สบาย"

- มีกลุ่มตัวอย่าง เพียงส่วนน้อยที่มีความคิดเห็นในการแก้ไขปัญหา โดยการไปพบแพทย์ หรือขอเด็กมาเลี้ยง

" จริงๆต้องไปหาหมอไปตรวจ แต่ถ้าทำใจได้ก็ไม่ต้องทำอะไร"

" ไปปรึกษาหมอ หรือไม่ก็ทำใจ"

" ถ้าไม่มีลูกเอาเด็กมาเลี้ยงก็ได้นะ"

จะได้เห็นว่ากลุ่มตัวอย่างได้มีการอธิบาย หรือบรรยายภาพและตอบคำถามโดยมีความสัมพันธ์กับปัญหาการมีบุตรยาก โดยมีการให้มีความหมายจากภาพว่า ผู้หญิงยืนมองครอบครัวที่สมบูรณ์พร้อมหน้าพร้อมตา มีพ่อแม่ลูก และสาเหตุที่ไปยืนดู คือ อยากมีลูกครอบครัวที่สมบูรณ์อย่างเข้าบ้าง กลุ่มตัวอย่างบางราย เคยประสบกับเหตุการณ์ที่ตนเองแอบมองครอบครัวอื่นเช่นนี้มาแล้ว และคิดว่าจากภาพที่ทำให้เกิดปัญหาตามมาตามมา คือ ทำให้อยากมีลูกมากขึ้น รู้สึกเสียใจ น้อยใจที่ตัวเองไม่สามารถมีลูก หรือครอบครัวที่สมบูรณ์เหมือนครอบครัวอื่นๆ ส่วนสาเหตุของปัญหาดังกล่าวคือการที่ไม่สามารถทำใจยอมรับกับปัญหาได้ วิธีแก้ไขคือ ทำใจยอมรับกับปัญหาที่เกิดขึ้น ไม่ยึดติดกับการมีบุตรมากจนเกินไป

จากการที่กลุ่มตัวอย่างตอบคำถามจากรูปภาพ สามารถสรุปความคิดของกลุ่มตัวอย่างในภาพรวมได้ว่า กลุ่มตัวอย่างมีความคิดว่า ผู้หญิงมีบุตรยากโดยทั่วไปมักจะมีความต้องการบุตร และถ้าหากทำใจยอมรับกับปัญหาการไม่มีบุตรไม่ได้ จะทำให้เกิดความทุกข์ใจ ไม่มีความสุข น้อยเนื้อต่ำใจโดยเฉพาะเมื่อพบเจอครอบครัวอื่น ที่พร้อมหน้าพ่อแม่ลูกมักทำให้รู้สึกมีปมด้อยมากขึ้น ดังนั้น วิธีแก้ไขคือ ทำใจยอมรับกับปัญหาของตนเองให้ได้

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PRA- Participatory Rapid Appraisal

กลุ่มหญิงมีบุตรยากที่แสวงหาการรักษา

ตารางที่ 3 ลำดับความสำคัญของบทบาทเพศหญิงตามการรับรู้ของหญิงมีบุตรยาก

บทบาทเพศหญิง	ลำดับที่ 1	ลำดับที่ 2	ลำดับที่ 3	ลำดับที่ 4
การทำงานบ้าน	-	3	2	10
มีลูก	9	3	-	1
ปรนนิบัติสามี	6	5	5	1
หารายได้ให้ครอบครัว	-	4	8	3
รวม	15	15	15	15

บท 2 จากข้อมูลสามารถจัดลำดับความสำคัญของบทบาทเพศหญิงได้ดังนี้

ลำดับที่ 1 มีลูก

ลำดับที่ 2 ปรนนิบัติ

ลำดับที่ 3 หารายได้

ลำดับที่ 4 ทำงานบ้าน

จะเห็นได้ว่ากลุ่มตัวอย่างให้ความสำคัญกับบทบาทของการให้กำเนิดบุตรเป็นอันดับแรก รองลงมาคือการปรนนิบัติสามี คือ การเอาใจใส่ดูแลสามี ให้สามีมีความสุข และมีความพึงพอใจ นอกจากนี้กลุ่มตัวอย่างยังให้ความสำคัญกับบทบาทเพศหญิงในการหารายได้ให้แก่ครอบครัวเป็นลำดับที่ 3 อาจเนื่องมาจาก การที่สามารถหารายได้ให้แก่ครอบครัวทำให้กลุ่มตัวอย่างมีสถานภาพในครอบครัวดีขึ้น และเป็นการแบ่งเบาภาระของสามีในการหารายได้มาจุนเจือครอบครัว และจากการที่กลุ่มตัวอย่างให้ความสำคัญกับการหารายได้ซึ่งต้องออกไปทำงานนอกบ้านทำให้กลุ่มตัวอย่างจัดลำดับบทบาทการทำงานบ้านอยู่ในความสำคัญสุดท้าย

