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Exploring the Impact of Infertility on Life of Couples treating for infertility: A Qualitative Study at the Teaching Hospital Jaffna, Sri Lanka

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Original Article

Abstract

Introduction: Infertility is a major life stressor that affects couples' well-being across multiple dimensions. Beyond its physiological implications, infertility can have profound effects on marital intimacy, social relationships, and psychological health. Although previous studies have examined the psychosocial consequences of infertility, limited evidence is available from Sri Lanka, particularly from the Northern Province, where sociocultural expectations surrounding childbearing may uniquely shape couples' experiences. Therefore, there is a need to explore the context-specific impact of infertility on the social, marital, and psychological lives of affected couples.

Objective: To explore the impact of infertility on the social, marital, and psychological life of couples attending the Infertility Clinic at the Teaching Hospital Jaffna, Sri Lanka.

Methods: A qualitative descriptive design was employed. Semi-structured, in-depth interviews were conducted with 20 participants (10 infertile couples) recruited purposively from the infertility clinic. Data were analyzed using content analysis as outlined by Sirilakshmi *et al*. (2024). .

Results: Three major themes emerged: (1) *Infertility impacted on my marital and sexual relationships, (2) How infertility affects my social interactions and lifestyle,* and (3) How my mental well-being *affected by infertility.* Infertility led to tension and emotional distance in marital relationships, social withdrawal and stigma in community interactions, and significant emotional distress including anxiety, guilt, and depression.

Conclusion: Infertility profoundly influences couples' relational, social, and emotional well-being. Integrating psychosocial counselling, couple therapy and culturally sensitive nursing interventions into infertility management could mitigate these effects.

Key Words: Infertility, lived experiences, couples, marital satisfaction, Sri Lanka

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Introduction

Infertility is defined as the inability to achieve pregnancy after 12 months of regular unprotected sexual intercourse [1]. It is a complex global public health issue that transcends biological boundaries to influence the social, emotional, and relational spheres of human life [2] Globally, infertility affects approximately 8-12% of adults of reproductive age, with prevalence rates varying across regions and socioeconomic groups [3] indicating 17.8% in high income countries and 16.5% in low income countries. Despite significant advances in assisted reproductive technologies (ART), infertility continues to impose heavy psychosocial burdens on affected individuals and their families [4].

Rather than being confined to biological limitations, infertility deeply influences couples' self-concept, the quality of their marital relationship, and their social connectedness [5]. In societies where parenthood symbolizes success, continuity, and social respectability, infertility may lead to stigma, isolation, and marital instability [6]. In patriarchal and collectivist cultures, childbearing is closely tied to gender identity and family honor; therefore, infertility, particularly female infertility can draw blame and discrimination [7].

Furthermore, In South Asian societies, fertility is closely intertwined with identity, gender roles, and social expectations [8]. In these contexts, womanhood and masculinity are often evaluated through the ability to produce children, and childbearing is seen as a social obligation rather than a personal choice. Parenthood is therefore widely regarded as a marker of marital success, and infertility may result in stigma, blame, or marginalization directed at one or both partners [9]. For couples seeking treatment, the journey can also be emotionally and financially exhausting. In South Asian societies, including Sri Lanka, reproduction is viewed as a moral and social responsibility, with couples often facing societal pressure to conceive soon after marriage [10]. When conception fails, women frequently bear the emotional burden and social blame, even when male infertility contributes equally to the problem [11]. The emotional repercussions include feelings of guilt, depression, anxiety, and reduced self-esteem [12]. Marital relationships can also become strained due to repeated medical procedures, performance anxiety, and communication breakdown between partners [13].

Several studies from Sri Lanka have documented the social and psychological dimensions of infertility, highlighting its broader impacts beyond biological dysfunction. Research among Sri Lankan women has shown that infertility is associated with significantly higher levels of psychological distress, including anxiety and depression, compared with fertile women, and that factors such as poor marital communication and intense pressure for childbearing are strongly linked to that distress [14]. Qualitative work in Sri Lanka has also highlighted how infertile women experience social marginalization and cultural silencing, as marriage without children is often interpreted as personal failure and a deviation from expected social roles [15]. Moreover, Sri Lankan sociological research indicates that infertile couples commonly confront social stigma, exclusion, and gendered blame, with women disproportionately held responsible despite evidence that male-factor infertility is also prevalent [16].

