THE PSYCHOLOGICAL IMPACT OF INFERTILITY ON AFRICAN WOMEN AND THEIR FAMILIES

by

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DEDICATION

To my son Musa Masego

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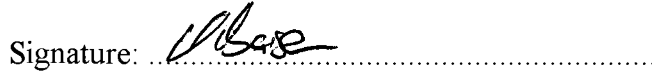
DECLARATION

Student No. 3279 - 103 - 8

I LANGUTANI FRANCINAH MABASA .... declare that the Psychological impact of infertility on African women and their families is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature: 

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SUMMARY

The purpose of this study was to investigate and describe the experience of infertility of African women, men and family member. It is hoped that this description will contribute to a deeper understanding of the psychosocial difficulties involved in the area of infertility and of the ways in which people respond to the situation of infertility.

A qualitative research approach was used, and in particular social constructivist-interpretive research and feminist research approaches. The sample consisted of 39 participants: 19 women, 10 men, and 10 family members faced with infertility.

The research orientation was field-based, concerned with collecting data using the technique of in-depth semi-structured interviews. Each participant was interviewed individually. The interviews were recorded on tape, transcribed in their full length and translated into English. Data were analysed on the basis of the interpretive feminist approach. Analysis of individual cases and cross-case analysis were employed.

The findings suggested a contextual definition of infertility, for example, for some, having had an ectopic pregnancy or a miscarriage meant that they did not fit into the definition of infertility. The findings revealed that for many African women and men, blood ties still defined the family and the persona. Thus, failure to have a blood child resulted in courtship and marital break up, extra-marital relationships, polygamy, and divorce and remarriage.

Infertility had serious psychosocial consequences for both the infertile individuals and their families. Participants experienced repeated periods of existential crisis, which began at different points for different participants. Analysis of gender differences indicated similarities in the experience of the crisis, but differences in terms of expression and ways of responding to the crisis. Family dynamics within the context of infertility were coloured by ambivalent feelings, resentment, insensitivity, and miscommunication, but also affection, and social support. Traditional and modern medical health systems offered the possibility of finding explanations and treatment, but there was further strain from the negative experiences with the health care system.

The findings in this study suggested the need for policy reformulation, for psychosocial intervention as part of the treatment plan, and for future research on the outcome of using various coping strategies.

Key Terms: Infertility; Psychological impact; Family; Crisis; Sexuality; Gender; Health care systems; Doctor-patient relationship; Coping mechanisms; Infertility management

CHAPTER 1
INTRODUCTION

1.1 The Context of Infertility

The interrelationship of psychology and physiology is perhaps greater in reproduction than in any other area. Psychological attitudes or states are frequently considered the source of problems as well as a product of them, especially when no clear cause can be identified. The anatomical and physiological sources of reproductive problems continue to be studied, making increasing information and treatment available to the medical community. However, being unable to conceive does not often result in physical pain but has painful social and psychological consequences (Lober, 1997). This prompts the need for a more holistic biopsychosocial understanding of infertility.

One way of understanding the context of infertility is through a review of the prevailing controversies surrounding the definition of infertility and the status of infertility in sub-Sahara Africa. Many researchers have pointed to the confusion and lack of consistency in criteria for the medical definition of infertility. Clinical infertility in developed countries is defined as "one year of regular unprotected intercourse not leading to pregnancy in a couple who try to get pregnant" (Sundby, 1994, p. 9).

The World Health Organisation (WHO) defines infertility as the inability to conceive (organic or functional) a pregnancy after two years of regular sexual intercourse without contraception, or inability to carry a pregnancy to live birth. WHO's definition considers the situation in which many women in developing countries tend to lack knowledge of modern measures of time or have problems of illiteracy, recall problems, and that they may have experienced perinatal death (WHO, 1991). Thus, the definition of infertility is greatly influenced by the socio-economic status and cultural background of individuals.

Although the definitions of infertility clearly indicate that infertility concerns a couple system, most South Africans tend to view infertility as a woman's problem (Goosen & Klugman, 1996).

To a certain extent, infertility in men is kept as a secret in the black South African community (Mabasa, 2000), and other African societies (Upton, 2001). Hence, this study focused on women as a primary sample. Although women were a primary sample, some infertile couples had men carrying the diagnosis of infertility. Thus, both infertile men and women were studied as explained under the sampling strategies in Chapter 5. The idea was to approach the study from the cultural position of participants.

A regional investigation in Britain suggested that one in eight childless couples seek specialist advice in their effort to conceive (Abbey, Andrews & Halman, 1994). In America, it is estimated that approximately 8% of all couples in which the woman is of childbearing age are infertile (Abbey *et al.*, 1994; Morrow, Thoreson & Penney, 1995). Sub-Saharan Africa has higher incidence rates (between 16.7% and 21.4%) than other African nations. The rate is between 9.8% and 12.2% in East Africa (Ericksen & Brunette, 1996). The WHO (1991) Task Force on Infertility estimated an even higher prevalence rate (30%) in Africa South of the Sahara, using a criterion of two years in married couples.

The incidence of infertility in South Africa is estimated at 15 to 20% (Martin, 1997). Local specialists in the field of reproductive health attribute the difficulty in obtaining the prevalence and incidence rates of infertility to the fact that individuals tend to consult different specialists in private practice and not in public institutions, where statistical records are usually kept (Futeran, 1989). Another problem could be due to the fact that Africans also consult with traditional healers, where records are not usually kept. Sundby (1994) contends that a lack of a health service infrastructure may play a role in the lack of estimations of infertility.

Having children is a natural part of the reproductive cycle that is questioned by few. The expectation of a vast majority of young people is that at some stage, they will become biological mothers and fathers. This expectation emanates from young people as individuals, as a couple, and from the society of which they are part (Daniels, 1993; Mabasa, 2000; Wirtberg, 1992). Thus, infertility can be a traumatic and worrying experience for men and women who, for cultural or personal reasons, view childbearing as central to their lives (Abbey *et al.*, 1994; Ndaba, 1994). Literature suggests that about 40% of infertile individuals experience psychological distress

associated with infertility (Morrow *et al.*, 1995). WHO's (1991) division of Family Health and Mental Health reported that reproductive health issues including infertility were accountable for many women seeking psychiatric and psychological services. This thesis is about studying infertility from the psychological context, thus providing an understanding into such issues as why reproductive health issues result in many women seeking psychiatric and psychological services.

The present study is about a group of people who could not participate in the life cycle in the way in which they had always anticipated they would – by having children. They were involuntarily childless or infertile. These individuals operate within several larger social systems. The most notable of these social systems is the couple and the extended family of parents and siblings. In order to understand the impact of infertility in context, I included all these groups of people as the target population of this study.

I met people whose needs for biological parenthood were not met in both my private and professional life. Working as a clinical psychologist, a lecturer and supervisor in clinical psychology training and in psychotherapy, I met individuals who could not adapt to infertility or to the fact that their daughters, sons, sisters, and brothers were childless. These experiences led to curiosity about the dynamics involved in infertility. As a social scientist, my intellectual frame that lay nearest to hand in approaching the study was the systems theory as applied to family dynamics. Therefore, the study was based on the theoretical framework that the individual psychological attitudes and reactions to infertility are formed and modulated in interaction with other members of the society (Williams, Bischoff & Ludes, 1992). Thus, the approach was psychosocial rather than individualistic, and included an interpretation of cultural influences. It was against this overall context that the study of infertility in black South African women and their social system was conducted.

1.2 Delineation of Thesis

Chapter 2 and Chapter 3 review the literature on infertility. Chapter 2 focuses on the biopsychosocial approach to understanding infertility, that is, the biological, psychological, and social understanding of infertility. This includes the analysis of cause and effect, and interventions

for infertility. Chapter 3 critically analyses the psychological literature on families, the cultural and family background of the studied population, and cultural aspects of infertility.

Chapter 4 discusses the background of the study. It provides the problem statement, aims, and objectives of the study, the research questions, and the theoretical grounding guiding the study.

Chapter 5 outlines the research method followed in the study. The qualitative research paradigm using in-depth interviewing. Included in this chapter are the ethical issues and challenges I experienced during the research process. The chapter also discusses the reliability and validity issues of the study.

The findings of the study are discussed in Chapters 6 and 7. Chapter 6 provides an interpretation of the results of the study from the African world-view. It focuses on cultural issues intricately related to the participants' experience of infertility and how the participants deal with infertility. Chapter 7 focuses on the impact of infertility from the men, the women and the family perspectives of the participants of the study. Experiences relating to sexuality and gender issues are also described. The struggle participants were faced within regard to the infertility experience is discussed. The chapter includes discussion on how infertility comes to be defined as a crisis and the struggles involved in searching for diagnosis and treatment, as well as findings on how the infertile and their families respond to the impact of infertility.

Chapter 8 provides an integrated interpretation of findings. It involves consideration of the implications of findings, and analysis of the findings including comparing and contrasting the findings with other relevant studies. The implications of the findings for practice and research methodology are also discussed.

Chapter 9 outlines suggestions for further research, how the findings of the study will be disseminated, and a consolidated conclusion of the thesis.

CHAPTER 2
BIOPSYCHOSOCIAL CONCEPTUALISATION OF INFERTILITY

2.1 Introduction

This and the next chapter encompass a literature review on infertility. This chapter is concerned with the biopsychosocial approach to infertility while the next chapter involves discussion on infertility with regard to gender, motherhood, and the family. Williams *et al.* (1992) provide a useful framework for looking at infertility from a biopsychosocial perspective. This broad view conceptualises infertility as a multifaceted problem involving physical, social, and psychological aspects. It is born out of the idea that human beings consist of biological, psychological and social components. The biological subsystem is the individual's physiological processes, including the biological causes and treatment of infertility, while the psychosocial subsystem refers to an individual's cognition, knowledge, belief, and emotions. Each component is equally important and one cannot function without the other. It is on the basis of this holistic view that the biopsychosocial model was conceptualised. Guided by the biopsychosocial model, the following literature review involves the conceptions of infertility from the biomedical, psychological and socio-cultural perspectives.

2.2 Biomedical Aspects of Infertility

Infertility is primarily a physical condition. In most instances, the fertility problem is taken to the health services in order to obtain a biomedical solution. Usually the problem receives a diagnosis and is treated as a disease (Lober, 1997). Psychotherapists who work with infertile couples need to be aware of the full scope of diagnostic and treatment modalities, and should know the medical practitioners providing the services in his/her area. If a psychotherapist is familiar with medical approaches to infertility and with the medical services in his or her area, he/she will better understand the stresses the infertile couple is faced with during the diagnosis and treatment procedures. The therapist who is knowledgeable about the biological factors of infertility may also be helpful in directing the couple towards getting proper medical treatment (Eupnu, 1995; Williams *et al.*, 1992). These issues guided the following literature review on the biomedical

aspects of infertility.

Infertility has been described as a disease, disorder, disability, handicap, illness, syndrome, condition, or condition caused by a disease. There is a disadvantage in calling infertility a disease because falling pregnant does not necessarily 'cure' infertility. It is possible for one to fall pregnant and bear a child using reproductive technologies. There is nevertheless some advantage to regarding infertility as a disease, which is thereby placed within the medical model which could for example assist infertile individuals in acquiring insurance coverage for their treatment. The medical community considers infertility to be a clinical problem for which they can sometimes offer a remedy. Therefore, it becomes unnecessary to ask whether infertility is a disease and which partner has the disease (U.S. Congress, Office of Technology Assessment, 1988).

2.2.1 Aetiology

The most recent view is that medical factors are primary causative agents of infertility (Eupnu, 1995). The aetiology of infertility is divided into four categories: the female factor, the male factor, combined male and female factor, and infertility of undetermined causes (Stanton & Dunkel-Schetter, 1991). There is no gender disparity in the cause of infertility: male and female factors each account for 40% while the remaining 20% is either shared or unexplained factors (Eupnu, 1995; Williams *et al.*, 1992).

According to Williams *et al.* (1992) infertility in women is due to three primary biological causes. First, the woman may not be producing and releasing mature eggs due to hormonal problems or ovarian cysts. Second, scarring or adhesions may interfere with the fallopian tubes being able to properly transport the egg from the ovary to the womb. Third, structural abnormalities or hormonal problems may result in the fertilised egg being unable to properly implant in the uterine lining. According to Goosen and Klugman (1996) one third of all cases of infertility in South African women result from pelvic infections due to sexually transmitted diseases, another one third is due to hormonal imbalance, and the remaining one third result from unknown causes.

Male infertility is due to the male producing an insufficient number of sperm and/or sperm of poor quality. Poor sperm production can be caused by hormonal problems. Infection of the testes or the prostrate gland and blocked tubes between the testes and seminal vesicles can also cause infertility. Physical or radiation damage to the testes and genital abnormalities like undescended testes can also cause male infertility (Williams *et al.*, 1992; U. S. Congress, Office of Technology Assessment, 1988).

2.2.2 Risk Factors for Infertility

The literature indicates an increase over the last decades in the prevalence rates of infertility in both western and African countries (Eupnu, 1995). However, explanations for these increases differ according to the cultural context (Martin, 1997). In western cultures, delay of first pregnancy by choice contributes to inability to conceive and maintain pregnancy. Exposure to toxins, sexually transmitted diseases, and other environmental insults can reduce couples' fertility in both African and western cultures (Eupnu, 1995; Goosen & Klugman, 1996; Mabasa, 2002; Martin, 1997). The following are risk factors associated with infertility.

Sexually transmitted diseases

Neisseria gonorrhoea, Chlamydia, trachomatis and mycoplasma are the most common bacteria that cause sexually transmitted diseases. Pelvic inflammatory diseases (PID), gonorrhoea, chlamydia infection, and mycoplasmal infection are the most common sexually transmitted diseases that affect fertility (Ericksen & Brunette, 1996; Measure Evaluation, 1999; U.S. Congress, Office of Technology Assessment, 1988). These diseases cause tissue damage, blocking the fallopian tubes in women and upper reproductive tracts in men. In women, the infection may ascend from the lower genital tract through the endometrium, causing endometriosis; to the fallopian tubes causing salpingitis; and to the ovaries, causing oophoritis (Measure Evaluation, 1999; U. S. Congress, Office of Technology Assessment, 1988). The consequences of PID include pain, discomfort, ectopic pregnancy, and infertility. Tubal infertility after PID is associated with the number and severity of PID episodes (Ericksen & Brunette, 1996; Pick, Ross & Dada, 2002). PID has been labelled the most common cause of infertility in Africa (Pick *et al.*, 2002).

Pick *et al.* (2002) found a positive association between infertility and gynaecological illnesses, especially sexually transmitted infections both in Durban and Johannesburg. This confirms the assertion by Goosen and Klugman (1996) that the majority of cases (85%) of infertility at Baragwanath Hospital, South Africa are due to sexually transmitted diseases. The high levels of sexually transmitted diseases can be partially explained by migration of workers, urbanisation, and disruption of rural families (Goosen & Klugman, 1996).

Contraception and postponement of pregnancy

There are different ways to analyse the link between controlling fertility and the risk of infertility. The analysis could be in the form of whether modern contraceptives cause infertility indirectly or whether postponement of pregnancy by contraceptives increases the exposure risk time and decreases the time available for conception. The analysis could also be in the form of whether postponement of childbearing indirectly influence vulnerability for infertility due to factors like sexually transmitted diseases, cysts, tumours and other diseases of the reproductive system (Sundby, 1994).

There have been no systematic studies confirming an effect of oral and injectable contraceptives to infertility (Sundby, 1994; U.S. Congress, Office of Technology Assessment, 1988). The intrauterine device (IUD) has been held responsible for impairing fertility in some cases (U.S. Congress, Office of Technology Assessment, 1988). There have been contrasting findings from different studies on the relationship between infertility and IUD. Some studies found a normal return to fertility after removal of IUD in order to get pregnant after uncomplicated use.

