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Socio Demographic and Psychosocial Impact of Infertility Among Women

Fatima Awan[1], Asma Khan[1], Dr. Lakhkar Khan[2]

1. PhD scholar, Department of Sociology, Abdul Wali Khan University, Mardan, Pakistan.
2. Assistant Professor, Department of Statistics, Post Graduate College, Mardan, Pakistan.

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Corresponding Author:
Fatima Awan
Email: Fatimaawan3887@gmail.com

Abstract: *The study is to examine the psychological and socio-demographic effects of female fertility. In order to evaluate the socio-demographic traits, attitudes, and psychological effects of infertility among 150 women who visited particular clinics, this study used a descriptive cross-sectional methodology. Respondents were selected using purposive sampling based on inclusion criteria of being diagnosed with infertility and willing to participate. Data were collected through a structured questionnaire divided into sections on socio-demographics, perceptions regarding infertility and its social implications, and psychological and health-related effects such as depression, anxiety, sleep, and food disorders. Confidentiality was upheld and ethical permission was secured. Chi-square tests were used to evaluate relationships between socio demographic characteristics and perceptions or psychological outcomes; p-values < 0.05 were deemed significant. The collected data was coded and analyzed using SPSS, with descriptive statistics (frequency, percentage) summarizing the variables. The findings show that the perception and emotional experiences of women with infertility are not affected by socio-demographic variables, but are representative of collective beliefs of society. Marriage duration was not significantly associated with depression, but fertility treatments were significantly associated with monthly income. These findings show that the effect of infertility on psychological and social components is significant for women across all groups.*

Introduction

A child is a blessing from Allah Ta'ala, and couples who are childless face many difficulties in their daily lives. Every civilization recognizes the family as an essential community institution and sees it as a fundamental chamber of public life. It is held accountable for creating future competition and giving their children warmth and affection. The clan is financially accountable for its adherents and contributes significantly to the communalization of the younger age group (McArthur, 2004). When this lesson is used appropriately, children learn to follow societal rules and values. An essential part of human society is a baby. Having children is highly valued in industrialized nations. The nation's total development is aided by a state that represents the birth and growing of children with unpaid regard for equally clan and nation in the areas of quality in education, no teenage employment, no violence, and no gender

bias. Children who receive proper care and assistance contribute to the development of the nation as a whole. The success of a nation is closely related to a child's good upbringing (Alam, Riaz, & Hussain, 2019).

For both men and women, infertility or barrenness can have detrimental effects such as depression, self-loathing, feelings of emotional inadequacy, isolation from the community, and marital strife (Rasak & Oladipo, 2017). Concerned relationships in sterile pairings, when the female bears the burden of guilt for being infertile, are also indicated by fear of stigmatization and social ridicule (Van Balen, 2012). In Africa, a problem with the female partner is frequently blamed for infertility. Because she bears the majority of the duty, she must employ traditional therapy (Miall, 1990). In India, guidance is a communal obligation that is determined by communal beliefs. According to Nwosu (2005), barrenness is a social issue in Nigeria and is described as a process where ambiguity is involved. In this context, ambiguity refers to something that can have multiple meanings, interpretations, or explanations. Barrenness is offered multiple meanings and interpretations in this study based on various perspectives. Contrary to popular belief, African women, especially those from Nigeria, who become infertile after marriage, are subjected to unpleasant and absurd experiments by their husbands, sister-in-laws, and other relatives who have some sort of connection to the husband. The occurrence is common throughout Africa, but it is especially well-known and observed in Nigeria. According to Gobbi (2013), one of the primary causes of voluntary barrenness is financial insufficiency, especially in developing countries like Nigeria where there are problems like financial recession, extreme poverty, financial underdevelopment, financial backwardness, a lack of communal amenities, and a lack of growth in employment or education. In these situations, couples may decide not to have children until they have enough money to raise them.

According to Aaronson (2014), financially disadvantaged couples choose to become barren in order to avoid "Antinatalism," which is the belief that having children without providing the necessities for their development and upbringing is intrinsically immoral.

According to Marri (2007), other reasons for voluntary barrenness include fear, disgust, and the physical consequences of pregnancy, such as weight gain, stretch marks, sagging or drooping breasts, facial uneven pigmentation, looser muscles in the pelvis that lessen the pleasure of sexual activity for both the woman and her partner, hemorrhoids, etc. One operational explanation of married couples' deliberate infertility, according to Inhorn (2003), is phobia for children, or hatred for children, which occurs when a couple has a strong fear of having children.