Quantitative evidence from community-based studies further shows that subfertile couples in Sri Lanka experience reduced quality of life, with psychological well-being varying by gender, age, marital duration, and childbearing history [17]. These studies collectively demonstrate that infertility in Sri Lanka has complex psychosocial implications shaped by cultural expectations of childbearing, yet the lived experiences of both partners together and how these unfold in different sociocultural settings such as Jaffna remain under-explored.

Prior studies have highlighted that infertility negatively affects marital satisfaction, sexual intimacy, and self-esteem [18, 19]. Couples experiencing infertility often report social isolation and a diminished quality of life resulting from negative community attitudes [20]. This reduction in quality of life is further compounded by social stigma, which frequently remains hidden and unaddressed in their daily lives. Exploring this concealed dimension of the lived experience of individuals facing infertility is crucial for understanding their psychosocial needs and life challenges. Although international research has extensively documented the emotional and relational impacts of infertility such as increased depression, anxiety, stress, and strain in intimate relationships [21, 22], there remains a paucity of evidence on how these experiences unfold within the Sri Lankan sociocultural context, where strong cultural expectations and extended family influences significantly shape perceptions and coping behaviors. For instance, studies from South Asian contexts have shown that infertile women often face social stigma, marital pressure, and family-imposed expectations to conceive, which can exacerbate psychological distress and influence coping behaviors [23, 24]. However, few studies have explored these dynamics specifically in Sri Lanka, highlighting a critical gap in understanding culturally nuanced experiences of infertility. Understanding the lived experiences of infertile couples within this cultural milieu is vital to inform the development of holistic, culturally appropriate psychosocial support services.

Therefore, this study sought to explore the impact of infertility on the social, marital, and psychological life of couples attending the Infertility Clinic at the Teaching Hospital, Jaffna, Sri Lanka, through a qualitative exploration of their lived experiences.

Methodology

Study Design

A qualitative approach and phenomenological design were used to capture participants' lived experiences of infertility. This means how participants experience when living with the issue of infertility in the socially embedded context.

Setting

The study was conducted at the Infertility Clinic, Teaching Hospital Jaffna, a tertiary care institution serving the northern province of Sri Lanka. Jaffna presents a distinctive sociocultural and historical context that makes it a meaningful site for exploring infertility experiences. The Northern Province, which was significantly affected by the three-decade civil conflict, has undergone substantial post-war social and demographic transitions. In the post-war period, there has been increased health-seeking behavior and expanding access to fertility treatments, including growth in both public and private sector reproductive services.

Furthermore, Jaffna society is characterized by strong kinship networks, pronatalist cultural expectations, and deeply embedded norms surrounding marriage and parenthood. Within such a context, childbearing is often closely linked to marital stability, social status, and gender identity. These sociocultural dynamics may intensify the social and psychological consequences of infertility, making Jaffna a particularly relevant setting for examining how infertility affects couples' marital relationships and social lives.

Participants and Sampling

At the initial stage of participant selection, a preliminary sample size of 22–26 individuals (11–13 couples) was proposed, based on recommendations in the qualitative research literature [25], with the intention of determining the final sample size according to data saturation. Purposive sampling was used to recruit participants who could provide rich, relevant, and diverse insights into the lived experiences of infertility. Couples who met the following inclusion criteria were considered eligible to participate in the study:

- Currently married and living together
- Diagnosed with primary or secondary infertility for at least one year
- Able to communicate in Tamil or English
- Willing to voluntarily share their personal experiences