Those studies that linked IUD to infertility indicate the risk of pelvic inflammatory disease and tubal infertility due to infections. Another relationship between IUD and infertility is related to an increased number of partners. Yet another argument is that IUD use in young women and the risk of PID may be related to young women's physiology. Hormonal cycles in young women often induce a cylinder epithelium lining of the cervix instead of a squamous epithelium, and this cylinder epithelium may be more penetrable by micro-organisms. Sundby (1994) concluded that although IUD users may not become subfertile, a relative risk should be enough to cause a concern;

especially because IUD seems an appropriate contraception for older women and not for young ones.

Female and male sterilisation has been linked with infertility, as people sometimes wish to reverse the operation. However, the reduced fertility is voluntary and most often performed on men and women who have already proved their fertility (Sundby, 1994).

Genetic and chromosomal abnormalities

There is a complex spectrum of chromosomal abnormalities associated with infertility. Mutation or deletions of sex-determining a chromosomal region have been linked with infertility. Women with XO and XY chromosomes are subfecund or infertile. XO and XY chromosomes are associated with premature ovarian failure. The genetic makeup of an individual too, may predispose that person towards certain diseases such as cancer and endometriosis (U.S. Congress, Office of Technology Assessment, 1988).

Genetic and chromosomal abnormalities can contribute to infertility in several ways. Chromosomal abnormalities can lead to early fetal loss or genetic diseases such as cystic fibrosis, which impair reproductive functioning in adults. Abnormalities can affect the chromosal health of a human embryo in different ways. The sperm or the oocyte can have chromosomal abnormalities; the early embryo can fail to divide; and the early embryo can fail to incorporate one or more chromosomes, resulting in an incomplete set of chromosomes (U.S. Congress, Office of Technology Assessment, 1988).

Cancer

There are different ways in which cancer affects infertility. Cancer can affect semen quality as well as the female reproductive tract. It has been associated with increased numbers of sexual partners and the increased occurrence of sexually transmitted disease. The tumour itself can affect fertility if there is direct gonadal involvement. Cancer treatment, surgery and chemotherapy and radiation therapy can also reduce fertility. Twenty percent (20%) of fertility deficits in men is associated with having been treated with surgery for childhood cancer (U.S. Congress, Office of Technology Assessment, 1988).

Endometriosis, induced abortions and ectopic pregnancies

Endometriosis is characterised by the presence of the cells of the uterine lining outside the uterus. The ovaries, fallopian tubes, and the peritoneum are the most usual sites of endometrium implants. Endometriosis contributes to infertility as it interferes with ovulation, ovum transport, implantation, or induction of early spontaneous abortions (U.S. Congress, Office of Technology Assessment, 1988). Abortion can lead to infertility if performed incompletely since it may become septic, thus causing infections. Therefore, abortion as causal factor of infertility is more prevalent in developing countries where abortion is commonly performed outside formal medical settings (Measure Evaluation, 1998; Sundby, 1994; U.S. Congress, Office of Technology Assessment, 1988).

Iatrogenic factors

U.S. Congress, Office of Technology Assessment (1988) defines iatrogenic factors contributing to infertility as those produced inadvertently by physicians or by their treatment. For example, appendicectomy and caesarean section could lead to tubo-ovarian adhesion, infant hernia repair could cause a blockage of vas deferens, and dilatation and curettage could lead to scarring and Asherman's syndrome.

Poor nutrition and smoking

Too much adipose and too little adipose tissue is associated with impaired fertility. Fatty tissue seems to directly influence reproductive maturation and function in both sexes. There is a general agreement that marked loss of weight is usually accompanied by an interruption of the reproductive cycles. Hence, people who suffer from anorexia nervosa tend to develop amenorrhea (Goosen & Klugman, 1996; U.S. Congress, Office of Technology Assessment, 1988).

2.2.3 Diagnosis and Treatment

Only an intensive infertility work-up can determine the specific causes of infertility. These include several physical examinations, frequent review of basal body temperature and intercourse records, laboratory tests, radiology tests, surgery, and trials of medical treatment (Eupnu, 1995). For

women, the evaluation should include examination of the cervical, uterine, tubal, peritoneal, ovarian, and immunology functioning. For men, a careful history and physical examination, baseline laboratory studies, and a detailed semen analysis are essential (Eupnu, 1995). These diagnostic and treatment procedures can be physically and emotionally invasive for the couple. They are time consuming, often continuing over a number of years, and often rigidly tied to some event (such as ovulation) in the reproductive cycle (Eupnu, 1995; Williams *et al*, 1992).

Treatments of infertility can be grouped into those that correct the cause of infertility and those that circumvent the cause via reproductive technologies or assisted conception. Female infertility is usually treated with fertility drugs to correct hormone problems. Surgical procedures are used to correct structural abnormalities, or to remove adhesions or scar tissue. Endometriosis can be treated either with drugs or surgery, depending upon its severity (Williams *et al.*, 1992). In males, inadequate sperm production due to enlarged veins, blocked tubes between testes and seminal vesicles are usually treated by surgical operation. Cooling the scrotum with ice packs is sometimes used. Infections and hormonal problems are treated with medication (Williams *et al.*, 1992).

Each country has its own policy about reproductive technology. Enquiries with the South African Department of Health and Welfare's sub-directorate of Maternal and Child Health indicated that there is no new policy guiding reproductive technology in the democratic South Africa. A 1986 policy is still in use. Among others, the policy was guided by the Human Tissue Act of 1983. The researcher's attempt to obtain an original copy of the policy from the sub-directorate of Maternal and Child Health where reproductive health is placed was unsuccessful. According to the U.S. Congress, Office of Technology Assessment (1988) the 1986 South African regulations specify that a physician who has been registered and approved by the Director General of the Department of Health may only perform artificial insemination by donor. The donor's spouse must agree to the use of his sperm for donor insemination, and the donor may limit the use of his sperm to recipients of specified religion and population groups. Donor insemination is available only to married women. The 1986 regulation does not address the legal status of the resulting child. Consequently, a South African court in 1979 ruled that a child conceived by donor insemination was illegitimate (U.S. Congress, Office of Technology Assessment,1988).

U.S. Congress, Office of Technology Assessment (1988) further states that oocyte donation is allowed in South Africa, and it is subject to the same regulations as those for donor insemination. The 1986 regulation did not address IVF except with regard to rules licensing the physicians and regulating the use of donor gametes. Commercial surrogacy was deemed ethically unacceptable. The medical profession in South Africa also opposed surrogate motherhood (U.S. Congress, Office of Technology Assessment, 1988).

The new reproductive technologies have a potential to empower or render women powerless. The rapid development of medical intervention creates unrealistic expectations in which infertile couples define themselves not as childless, but as 'not pregnant yet' (Greil, 1991). Women do what they are told to do by 'medical experts'. They find it difficult to give up the infertility treatment. Moreover, the new reproductive technologies represent a new burden for women who are expected to try 'hard enough', which may bring about guilt for not trying harder by going for more IVF after repeated failure (Sewpaul, 1995). The long-term effects of new medications on the couple and on any child they may conceive are unknown (Eupnu, 1995).

2.3 Psychological Aspects of Infertility

Although infertility is mainly viewed from a biomedical perspective, its consequences go beyond the physiological component. The problems of infertility have an existential dimension and the social and psychological aspect of the causes, care and consequences of infertility are as important as the physical aspect (Sundby, 1994). It has an impact on the broad patterns of social life including social roles, power, status, and interpersonal functioning (Brown, 1995). Thus, the psychosocial consequences of infertility become as important as the biological ones and can no longer be ignored, and should be considered in the examination and management of infertility (Lober, 1997).

One of the current debates on the psychosocial aspects of infertility relates to the question of whether infertility results from psychological problems or vice versa. To address this question, Greil (1997) and Wright, Allard, Lecours and Sabourin (1989) put forward the following

assumptions: (a) psychological distress triggers infertility, (b) infertility triggers psychological problems, and (c) there is a bi-directional relationship between psychological distress and infertility. Arguments for and against these assumptions are elucidated in the following subsections.

2.3.1 Conceptual Understanding of Infertility

2.3.1.1 Psychogenic hypothesis

As little as two decades ago, infertility was quite widely conceived of as a psychosomatic illness. This assumption was applied primarily in cases where no organic cause for infertility could be identified (Greil, 1997; Stanton & Dunkel-Schetter, 1991; Sundby, 1994). The psychogenic causal model was based on either the psychodynamic theory or on stress as a causal factor.

Earlier studies (Noyes & Chapnick, 1964; Patensco, 1986; Seward, Wagner, Heinrick, Block, & Meyerhof, 1965) appeared to confirm the psychogenic hypothesis that infertility is rooted in intra-psychic conflicts. The psychodynamic theory of infertility involves the assumption that unresolved childhood conflicts with parents especially on topics such as sexuality, extends into adulthood and find their neurotic solution in a failure to conceive (Noyes & Chapnick, 1964; Patensco, 1986; Seward *et al.*, 1965; Sundby, 1994). This model of infertility was dominant in psychology until the mid-1980's (Greil, 1997). These earlier studies (Noyes & Chapnick, 1964; Patensco, 1986; Seward *et al.*, 1965) identified psychogenic infertility only among women with unexplained infertility (Sundby, 1994; Wirtberg, 1992). It has been difficult to account for the role of the man, or the relational aspect of infertility, from this point of view.

Psychodynamic hypotheses generated research designs to demonstrate personality or emotional differences between fertile and infertile women. Such studies (Aghanwa, Dare & Ogunniyi, 1999; Sundby, 1994; Klempner, 1992; Stanton & Dunkel-Schetter, 1991; Wright *et al.* , 1989), unlike the earlier studies, concluded that there are no indications that the rates of psychopathology in infertile persons are higher than in the normal population. Thus, research failed to support the psychogenic causal hypothesis and it has now fallen into disfavour (Moller & Fallstrom, 1991;

Sundby, 1994; Wirtberg, 1992).

It appears that earlier studies (Noyes & Chapnick, 1964; Patensco, 1986; Seward *et al.*, 1965) that supported the psychogenic hypothesis may have been based on methodological flaws. Methodologies used largely lacked reliability and different criteria were used, ranging from the interpretation of results from psychotherapy to Rorschach tests and many different psychometric tests. A problem in choice of methods was that many of the tests used were aimed at detecting severe psychopathology, or identifying neurosis or psychosis in classical terms. Most infertile couples, however, are normal functioning people with only minor psychopathology (Aghanwa *et al.*, 1999; Klempner, 1992; Stanton & Dunkel-Schetter, 1991; Sundby, 1994; Wright *et al.*, 1989).

Another methodological problem is that earlier researchers had most often assessed the psychological profile of patients when infertility was manifest. Thus, it had been difficult to determine if psychological differences were related to causes of infertility, or if they were transient consequences of being infertile (Sundby, 1994). Aghanwa *et al.* (1999) found that none of the infertile patients in their study provided a history of psychiatric illness prior to being diagnosed. Current researchers (Aghanwa *et al.*, 1999; Sundby, 1994; Klempner, 1992; Stanton & Dunkel-Schetter, 1991; Wright *et al.*, 1989) associate the recent lack of evidence of psychogenic causality to better study design and much stricter criteria for the analysis.

Concurrent with the research that failed to support a psychogenic model for infertility, procedures for diagnosing biomedical causes improved. As medical diagnosis improved and as interest in the psychogenesis of infertility waned, it became increasingly apparent that the heightened emotional distress experienced by many infertile couples, may be more a consequence of infertility than a cause (Stanton & Dunkel-Schetter, 1991). Moreover, the psychogenic interpretation of infertility has come to be seen as a mechanism for minimising the reality of the suffering associated with infertility and as means of blaming the victims for their own suffering. Therefore, the psychogenic view has not been popular in recent years with researchers, counsellors, and the infertile themselves (Greil, 1997).

2.3.1.2 Stress hypothesis

Some researchers are replacing the psychodynamic version of the psychogenic hypothesis with a hypothesis based on the idea that stress causes infertility (Greil, 1997; Wasser; 1994).

The problem of stress assessment in infertility studies is that it is difficult to define levels of stress and types of stressors as these may be individually modified and biological stress markers may be transient through time. For instance, because of the interference with the menstrual cycle in the female, very strict timing of tests is required, and stress may interfere with fecundity in one cycle and not the next. Another problem is that in chronically high levels of stress most often the organism also biologically adapts to the stressor, otherwise breakdown of the organism is the result (Sundby, 1994).

The misconception that if a couple adopts a child they are very likely to achieve pregnancy thereafter is usually associated with stress as a causal factor of infertility (Greenfeld, 1997). However, there is no scientific evidence for the hypothesis that couples who adopt will experience higher fertility. There is also no clear evidence that adoption relieves tensions relating to the maternal role, thus having a positive influence on psychological causes of infertility (Sundby, 1994; Klempner, 1992). In a study by Greenfeld (1997) only about 5% of infertile couples who adopted achieved pregnancy.

2.3.1.3 Crisis perspective

As mentioned, the literature now de-emphasises psychopathology as the cause for infertility. Most contemporary studies (Aghanwa *et al.*, 1999; Andrews *et al.*, 1992; Greenfeld, 1997; Greil, 1997; Klempner, 1992; Moller & Fallstrom, 1991; Stanton & Dunkel-Schetter, 1991; Sundby, 1994; Williams, 1997; Wirtberg, 1992) assume that infertility is the source rather than the result of psychological distress. This assumption is supported by evidence that most of the psychological problems associated with infertility seem to relate to the social and practical consequences of infertility (Aghanwa *et al.*, 1999; Andrews, Abbey & Halman, 1992; Klempner, 1992; Stanton & Dunkel-Schetter, 1991; Wright *et al.*, 1989). Infertility triggers psychological distress on certain

dynamics such as self-esteem, identity, intense grief-reactions, increased anxiety, sexuality, marital function, and life quality (Aghanwa *et al.*, 1999; Andrews *et al.*, 1992; Greenfeld, 1997; Klempner, 1992; Stanton & Dunkel-Schetter, 1991; Williams, 1997; Wirtberg, 1992).

There is clinical and empirical evidence that infertility is indeed a difficult and stressful life event, and that with this, there is a vast range of elements in the infertility experience where psychological problems are expressed (Edelman & Conolly, 1996; Mikulincer, Horesh, Levy-Shiff, Manovich, Shalev, 1998;). Lazarus and Folkman (1984) defined stress as a "relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19). Like most life stress, infertility is not a discrete phenomenon but a process. The impact begins with a suspicion that something is wrong, and then increases in intensity as infertility and its investigations continue (Leiblum, 1997).

With the primary goal of aiding infertile couples in managing their experience, mental health practitioners began to conceptualise infertility as one of the major life crises (Berger, 1980; Cook, 1990; Terry, 1991(b)). Conceptualising infertility in this way helps to stimulate awareness among professionals. It offers both an analytical framework for understanding the couple's experiences and reactions, as well as pointing towards a way of helping the couple on a psycho-social level, and legitimises adjustment to infertility as a problem worthy of empirical investigation (Stanton & Dunkel-Schetter, 1991).

There are two common types of crises within crisis theory, namely, the traumatic and the developmental crisis. Traumatic crises involve the occurrence of a sudden, unexpected, and taxing experience or changes in identity, or basic life-values. Developmental crises or life crises are events which are of apparently normal nature or even expected part of socially accepted change within the individual's life cycle – such as becoming a parent and getting married (Wirtberg, 1992).