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Participatory Rapid Appraisal (PRA)

กลุ่มหญิงมีบุตรยากที่ไม่แสวงกาการรักษา

ตารางที่ 4 ลำดับความสำคัญของบทบาทเพศหญิงตามการรับรู้ของหญิงมีบุตรยาก

บทบาทเพศหญิง	ลำดับที่ 1	ลำดับที่ 2	ลำดับที่ 3	ลำดับที่ 4
การทำงานบ้าน	-	4	4	8
มีลูก	1	4	7	3
ปรนนิบัติสามี	4	8	2	1
หารายได้ / หาเงิน	10	1	2	2
รวม	15	15	15	15

จากข้อมูลสามารถจัดลำดับความสำคัญของบทบาทเพศหญิงได้ดังนี้

ลำดับที่ 1 การหาเงินหารายได้เข้า

ลำดับที่ 2 บรนนิบัติสามี

ลำดับที 3 การมีลูก

ลำดับที่ 4 การทำงานบ้าน

จะเห็นได้ว่ากลุ่มตัวอย่างให้ความสำคัญกับการหารายได้เข้าบ้านมากที่สุด เนื่องจากการที่สามารถทำงานหารายได้ ทำให้เป็นผู้รับบทบาทการผลิตเชิงเศรษฐกิจภายในครอบครัว และทำให้ตนเองมีสถานภาพ และอำนาจต่อรองภายในครอบครัวมากขึ้นด้วย และการปรนนิบัติสามีซึ่งเป็นความสำคัญที่รองลงมา มีความสำคัญในแง่ของการทำให้สามี มีความสุข มีความพอใจ โดยการดูแลเอาใจใส่สามีตามบทบาทหน้าที่ของภรรยาที่ดี ส่วนความสำคัญต่อการมีบุตร ซึ่งเป็นลำดับที่ 3 เนื่องจากรับรู้ว่าตนเองไม่สามารถมีบุตรได้ ตามบทบาททางเพศหญิงที่ควรจะเป็น แต่กลุ่มตัวอย่างส่วนใหญ่สามารถทำใจยอมรับกับปัญหาได้ จึงทำให้ความสำคัญต่อการมีบุตรอยู่ในลำดับหลังๆ และทดแทนโดยการที่ให้ความสำคัญ ในสิ่งที่ตนเองสามารถทำให้สถานภาพในครอบครัวของตนดีขึ้นคือการหารายได้ช่วยสามี ส่วนการทำงานบ้านเป็นความสำคัญลำดับสุดท้าย เนื่องจาก กลุ่มตัวอย่างให้ความสำคัญกับการทำงานหารายได้ ให้ครอบครัวมากขึ้น จึงจำเป็นต้องออกไปทำงานนอกบ้าน ทำให้ความสำคัญต่อบทบาทในการทำงานบ้านลดลง แต่ถึงอย่างไรก็ยังมีการให้ความสำคัญต่อบทบาทเพศหญิงในการทำงานบ้านอยู่นั้นเอง

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FREE-LISTING

จากการเก็บข้อมูลด้วยวิธีการ Free listing สามารถนำมาสรุปประเด็นข้อมูลของกลุ่มตัวอย่างหญิงมีบุตรยากที่ไม่แสวงหาการรักษาได้ดังนี้

1. ผู้หญิงผู้ชายแตกต่างกันอย่างไร

ผู้หญิง

- บทบาทหน้าที่ต่างจากผู้ชาย
- อวัยวะเพศลักษณะสรีระร่างกาย
- ผู้หญิงมีท้องได้ / เลี้ยงลูก
- ผู้หญิงต้องรับผิดชอบมากกว่า
- อดทน
- อ่อนแอกว่า
- อ่อนโยน / อบอุ่น
- ละเอียดรอบคอบ / ขยันอดทน
- ช่างจดจำ
- ผู้หญิงเสี่ยงต่อการเป็นโรคมากกว่าผู้ชาย