Data Collection

Before commencing the interviews, firstly, well trained and experienced researchers (graduated staff nurses who served as data collectors in conducting qualitative interviews and undergraduate students who conducted this study under supervision and were trained by the supervisor) provided infertile couples with necessary care in infertile clinics and made deliberate efforts to build a good relationship with the participants to ensure comfort and trust throughout the study process. Researchers approached the participants and began by introducing themselves. Then, the researchers engaged in informal, friendly conversations before the formal interview to create a relaxed atmosphere and reduce participant anxiety. Next, the purpose of the research, the procedures involved and the significance of the participants' contributions were clearly explained. Then, participants were reassured about the confidentiality of their information and their right to withdraw at any stage without any consequence. By showing respect, and genuine interest in the participants' experiences, the researchers were able to establish mutual trust and rapport, which encouraged open and honest sharing during the interviews.

Data Collection Procedure

After establishing a good rapport with the participants, as described above, the interview process was initiated. At this stage, all individuals who agreed to participate were provided with detailed information about the study, including its aim, their role as participants during the interviews, and the measures taken to ensure privacy and confidentiality. This information was delivered both verbally in a group setting and through the distribution of a written participant information sheet. Sufficient time was then allowed for participants to read the information, reflect on it, and ask any questions or seek further

clarification. Following the clarification of all queries, informed written consent was obtained from each participant. Subsequently, separate interviews were conducted with husbands and wives to ensure privacy and confidentiality in the absence of their spouses. This approach enabled participants to express their thoughts and experiences freely without fear of confrontation or influence from their partners.

Data were collected through face-to-face interviews using a semi-structured interview guide prepared in English by referring literature related to the study topic. The guide was then translated into Tamil and back translation was undertaken following the 7- step framework "*Translation and Cultural Adaptation of Patient-Reported Outcomes Questionnaires – Principles of Good Practice*" developed by Wild, Grove, Martin, Eremenco, McElroy, Verjee Lorenz, *et al*. in 2005 [26]. This was done by professional translators and bilingual experts in English and Tamil languages to assure semantic equivalence. During the translation process, one bilingual expert and three professional translators were involved in the steps of initial translation, forward translation and backward translation. The forward and backward translations of the research instrument demonstrated a high level of semantic and conceptual equivalence. Only a few minor discrepancies were identified, primarily related to wording and phrasing rather than meaning. These differences were carefully reviewed by the research team in consultation with bilingual experts, and consensus was reached through discussion to ensure conceptual accuracy and cultural appropriateness. The final version of the instrument was refined accordingly, preserving the original intent and ensuring clarity for the target population.

Before conducting actual interviews, the Tamil translated version of the interview guide was pre-tested with a purposively selected few potential participants who were not included in the main study. Their voluntary participation helped the research team to assess the clarity, cultural relevance, and comprehensibility of the questions. A few necessary modifications were made based on participants' responses. For example, certain technical terms were replaced with more commonly used local expressions to enhance understanding. These revisions helped ensure that the final version of the interview guide was both linguistically appropriate and easily understood by the target population.

Interviews explored participants' marital and sexual relationships, social experiences, and emotional reactions to infertility. Each session lasted 45–60 minutes and was audio-recorded with participants' consent. Field notes were taken to capture non-verbal cues of participants. Interviews were conducted by the researchers in private settings selected by the participants according to their convenience, with careful attention to ensuring privacy and confidentiality. To ensure participants' privacy and confidentiality, all interviewed data were anonymized using identification codes instead of personal names and stored securely in password-protected devices accessible only to the research team (research supervisor and the undergraduate researchers of this study). Any potentially identifying information was removed during transcription to further safeguard participants' privacy. Data collection continued until data saturation was reached at the 20th participant, resulting in a final sample of 20 participants (10 couples).