Wirtberg's (1992) study concluded that infertility often involves both types of crises. The study found that a sense of loss was very strong and yet there were no specific traumatic events identified as the trigger for such a feeling. The crisis of infertility is also developmental in that

infertility may impede the acquisition of generativity, which Erikson postulated as a central developmental task of adulthood (Stanton & Dunkel-Schetter, 1991).

Moller and Fallstrom (1991) explored the nature of psychological crisis in their longitudinal study. The patients in their study experienced an existential challenge to dimensions of affinity/abandonment, meaningfulness/meaninglessness, and positive self-concept versus rejection. Insecurity in gender identity seemed to lead to a greater risk for emotional disturbance. Infertility often feels like an ongoing and debilitating crisis because it has adverse effects on the patient's self-esteem and the couple's sexual relationship (Greenfeld, 1997) indicated in the following phases of the crisis experience.

Many studies (McDaniel, Hepworth, & Doherty, 1992; Terry, 1991 (b); Wirtberg, 1992) conclude that infertile persons go through several stages of the crisis experience. As in the case of other major crises such as death, infertile persons progress through several stages of mourning following diagnosis. During treatment, they endure a chronic hope and a loss cycle every 28 days of the menstrual cycle. Like chronic illness, adjustments in lifestyle must be made to accommodate the diagnosis and treatment procedures.

Williams (1997) and Wirtberg (1992) identified the following phases of the crisis experience most infertile individuals go through after diagnosis. Firstly, the initial reaction to infertility involves surprise and shock. Secondly, denial: "this can't be happening to me" is a common response in the next phase of the crisis. Denial allows the person to adapt and reorganise their cognitive map of the world at their own pace. However, if it becomes a permanent response, denial may prevent working through the problems, and create difficulties in the individual or couple's relationships. Thirdly, there is anger due to unsatisfactory contact with the medical system, painful treatment procedures, and pressure from friends or relatives. Whatever the reason for it, anger can be of great value to an individual in terms of helping him/her to understand the situation, providing he/she is allowed or encouraged to express and thereby explore its significance. Fourth, social isolation: the experience of infertility is very personal and may even indirectly assume a sexual character. Therefore, many choose to keep their infertility a secret. Fifth, guilt: one dominant conceptual pattern in our culture which we use to explain how and why things happen is that of

cause and effect. Common causal explanations, which accompany or generate feelings of guilt in relation to infertility are abortions, venereal diseases, extramarital affairs, masturbation, and homosexual activity. In Wirtberg's (1992) study, guilt was often expressed about using the pill as a contraceptive; and in religious terms where infertility was seen as God's punishment for earlier sins. Grief over something as intangible as a dream, an expectation, or a lost possible part of the future can be hard to grasp. Infertility contains many aspects of loss: the loss of genetic continuity, the loss of the experience of pregnancy and birth, loss of the identity as a parent, the loss of achieving a "real" family, and in many cases the loss of a "ticket" to many network or community activities.

Conceptualising infertility as a stressful experience provides a framework for understanding stress and coping with infertility. (a) It specifies the conditions under which infertility is likely to be perceived as stressful. (b) It points to factors that are likely to facilitate or impede adjustment in infertile persons. (c) Lastly, it serves as a guide for defining what constitutes successful adjustment to infertility (Stanton & Dunkel-Schetter, 1991). The way people subjectively appraise and cope with infertility seems to be directly related to their emotional reactions to it (Mikulincer *et al.*, 1998).

2.3.2 Psychological Intervention in Infertility

One dimension in the discussion of psychological aspects of infertility is the interaction between the customers – the infertile couples – and the health services (Sundby, 1994). Although many studies have concluded that infertility investigation and treatment should not consist of medical procedures only, there are few examples of successful programmes that have included psychological counselling in their regular clinical work. Where there are, they are often linked with special procedures like in-vitro fertilisation (IVF) programmes and not linked to the whole infertility process (Andrews *et al.*, 1992; McDaniels *et al.*, 1992).

There is an expressed need for psychological counselling among infertile couples that has so far not been met by medical services in most settings (Sundby, 1994; Williams, 1997). Patients are usually satisfied with the somatic part of their treatment, but they are dissatisfied with the

psychosocial support during the process and with the fact that adoption is not included as a possible solution (Klempner, 1992; Sundby, 1994). Thus, some of the problems with infertility treatment are structural ones, failing to provide patients with continuity and support. Satisfaction with a medical process is of course confounded by many factors. A positive outcome may influence the positive attitude towards the services, but even patients who suffer from adverse outcomes may express satisfaction if their emotional needs are met (Sundby, 1994).

In view of the stress and emotional problems that infertile persons have to face during and after fertility treatment, counselling infertile persons is considered important. The patients should be informed about counselling at first encounter. Interventions the therapist might consider in working with infertile women, and preferably with their husbands as well, would more specifically include grief work, letting go, stress management, and self-esteem building techniques. Other intervention techniques to be considered include monitoring anxiety levels, progressive relaxation exercises, determining key stressors and doing cognitive restructuring around them, creative visualisation, and problem solving. Suggestions could be made for bibliotherapy and symptom specific support groups such as can be found with Resolve Inc. (Daniels, 1993; Leiblum, 1997; Williams, 1997).

These techniques should address the following areas identified by Ponjaet-Kristoffersen and Baetens (1999). First, counselling should focus on restoring self-esteem and dealing with feelings of worthlessness, anxiety, and guilt. Second, counselling should enable infertile couples to develop adequate coping strategies in order to deal with the high levels of stress during the treatment, especially because treatment can fail over and over again. Third, counselling should provide accurate information and should not in any way obscure the possibility of failure, so as to give infertile persons an opportunity to anticipate negative outcomes, thus enabling them to cope more effectively. Fourth, infertility involves a couple. Therefore, counselling should address the negative influence of infertility problems on the emotional and sexual relationship between the partners (Ponjaet-Kristofferse & Baetens, 1999).

According to Daniels (1993) counselling tends to focus on the psychological but to neglect the social aspect of the psychosocial continuum. The focus is too much on the individual, internal and

intrapsychic and not sufficiently on the social, which emphasises the interpersonal factors and the links between individuals and their social networks. Thus, a more holistic approach is required.

Psychological intervention approaches to infertility seem to cohere with the rejection of the psychogenic hypothesis. Intervention is usually focused on helping infertile individuals deal with the consequences of infertility. However, some medical specialists do still refer their patients for psychological intervention in cases of suspected psychogenic infertility with positive outcome (Dr Louise Olivier, personal communication, September, 2001).

There is a scarcity of literature addressing psychological intervention of infertility from a South African perspective. There is also an indication that infertility/fertility clinics do not incorporate psychological intervention to form a multi-disciplinary team of infertility treatment. Some medical specialists in infertility treatment refer their patients for psychological intervention with independent psychologists (Dr Louise Olivier, personal communication, September, 2001). It seems that very few infertile persons gain access to psychological intervention in South Africa.

2.3.3 Infertility: Ways of Coping and Social Support Factors

Ways which infertile persons use to deal with infertility include questioning the motives for biological parenthood, causal explanations for infertility, seeking help, using social support, and pursuing other life goals. The individual coping strategies and perceived social support plays a central role in mediating the use of these ways of dealing with infertility (Kleinke, 1998; Stanton & Dunkel-Schetter, 1991). These two mediating factors are discussed in the following subsections.

2.3.3.1 Coping strategies

Coping strategies are cognitive and behavioural efforts that are used by people to deal with stress (Coyne, Aldwin, & Lazarus, 1981). Kleinke (1998) defines coping as the efforts we make to manage situations we have appraised as being potentially harmful or stressful. The coping process has three key features: (a) It involves a certain amount of effort and planning. (b) It does not

assume that the outcome will always be positive. (c) It emphasises coping as a process taking place over time (Kleinke, 1998).

Individuals may employ a variety of coping strategies to deal with problems related to infertility. For some, it is coping with loss, for others it may be dealing with a negative identity, while others may even be coping with a significant disruption in anticipated life course or a combination of both (Stanton & Dunkel-Schetter, 1991). Within a cognitive model of coping, Coyne *et al.* (1981) distinguished between coping strategies that are employed to confront and seek solutions to the situation (problem-focused strategies) and emotion-focused strategies, which are used to regulate the associated level of emotional distress. In addition to coping strategies that represent these two categories of coping, strategies can serve as both problem- and emotion-focused functions. Seeking social support is one such strategy, such that others can provide one with emotional support and practical or informational support (Hynes, Callan, Terry & Gallois, 1992).

Problem-focused strategies have a positive association with measures of psychological well being while emotion-focused and avoidance strategies tend to be associated with poor mental health (Abbey & Halman, 1995; Hynes *et al.*, 1992; Stanton, Tennen, Affleck & Mendola, 1991). However, Hynes *et al.* (1992) argue that the effectiveness of a particular strategy of coping is dependent upon the match or goodness of fit between the strategy and the controllability of the event. In controllable events, it is proposed that problem-focused coping will be adaptive, while reliance on emotion-focused coping is considered maladaptive. A reverse pattern applies for uncontrollable events as there is presumably little point in engaging in strategies actively to deal with a problem when it is not amenable to control. In such situations, it is expected that the use of emotion-focused strategies will be adaptive, while the use of problem-focused coping is proposed to be maladaptive. Hynes *et al.* (1992) suggest further research considering the role of factors such as perception of personal control and social support resources, that may influence women's adaptation to infertility.

Several factors such as gender and age play a role in the coping process. Firstly, there are gender differences in coping with the problem of infertility. Women find it more helpful to talk to people outside their marriage about the problem of infertility than men. In Brand's (1989) study, women

reacted positively to the postulation: "I like to talk to someone about the fact that my marriage is childless". Men on the other hand, find it difficult to emotionally and verbally express their hurt, and avoid sharing the pain to protect their partner. Ironically, this causes additional hurt to women, who perceive the reluctance to talk and withdrawal as abandonment and disinterest rather than as a way of coping with the infertility (Williams *et al.*, 1992).

2.3.3.2 Social support

There are three different positive effects of social support relationships, namely, presence of social ties, structural characteristics of social networks and functions which provide social support. Andrews, Abbey and Halman (1991) identified three types of social support: esteem or emotional support, information or affirmation support and material or instrumental support. Esteem or emotional support involves communication of love, care, and respect. Since infertility involves a sense of failure and threatens individuals' self-esteem and sense of mastery, the knowledge that one is loved and valued can mitigate the sense of loss, thus increasing levels of psychological well-being (Wills, 1985). Emotional support is useful when you need someone to confide in, when you need someone to lean on. Emotional support also involves the knowledge that one belongs to a network of mutual obligation (Kleinke, 1998).

Information or affirmation support involves providing individuals with information that helps them evaluate their situation themselves. This often entails affirming that their thoughts and feelings are normal, given the circumstances of infertility. It also helps infertile persons who are unaware of how infertile people typically feel (Andrews *et al.*, 1991). Feedback from others help the infertile to face the challenge of infertility (Kleinke, 1998). Material support or instrumental support involves providing concrete aid, where the person is unable to handle the problem on his/her own (Andrews *et al.*, 1991; Kleinke, 1998). According to Andrews *et al.* (1991) instrumental support has the weakest link to psychological well being.

In addition to these three forms of social support, Kleinke (1998) also described a fourth type of social support, which provides a sense of belonging; a feeling that you "fit in" with other people. This type of social support has been applied to form support groups for people sharing similar

circumstances.

Infertility is chronic in nature, and over time, it becomes difficult for the network to remain mobilised to provide specific support functions when stress is chronic. Thus, over time, support providers may become less responsive to signs that support is required (Andrews *et al.*, 1991). Moreover, people tend to give their support conditionally. In a case study of perceptions of infertility in a community of black South Africans, respondents indicated that infertility is not acceptable if it is a consequence of abortion or sexual transmitted diseases (Mabasa, 2000). With such notions, it is apparent that most infertile women will not get social support, especially because 80 to 85% cases of infertility at Chris Hani Baragwanath hospital is due to tubal damage as a result of sexually transmitted diseases and pelvic inflammatory diseases (Goosen & Klugman, 1996).

2.4 Socio-cultural Aspects of Infertility

The traditional African world-view is holistic and seeks harmony. The concept of ***ubuntu*** (humanity) contends that people become human and empowered only in the context of a community, and only when they become seekers of the type of connections, interactions, and meetings that lead to harmony (Amadiume, 1995; ya Azibo, 1996). The community is seen as a unique structure that includes all components and the relations that link them, providing a context for all activities and decision making behaviour (ya Azibo, 1996). The construction of illness and health arises out of a social and cultural context, through interaction, and at the level of the individual (Shlomo, 1999; ya Azibo, 1996). According to Shlomo (1999) culture creates beliefs and values that serve the family in its attempt to struggle with existential problems. These problems lead to anxiety because they do not lend themselves to simple answers. Thus, infertility is intricately related to the socio-cultural system to cause distress or harmony amongst Africans.

Shlomo (1999) further contends that the family's modes of coping with existential problems are decisively influenced by how it interprets ecological constraints such as infertility. The extent to which the constraints constitute stressors, causing problems and difficulties, is partly determined by their subjective meaning for the family. The interpretations given to the constraints by the

family are, in turn, derived from the family's basic premises and its beliefs and values.

Here are some types of interpretations: First, spiritual and mystical interpretations - the family attributes the constraints to abstract supernatural forces such as fate, luck or other spiritual powers not anchored in any concrete entity. Second, magical interpretations - the family attributes the constraints to the magical influence of people or quasi-human agents (animals, devils, and gods). Third, mythical interpretations - the family interprets the constraints by referring to myths shared by the social group (Shlomo, 1999).

Thus, everyday discourse reflects both the negative and positive cultural construction of fertility and infertility. For example - positively as in "a fertile mind", "pregnant with hope", and a "fruitful enterprise"; and negatively as in "fruitless labours", a "sterile approach", and "barren soil" (Burgwyn, 1992). Men and women continue to be defined in terms of their reproductive capacities in contemporary societies. This commitment to parenthood is shown in both African and Christian religion (Miall, 1994; Sekhukhune, 1993). These cultural constructions are a vital consideration in examining the socio-cultural implications of infertility. It seems that infertility is not a crisis for the couple only, but is a disaster for the whole community (Mabasa, 2000; Sewpaul, 1995).

2.4.1 Causal Beliefs about Infertility

Earlier studies (Brand, 1989; Greil, 1991; Kayongo-Male & Onyango, 1994; MacCormac, 1994; Miall, 1986; Ndaba, 1994; Stanton & Dunkel-Schetter, 1991) found causal explanations of infertility to be supernatural (a curse, witchcraft and God's will) in African cultures and biomedical in western cultures. Mabasa's (2002) study of socio-cultural aspects of infertility among black South Africans found a different causal explanatory pattern wherein biomedical, supernatural, psychological and mythic explanations were reported.

Witchcraft is a mysterious act that causes misfortunes, illness, and death to others. Usually, the act takes place between people in close relationships, in the neighbourhood, or with co-workers. When in harmony, people tend not to interpret problems in terms of witchcraft, but when in conflict, attributions of witchcraft are likely to occur (Sekgena, 2000). Conditions like infertility

are then more likely to be linked to witchcraft (Brand, 1989; Greil, 1991; Kayongo-Male & Onyango, 1994, Mabasa, 2002; Ndaba, 1994). Explanations of infertility in this context imply that the infertile person is not responsible for his/her infertility. This is usually attributed to secondary infertility whereby the person has already proven his/her fertility. His/her infertility is lessened and more negotiable than that of a primary infertile individual. If there is no child at all, infertility is ascribed to some personal transgression in which a person has broken taboos, particularly sexual taboos (Upton, 2001).