Because they are opportunity-driven, some couples choose not to have children. Meyers (2001) asserts that highly educated women have substantial opportunity costs when they are unemployed and earn high salaries. Although it is not a major issue in developing countries, opportunity-driven infertility is the main reason of high rates of infertility in industrialized nations. The main cause of involuntary barrenness, according to Mosher and Pratt (2013), is sterility—the inability of a married couple to get pregnant after a year of unsafe sexual contact.

The Resolution on the Privileges of Individuals with Incapacities covers sterility because it is a disability (a lack of function). Approximately 34 million people, primarily from developing countries, are sterile due to improper abortion practices and maternal sepsis (long-term maternal sickness resulting in a disability).

According to Abiodun (2010), the consequences of being barren are typically more severe in Africa and are marked by social stigmatization. Mother-in-law is the source of the most stigmatization. Mother-in-laws typically have a negative attitude toward their daughters-in-law who are infertile. In-laws have a

generally negative view toward the sterile woman, and over time, they do assist her dehumanization since they think the lady is contributing to the end of their lineage. In an effort to ensure the survival of their lineages, in-laws therefore support the marriage of a second wife. The sterile female is despised by other women, who frequently think that the barren female is responsible for their predicament. Other women's negative attitudes toward infertile women include gossip, mocking laughter, demeaning glances, direct or oblique references to their predicament, and occasionally outright confrontation. The way most kids treat the sterile sometimes begs for sympathy. Since they don't have any peers in the sterile woman's household, most children have a negative attitude about infertile women; they usually don't value them and think they have nothing to gain from them.

Children occasionally make fun of sterile women, calling them witches, and they hardly ever lend a hand with household chores. But when the sterile lady adopts a child, their attitude naturally shifts to one of positivity due to the child's existence. Most husbands of infertile women have an empathetic, indulgent, tolerant, and loving attitude toward their spouses during the first two years of marriage. These men' attitudes deteriorate over time due to pressure from friends and family. The majority of the time, they blame their spouses for the lack of children in their households, and they frequently beat their wives in response to slight provocation. They do eventually have second wives in order to conceive. Sometimes the sterile woman gets angry and gets kicked out of her married family. All of her in-laws will endorse the action in such a scenario and even place a great deal of blame on her. Sometimes the sterile lady is compelled to leave her husband's home empty-handed since she is not permitted to take anything. Tears and a broken heart might accompany her home. Additionally, there are two main reasons why the majority of infertile women's spouses flirt with other women. The first step in getting a second marriage is usually to find out whether they can have a kid through another woman. The other woman is brought home as a second wife once she becomes pregnant. Second, to punish their wives for allegedly failing to fulfill their social obligation to procreate. As a result, men often attempt to get close to their wives by publicly and even privately flirting. Even after death, people's perceptions of the deceased infertile woman differ. Usually, such a woman is not given full funeral ceremonies. In certain parts of southeast Nigeria, for example, there are no gunshots to accompany burials. The traditional dance that is supposed to be led by them is also missing, which makes sense given that she had no children. It's also possible to reject other cultural customs. Similarly, Hartung (2004) observes that the son-based transmission of money results from the greater reproductive benefit to which men can employ income compared to women; that is, men often use wealth to acquire more females (mates) and offspring.

This paper aims to analyze Socio demographic and Psychosocial Impact of Infertility among Women

Theoretical Framework

Labeling Theory

Macionis and Greber (2010) define stigma as a very negative label that modifies an individual's sense of self and social identity. Labeling theory states that individuals acquire a label when they embrace it as a part of who they are. This hypothesis basically suggests that infertile pairs are branded as unproductive to society in order to illustrate this study. Fertility increases the number of ideas that are deposited in a community, and when a couple's major function—procreation—is absent (barrenness), they are deemed unproductive. Labeling theory looks at how society views a person, circumstance, or occurrence.

Barrenness is viewed as a deviant conduct in marriage, according to Gerber (2010). He went on to say that producing children, or procreation, is the main and fundamental goal of marriage; but, if this goal is not achieved, it is viewed as abnormal conduct, and the couple in question is stigmatized.