Data Analysis

All recorded interviews were transcribed verbatim and back-translated into English by professional translators and bilingual experts in English and Tamil, after discussing the study aim and objectives with researchers. Then, interview transcriptions were analyzed using eight step Qualitative Content Analysis (QCA) method proposed by Sirilakshmi *et al*.in 2024 [27]. Initially, groundwork was completed by preparing transcripts and familiarizing with the data through repeated reading, after which initial codes were generated. Next, the data were collated into categories, which were then refined and organized into subthemes. The categories and subthemes were reconsidered by reiterating the analysis process, and some categories were promoted to candidate themes. Next, these subthemes and candidate themes were analyzed and to identify emerging themes and patterns, which were then promoted to overarching themes. The themes were interpreted in alignment with the study objectives. Trustworthiness was ensured through investigator triangulation and the use of member checking technique. In this process, the themes and subthemes derived from the data analysis were presented to the participants to verify whether they accurately represented their experiences of infertility. A few participants who were willing to review the findings confirmed that the themes closely reflected their lived experiences. Therefore, the authenticity and credibility of the study were strengthened.

Ethical Considerations

Ethical clearance for the study was obtained from the Ethics Review Committee of the Faculty of Medicine, University of Jaffna (Ref. No: J/ERC/24/162/DR/0099). Permission to conduct the study was also obtained from the Director, Chief Nursing Officer, and In-Charge Nursing Officer of the respective clinic setting.

Prior to data collection, all potential participants were provided with a comprehensive information sheet outlining the purpose of the study, procedures involved, potential risks and benefits, and their rights as participants. The researchers explained the study objectives in detail and ensured that participants clearly understood their role before agreeing to take part. Participation was entirely voluntary, and individuals were informed that they could withdraw at any time without any consequences. Face-to-face semi-structured interviews were conducted in a reserved room adjacent to the clinic within the hospital premises. The room was located in a quiet area with restricted access and minimal external interruptions, ensuring that no unauthorized individuals were present during the interviews. This arrangement safeguarded participants' privacy and helped maintain the confidentiality of the information shared.

Written informed consent was obtained from each participant prior to the interviews. Confidentiality was maintained by anonymizing all identifying information, and data were securely stored with access limited to the research team. Interviews were conducted in private settings to ensure participants' privacy, comfort, and dignity throughout the research process.

Results

Demographic Characteristics of Participants (n=20)

The demographic profiles of study participants are presented here. A total of

20 participants (10 couples) diagnosed with infertility and currently receiving treatment were recruited for the study. Regarding the demographic characteristics, the majority of participants (75%) identified as Hindu, whereas 25% identified as Christian. The majority of participants (40%) were between 31 and 35 years of age, with 30% falling within the 25–30 age range and another 30% between 36 and 40 years. In terms of infertility type, 70% of participants were diagnosed with primary infertility, whereas 30% experienced secondary infertility.

Theme 1: How infertility impacted my marital and sexual relationships

The theme "How infertility impacted my marital and sexual relationships" emerged from several subthemes including loss of intimacy and spontaneity, performance anxiety and guilt, and blame and emotional distancing all of which are repeatedly highlighted from participants' stories. Many couples described infertility as a source of marital tension and emotional distance. The diagnosis often transformed sexual intimacy into a task-oriented act driven by medical timing rather than affection.

> *"We used to be very close, but now every time we try, it feels like a duty, not love," (a female participant, age 34).*

> *"We were very friendly before; I mean after we sought medical treatment. Now we are very official like ..... No lovely feelings. My wife is very rude now, so, our sexual relationship is like a doctors' prescription. I feel we are very distant now" (a male participant, age 39).*

> *"This is our problem, I mean this issue is between me and my husband, okay. But my in-laws intervened now and make troubles. So, we don't have a happy life now. I feel like we do not have a sex life now. Husband ignores me" (a female participant, age 30).*

Partners reported feelings of inadequacy, guilt, and loss of sexual spontaneity. Some women felt blamed by their husbands or in-laws, while a few men described frustration

Table 1. Themes and subthemes emerged from Content Analysis

	Theme 1	Theme 2	Theme 3
Themes	**How infertility impacted my marital and sexual relationships**	**How infertility affects my social interactions and lifestyle**	**How my mental well- being is affected by infertility**
Sub themes	• Loss of intimacy and spontaneity • Performance anxiety and guilt • Blame and emotional distancing • Marital resilience or strain	• Social withdrawal and avoidance • Perceived stigma and gossip • Financial strain and lifestyle adjustment • Loss of social identity as parents	• Anxiety and depression • Guilt and self-blame, • Loss of control and uncertainty • Faith-based or emotional coping

from repeated treatment failures. Communication breakdowns were common between couples.