According to Upton (2001) such taboos include the use of Western contraceptives, drinking hot beverages and certain kinds of food. Women avoid eating pumpkin and various gourds as they are believed to block the womb and, if the woman is already pregnant, make it impossible for a child to come out. Another cultural construction is that a pregnant woman or women who are trying to fall pregnant are not supposed to enter the cattle kraal. If a woman does so, both she and the cattle will become sterile or potentially abort.

The mythic causal explanations include the belief that infertility result when *madi a sa tlhakani* (Northern Sotho for incompatible blood) and when the blood is poisoned (Mabasa, 2000). Infertility also results from a traditional method of conception gone wrong. As a method of contraception, a girl wets a cloth with her menstrual blood and gives the cloth to her grandmother. The grandmother is supposed to hide the cloth underground where only she knows. When the girl is ready to bear children, the grandmother digs out the cloth and gives it to the girl who must then throw it away from behind herself to any place, after which she can conceive. There is a belief that if the cloth is not recovered, either because the grandmother forgot where she hid the cloth or she died before she could give back the cloth to the owner, that girl will never bear children (Sekgena, 2000).

As a curse, infertility is attributed to the woman's faulty behaviour (Brand, 1989; Mabasa, 2000). For example, God or the ancestors could punish the woman who had an abortion by damaging her reproductive organs so that she could not conceive (Mabasa, 2000). For the Bangangte' women in Cameroon, the woman's faulty behaviour (such as neglect and disrespect for parents and husband) is believed to cause her own reproductive misfortunes, and is referred to as her "bad

cooking" (Feldman-Savelsberg, 1994). In South African ethnic groups, among others the Nguni, infertility is attributed to a failure to perform rituals related to food symbolism:

> The groom's mother had not favoured the marriage and had not given cake to her kin. When no child was born the groom, himself a devout Christian, was reported to be anxious about his mother's failure to distribute the cake (Wilson, 1972, p. 195, in, Sekhukhune, 1993).

The migrant labour laws which were in force during the apartheid years did not allow men to live with their families near their places of work in urban areas. There was a spread of sexually transmitted diseases and men could only visit their wives in rural areas at specified leave periods, during which time their wives might not be ovulating and thus conception could not occur (Goosen & Klugman, 1996; Sundby, 1994; WHO, 1991). Although such labour laws have been abolished, men have made this living arrangement a way of life. A rural home is believed by many to be secure, and the urban areas are regarded as a place of work and not a home (Sekgena, 2000). Although women can now visit their husbands in urban areas, this type of life style can still hinder fertility.

2.4.2 Management Strategies

In contemporary South Africa, black people consult traditional healers, faith healers and modern physicians in their quest to deal with infertility (Lundgren & Paulson, 1997; Mabasa, 2000; Ndaba, 1994). The traditional doctor uses herbs and other medicinal preparations to treat infertility. The diviner, on the other hand, operates in a traditional religious context and acts as a medium of communication with the ancestors. The faith healer integrates ritual and traditional practices (Ndaba, 1994). Traditional treatment involves use of herbs and rituals such as slaughtering a goat to appease the ancestors (Mabasa, 2000; Ndaba, 1994; Sewpaul, 1999).

Among the Northern Sotho speaking people, an infertile woman undergoing the traditional treatment of infertility is obliged to keep the orders of the medicine-man at all times. Failure to do so would result in her inability to conceive. The woman is expected to walk around with a loinskin used to carry a baby on the back. If people who are not familiar with the ritual inquire about the whereabouts of the baby, the woman is advised to reply that *"ngwana o gae"* (the baby is at

home) or "*ngwana o gona*" (the baby is present) (Sekhukhune, 1991). From a modern 'Western' perspective, this cultural practice can be interpreted as an encouragement for infertile women to use defensive denial as a coping strategy. Although probably effective in many cases, this way of coping could have negative consequences for infertile women' s mental well-being when used over a long period.

Traditionally, African men are allowed to marry many wives in order to guard against the possibility of childlessness. Children are so important that if the wife is identified as being infertile, arrangements are made for the husband to marry another wife or for his wife to "marry" her own woman to bear children for her. The family of origin will in many cases provide their son in-law with a surrogate, usually a younger sister to the infertile woman, to bear children on her elder sister's behalf (Kayongo-Male & Onyango, 1994; Miall, 1994; Ziehl, 1994). According to Kayongo-Male and Onyango (1994) in African tradition, when a man realises that he cannot have children, he accepted his limitations. Arrangements are made in secret with his full consent for his wife to have children either with a close relative or a friend whom he trusted would not let him down by either divulging the arrangement or taking the wife from him.

When these management options failed, a traditional form of adoption is considered. An infertile couple is usually given a child by relatives to raise as their own. A recent study (Mabasa, 2002) found that this traditional form of adoption is considered somewhat undesirable because it is impossible for infertile persons who adopted to feel like real parents. Other problems perceived to exist and associated with formal adoption include notions that the father might sexually abuse the adopted child and that the extended family might ostracise the adopted child, because of a belief that the child is not of their own blood.

2.5 Conclusion

This chapter stressed the importance of a biological, psychological, and socio-cultural understanding of infertility. It provided causal explanations for infertility. In addition, this chapter presented possible interventions which medical practitioners, psychotherapists, faith healers and traditional doctors use to help couples deal with the challenges of infertility. The chapter reflects

that most of the literature on the biological and psychological studies of infertility are based on clinical samples while those of socio-cultural studies are based on anthropological and sociological studies. According to the biopsychosocial approach to infertility, methods of intervention should have a theoretical grounding as well as be sensitive to the socio-cultural context in which the condition occurs. Thus, literature on the psychological theories and cultural bases that influence the impact of infertility are discussed in the next chapter.

CHAPTER 3

INFERTILITY, THE FAMILY SYSTEM, GENDER AND MOTHERHOOD

3.1 Introduction

To a large extent, it is the meanings attached to concepts such as family, motherhood, and gender that influence reactions to infertility (Stanton & Dunkel–Schetter, 1991; Wirtberg, 1992). This chapter reviews literature on conceptual approaches to understanding the family system, the concept of motherhood and that of gender identity development. Each of these concepts is approached from both the psychological perspective and the African cultural context.

3.2 Infertility and the Family System

The family as a focus of methodologically consistent study is a relatively recent phenomenon. Efforts at understanding family functioning have traditionally employed a deficit model focused on structure rather than on process. Thus, the topics of concern for researchers have generally been problems and pathology, while the major independent variables consisted of structural dimensions such as father-absence or family type, divorce, or single-parent. More recently scholars have begun to recognise the limitations of such a negativistic, structural approach to the study of families. Researchers have attempted to describe healthy families and to take note not only of the process dimensions within healthy families, but also of the variety of family forms that may be supportive of normal growth and development for both adults and children (Becvar & Becvar, 1996).

The great diversity of family life makes it difficult to describe 'ideal' family life patterns (Barker, 1996). Barker (1996) describes the family as a psychosocial system, as follows: (a) Families are systems having properties, which are more than the sum of their parts, sharing a specific physical and psychological space. (b) The operation of such systems is governed by certain general rules. (c) Every system has a boundary, the properties of which are important in understanding how the system works. (d) The boundaries are semi-permeable. (e) Communication and feedback mechanisms between the parts of a system are important in the functioning of the system. (f) A

family is replete with assigned and ascribed roles for its members, has an organised power structure, and has elaborated ways of negotiating and problem solving that permits various tasks to be performed effectively. (g) Events such as the behaviour of individuals in a family are better understood as examples of circular causality, rather than as being based on linear causality. (h) Family systems, like other open systems, appear to have a purpose. (j) Systems are made up of subsystems and themselves are parts of larger supra-systems.

Supra-systems to which families may belong include the extended family, the neighbourhood, clan, village, and church community. The family system on the other hand is composed of smaller units or sub-systems. These are the spouses' sub-system, the children's sub-system, the females' sub-system, males' sub-system and individual sub-system. Sub-system configurations such as the mother-son sub-system and father-daughter sub-system also exist. Each family member has a certain role to play within the family and each family system has a set of rules that govern the behaviours of family members. Each family member may belong to several sub-systems simultaneously, entering different complementary relationships with other members (Hoffman, 1981).

Family researchers and family therapists (Barker, 1996; Becvar & Becvar, 1996; Chandra *et al.*, 1991) continue to apply ideas from the family developmental life cycle approach, which includes childbearing as a developmental milestone. Consequently, the psychological formulation of problematic families is grounded on the notion that the inability to have children often precipitates a crisis in the family. According to Chandra *et al.* (1991) the effect of children on the well-being of parents and the quality of their marriage is one of the central themes in family research. Parenthood forms one of the important milestones in a family's developmental life cycle. Thus, infertility can halt family growth and prevent a dyadic relationship from evolving into a relatively more stable triadic one. The following paragraphs describe the stage-critical family life cycle and the dynamic process model of family development and their relationship to the understanding of infertility.

The stage-critical family life cycle schema is a model that uses family developmental milestones like marriage or childbearing to describe the family life cycle. The schema posits a model of the family in which particular life stages of the family confront family members with particular tasks which may be mastered or not (Becvar & Becvar, 1996). From this perspective infertility marks the lack of mastery of certain stages in the family life cycle (Benazon, Wright & Sabourin, 1992; Upton, 2001).

Table 1 summarises the stages of family life cycle and critical tasks for each stage as described by Barker (1996) and Becvar and Becvar (1996). It is noticeable from the table that infertility is not catered for in 'normal' family development.

Table 1: Stages of family life cycle

Family Life Stage	Critical Tasks
Unattached adult	Differentiation from family, development of peer relations and initiation of career.
Newly married	Formation of marital system, making room for spouse with family and friends and adjusting career demands.
Childbearing	Adjusting marriage to make room for child, taking on parenting roles and making room for grandparents.
Pre-school age child	Adjusting family to specific needs of child/children, coping with energy drain and lack of privacy and taking time out to be a couple.
School age	Extending family/society interactions, encouraging the child's educational progress and dealing with increased activities and time demands.
Teenage child	Shifting the balance in the parent-child relationship, refocusing on mid-life career and marital issues, and dealing with increasing concerns for older generation.
Launching center	Releasing adult children into work, college, marriage; maintaining supportive home base and accepting occasional returns of adult children.
Middle-aged adult	Rebuilding the marriage, welcoming children's spouses, grandchildren into family and dealing with ageing of one's own parents.
Retirement	Maintaining individual and couple functioning, supporting middle generation; coping with death of parents, spouse and closing or adapting family home.

The stage-critical family model has been criticised because it follows the progress of a couple through a traditional pattern of marriage, child-bearing and child-rearing (Benazon *et al.*, 1992; Upton, 2001). Other shortcomings of stage models of family development are as follows: (a) They describe isolated moments, or arbitrary punctuation, in what from the systems perspective is an on going and interactive process. (b) They tend to describe a traditional pattern reflective of only

a small portion of western families today. (c) They tend to focus on the developmental milestones of one individual, usually the first child, and are weak in their ability to capture the complexity or reflect the many levels of family interaction. (d) Even though the general characteristics of each stage outline specific issues and tasks, as well as style of progress through the life cycle, these may vary a great deal from family to family. (e) Like many theories that attempt to define living phenomena, the model is historically bound and therefore periodic revisions are necessary in order for it to reflect the developmental process of individual and families relative to changes in the larger society (Becvar & Becvar, 1996).

The stages are closely tied to childbearing to exclude the infertile or childless family developmental processes (Upton, 2001). In this regard, the implication is that families and couples experiencing infertility are either fixated on the 'newly married' stage or have skipped the childbearing stage of the family life cycle, thereby rendering the families faced with infertility incomplete (Benazon *et al.*, 1992). There are variations in family life-cycle over the past decades, and families will continue to evolve and change (Becvar & Becvar, 1996).

Based on these dilemmas, Becvar and Becvar (1996) proposed a dynamic process model of family development. This model describes the family life cycle using the couple's marital relationship. The stages of marriage were derived from the relevant aspects of the family life-cycle model and Becvar and Becvar's (1996) own clinical practice. The dynamic process model integrates individual and marital development theories. It captures and depicts particular characteristics of each family's life cycle. Instead of solely defining each stage relative to the presence of children, and/or particular developmental milestones characteristic of individuals living traditional patterns of family life, this model is applicable to the variety of couples and families. The dynamic process model integrates both individual and family models and can reflect the interaction between the generations and broader family context in which the client system exists. The dynamic process model uses the following stages of marriage, with its stage-critical tasks.

Table 2: Stages of marriage

Life stage	Stage critical tasks
Honeymoon period	Differentiation from family of origin, making room for spouse with family and friends and adjusting career demands.
Early marriage	Keeping romance in the marriage, balancing separateness and togetherness and renewing marriage commitment.
Middle marriage	Adjusting to mid-life changes, renegotiating relationship, and renewing marriage commitment.
Long-term marriage	Maintaining couple functioning, closing or adapting family home and coping with death of spouse.

The dynamic process model differs from the stage-critical family life cycle in that it accommodates diversity in family development. This model accommodates diversity because it describes the unique characteristics and individual differences in each client family. It assumes continued growth, change, and development. Consistent with a cybernetic epistemology, the focus is on family process at various levels rather than on content. The process dimension of family functioning focuses on how families, regardless of their particular structure, organise their resources and function to accomplish their objectives. In this regard, a healthy family refers to the family's success in functioning to achieve its own goals. Family process must be considered first, then always in context of structural and cultural relativity. Cultural identity influences the definition of family, family life-cycle phases, with emphasis placed on various traditions and celebrations, children, occupational choice, characteristic problems, and logical solutions (Becvar & Becvar, 1996; Shlomo, 1999).

However, the dynamic process model also does not incorporate infertile families in its attempt to diversify families. Moreover, given the developmental challenges of family contexts, punctuated by divorce, single parent parenthood, remarriage and step parenting, there are many different

forms of a family structure. Thus, a single model perspective of the family no longer exists. Cultural variations and social changes brought varieties of families such as communal families, families with cohabiting parents and families with homosexual parents. Families vary in their form and composition. Thus healthy family functioning can take many forms depending on the theoretical orientation of the assessor, cultural values of families and their ethnic background (Barker, 1996; Becvar & Becvar, 1996). For instance, premarital sex and the common practice of non-married couples living together have become acceptable in many societies (Becvar & Becvar, 1996; Preston-Whyte, 1993).

3.3 Infertility and the African Family

Black people in South Africa have been anthropologically classified into four main ethnic groups. These are the Nguni (who consist of the Zulu, the Swazi, the Xhosa and the Ndebele), the Sotho (who consist of the Southern Sotho, the Northern Sotho and the Tswana), Tsonga/Shangaan and the Venda (Nzimande, 1996). This form of classification is controversial in the sense that it is not absolute and it has given rise to many debates in academic and other circles. Although Nzimande (1996) states that each group has its own culture, he seems to agree with Preston-White (1988b) who contends that these ethnic groups also show a remarkable degree of cultural cohesion with similar marriage and family structures. This notion allowed Nzimande (1996) to review research on South African black family structure broadly and not focus on each ethnic group separately.

From an African world-view, the nuclear family is seen as a stage in the development of a family structure, with the extended family structure seen as an ideal level of family development. The extended family consists of a kinship network of grand parents, uncles, aunts, adult siblings, cousins and other relatives (Nzimande, 1996). The growth of the family is affected by fertility, marriage, divorce, and, mortality. Although there is now a tendency for black family systems to shift to a nuclear type of family as viewed from the Western perspective, this type of nuclear family and extended families exist side by side in African culture (Nzimande, 1996; Lesthaeghe, 1989). Modernisation lead to loss of cohesiveness essential for survival of an extended family structure and the nuclear family forms 59% of the types of family structures among black South Africans (Nzimande, 1996). Nzimande (1996) found that although the nuclear family exists as a

separate unit, the extended family is expected to provide support in times of need. The decline in extended family arrangements has lead to a decline in the availability of social support.