Objectives

1. To determine the association between educational status and perception that obesity causes infertility.
2. To examine the relationship between type of family (joint or nuclear) and feelings of inferiority among women due to childlessness.
3. To assess the association between duration of marriage and experiences of depression related to infertility.
4. To explore the relationship between monthly income and utilization of fertility treatments (IUI, IVF, ICSI)

Methodology

Research Design

In order to evaluate the socio-demographic traits, attitudes, and psychological effects of infertility among 150 women who visited particular clinics, this study used a descriptive cross-sectional methodology.

Sampling Technique

Respondents were selected using purposive sampling based on inclusion criteria of being diagnosed with infertility and willing to participate.

Data Collection Tool

Data were gathered using a standardized questionnaire with sections on socio-demographics, perceptions regarding infertility and its social implications, and psychological and health-related effects such as depression, anxiety, sleep, and food disorders. Ethical approval was obtained, and confidentiality was maintained.

Data Analysis

Chi-square tests were used to evaluate relationships between socio-demographic characteristics and perceptions or psychological outcomes; p-values < 0.05 were deemed significant. The collected data was coded and analyzed using SPSS, with descriptive statistics (frequency, percentage) summarizing the variables.

Result and Discussion

Out of 150 respondent 67.3% belongs to joint family while the rest belongs to nuclear. Majority of respondent (86.7%) are housewife.

This could lead to a greater understanding of the effects of unintentional Barrenness in both marriage patterns. The majority of respondents (36.7 percent, or 55 pairs) said their marriage lasted between two and five years. 6. The majority (i.e. 54.7 percent) of pairs had a monthly family income of more than 20,000 rupees.

Majority of females (58.0%) supported view that they have irregular menstrual cycle. Majority respondent 57.3% agree that they have serious gynecological infection.51.3% rejected that they diagnosed with obstruction in tubes. Majority of females (83.3%) rejected that view of advance type of fertility treatment. IUI. IVF. ICSI. (50.0%) females are denied that doctor advised you medication for stimulation of ovaries. Majority respondent (56.7%) rejected view sterility enhance with age. Majority respondent (68.7%) disagrees that anyone in their family has history sterility. (54.7%) rejected that obesity is cause of sterility. Majority of female (78.0%) agree that male sterility is not highlighted in our society.

Barrenness, according to the majority of female respondents (79.3%), is a complicated matter that makes infertile female feel inferior to other female who have children. A significant number of female respondents (54.0 percent) said they avoided communal functions, especially those involving alcohol. The majority of female respondents (82.7%) agreed that infertile female is dissatisfied. The majority of females (76.0 percent) agreed that having children strengthens the marital bond.

Similarly, the majority (84.7 percent) of female spouses agreed that Barrenness causes family discredit and disdain among relatives. The majority of wives (76.7 percent) stated that if the first wife or wives are not pregnant, the man would take several wives in order to have offspring. The majority of females believe that men prefer remarriages, which leads to fights among wives if they live in a joint household (88.75percent).

Distribution of respondents' educational status by frequency and percentage

Educational status	Frequency	Percent
Literate	100	66.7
Illiterate	50	33.3
Total	150	100.0

Table 4.2 shows that 100 respondent that make 66.67%of total respondent were literate. 50 respondents that make 33.3% of total respondent were illiterate.

Frequency and percentage of duration of marriage of respondent

Duration of marriage of respondent	Frequency	Percent
2-5	55	36.7
6-10	42	28.0
10 to above	53	35.3
Total	150	100.0

Table 4.4 reveals that 55 respondent that make 36.7% were belong to first group of duration of marriage (2-5).42 respondent that make 28.0% were belong to 2nd group of duration of marriage(6-10).53 respondent that make 35.3% were belong to 3rd group of duration of marriage(10 to above).

Frequency and percentage distribution of monthly income of respondent

Frequency	Percent	Valid Percent
38	25.3	25.3
82	54.7	54.7
30	20.0	20.0
150	100.0	100.0

Table 4.6 shows that 38 respondent that make 25.5% having monthly income of group first range (10000-20000).82 respondent that make 54.7% having monthly income 2nd group range (20000-50000).30 respondent that make 20% having monthly income 3rd group (60000 to above)

Frequency and percentage distribution of respondent regarding view that do you think obesity can cause sterility?

Do you think obesity can cause sterility		Frequency	Percent	Valid Percent
Valid	Agree	68	45.3	45.3
	Disagree	82	54.7	54.7
	Total	150	100.0	100.0

Table 4.15 shows that 68 respondent that make 45.3% are agree of above statement .82 respondent

that make 54.7%are disagree of above statement.