Some couples adapt and strengthen their bond; others experience emotional divorce or dissolution. The following excerpt shows how a female participant experienced a strengthened bond with her husband during their infertility journey.

> *"This journey brought us closer than ever. We learned to lean on each other when things got tough, and that support kept our marriage strong." (Female participant, 37 years).*

Another male participant explained how infertility created distance between him and his partner, exposing them to the unique challenges of infertility

> *"At one point, it felt like we were just living under the same roof. We stopped talking about our feelings; infertility slowly built a wall between us." (Male participant, 38 years).*

Theme 2: How Infertility affects my social interactions and lifestyle

The theme "How infertility affects my social interactions and lifestyle" explain participants' views on how their social life and lifestyle have been affected by infertility. Several subthemes repeatedly emerged in the majority of participants' interview transcripts, including social withdrawal and avoidance, perceived stigma and gossip, financial strain and lifestyle adjustments, and loss of social identity as parents. These subthemes reflect how infertility affected couples' lives in many ways. Participants reported avoiding community events, family functions, and gatherings where children were present. Some faced insensitive questions or stigma from relatives. Following excerpts show their silent struggles.

> *"People keep asking when we will have a child. It hurts, so we stopped visiting family functions," (a male participant, age 38).*

> *"Some people, even our relatives do not like to see me or my husband in the morning particularly when they go for some special events. I mean they think that we are very unlucky people because we do not have children no" (a female participant, age 31).*

> *"Now we are at zero level financially. We spent a lot of money for medical checkups and treatments. We still hopeful, but we have to give up our many routines we were doing before like going on trips, helping others financially, and life enjoyments. However, we got use to them now" (a male participant, age 39).*

Women especially described isolation and reduced social participation due to shame and judgment. Financial strain from ongoing medical treatment also limited lifestyle choices and leisure activities.

Theme 3: How my mental well-being affected by Infertility

The theme "How my mental well-being affected by infertility" captures participants' views on how they have been psychologically impacted by their infertility. Repeatedly emerging subthemes from participants' voices including anxiety and depression, guilt and self-blame, loss of control and uncertainty, faith-based or emotional coping reflect their silent struggles and the efforts they made to cope with their challenging life. All participants reported

psychological distress, though intensity varied. Common emotions included sadness, disappointment, hopelessness, and frustration. Many described anxiety before medical appointments and feelings of failure after unsuccessful treatments.

> *"Every month when I get my period, I cry. It feels like something inside me breaks," (a female participant, age 32).*

> *"Sometimes, I hate myself so much, especially when my husband blames me. I keep wondering why I even got married if I can't have a child. I never knew things would turn out this way. It feels so painful and unfair." (a female participant, age 34).*

> *"I feel so anxious all the time, thinking about what others might say because I have no children. Sometimes I can't sleep, and I just sit there feeling empty. It's like I've lost a part of who I am." (a male participant, age 40).*

> *"I feel like I have no control over my own life anymore. Every month I hope for a change, but nothing happens. I don't know what my future will be like without a child." Every month I keep hoping and praying, but nothing changes. In our society, it's hard for a woman like me." (a female participant, age 34).*

Both men and women experienced low self-esteem and emotional exhaustion. Some couples reported depressive symptoms, while others relied on faith and spiritual coping.

Although the themes are presented separately for clarity, they were deeply interconnected in participants' lived experiences. The strain on marital and sexual relationships (Theme 1) often intensified social withdrawal and altered lifestyle patterns (Theme 2), particularly due to stigma, intrusive questioning, and cultural expectations surrounding parenthood. These relational and social challenges, in turn, contributed to emotional distress, lowered self-esteem, anxiety, and persistent sadness (Theme 3). Similarly, compromised mental well-being further affects marital intimacy and reduces engagement in social interactions, creating a cyclical and mutually reinforcing pattern. Thus, infertility was experienced not as isolated relational, social, or psychological difficulties, but as an intertwined and cumulative disruption in life.