As is the case with the concept of 'family', that of 'household' remains beset with problems of definition. To define what constitutes a household is made particularly difficult by the migrant labour system in South Africa. In South Africa, perhaps more so than in other parts of the world, the household is not a spatially discrete entity, but one that exists simultaneously in multiple spaces, economies, provinces and urban-rural morphologies (Moultrie & Timaeus, 2001). Moultrie and Timaeus (2001) used women at a child-bearing age as the primary unit of analysis to come up with the following different types of living arrangements in South Africa: (a) The presence or absence of her husband in the household. (b) The presence or absence of relatives of her generation (for example, brothers, sisters-in-law, or cousins) in the household. (c) The presence or absence of relatives of her parents' generation (for example, her father or aunts) in the household. These types of living arrangements have implications for infertility. For instance, the migrant labour system could cause infertility whereby the husband could only visit his wife during her infertile reproductive cycle.

One of the things that have not changed much in the African family is the value of children. Children are important for the whole kin group among Africans, to the extent that they are thought of as belonging to everybody in the system, not just the parents (Kayongo-Male & Onyango, 1994, Mabasa, 2000; Sewpaul, 1995). *"N'wana a hi wa wun'we"* (Xitsonga expression literally meaning that a child is not for one person) clearly indicates that the couple not only bears a child for themselves, but for the whole clan. Many Africans also still see children as a security system in old age. Childbearing and bringing up children serve to perpetuate the family name and to maintain the link between the ancestors and the living.

The extent to which Africans value children is also shown in how children brought into the marriage (when their mother gets married) are regarded as part of the new family as indicated in the following expressions:

(a) *"Ku koka rhanga na vana va rona"* (Xitsonga expression literally meaning to pull up a type of an African cucumber with its fruits), which means the man who marries a woman who has children, is also pulling her children into the marriage.
(b) *"Ngwana ke wa kgomo"* (Northern Sotho expression meaning a child belongs where *lobola* [bride-wealth] has been paid). Ziehl (1994) contends that the practise of lobola implies the transfer of a woman's reproductive rights from her family of origin to her family in-law. From this perspective, *lobola* is viewed as compensation to the woman's family of origin for loss of control over their daughter's present or future offspring. Therefore, the husband may demand the return of the *lobola* in case his wife is infertile.

Sociologists have argued that society should be held responsible for perpetuating the notion that the marital relationship is incomplete without the addition of children (Benazon *et al.*, 1992). Black South Africans fear reproductive failure to such an extent that childbirth outside official marriage is considered legitimate in some circumstances. Marriage and childbirth in African culture has become divergent such that pregnancy outside marriage does not necessarily lead to marriage, while marriage on the other hand is expected to produce children (Preston-White, 1993). According to Lundgren and Paulson (1997) black South African women report that they no longer want to be in polygamous marriages. Contrary to this, Popenoe, Cunningham and Boult (1998), and Lesthaeghe (1989) contend that polygyny is an accepted form of family life among many black South Africans. This practise is used to guard against infertility (Kayongo-Male & Onyango, 1994). While some black South African parents encouraged their sons to divorce an infertile woman and marry somebody else (Hilton-Barber, 1998) other parents do not want their sons to divorce but instead, encourage their sons to marry another wife (Sekgena, 2000).

3.4 Infertility and the Conceptual Understanding of Gender

Conceptual analysis of gender development provides insight into how gender is intricately linked to reproductive roles, and impact on infertile individuals' gender identity. Gender is conceptualised in this section using different theoretical perspectives. These are the essentialist, psychoanalytic, and social constructionist perspectives.

The distinction between sex and gender is now commonly made. Sex refers to physiological denotations like biology, hormones, and chromosomes. Gender on the other hand, connotes the social and historical constructions of masculine and feminine roles, behaviours, attributes, and ideologies, all of which are related to, but not directly attributable to, biological sex (Imam, Mama & Sow, 1997). According to Biaggio and Hersen (2000), research on sex differences prior to the 1960's was aimed at describing inherent differences between women and men and was influenced by the essentialist view. The essentialist view contends that behavioural differences are rooted in biological differences and presumes that an individual's core personality, which determines such behaviours, is separable from the individual's social and cultural context. This traditional view is rooted in a belief in sex differences in which female identity is distinct from or in opposition to, normative male identity. This biological essentialist view, in which sex and gender are inseparable constructs, has its roots in Freudian psychoanalysis and its explanations of male and female gender identity development.

Psychoanalytic theory describes the development of gender identity from two perspectives, the phallocentric Freudian view of oedipal psychosexual development, and the gynocentric view of mother-centred affiliation and differentiation. The psychoanalytic theories regard gender as a component, and a distinctly salient one, of a person's identity and personality, such that a person's desires, motives, and interests derive from and enforce such an identity, leading the person to behave in ways consistent with that identity. From the phallocentric perspective, Freud believed that the process of phallic resolution causes males to have a well-developed sense of morality and understanding of social order, or what he termed a strong superego psychic structure. Lack of the phallus as well as issues around penis envy makes it difficult for women to achieve a complete phallic resolution. Consequently women are seen as inferior or incomplete men (Biaggio & Hersen, 2000).

Neo-Freudians attempted to extend and modify his views, while others attempted to discredit them. Clara Thompson noted that child bearing and rearing is of value because women achieved status in both domestic and public arenas through such activities. Thus, according to Thompson, a female's feminine identity lay not in penis envy, but in her desire to be a valued member of her

society. Furthermore, the greater the social value placed on procreative activity for females in a given society, the more male dominant and oppressive the society and the less likely females were to hold other socially valued positions (Biaggio & Hersen, 2000). Although Thompson's intention was to point out the social injustice of male-dominant arrangements, it becomes ironic that her view also reflects a situation that renders infertile women worthless in society. Infertile women are not able to negotiate - through child bearing - the social status which fertile women can achieve. Thompson's view also perpetuates the patriarchal notions that women often experience the loss of being a parent more deeply than men (Williams *et al.*, 1992).

Unlike phallocentric theorists, gynocentric theorists consider female identity development as the standard for normative development rather than merely a derivative of masculine identity development. In addition, the role of the mother rather than that of the father are emphasised in development. Karen Horney, Melanie Klein, Nancy Chodorow and Helen Deutsch articulated the gynocentric view (Biaggio & Hersen, 2000). Unlike Freud, Horney believed that a female's desire for a child was not the necessary outcome of penis envy, but a primary, instinctual, biological need. She also held that males attribute penis envy to women because of a fear of women that originated in their early fear of the mother and their own desire to reproduce as women do. Horney also suggested that men experience "womb envy" derived from their lack of ability to bear offspring (Biaggio & Hersen, 2000).

Hellene Deutsch and Nancy Chodorow provided an alternative to Horney's explanation of the development of gender identity. They believed that gender identity is based on the recognition of the dual roles of women, that is, the sexual and the nurturant chaste mother. Males come to accept and value the sexualised image of females during the process of their identity development. Rejecting the nurturant, chaste mother image allows a boy to separate from his mother and to form a separate distinct identity. Conversely, girls accept the mother image and reject the sexualised lover image. Feminist theories from various academic disciplines and political agendas criticised the psychoanalytic accounts of gender identity development for focusing on anatomy and unconscious motives and ignoring the sociocultural conditions that better accounted for the relatively inferior status of women (Biaggio & Hersen, 2000).

Social construction of gender is often confused with the socialisation of gender. The position arguing that gender is socially constructed is not simply an assertion of the environmental origin of gender traits. Rather, the constructionist argument is that gender is not a trait of individuals at all, but a social construct that identifies particular transactions that are understood to be appropriate to one sex. Gender so defined is not resident in the person, but exist in those interactions that are socially constructed as gendered (Gergen & Davis, 1997; Hare-Mustin & Marecek, 1990). Thus, relationality is a quality of interactions not of individuals, and it is not essentially connected with sex. The factors defining a particular transaction as feminine or masculine are not the sex of the actors but the situational parameters within which the performance occurs. Therefore, none of us is feminine or masculine or fails to be either of those. In particular contexts, people do feminine; in others, they do masculine (Gergen & Davis, 1997).

An understanding of how cultural systems shape our perceptions of individuals as a function of their biological sex, and how we attach meaning to those sex-linked conceptualisations, underlies the social constructionist perspective of gender. Social constructionists explore the meaning of gender through socio-cultural frameworks and attempt to show how such meaning making by dominant social formations sustain sex-based inequality. Social constructionists contend that the meaning of gender is incomplete in that it is created and sustained only by the dominant group and excludes all other social groups, like women, persons of both sexes from lower socio-economic classes, and non-heterosexuals. Role distinctions by sex are determined through a given society's division of labour by sex, which further determine that society's modes of production and reproduction (Biaggio & Hersen, 2000).

Social constructionists Hare-Mustin and Marecek (1990) argue that the meaning of gender is created by males and disseminated through language. By conceiving of gender as something that we "do" rather than what we "are", the social constructionist perspective allows us to identify those cultural standards that contribute to our definitions of "maleness" and "femaleness" or "masculinity". Another aim is to dispel falsely constructed notions of gender that sustain unequal power relations between sexes (Biaggio & Hersen, 2000).

The question of how gender develops or is adopted is no longer salient. Rather, the question of how gender is constructed and why such constructions persist and have such profound implications for our behaviour is of greater import. Only by disentangling biological sex from systems of power and privilege, by deconstructing the meaning of gender itself, can we begin to recognise and value the broad spectrum of characteristics that comprise individuals of all ages, ethnicities, sexualities, and socio-economic groups (Biaggio & Hersen, 2000).

Thus, the sociocultural orientation towards child-bearing as a gendered role need to be deconstructed. Fertility and child bearing is conceptualised as a gendered division of labour asigned to women as their primary responsibility. The social constructionist perspective examines the complexities of status, stigma, and power of social forces aimed at controlling women who deviate from their expected roles (roles of fertility and child-bearing) (Hamilton, 1994). This issue brings in the social construction of motherhood as examined below.

3.5 Infertility and Motherhood

Literature on motherhood is centred on two themes - that of collusion with patriarchy and that of difference in the experience and construction of motherhood - which are not necessarily mutually exclusive approaches in practise. The South African treatment of both themes is embedded in pre-occupations with the struggle by blacks against apartheid and white supremacy. Black women used motherism as a force against apartheid. The context in which motherhood has most often been discussed, and the aspect which continues to hold the most interest for researchers, has been its expression in political organisation and campaigns, rather than the day-to-day experiences of mothers. Of the two themes, colluding with patriarchy has been the dominant to date. From this perspective, women are presented as uncritically endorsing motherhood. However, motherism is not feminism, for motherist movements are not fighting for their rights as women, but for their rights as mothers (Imam *et al.*, 1997; Walker, 1995). Our society today sees a mother as a woman who is defined and defines herself in terms of biological motherhood (Hamilton, 1994; Tong, 1997).

Reproduction (including reproductive technologies) and mothering is seen as either the cause of women's oppression or the source of women's liberation. In *"The dialectic of sex"* Firestone (1970) claimed that patriarchy – the systematic subordination of women - is rooted in the biological inequality of the sexes. However, according to Hamilton (1994) and Tong (1997), inequality between the sexes should not be attributed to observable biological differences between them, but to the fact that men's and women's differing reproductive roles led to the first division of labour and the origins of class, as well as furnishing the paradigm of caste discrimination based on biological characteristics. According to Tong (1997) radical feminists view the joy of giving birth to be a patriarchal myth. Moreover, biological motherhood is the root of further evils, especially the vice of possessiveness that generates feelings of hostility and jealousy among human beings. This possessiveness plays itself out in the intense wish of people to pass their property on to their children, and the extent of favouring of one child over the other on account of its being the product of one's biology.

Thus, women must seize control of reproduction in order to eliminate the sexual class system, and move towards an androgynous society. The argument for this view is that reproductive technologies, through contracted motherhood, and sperm and egg donation, makes it possible to dilute the different roles in the reproductive drama. Firestone (1970) believes that eliminating biological reproduction will make it possible to overcome all of the relations, structures, and ideas that have always divided the human community; for example oppressing male/oppressed female and fertile/infertile persons (Biaggio & Hersen, 2000).

Firestone (1970) has been challenged by many feminists, including radical feminists, who insist that it would be a mistake for women to give up biological motherhood for ex-utero child gestation. In this regard, reproductive technologies do not equalise the natural reproductive power structure. It appropriates the reproductive power from women and places it in the hands of men who would then control both the sperm and the reproductive technology that could become indispensable. It is also implausible in its notions of who counts as a mother. Sociologist and social historians contend that motherhood lies at the core of a woman's identity to an extent that women are defined as mothers and life-givers across racial and cultural lines (Walker, 1995).

The theme of difference in the experience and construction of motherhood tend to view motherhood as having the potential for emancipating women. For example, in political circles motherhood is often constructed within a collective rather than individualistic notion. Women are viewed not as nurturer within the privatised family, but collectively as mothers of the next generation (Walker, 1995). Hence, the reference to women in progressive political parties as 'mothers of the nation'.

According to Walker (1995) motherhood embraces three different terrains as follows. (a) Mothering work, that is, the practise of motherhood. (b) The discourse of motherhood, embracing norms, values, and ideas about the 'good mother' that operate in any society or sub group. (c) Motherhood as social identity, which consists of those aspects of self-image, positively or negatively valued, which derive from membership of various social groups to which an individual belongs.

(a) The practise of motherhood: In South Africa, physical care of children is often not the sole or primary responsibility of the mother. It is delegated in the case of many middle-class women, to a domestic worker or a nanny, or, in the case of many working-class women, to other family members, such as grandmothers or older female siblings (Walker, 1995). Motherhood is regarded as a myth based on threefold belief that 'all women need to be mothers, all mothers need their children, all children need their mothers'. The need to be a mother owes nothing to biological sex, but everything to the way in which women are socially and culturally conditioned to be mothers. Studies conducted in the seventies (Firestone, 1970; Oakley, 1974) have long disputed the belief that unless a woman's 'maternal instinct' is satisfied, she will become increasingly frustrated. Instead, mothers are not born but they are made. The assertion that all children need their mothers is according to Tong (1997) the most oppressive feature of the myth of biological motherhood. The myth asserts that children need biological, not social mothers.

Boundaries distinguishing biological mothers of children from other women who care for children are often fluid and changing. Biological mothers are expected to care for their children. However, African communities have also recognised that vesting one person with full responsibility for

mothering a child may not be wise or possible. Therefore, other mothers, women who assist blood-mothers by sharing mothering responsibilities, have been central to the institution of black motherhood. The centrality of women in African extended families is well known. Organised, resilient women-centred networks of blood-mothers and other-mothers are key in understanding this centrality. Grandmothers, sisters, aunts, or cousins act as other-mothers by taking on childcare responsibilities for each other's children. When needed, temporary child-care arrangements are turned into long-term care or informal adoption (Nzimande, 1996; Walker, 1995).

In traditional sub-Sahara African societies, women serve two primary functions, that of agricultural workers and procreators on behalf of corporate kinship groups. The reproductive function itself is so crucial to both the individual woman and to the two kinship groups concerned - that is the family in-law and the family of origin - that the status of adulthood for women is almost completely contingent on motherhood. Therefore, the last instalment of *lobola* (bride-wealth) is often transferred upon the birth of the first child only. The position of women is partially contingent upon various patterns of kinship organisation. In the strictly patrilineal societies, the rights in genetricem (this implies that the woman belongs to her clan of marriage and her offsprings whether married or not, belong to the children's father's clan) belong exclusively to the husband's clan, even in instances of a child being born from an extramarital relationship (Lesthaeghe, 1989).