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Table: Chi-square Analysis of Respondent Variables

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.079[a]	1	.299		
Continuity Correction[b]	.752	1	.386		
Likelihood Ratio	1.084	1	.298		
Fisher's Exact Test				.310	.193
Linear-by-Linear Association	1.071	1	.301		
N of Valid Cases	150				

There was no statistically significant correlation between the variables under study, according to the Chi-square test (χ^2 = 1.079, df = 1, p =.299). This shows that there is no relationship between the variables.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.154[a]	2	.561
Likelihood Ratio	1.150	2	.563
Linear-by-Linear Association	1.034	1	.309
N of Valid Cases	150		

Results revealed no significant association between the variables (χ^2 = 1.154, df = 2, p = .561). Hence, the relationship between the variables was not statistically meaningful.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.662[a]	2	.097
Likelihood Ratio	4.838	2	.089
Linear-by-Linear Association	2.677	1	.102
N of Valid Cases	150		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is .35.

There was no statistically significant correlation between the variables. (χ^2 = 4.662, df = 2, p = .097). Although close to significance, the relationship did not meet the required threshold (p < .05)

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.046[a]	2	.049
Likelihood Ratio	6.175	2	.046
Linear-by-Linear Association	3.821	1	.051
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 2 cells (33.3%). The minimum expected count is .35.

There was a statistically significant correlation between the variables. ($\chi^2 = 6.046$, df = 2, p = .049). This suggests that the variables are significantly related

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.176[a]	2	.916
Likelihood Ratio	.177	2	.915
Linear-by-Linear Association	.031	1	.861
N of Valid Cases	150		

The Chi-square analysis showed insignificant association ($\chi^2 = .176$, df = 2, p = .916), indicating a very weak or no relationship between the variables.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	7.598[a]	4	.107
Likelihood Ratio	8.415	4	.078
Linear-by-Linear Association	6.276	1	.012
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 3 cells (33.3%). A count of at least.84 is anticipated.

The Pearson Chi-square test was not significant ($\chi^2 = 7.598$, df = 4, p = .107). However, the linear-by-linear association was significant (p = .012), suggesting a trend-based relationship.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	23.690[a]	4	.000

Likelihood Ratio	25.240	4	.000
Linear-by-Linear Association	21.992	1	.000
N of Valid Cases	150		

A highly significant association was observed ($\chi^2 = 23.690$, df = 4, p = .000). This indicates a strong association between the variables.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	24.752[a]	4	.000
Likelihood Ratio	29.554	4	.000
Linear-by-Linear Association	16.777	1	.000
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 3 cells (33.3%). This is the lowest anticipated count.28.

The results showed a highly significant association between the variables ($\chi^2 = 24.752$, df = 4, p = .000), confirming a strong statistical relationship.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.259[a]	2	.196
Likelihood Ratio	3.253	2	.197
Linear-by-Linear Association	2.409	1	.121
N of Valid Cases	150		

a. The predicted count of 0 cells (0.0%) is less than 5. 13.60 is the lowest anticipated count.

No statistically significant association was found ($\chi^2 = 3.259$, df = 2, p = .196). The variables were found to be independent.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.023[a]	4	.732
Likelihood Ratio	2.726	4	.605
Linear-by-Linear Association	.430	1	.512
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 3 cells (33.3%). A count of at least.60 is anticipated.

The Chi-square test showed no significant relationship (χ^2 = 2.023, df = 4, p = .732), indicating no association between the variables.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.790[a]	4	.310
Likelihood Ratio	3.993	4	.407
Linear-by-Linear Association	.035	1	.851
N of Valid Cases	150		

a. 3 cells (33.3%) have expected count less than 5. The minimum expected count is .20.

The results indicated no statistically significant association (χ^2 = 4.790, df = 4, p = .310).

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.074[a]	4	.545
Likelihood Ratio	3.599	4	.463
Linear-by-Linear Association	1.806	1	.179
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 3 cells (33.3%). This is the lowest anticipated count.20.

There was insignificant association between the variables (χ^2 = 3.074, df = 4, p = .545).