ผู้ชาย

- บทบาทหน้าที่
- ไม่มีความรับผิดชอบ
- แข็งแรง
- ต้อง ดูแลครอบครัว เป็นหัวเรี่ยวหัวแรงของครอบครัวปกครองคนในครอบครัว
- เข้มแข็ง
- ทำงานหนักได้

2. บทบาทของผู้หญิงไทยมีอะไรบ้าง

- เป็นภรรยาที่ดี
- เป็นแม่บ้าน
- เป็นคู่คิดของสามี
- ทำงานบ้าน
- ดูแลสามี
- ทำมาหากินช่วยสามี
- ทำงานนอกบ้าน
- ทำมาหากิน เลี้ยงตัว และช่วยสามีหากิน
- ทำงานบ้านเป็นหลัก ทำงานนอกบ้านด้วย

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- เคียงบ่าเคียงไหล่สามี ช่วยคิด ช่วยหาเงิน

3.ผู้หญิงมีลูกยากจะรู้สึกอย่างไร

- อยากได้ อยากมีลูก (พบมากที่สุด)
- อาจรู้สึกแตกต่างกันไปบางคนอาจจะอยากมีลูกมากเกิดทุกข์ บางคนเฉยๆ
- เหงา
- มีปมด้อย
- รู้สึกผิดปกติไม่เหมือนคนอื่น
- อยากมีคนไว้ให้แสดงความรัก

4. ในฐานะที่ท่านมีลูกยากท่านรู้สึกอย่างไร

- เฉยๆ
- อยากได้แต่ไม่มาก ไม่ซีเรียส
- อยากมี แต่ไม่มีเอง
- เฉยๆ มีก็ได้ไม่มีก็ได้
- มีก็ดีไม่มีก็ได้
- ผิดปกติไม่เหมือนคนอื่น
- วิตกกังวล
- น้อยใจ ว่าทำไมเราไม่มีลูก ไม่ถึงกับเสียใจ

5. คำพูดที่ท่านได้ยินเพื่อนบ้านญาติผู้ใหญ่ ญาติพี่น้องพูดถึงปัญหาการมีลูกยากของท่านของท่านว่าอย่างไร

ส่วนมากเป็นคำพูดจากเพื่อน และญาติพี่น้องในเชิงเป็นการทักท้วง / พูดถึงฝ่ายหญิงเป็นส่วนใหญ่

- เมื่อไหร่จะมี ลูก (พบมากที่สุด)
- คนอื่นมีกันหมดแล้วเมื่อไหร่จะมี
- อายุมากแล้วทำไมยังไม่มีลูก
- ทำไม่เป็น / ไม่มีน้ำยา ไม่มีวาสนา
- เดี๋ยวมีลูกไม่ทันใช้หรอก
- ไม่ค่อยทำกิจกรรมหรือเปล่า

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6. คำโฆษณาของแพทย์หรือโรงพยาบาลที่เกี่ยวกับปัญหาการมีบุตรยากที่ท่านได้ยินมามีอะไรบ้าง

- ส่วนมากพบว่าไม่เคยได้รับรู้ ได้ยิน และไม่สนใจ
- บางรายจำไม่ได้ว่ารายละเอียดเป็นอย่างไร แต่ดูในโทรทัศน์ตอนเช้าๆ
- บางรายไม่รู้

FREE – LISTING

การเก็บข้อมูลด้วยวิธีการ Free listing สามารถนำมาสรุปประเด็นข้อมูลของกลุ่มตัวอย่างหญิงมีบุตรยากที่แสวงหาการรักษาได้ดังนี้

1. ผู้หญิงผู้ชายแตกต่างกันตรงไหนอย่างไร

ผู้หญิง

- ผู้หญิงมีลูกได้ (พบมากที่สุด)
- ท้องได้ และต้องมีลูกให้ผู้ชาย
  ครัว
- ลำบากกว่าผู้ชาย รับผิดชอบในครอบครัวมากกว่า
  ต้องรับผิดชอบอุ้มท้อง / เลี้ยงลูก
  ใหญ่
- โครงสร้างร่างกายของผู้หญิงเล็กกว่า
- อวัยวะสืบพันธ์ซับซ้อนมากกว่า
- อดทนมากกว่า
  ครัว
- เป็นเพศที่อ่อนโยน อ่อนหวาน
- เป็นเพศที่สวยงาม
- ร่างกายซับซ้อนมากกว่า
- ตั้งท้องได้มีมดลูก
- อดทนรับผิดชอบงานในบ้านทุกอย่าง
- สรีระร่างกายที่ต่างกัน