One concept that has been constant throughout the history of African societies is the centrality of motherhood in religions, philosophies, and social institutions. Traditionally, mothering was not a privatised nurturing occupation reserved for biological mothers, and the economic support of children was not the exclusive responsibility of men. Instead, for African women, emotional care for children and providing for their physical survival were interwoven as interdependent, complementary dimensions of motherhood (Gergen & Davis, 1997; Imam *et al.*, 1997; Kayongo-Male & Onyango, 1994; Lesthaeghe, 1989). In fact, black women's experiences as other-mothers have provided a foundation for Black women's social activism (Walker, 1995).

(b) The discourse of motherhood: The discourse of motherhood embraces not only ideas about 'the good mother', but is also bound up with ideas about womanhood and female gender identity. The expectation that all women desire to be mothers leads to the assumption that adult womanhood is synonymous with mothering. Women themselves have often associated motherhood with "official' adulthood (Biaggio & Hersen, 2000). Menarche is a milestone in women's development and a psychologically significant event. It provides a dramatic dermacation between girlhood and womanhood. In many societies like African societies, menarche is celebrated as a rite of passage to adulthood. Celebrations range from parties with the girl's friends or with other women in the family or village to rituals of cleansing (Biaggio & Hersen, 2000; Harrison & Montgomery, 2001).

(c) Motherhood as social identity: This self-image is not personal and individualised, but is grounded in a social context and mothers' recognition of themselves as part of a distinct group, that of mothers. Social identity involves women's own construction of an identity as mothers informed by the discourse of motherhood, mediated by the practise of mothering, but not simply derivative of either. However, women are not only 'women', nor are they only 'mothers' (or deviant non-mothers). They have a range of other identities including 'wife' (which need not be synonymous with mother), worker, student, black, and Christian (Biaggio & Hersen, 2000).

These three dimensions of motherhood are located in particular social formations, with particular family systems and productive systems, which impact on their content, power, and meaning. In the South African context they are embedded in a particular system of gender relations, in which women as mothers but also as workers, citizens and political activists are devalued and subordinated in relation to men.

If mothering refers to any relationship in which an individual nurtures and cares for another, then a person does not need to be a biological mother in order to be a social mother. However, patriarchy teaches us that the woman who bears a child is best suited to rear that child (Gergen & Davis, 1997). In the language of most black South Africans, the term 'woman' and motherhood are synonymous. The biological ability to bear children, in other words, a woman's fertility, lies at the root of a mother's experiences of mothering, and their roles and responsibilities as mothers

(Walker, 1995).

Feminist writers contend that motherhood in itself is not a problem. The problem lies with the patriarchal institutions and social constructs of motherhood. Making motherhood the primary role of women (Sewpaul, 1995) and making men and men's reproductive roles determine their identities (Mabasa, 2000; Tolman & Szalach, 1999) is the problem. Feminist theory has succeeded in exposing the shortcomings in the traditional views of motherhood. Now the problem lies with the lack of consensus on how to conceptualise and theorise motherhood. On the one hand, white, western feminists oscillate along a spectrum that stretches between attacks on motherhood as a patriarchal construct and the affirmations of it as a valuable identity and responsibility that must be defended against male control and masculinist values. Black and third world feminists, on the other hand, have criticised what they regard as the ethnocentrism of much of this debate. Most recently, post-modern social theory has subjected the unitary concept of motherhood to a radical deconstruction (Walker, 1995).

3.6 Conclusion

The themes of this chapter emphasise how the multiplication of perspectives reveals complex representations of human development, social roles and family functioning within the context of fertility and infertility. The chapter provided an understanding of how gender development theories, ideologies of familism and the conception of motherhood can impact on infertile individuals and their families. For instance, patriarchal family values promoted the notions that families are incomplete without children and that biological parenthood affirmed gender identity. The chapter also gave an analysis of how feminist thought challenges these patriarchal notions. The background of the study, its purpose and the theoretical frame work grounding the study, are discussed in the next chapter.

CHAPTER 4
RATIONALE AND FRAMEWORK OF STUDY

4.1 Introduction

This chapter situates the context of the study, which includes discussion and description of the research problem, the objectives of the study, clarification of concepts used in the study and the rationale for the study. The theoretical framework in which the study is grounded is also discussed in this chapter.

4.2 Research Problem

Infertility can be a traumatic and a worrying experience for men and women who, for cultural or personal reasons, view childbearing as central to their lives (Ndaba, 1994; Abbey *et al.*, 1994). Yet, most demographic studies in sub-Saharan Africa focus on fertility rates and the need to lower the high fertility rate (Harrison & Montgomery, 2001; Lesthaeghe, 1989; Potts & Marks, 2001; Upton, 2001). Focusing on the often overlooked demographic phenomenon of infertility can begin to elucidate and help explain the prevailing trends of decreasing over-all fertility rates, yet increasing extramarital fertility rates in sub-Saharan Africa (Lesthaeghe, 1989; Perston-Whyte, 1993; Potts & Marks, 2001; Upton, 2001).

The psychological effects of infertility bring about an imperative need for psychological knowledge and insight into the meaning of infertility and how this interacts with culture to influence psychological responses. However, there is limited research on the psychological aspects of infertility, particularly in the African context. Most of the available literature on infertility studies is based on western societies (Eupnu, 1995) while much of the South African literature is based on nursing, medical, and anthropological case studies (Goosen & Klugman, 1996; Lundgren & Paulson, 1997; Ndaba, 1994; Sekhukhune, 1993).

The Literature review also indicates that most infertility studies are based on clinic samples. According to Greil (1997) focusing on those who experience infertility as patients rather than on the other social actors involved, impeded progress in understanding the psychological consequences of infertility. It becomes difficult to separate the psychological consequences of infertility from the psychological consequences of infertility treatment. Hence, there is need for studies that involve such under-studied portions of the infertile populations as those who are not economically well off, those who do not seek medical treatment, and those who use the multiple treatment options available in South Africa.

Most definitions of infertility clearly indicate that infertility concerns the couple system. However, most black South Africans tend to view it as a woman's problem (Goosen & Klugman, 1996; Mabasa, 2000; Ndaba, 1994). To a certain extent, infertility in men is kept as a secret in the black South African community. Therefore, most women in infertile relationships tend to accept the blame of being an infertile partner without medical evidence (Mabasa, 2000). Consequently, there is a consensus between both sexes that the psychological effects of infertility are greater for women than for men (Williams *et al.*, 1992; Brand, 1989).

Tradition and religion commonly have a great impact on how children are valued, and create norms regarding reproductive expectations. According to the literature review, in African communities, the cultural expectation is so strong that couples are almost asked "how many" and "when" rather than "whether" they will have children (Eupnu, 1995). To many people, the possibility of being unable to bear children simply does not occur. As indicated in the literature review, this results in infertility being potentially, one of the most stressful and painful issues many couples and their social network will have to face. The problem becomes more difficult when one considers the high infertility rates in South Africa (see Chapter 1).

It seems that societal expectations and pressure negatively affect infertile couples' and their families' mental well being. Women in infertile relationships are often blamed and constantly subjected to stigmatisation, derogation, and humiliation. These societal attitudes negatively affect the infertile woman's sense of belonging, her identity, and her status in the society. However, it is not well known how black South African men and women, and their social systems, react and

cope with this problem.

Some cultural practices that were previously used to manage infertility no longer hold. Socio-political and economic changes have led to a synthesis of diverse systems into a sociocultural model in which African values and family life are neither purely traditional nor entirely Western (Kayongo-Male & Onyango, 1994). Thus, the process of change has exposed African families and individuals to conflicts and problems, which centre, among others, on marriage, roles, inheritance, and African lifestyle. Polygamy used to help by providing children in a family where one of the partners was infertile. In this regard, family members were able to achieve parental goals, and infertile women were not ostracised because there would be children in the family. However, black South African women no longer want to be in polygamous marriages (Lundgren and Paulson, 1997). This leaves a gap in the management of infertility, at least from an African perspective.

The decline in social support that used to be provided by the extended family structure have far reaching implications for the welfare of the black family and the community. This calls for the development of formal social support structures and measures to complement the family structure (Nzimande, 1996).

In view of the above stated problems, the problem statement of the study is as follows: What is the psychological impact of infertility on black South African women and their families?

4.3 Rationale for the Study

The rationale for this study is to fill the gaps in the literature about infertility, especially from the psychological and the African perspectives. The literature on people with infertility is fairly small, and there are almost no studies considering the impact of infertility on the extended family. Family studies have become multi-disciplinary, yet the bridges between the social sciences and the clinical field need to be developed further for mutual exchange of perspective and approaches to understanding family functioning. Moreover, individual adaptation needs to be explored at the family system level. Accounts of experiences and their meaning for family members can be particularly valuable for understanding family development over time, as well as for understanding

the formation and transformation of family belief systems that both shape and reflect family organisational patterns and communication process.

It is the intention of this study to begin to build up knowledge concerning infertility and cultural antecedents in the South African context. The study could generate useful information that can help health care providers identify patients at risk, and guide therapeutic interventions to reduce psychological distress experienced by infertile individuals and their social network.

4.4 Objectives of the Study

The following are the specific objectives of the study.

(a) To determine the psychological experiences of infertility of African women and their families.
(b) To determine the perceptions of African women and their families with regard to infertility.
(c) To determine ways in which the psychological impact of infertility is mediated by Western and African cultural practices and understandings, and how women and their families draw on these practices and understandings to manage their experiences of infertility.

4.5 Theoretical Framework

4.5.1 Biopsychosocial Model

There is a paradigm shift from reductionist models in psychology and medicine to a systems approach, which is characterised by the biopsychosocial model. The biopsychosocial model provides a more comprehensive health care model and a useful framework for examining infertility because it embraces the biological, psychological and social elements of human functioning within an interactive conceptual framework (Schlebusch, 1990; Williams *et al.*, 1992).

In the biopsychosocial model, each individual is composed of both biological and psychological subsystems. The biological subsystem refers to an individual's physiological processes, while the psychological subsystem refers to an individual's cognition, knowledge, beliefs, and emotions

(Williams *et al.*, 1992). The model recognises that not only are social, cultural, and psychological factors intrinsically part of infertility and its treatment, but that psychology provides a special expertise within this realm (Schlebusch, 1990; Tolman & Szalach, 1999). Little attention has been paid to social and cultural factors which mediate women's psychological experiences of biological events (Schlebusch, 1990).

The general systems theory, on which the biopsychosocial model is based (Schlebusch, 1990), assumes that individuals are non-separate entities of an environment, that reality is a product of change and stability, being and becoming; and causality is dynamic (Schlebush, 1990; Stones, 1996; Tolman & Szalacha, 1999). Therefore, the theoretical framework contends that the individual's psychological attitudes and reactions to infertility are formed by and modulated in interaction with other members of the social system (Williams *et al.*, 1992). Furthermore, the model implies that society made infertile persons what they have become; it shaped their behaviour, their aspirations, and their attitudes towards themselves and towards the society at large (Tolman & Szalacha, 1999). Although the model contends that past research serves as an important guide for hypothesis generation, it also suggests that, depending on the type of life problem and the individual stage of adjustment to the problem, reactions can differ (Stones, 1996).

Tolman & Szalacha (1999) contend that any system, be it physical, mental, ideological, or social, can be analysed at various levels from various points of view. This study examines the system from the point of view of women, including their partners and family members. Therefore, the approach is psychosocial rather than individualistic, and includes a focus on the interaction of cultural influences

Although grounded on systems theory, the theoretical position will be eclectic in the sense that the study will draw concepts from sociology, anthropology, ethnology and linguistics. Reviewed literature show that the problems of infertility affects all areas of life and to limit oneself to one theoretical perspective will be to miss out on much of the complexity of the phenomenon.

4.6 Research Questions

The thesis attempts to answer the following research questions, which were formulated on the basis of the research problem, literature review, and the theoretical framework of study.

- What are the psychological experiences of African women and their families, in regard to infertility?

The specific sub-questions in this regard are: (a) When does the experience of infertility begin, and for whom? (b) On the individual level: How do men and women react and adapt to infertility? (c) On the couple level: Who in the couple's relationship is influenced and affected by infertility? How do they communicate about the situation? What role does gender play? (d) On the level of family: How are families influenced and affected by infertility? (e) On the level of social network: How are the men, women, and couple relationships affected?

- What are the choices, attitudes and practices of women, their partners, and their families in dealing with infertility?

The specific sub-questions here are: (a) How do infertile women, their partners, and their families deal with infertility (b) What is the role of the family system in making decisions towards the management of infertility? (c) What are the experiences of infertile women and their families with the health system? (d) What social support resources are available for infertile men and women? (e) On the level of culture: How do women and their families position themselves within Western and African understandings and practices related to infertility?

4.7 Conclusion

The conceptual framework that guided the current study is the biopsychosocial approach. Studying infertility from the biological, psychological, social and cultural dimensions provide an alternative of looking at different aspects of the same problem (infertility). The study sought to achieve an understanding of infertility from the psychological and the socio-cultural aspects of infertility. Thus the objectives of the study and the research questions were formulated applying the biopsychosocial model. The research method used is discussed in the next chapter.

CHAPTER 5
RESEARCH METHOD

5.1 Introduction

The fact that infertility is a reproductive health and a gender issue embedded in cultural context informed the choice of feminism and social constructionism as research paradigms. The form of enquiry was exploratory, and aimed at gaining an understanding of the impact of infertility on African women and their families. I used in-depth interviews to collect data, and this was analysed using interpretive strategies congruent with the broader paradigm chosen. Ethical considerations and other challenges encountered during the research process are also discussed in this chapter.

5.2 Research Paradigm

Historically, there has been a strong emphasis on quantification in science. However, recently there has been counter-pressures against quantification. One of the main counter arguments against quantitative research is its context stripping. Quantitative research strips from consideration, through appropriate controls or randomisation, other variables that exists in context, that might greatly influence the findings were they allowed. Qualitative research, by contrast, provides as much contextual information as possible (Denzin & Lincoln, 1998); Guba and Lincoln; 1998). Hence, the current study is grounded in the qualitative research approach.

According to Guba and Lincoln (1998) research paradigms define for the inquirers what it is they are about, and what falls within and outside the limits of an inquiry. In addition to being broadly qualitative, the current study is based on feminism and social constructionism or the feminist social constructionist paradigm. Feminist research highlights the oppression of women, pursuing concepts of empowerment and emancipation. The social, dialogic nature of inquiry is central to constructivist thinking (Denzin & Lincoln, 1998; Gergen, 1985; Guba & Lincoln, 1989; Steier, 1991). This requires attending both to the inquirer's own self-reflective awareness of his or her own constructions and to the social construction of individual understandings, including that of the inquirer (Denzin & Lincoln, 1998; Gergen, 1985).

Guba and Lincoln (1989) contend that the best means of developing joint constructions is the hermeneutic-dialectic process, so called because it is interpretive and fosters comparing and contrasting divergent constructions in an effort to achieve a synthesis. Gergen (1985) termed this process an interactive approach to inquiry, the reflexive elaboration of the event. It is a process in which the researcher and participants open a socio-psychological phenomenon - in this case, infertility - to inspection and through dialogue, generate a process of continuous reflexivity, thereby enabling new forms of reality to emerge. This process of interactive approach guided the process of data analysis as described section 5.7 below.