Discussion

The present study provides deep insights into the multifaceted effects of infertility on Sri Lankan couples, particularly those living in the Jaffna district, of the Northern Province. The findings revealed that infertility profoundly disrupts couples' lives across three interrelated domains: marital/sexual, social, and psychological. Marital relationships often become strained, as intimacy turns mechanical and emotional distance increases. Infertility significantly affects the social lives and psychological well-being of both partners, consistent with findings from global and Sri Lankan literature [14, 28, 13, 4]. However, the present findings also reveal distinctive sociocultural nuances within the Sri Lankan context, where infertility is frequently perceived as a woman's personal failure and primary responsibility [15]. The study particularly highlights how these experiences are shaped by the sociocultural context of Northern Sri Lanka where infertility must be understood within a strongly pronatalist cultural framework [29]. In this setting marriage is closely linked to childbearing, lineage continuation,

and fulfillment of familial duty. Parenthood is widely regarded as a social expectation rather than a personal choice. In such a context, childlessness may be perceived as a deviation from normative marital roles. Sri Lankan evidence indicates that infertility is frequently attributed to women, reinforcing gendered stigma and marginalization. Women are often positioned as primarily responsible for reproduction, regardless of medical causation, intensifying emotional burden and social blame [15].

Marital and sexual implications

The first theme emphasized how infertility disrupts intimacy and emotional closeness. Participants described a gradual transformation of sexual relations into an emotionally burdensome routine dictated by medical schedules and treatment expectations. Studies across South Asia, the Middle East, and other countries have similarly documented declined in sexual spontaneity, with partners experiencing frustration and decreased satisfaction [30,5,13,18]. In the current study, both male and female participants expressed guilt, resentment, and emotional withdrawal, which, over time, eroded marital harmony. Similar findings have been documented globally, showing that infertility reduces marital satisfaction and sexual fulfillment [30,19]. Yet, a few couples in this study demonstrated resilience suggesting that mutual empathy and communication can buffer against relational breakdown. These findings highlight the importance of couple-based interventions and open dialogue facilitated by counsellors or fertility specialists.

Social stigma and lifestyle changes

The second theme reflected how infertility profoundly affects the social life of couples. In collectivist societies like Sri Lanka, where childbearing is integral to identity and social belonging, infertility can lead to marginalization. Some participants reported avoiding family gatherings and public functions to escape intrusive questions about childbearing, a finding consistent with studies by Nsabimana, Ninihazwe and Irambona, in 2024 [31]. Comparable patterns of exclusion have been observed in Ghana, Pakistan, and Iran [20, 9].

Women experienced greater stigma and emotional hurt, reflecting persistent gendered stereotypes in which fertility defines womanhood. In the Sri Lankan context, where extended family systems are still prevalent [32], infertility becomes a collective concern that invites gossip and social exclusion. This social environment not only intensifies emotional suffering but also influences lifestyle changes, leading couples to limit social contact and focus on costly fertility treatments, further straining family finances [33]. The intersection of financial stress and social withdrawal has also been reported in other Asian contexts, underscoring infertility as both a medical and socioeconomic challenge [34]. These experiences mirror international studies highlighting that infertile couples often face social exclusion and reduced quality of life [20, 8].

Psychological distress and coping

The third theme exposed deep psychological turmoil among participants, characterized by sadness, helplessness, and existential distress. Depression and anxiety, loss of control and uncertainty, faith-based or emotional coping were frequently mentioned. These experiences align with the findings of Galhardo *et al*.in 2020 [12] and Liyanage *et al*, in 2024 [28], who noted that infertile individuals often experience symptoms of depression and

anxiety comparable to those with chronic illnesses. Interestingly, several participants in this study turned to spirituality, religious rituals, and faith as coping mechanisms. Such coping aligns with the cultural context of Sri Lanka, where religion and collective belief systems play central roles in dealing with adversity. However, some couples resorted to emotional withdrawal, indicating maladaptive coping that may lead to prolonged psychological distress. Psychologically, couples experienced intense distress, manifesting as anxiety, sadness, and hopelessness. Consistent with local and international literature, infertility stress significantly predicts depressive symptoms and lower well-being [35, 28, 36, 8].