ผู้ชาย

- มีลูกไม่ได้
- สบายกว่าแค่หาเลี้ยงครอบ
- ผู้ชายทำให้ผู้หญิงท้อง แต่ไม่
- แข็งแรงโครงสร้างร่างกาย
- ต้องมีความรับผิดชอบสูง
- เข้มแข็งเป็นผู้นำ
- เป็นผู้นำปกป้องดูแลครอบ
- ดูแลครอบครัวให้มีความสุข
- หาเลี้ยงครอบครัว

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2. บทบาทของผู้หญิงไทยมีอะไรบ้าง
- มีลูก
- ทำให้ครอบครัวอบอุ่น / สมบูรณ์
- ทำให้สามีมีความสุข
- ทำงานหาเงินช่วยสามี
- เป็นภรรยาที่ดี (พบมากที่สุด)
- มีลูกสืบวงศ์ตระกูล
- ทำงานหาเงินจุนเจือครอบครัว

3. ผู้หญิงมีลูกยากจะรู้สึกอย่างไร
- อยากมีลูก (พบมากที่สุด)
- เหงา
- เฉยๆ
- เสียใจที่มีลูกไม่ได้
- เครียด

4. ในฐานะที่ท่านเป็นผู้มีบุตรยากท่านรู้สึกอย่างไร
- อยากมีลูก (พบมากที่สุด)
- อิจฉาคนที่มีลูก
- รู้สึกผิดปกติไม่เหมือนคนอื่นเขา
- เหงา น้อย เครียด ทำไมเราไม่มี
- อยากทำหน้าที่ของตัวเองให้สมบูรณ์
- เฉยๆ (พบ 1 ราย)
- น้อยใจตัวเอง

5. คำพูดที่ท่านได้ยินเพื่อนบ้าน ญาติผู้ใหญ่ ญาติพี่น้อง พูดถึงปัญหาการมีลูกยากของท่านว่าอย่างไร

-ส่วนมากพบว่าเป็นคำพูดจากเพื่อน ญาติโดยเฉพาะแม่สามี
- ไม่มีน้ำยา
- เมื่อไหร่จะมีซักที (พบมาก)
- ไม่กลัวสามีไปมีคนอื่นหรือ

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- ไม่มีปัญญามีลูก
- ไม่มีลูกก็ดีสบาย ไม่ยุ่ง
- แก่แล้วนะ เมื่อไหรจะท้องกับเขาซักที

6. คำโฆษณาของแพทย์หรือโรงพยาบาลที่เกี่ยวกับปัญหาการมีบุตรยากที่ท่านได้ยินมามีอะไรบ้าง

-รพ. ตำรวจ ประสบความสำเร็จอีกขั้นของการรักษาผู้มีบุตรยาก (หนังสือพิมพ์)

- รพ. ศูนย์ นครปฐม ก็ทำเด็กหลอดแก้วได้ (เพื่อนๆบอก)
- รายการบ้านเลขที่ 5 หมอ รพ. พระราม 9 บอกว่ารักษาวิธีการใหม่คือ บลาสโตซีส
- รพ. ตำรวจทำ TESE สำเร็จ (หนังสือพิมพ์)
- รพ. ศูนย์ นครปฐมทำเด็กหลอดแก้วได้ (หนังสือนิตยสาร)
- จาก TV รพ. พระราม 9 , เจตริน , ราชวิถี

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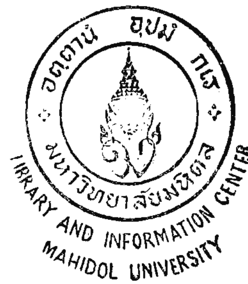

BIOGRAPHY

NAME	Miss Sineenard Phatdiphan
DATE OF BIRTH	February 18 1975
PLACE OF BIRTH	Nongkai, Thailand
INSTITUTIONS ATTENDED	Diploma is Nursing Science at Boromrajonani College Of Nursing, Udonthani ,1993-1997 Mahidol University, 1998-2002 Master of Arts (Medical and Health Social Sciences)
POSITION & OFFICE	2000-Present ,Department of Nursing Phyathai 1 Hospital

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