The nature of the research design begins with issues and or concerns (in this case infertility) of participants and unfolds through a dialectic of interaction, analysis, critique, reiteration and reanalysis, that leads eventually to a construction of the findings, that is, the outcome which reflects a credible level of understanding (Guba & Licoln, 1989). Therefore, the goal of constructivist inquiry is to achieve consensus on issues and concerns that define the nature of the inquiry (Denzin & Lincoln, 1998). The form of enquiry in this study is exploratory. The study is exploratory in nature because it attempts to develop a basic understanding of infertility as a psychological construct within a cultural context.

5.2.1 Feminist Social Constructionist Research Paradigm

Feminist social constructionism views gender as an agreement that arises from social exchanges. The basic tenets of feminist social constructionism are that knowledge is socially constructed, there is no single version of truth, meaning is constituted through discourse, and individuals are viewed as multiply-voiced (Gergen & Davis, 1997).

The feminist social constructionist theories assert that society is patriarchal, and that there are social forces in place to maintain this unequal power structure and gender based inequalities (Gergen & Davis, 1997). In the context of fertility, the agents of these inequalities are the men, the women themselves, and the in-laws, who tend to handle infertility differently depending on whether it is a man or a woman who carries the diagnosis of infertility. Thus, women become agents of male power (Gergen & Davis, 1997; Sewpaul, 1995).

5.2.1.1 Feminist research

Feminist research seems to imply different things to different people. According to Olesen (1994) there are no approaches that can be separated out as purely feminist, because feminists are diverse in their approaches. However, Stanley (1990) states that there is a distinct way of seeing, knowing and being in the world of research carried out by feminists. According to Tolman and Szalacha (1999) feminism appears straightforward; the devil is in the details. It encompasses diverse frameworks, ideologies, attitudes, and analyses of political, economic, and social inequalities between women and men.

Grbich (1999) identifies five enduring principles common in feminist research. First, there is a need to centre the social constructedness of gender. The pervasive influence of gender divisions on social life is one of the most important defining characteristics of feminist research (Olesen, 1994). The social constructionist theories view gender not as an individual trait, but as a construct that identifies particular transactions that are understood to be appropriate to one sex (Gergen & Davis, 1997). Second, an acceptance that women are oppressed. It should be noted that responses to this oppression vary from total powerlessness to active verbal and other forms of interactive negotiation. Third, there is a non-exploitative, egalitarian and emancipatory relationship between the researcher and the participants. Fourth, there is an exposure of the researcher's position, experiences, emotions and values, and how these influence the researcher's view of reality, and how this reality is handled during the analysis and interpretation of the realities of the participants. Fifth, the presentation of findings should address issues of power, honesty, and ownership.

A feminist perspective is useful to inform inquiry into any aspect of female experience that is systematically denigrated and denied in a patriarchal society (Gergen & Davis, 1997). Earlier feminist research focused almost exclusively on women as subjects of study. However, there is an increasing argument that gender implies understanding women's experiences in relation to men, and that it is as important to focus on men and masculinity as it is to study women and femininity (Stanely, 1990). Social constructionist theory contends that there is a multiplicity of world-views dependent upon individuals' historical and cultural locations (Gergen & Davis, 1997). Thus, the

infertile women and their families have different notions of the infertility experience.

The feminist research approach is critical of traditional paradigms where the researcher is in control of the relationship, replicating patriarchal power relationships (Barker, Pistrang & Elliot, 1994). Feminist research not only attempts to understand, but also to emancipate the informants. A feminist perspective allows for research designs that create rapport, and a dialogue with those who give their time to participate in research. It allows for education and provision of support beyond the study in an attempt to minimise differences in power relations (Grbich, 1999). It consists of an organising principle of listening to and taking women's voices seriously, particularly in data collection and data reduction, as well as in data analysis and interpretation. Feminism allows the researcher to assume an insider's position. The position is achieved by appreciating the experiences of participants. This involves sameness of life experiences, such as being of the same race, sexuality, and sharing the same experiences of oppression (Grbich, 1999).

Furthermore, feminist research allows for personal reflexivity, that is, a disciplined self-reflection of the researcher's identities as a member of the society, ethnic group and gender groups influence his/her world and, how his/her work influences these aspects of self (Eagle, Hayes & Sibanda, 1999; Tolman & Szalach, 1999; Reinharz, 1992). The researcher listens directly to what the informants are saying and responds personally without hiding behind the facade of the objective researcher (Barker *et al.*, 1994).

Reinharz (1992) approaches the definition of feminist research from a political rather than a methodological perspective. According to her: (a) Feminist research methods are methods used in research projects by the people who identify themselves as feminist or as part of the women's movement; (b) Feminist research methods are methods used in research published in journals that publish only feminist research, or in books that identify themselves as such; (c) Feminist research methods are methods used in research that has received awards from organisations that give awards to people who do feminist research. Thus in this view a person does not have to identify her research methods as feminist research methods but rather to identify herself as a feminist doing research (Reinharz, 1992). This kind of definition of feminist research is an attempt to counter the tendency for researchers to define their methods as feminist only when the method is unusual.

There is no politically correct feminist method, but rather a variety of perspectives. Therefore, feminist research is driven by its subject matter, rather than by its methods. Feminist research uses any method available and any cluster of methods needed to answer the questions it sets for itself (Eagle *et al.*, 1999; Reinharz, 1992).

Feminist interview research was used in the study. The type of interview method used is semi-structured interviewing. The method differs from ethnography in not including long periods of researcher participation in the life of the interviewee. It also differs from survey research or structured interviewing by including free interaction between the researcher and the interviewee. Interviewing is consistent with many women's interest in avoiding control over others and developing a sense of connectedness with people (Eagle *et al.*, 1999).

5.2.1.2 Social constructionism

Social constructionism is primarily concerned with epistemology (knowing) and not with ontology (being) (Gergen, 1985; Steier, 1991). According to Steier (1991) ontological reality does exist, but we cannot in any sense know a real world. We cannot even imagine what the word 'to exist' might mean in an ontological context, because we cannot conceive of 'being' without the notions of space and time. Thus, reality is the result of the social processes accepted as normal in a specific context, and knowledge claims are intelligible and debatable only within a particular context or community (Denzin & Lincoln, 1998; Gergen, 1985; Steier, 1991).

Contrary to the emphasis in constructivism, the focus of social constructionism is not on the meaning-making activity of the individual mind but on the collective generation of meaning as shaped by conventions of language and other social processes (Denzin & Lincoln, 1998). Instead of focusing on the matter of individual minds and cognitive processes, Gergen (1985) and other social constructionists turn their attention outward to the world of inter-subjectivity, shared social constructions of meaning, and knowledge. The key features of social constructionism are as follows.

First, social constructionism posits that 'facts' are dependent upon the language communities that have created and sustained them. Thus, definitions and all forms of naming are socially constructed. The social constructionist perspective suggests a role for language in both reflecting and shaping the culture. Language is an important mechanism involved in describing and creating social constructions of infertility (Gergen & Davis, 1997).

Second, social constructionism contends that people generate their truth from language available to them. Thus, any 'fact' about the world depends upon the language within which it is expressed. Objects are known through their names. Words do not simply 'map' or 'copy' the world; they create how we perceive the world (Gergen & Davis, 1997). The implication of this view on a psychology of gender is that terms of understanding within the field are open to question and reconstruction.

Third, the social constructionist position implies that any type of description of the nature of reality is dependent upon the historical and cultural location of that description. The social constructionist position helps to overcome the conflicts that may occur when different versions of reality come into contention. From this position, it is possible to acknowledge the multiplicity of world-views, and to work towards creating conditions wherein the separate parties can find opportunities for mutuality, tolerance, and compromise (Efran, Lukens & Lukens, 1988; Gergen & Davis, 1997).

Fourth, social constructionists generally hold that there are no universal ethical principles, but that they are constructed. Thus, there is no single way to set ethical standards, but many. This implies moral principles cannot be hierarchically arranged to give preference to justice considerations over values of caring. The social constructionist approach contends that answers to moral dilemas are dependent on the communities. A concern with the nature of values is intrinsic to a social constructionist position, and when one evaluates a scientific explanation one can ask what are the ethical considerations that are embedded in the framing of the explanation, its origins, its classification system, and its consequences. One cannot ignore value considerations and claim that one is merely 'reporting the facts'. Because facts are socially constructed, they are always subject to questioning for their ethical implications. This is considered consistent with the political goals

of feminism (Gergen & Davis, 1997).

Fifth, social constructionists emphasise that any claim to reality can be viewed with scepticism. Unlike some scientific viewpoints that claim that we can know the facts about the world by merely looking , smelling, touching, and/or listening, the social constructionist position emphasises that our sensory experiences are mediated by our linguistic descriptions of our experiences. That is, we know our sensory worlds via language, just as we know the abstract world. The social constructionist position does not allow exceptions to this skeptical stance, even when one's private sensory experiences are at stake. We cannot know our selves, free of cultural constrains, any more than we can know other parts of the world. We must always recognise ourselves embedded in cultural communities. One can ask questions about the world, but cannot claim to have discovered the truth. The best one can expect is that a new interpretation, different perspective, or an interesting slant can be created. In this sense, social constructionism invites creativity, new interpretations, and openness to other fields of knowledge. Whether a new interpretation becomes acceptable depends importantly upon others in the linguistic community.

According to Guba and Licoln (1989) the constructionist, interpretive, naturalistic and hermeneutics approaches are all based on similar notions. However, interpretivist and constructionist persuasions are usually "somewhat artificially disentangled ... to afford a closer look at salient aspects of each. Yet it should be apparent that current work in these methodologies reflects the synthetic impulse of the post-modern zeitgeist" (Denzin & Lincoln, 1998, p. 245). Therefore, an interpretive approach was also applied in this study. According to Terre Blanche and Durrheim (1999) the interpretive approach assumes that reality consists of peoples' subjective experiences of the external world and that such subjective experiences can be understood by interacting with and listening to their stories. The assumption here is that reality can be understood and interpreted but not predicted or controlled (Ivey, 1999). It was necessary for me to use the interpretive paradigm because I wanted to go beyond the data, to account for certain gaps in the data, and to account for a totality of the infertility experience (Giorgi, 1992).

Giorgi (1992) explains the motives for using the interpretive strategies as: (a) to move from multiple to univocal meaning, (b) to bring closure to incomplete data, (c) to account for unconscious motivations because they lack transparency, thus to account for certain types of discrepancies in a subject report. The reasoning was that practical affairs force people to make decisions despite inconclusive or ambiguous results. In such a case, interpretation is justifiably called for.

Interpretation involves the external attribution of meaning, rather than description of meaning already implicit in the experience (Giorgi, 1992; Ivey, 1999). The constructionist persuasions blend the phenomenological interpretive perspective with critical hermeneutics. It is concerned with portraying the lived reality of women's lives within a broader social context. The feminist stand point persuasions argue that women's lived experiences are not captured in existing conceptual schemes (Gergen &Davis, 1997; Denzin & Lincon, 1998), but are focused on the ways in which gender is socially constructed. Hence the study used the social constructionist feminist research paradigm.

5.3 Sampling

Qualitative research is not concerned with statistical accuracy and representatives, but with detailed and in-depth analysis (Terre Blanche & Durrheim, 1999). This makes sampling strategies for qualitative and quantitative methods different. In contrast to quantitative research, qualitative research is grounded in non-positivist paradigms where sample extensiveness has to do with the information richness of cases selected rather than purely with the number of cases.

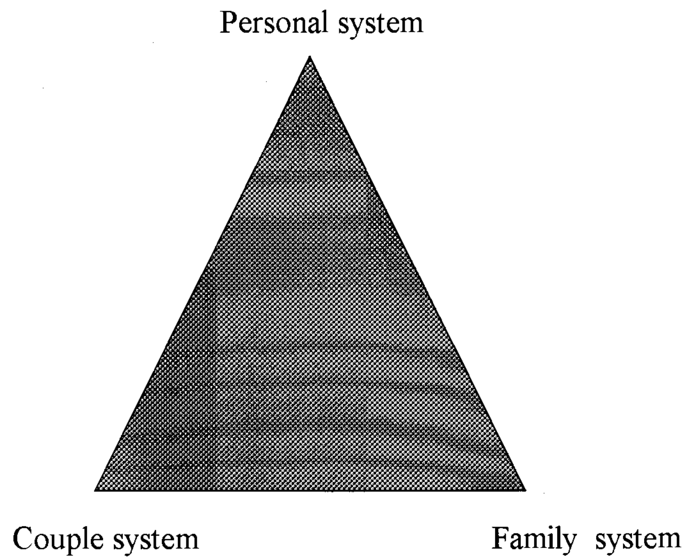
Non-probability sampling techniques were employed. These techniques are not concerned with representativity, but in selecting information-rich cases (Barker *et al.*, 1994; Grbich, 1999; Terre Blanche & Durrheim, 1999). The process involved the following three steps: (a) specifying the target population, (b) choosing the sampling procedure and (c) determining the sample size (Barker *et al.*, 1994; Grbich, 1999; Terre Blanche & Durrheim, 1999).

5.3.1 Target Population

The first step in the sampling process involved defining the group from which the participants were selected. The target population is black infertile South African women (that is, women who were in an infertile couple relationship and believed that they carried the diagnosis irrespective of whether they indeed carried the diagnosis or their partners did) and their families. South African women are not a homogenous group; there are class, culture, and sexual orientation differences, which need to be respected (Leissing, 1994). However, different black ethnic groups in South Africa tend to show similar cultural patterns (Nzimande, 1996; Preston-Whyte, 1988b). Moreover, studies (Mabasa, 2000; Ndaba, 1994 & Sewpaul, 1995) indicate similar basic practices or cultural universals regarding infertility among the different South African ethnic groups. Thus, the proposed study investigated black South African women and their families in general, neither focusing on a specific ethnic group or on ethnic differences.

However, infertile women do not exist in a vacuum. The social and cultural contexts in which they find themselves need consideration. Infertile women's partners and families were therefore included in the target population so as to provide a holistic picture of the mental health aspects of infertility amongst black South Africans. Therefore, three groups of participants, that is, 'infertile' women, their partners, and their families of origin and in-law were targeted to participate in the study. This allowed for triangulation of data sources.

According to Brink (1993) triangulation refers to the use of two or more data sources, methods, investigators, theoretical perspectives and approaches to analysis in the study of a single phenomenon. Becvar and Becvar (1996) contend that it is more appropriate to speak of a multiverse (many points of view) than a universe (single objective reality), and triangulation does not allow one to 'home in' on a single reality, but to get a sense of the universe of possibilities within which a phenomenon occurs. Rather than focusing on sub-units, the unit of analysis should be the system or lager context. Thus rather than thinking of the women, their partners and their families as different components of the target population, one could also say that the research 'targeted' three interlocking systems, as illustrated below:



The form of triangulation employed here should thus not be confused with the form of triangulation used by traditional positivist research as a method of validation, since there is no single or triangulated truth (Denzin & Lincoln, 1994). Including three sample frames and organising the qualitative data into three different subsystems revealed how the three groups voiced their experiences of infertility and how their experiences had different qualities.

The inclusion criteria were as follows: (a) Women who consider themselves to be infertile irrespective of whether they carry the infertility diagnosis or the diagnosis is carried by their partners. (b) The infertility must be primary; both clinical and non-clinical cases were included. (c) Both married and non-married women were included. (d) The age group of women should be between 20 years and 50 years. This population of women was targeted because it is at this stage where women are expected to play their reproductive roles, and tend to realise that they are unable to bear children. The inclusion criteria for partners and family were that they should be the current partner or part of the immediate family of one of the 'infertile' women included in the sample.