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.345[a]	1	.246		
Continuity Correction[b]	.972	1	.324		
Likelihood Ratio	1.342	1	.247		
Fisher's Exact Test				.297	.162
Linear-by-Linear Association	1.336	1	.248		
N of Valid Cases	150				

a. The predicted count of 0 cells (0.0%) is less than 5. 22.67 is the lowest anticipated count.

b. Only calculated for a 2x2 table

The Chi-square test showed no statistically significant association ($\chi^2 = 1.345$, df = 1, p = .246). Fisher's Exact Test also confirmed non-significance.

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.917[a]	2	.052
Likelihood Ratio	6.786	2	.034
Linear-by-Linear Association	5.752	1	.016
N of Valid Cases	150		

a. The predicted count is fewer than 5 in 2 cells (33.3%). 1.00 is the lowest anticipated count.

The Pearson Chi-square value was marginally non-significant ($\chi^2 = 5.917$, df = 2, p = .052). However, the linear-by-linear association was significant (p = .016), suggesting a possible directional relationship

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.817[a]	2	.090
Likelihood Ratio	5.517	2	.063
Linear-by-Linear Association	4.781	1	.029
N of Valid Cases	150		

a. The projected count of two cells (33.3%) is lower than Fifth. This is the lowest anticipated count.33

Although the Pearson Chi-square was not significant ($\chi^2 = 4.817$, df = 2, p = .090), the linear-by-linear association was significant (p = .029), indicating a trend effect

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.400[a]	2	.041
Likelihood Ratio	7.308	2	.026
Linear-by-Linear Association	6.337	1	.012
N of Valid Cases	150		

a. The projected count of two cells (33.3%) is lower than Fifth. This is the lowest anticipated count.33rd.

A statistically significant association was found ($\chi^2 = 6.400$, df = 2, p = .041). This confirms that the variables are significantly related.

The results of the study at hand underscore the multifaceted nature of infertility among women. The

Chi-square test findings indicated there to be no linear relationship between many variables of a socio-demographic nature and women's perception of, as well as emotional experiences with, infertility. For example, educational background had no linear or statistically significant relation to the perception of obesity as a cause of infertility, thus suggesting that knowledge on factors related to infertility is more a function of collective or shared societal beliefs. Additionally, there is no linear relation between feelings of superiority/inferiority among infertile women irrespective of whether living as a nuclear or combined family.

Further, the analysis indicated non-significant association between the duration of marriage and depression due to infertility, though the association was close to significance. This indicated that the distress associated with infertility might occur as soon as couples enter into marriage and continue throughout their lives, as opposed to rising with the increase in the years of marriage.

Emotional reactions associated with infertility are apparently entrenched in society's perception of child-bearing as well as the success of a married life as a social responsibility, as opposed to time-linked parameters.

Conversely, monthly income showed a statistically significant relationship with the use of fertility therapies such as IUI, IVF, and ICSI. This shows the important influence of economic endowments on access to specialized reproductive healthcare services. Women who belonged to higher earning groups showed a greater likelihood of seeking medical assistance, which was a reflection of the inequality of access as well as the cost associated with the treatment of infertility issues. This shows how the problem of infertility has been a social as well as a medical concern, even more so within developing countries. There were some psychosocial factors which did not demonstrate any significance with the studied variables, which show that the feeling of being isolated, being distressed, or feeling stigmatized could be common across the surveyed infertile women across their demographics. The non-significant associations, although appreciable, depict that the stress caused by the experience of infertility impacts women in the same manner, irrespective of their educational, family, or economic status. In totality, the data supports the fact that the experience not only affects the private as well as joint life of the women, but their mental well-being as well.

Conclusion

The current study verifies that infertility has a significant socio-demographic and psychosocial effect on females. Socio-demographic and psychosocial effects of infertility, including feelings of inferiority, mental anguish, and loneliness, were established by this study to be common among females despite their level of education, family structure, and marriage duration. Such an observation underlines that stigma and mental anguish associated with infertility have long been ingrained in social mores and maternal and marital ideologies in society.

Moreover, the research emphasizes the importance of economic status as a factor that determines the accessibility of infertility care. Women who earned higher monthly income were likely to access advanced infertility services. Infertility, thus, arises not only as a health problem but also as a social and economic issue that concerns women's mental health and socialization.

Concluding, the paper stresses the importance of a more holistic approach towards the treatment of infertility, which encompasses more than just medical attention, but also counseling and awareness programs as well. De-stigmatizing the condition by creating a sense of joint responsibility towards fertility, apart from enhancing access, is required to alleviate the psychosocial impact of infertility on women.

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