These three domains are not isolated; psychological distress can exacerbate marital tension, while social stigma reinforces emotional pain. Interventions must therefore adopt a holistic and culturally sensitive approach.

From a nursing perspective, integrating psychosocial counselling and couple-centred care into infertility services is critical. Nurses and midwives can play a pivotal role in early screening for psychological distress, facilitating referrals to counselors, and promoting open communication within couples.

This underscores the urgent need for integrated mental health services within infertility care. Counselling sessions focusing on emotional expression, resilience building, and social support can improve mental well-being and enhance treatment outcomes [37]. Moreover, involving both partners in counselling can prevent blame dynamics and strengthen mutual understanding.

Cultural implications and clinical significance

This study adds culturally grounded insights to the global infertility discourse. In conservative societies, infertility is not just a personal health condition but a social identity crisis. The findings from Jaffna reflect the importance of community education and destigmatization programmes to foster empathy toward infertile couples. Fertility clinics should integrate psychosocial components into treatment, including couple therapy and peer-support groups. Clinicians and nurses must also be trained to identify signs of emotional distress and provide appropriate referrals.

Strengths and limitations

A major strength of this study lies in its contextual relevance and the use of semi-structured interviews that captured authentic narratives focusing on study objectives. However, findings may not be generalized beyond similar cultural or clinical settings. Future studies across ethnic groups could explore culture and ethnic differences of infertile related experiences and gender-specific coping patterns or compare psychological effects between primary and secondary infertility groups.

Conclusion

Infertility is not merely a biomedical condition but a complex, multidimensional experience that profoundly affects marital relationships, psychological well-being, and social identity, particularly within the strongly pronatalist sociocultural context of Sri Lanka. The findings of this study highlight the urgent need to move beyond treatment-focused models of care

toward comprehensive, multidisciplinary approaches that integrate psychosocial support into routine fertility services. Structured psychological screening and culturally sensitive counselling should be embedded within infertility management, with particular emphasis on couple-based interventions that strengthen communication, mitigate emotional distancing, and promote shared coping. In addition, the establishment of peer-support mechanisms within clinical or community settings may help reduce stigma, normalize experiences, and enhance resilience among affected couples. Capacity building of nurses and reproductive health professionals in psychosocial assessment and therapeutic communication is also essential to ensure holistic care delivery. At a broader level, national reproductive health policies should formally incorporate psychosocial components into infertility services to address the relational and emotional dimensions of infertility alongside medical treatment.

Ethical Approval

Ethical clearance for the study was obtained from the Ethics Review Committee of the Faculty of Medicine, University of Jaffna (Ref. No: J/ERC/24/162/DR/0099). Permission to conduct the study was also obtained from the Director, Chief Nursing Officer, and In-Charge Nursing Officer of the respective clinic setting.

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Conflict of interest statement

No conflict: The authors declare that they have no known competing financial interest or personal relationship that could have appeared to influence the work reported in this work.

Data availability statement

The data that support the findings of this study are available from the corresponding author [AYPM] upon reasonable request.

Statement of the use of Artificial Intelligence

AI-assisted language tools were utilized to improve grammar, clarity, and overall readability of the text. The AI tools were not used for data generation, data analysis, interpretation of findings, or development of scientific conclusions.

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Author Contributions

The student authors were responsible for the development of the research proposal, data collection, preliminary data analysis, and drafting of the manuscript. The supervisor provided overall guidance and supervision throughout the study process, with substantial contributions to data analysis, critical review of interpretations, and extensive revision and refinement of the manuscript. All authors reviewed and approved the final version of the manuscript and agree to be accountable for the content of the work.

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