5.3.2 Sampling Strategies

The second step in the sampling process involved choosing the sampling procedure. A purposive sampling method was used, where the researcher's judgement is used to select unique and information-rich cases for in-depth investigation (Barker *et al.*, 1994; Grbich, 1999; Neuman, 1997; Terre Blanche & Durrheim, 1999) as described in the target population above. A convenience or opportunistic sampling method was used to identify infertile women, their partners, and their families for possible inclusion in the sample. I networked with friends who were general medical practitioners and psychologists, a gynaecologist, and a colleague at work to obtain the sample (see section 8.5.3 for ethical issues and informed consent).

The objectives of the study were discussed with these networking figures. These friends referred their patients with a history of infertility who consulted them for any other condition, and not necessarily infertility. The one gynaecologist was interested in collaborative research with me, hence his willingness to refer his infertile clients. The work colleague, who also helped me in the field, served as a networking figure in her community.

In addition to this, a snowball sampling or chain referral method was also used in that some infertile women identified similar others who were willing to participate in the study. Thus, at the conclusion of each interview, the participants were asked to suggest another person in a similar situation who was to participate in the study. The infertile women had to first talk to these participants before the researcher contacted them. Theoretical sampling or sampling to redundancy was also employed. This method guided the sample size as described below (Barker *et al.*, 1994; Grbich, 1999; Terre Blanche & Durrheim, 1999).

5.3.3 Sample Size

The theoretical sampling method involved interviewing more and more participants until the same themes emerged repeatedly, and no new variation or features of the phenomena could be gained by increasing the sample size (Barker *et al.*, 1994; Terre Blanche & Durrheim, 1999). 'Infertile women' served as a point of entry in which their spouses and family members were obtained for

the interviews. Although the information from infertile women became redundant, more infertile women whose partners were willing to participate in the study were interviewed until the data obtained from the infertile women's partners became redundant as well. Halting the interviews was guided by the fact that (a) no relevant new information seemed to be emerging, (b) category development was dense, and (c) relations among categories were well established and validated by their recurrence (Barker *et al.*, 1994; Kelly, 1999)

A sample size of 10 infertile couples and 9 infertile women was achieved. That is, 19 women and 10 men (partners of 10 of the 19 women) were interviewed. In addition 10 family members (5 each from the family of origin and the family in-law) was achieved. Thus, a total number of 39 participants were interviewed. Although theoretical sampling cannot be predetermined (Barker *et al.*, 1994), saturation can typically be obtained with a sample size of 5 to 10 for rich protocols obtained from longer periods of interviewing, with clearly defined areas and careful sampling (Barker *et al.*, 1994).

5.3.4 Biographical Characteristics of the Participants

This section provides the biographical characteristics of participants, while the reproductive history of men and women participants is described in relevant sections of the findings of the study. The strategies used to obtain participants influenced the biographical characteristics of the participants. It can be seen from Tables 3,4, and 5 that most participants, including those from villages, do not represent typical rural poor participants, but a middle class. This brings about implications for the participants' relationship with me (see 5.7.3 below) and the generalisation of findings (see 5.7.5 below).

5.3.4.1 Women participants

The biographical characteristics of women who participated in the study are summarised in Table 3. It can be observed from the table that the age of women ranged from 25 years to 48 years with a mean age of 36.9 years. The table further indicates the language groups of the women. Thirteen were Northern Sotho, four were Tsonga, one was Tswana, and another one was Swazi. Twelve

women were married, three were cohabiting, two were single, one was separated, and the other one was widowed. She lost her husband about five months after the interviews. Therefore, her interview data represented a live husband.

Although most (15) women were not biological parents, they had experienced social mothering. Two (woman 1 and woman 9) had formally adopted a boy child each. One (woman 4) of the women had familially adopted a boy child, and another one (woman 14) was fostering her late sister's child. Woman1 had adopted a girl child familialy (her husband' s brother's child) and lived with her for a period of 10 years. There developed conflicts between the adoptive parents and the biological parents when her adoptive parents did not agree that the girl lived with a boyfriend at a rented house and the girl with her biological parents decided that the girl move back with her biological parents.

Table 3 also indicates the educational level of the women. Most of the women interviewed had tertiary education, thus limiting the class difference between myself and the participants. It can be noticed from the table that seven women (W3, W6, W9, W14, W18, and W19) had a teaching qualification. They were all working as permanently employed teachers except for woman 3 who was working part time in an adult education programme. Woman 1, woman 12, and woman 13 were qualified nurses. Woman 1 had specialised in midwifery. She stated she wanted to gain experience about pregnancy and child bearing, by becoming a midwife. Although not doing what she was qualified for (N4 electronics), woman 11 was working as a controller in a milling company. Woman 4 was a public administration graduate. She held a senior position as an administrator in the public service. Woman 7 and woman 8 had grade12 and did not have formal employment. Woman 7 held a position of 'chief mother' in her community. Woman 7 was in a polygamous marriage. Her husband, who is a chief, has another wife with whom he has children. It is a custom among traditional Northern Sotho communities that the chief's first born child is not necessarily an heir to the throne. The clan chooses a woman whom it marries for the chief and this woman has a specific responsibility to bear the clan a future chief. Woman 7 is such a chief mother. Woman 2 and woman 16 had secondary education and were not formally employed. Only woman 15 had a primary education and she was not formally employed. Women 1, 4, 6, 9 and 12 were continuing with their education.

All the women were Christians and they belonged to different churches. Only woman 4 indicated that her religious affiliation was 'none'. Nine women lived in villages, which are usually considered to be rural; eight women lived in townships or peri-urban areas; and one woman (woman 12) lived in a city. All the women interviewed lived in the Northern Province, except for woman 12 and woman 13 who were from the Gauteng Province.

Thus the sample was fairly diverse in terms of the women's domestic circumstances and degree of urbanisation, but most of the women could be considered to be Christian, broadly middle class and not overtly traditional in their outlook.

Table 3: Characteristics of women participants

	Age in years	Home Language	Marital status	Parental status	Educational Qualifications	Occupation	Religion	Domicile
W1	47	N. Sotho	Married	Adopted (one)	Gen.Nurs.Dip. Midwifery	Nurse	N.G. Church	Township
W2	43	N. Sotho	Widowed	None	Grade 8	Unemployed	Methodist	Township
W3	35	N. Sotho	Cohabiting	None	Grade 12 Snr. Teachers Dip.	Teacher	Methodist	Village
W4	42	N. Sotho	Single	Familial adoption	B Hons Admin, Pers. Compt., Org. & Method Study Dip.	Administrator	'None'	Township
W5	30	Xitsonga	Married	None	Grade 12	Housewife	Methodist	Township
W6	39	N. Sotho	Married	None	Grade 12, Prim. & Sec. Teachers Cert.	Teacher	Nazarene Church	Village
W7	40	N. Sotho	Married	None	Grade 12	Housewife	Unit. Christ Church	Village
W8	25	N. Sotho	Cohabiting	None	Grade 12	Housewife	ZCC	Village
W9	42	N. Sotho	Married	Adopted (one)	Grade 12 Teachers Dip.	Teacher	Presbyterian	Village
W10	48	N. Sotho	Single	None	Grade 7	Unemployed	Congr. Church	Village
W11	29	Swazi	Married	None	Grade 12 N4 Electronics	SEPO Controller	Methodist	Township
W12	42	Setswana	Married	None	General Nursing Diploma	Nurse	Presbyterian	City
W13	32	N. Sotho	Married	None	General Nursing Diploma	Nurse	Dutch Ref.	Town
W14	44	N. Sotho	Cohabiting	Fostering	BA. Snr. Teacher Diploma	Teacher	Lutheran Church	Village
W15	41	N. Sotho	Married	None	Grade 6	Housewife	Roman Catholic	Village
W16	31	N. Sotho	Separated	None	Grade 9	Housewife	Apostle	Village
W17	28	Xitsonga	Married	None	Grade 12	Med. Practise Rec.	E. P. C.	Township
W18	29	Xitsonga	Married	None	Grade 12 Snr. Teachers Dip.	Housewife	Ass. of God	Township
W19	34	Xitsonga	Married	None	Grade 12 Snr Teacher Dip.	Teacher	Ass. Of God	Township

5.3.4.2 Men participants

Table 4 summarises the biographical information of men participants. It could be observed from the table that the age of men ranged from 29 years to 61 years with a mean age of 38.1 years. Five of the ten men were Northern Sotho and the other five were Xitsonga speaking. Man 4 was a Xitsonga speaker and he was married to a Swazi speaking woman (woman 11). All men participants were married except for man 10, who was cohabiting. Six men (M2, M5, M6, M7, M8, and M9) did not have children. Man 3 had four biological children with his other co-wife. Man 1 had formally adopted a child, and man 4 had an extramarital child.

Five men had tertiary qualifications. Man 1 and man 10 had teachers' diploma certificates, and were working as teachers. However, man 1 held a permanent job while man 10 was temporarily employed in an adult education programme. Man 4 had an N4 electrical engineering qualification. He was working as an electrician at the time of interviews. Man 5 had a general nursing diploma, and he was working as a nurse. Man 7 had grade 12, and he was doing clerical work in a private medical practise. Man 8 also had grade 12, and he was a paramedic (ambulance services) in a local hospital. Man 9 had a law degree. He was a privately practising attorney. Man 2 had a grade 11 education. He worked as a machine operator in the mines. Man 3 had grade 9 education, and he served as a chief in his community. He was referred to as a king in his community. Only man 6, who had a grade 7 education, was unemployed. He stated that he was dependent on his retired mother teacher for financial support.

All the men were Christians. They belonged to different church groups as indicated in table 4. Seven of the ten men interviewed lived in townships, the other three lived in villages. All the men were from the Northern Province except for man 5 who lived in Gauteng Province.

Thus the sample of men was similar to that of women in some characteristics. It was fairly diverse in terms of the men's socio-economic circumstances, most of the men could be considered to be Christian, broadly middle class and not particularly traditional in their outlook.

Table 4: Characteristics of male participants

	Age	Language	Marital status	Parental status	Educational level	Occupation	Religion	Domicile
M1)	49	Northern Sotho	Married	Adopted (one)	Grade 12 Snr. Teachers Diploma	Teacher		
M2	33	Xitsonga	Married	None	Grade 11	Sec. Operator	Methodist	Township
M3	61	Northern Sotho	Married	Four	Grade 9	Chief	United Congr. Church	Village
M4	29	Xitsonga	Married	One Child	Grade 12 N4	Electrician	Christian	Township
M5	35	Northern Sotho	Married	None	General Nursing Diploma.	Nurse	Apostolic Church	Town
M6	40	Northern Sotho	Married	None	Grade 7	Unemployed	Roman Catholic	Village
M7	31	Xitsonga	Married	None	Grade 12	Clerical	EPC	Town
M8	31	Xitsonga	Married	None	Grade 12	Paramedic	Assemblies of God	Township
M9	35	Xitsonga	Married	None	B Jurisprudence	Attorney	Christian	Township
M10	37	Northern Sotho	Cohabiting	One	Grade 12 Senior Teachers Cert.	Teacher	Methodist	Village

5..3.4.3 Family members participants

Table 5 summarises the characteristics of family members which includes the family of origin and family in-law of women participants. It can be seen from the table that the family participants were mostly mothers, sisters and brothers of men and women participants. Family members of women 4, 11, 13, 14, and 18 represented the family of origin of women participants. Family members of women 6, 7, 8, 13, and 19 represented the family in-law of women participants.

The family members were in young, middle and late adulthood. The educational level of family members interviewed ranged from illiterate to tertiary education. They were pensioners, teachers, and medical doctors. It was more difficult to obtain family members for the interviews. Therefore the sample size was limited not only by a feeling that I reached redundancy, but also by the practical difficulties of obtaining family member participants.

Table 5: Characteristics of family members

Participant	Age	Relations to woman	Educational level	Occupation
FO1(W4)	65yrs	Mother	Grade 5	Pensioner
FO2(W14)	67yrs	Mother	Illiterate	Pensioner
FO3(W11)	34yrs	Brother	B. Ed	Teacher
FO4(W)	34yrs	Sister in-law	Ed. Diploma	Teacher
FO5(W17)	36yrs	Brother	MBCHB	Medical doctor
FI1(W19)	33yrs	Brother in-law	MBCHB	Medical doctor
FL2	63yrs	Mother in-law	Illiterate	Unemployed
FL3	66yrs	Mother in-law	Illiterate	Pensioner
FL4	43yrs	Sister in-law	Grade 7	Housewife
Fl5	47yrs	Sister in-law	Grade 8	Housewife

5.4 Data Collection

5.4.1 Interviews

The use of semi-structured and unstructured interviews has become the principal means by which feminists have sought to achieve the active involvement of their respondents in the construction of data about their lives (Reinharz, 1992). The interview approach used the shared understanding model. The central notion of this model is empathic understanding (Gergen & Davis, 1997). The shared understanding model prescribes that the interview follows a guide rather than a predetermined set of questions. Semi-structured interviews assume that the researcher does not know all the necessary questions in advance. Consequently, I could not predetermine a full list of questions to be asked. Semi-structured interviews also assume that not all participants will necessarily find equal meaning in similarly worded questions (Berg, 1995).

Therefore, I approached each interview with few presuppositions. I asked questions for clarity, paraphrased, and made interpretations while the interview was in process. By probing, the interviewer encourages the interviewees' responses and corrections (Berg, 1995; Denzin & Lincoln, 1994; Gergen & Davis, 1997; Terre Blanche & Durrheim, 1999). The respondents were active participants whose insights, feeling, and co-operation were essential parts of the discussion process that revealed their subjective meanings (Kelly, 1999; Neuman, 1997). Considering the sensitive nature of the subject, the interview model allowed an in-depth understanding of the respondents' experiences.

My approach was informal, giving priority to establishing rapport and creating a feeling of being understood. My clinical skills of empathy and clinical intuition helped me to probe further and to avoid biases. Since the interviews were conducted individually, informing participants that information obtained from one partner or family member would not be discussed (see section 5.7.2 for ethical issues and informed consent) with the other seemed to have encouraged openness.

The interviews were carried out over a period of fourteen months (April 2000 to May 2001) in several locations convenient to the participants. The locations were homes of the respondents, the gynaecology clinic of a private specialist, offices of general medical practitioners, and out patient psychology departments of two secondary and tertiary health care services. Individual interviews were conducted in rooms and were as private as possible, generally without anyone present. It has been found that the male partners in couples interviews tend not to participate fully in the interview because infertility is seen as a woman's problem (Mabasa, 2000). For this reason separate interviews were conducted instead of couples interviews, thus helping to avoid the pitfall of 'feminising' the problem and assuming that the woman's story is the couple's story (Sundby, 1994).

The initial part of the interview was based on eliciting demographic data, such as age, education, occupation, and marital status. These questions helped ease both me and the respondents into the more sensitive material. The second part of the interview dealt with the respondents' experiences of infertility. The point of entry was as follows: "Could you please tell me your story about the fertility problem?" The term a "fertility problem" was used throughout the communication with the networking figures and the participants. It lessened the distressing factor of the 'finality' of infertility to participants who still had hope for biological children. After telling their stories, the respondents were probed to elicit explanations and further details.

Then I used the guideline questions to probe on unexplored issues and to focus the discussions, but was not limited merely to these guideline questions. The guideline questions were aimed to obtain information on the following themes, from the women and their partners. (a) History of infertility, (b) causal explanations of infertility, (c) the impact of infertility, (d) treatment history and experiences with the health care services, (e) attitudes towards alternate treatment options, (f) how the infertile couple perceived social support and, (g) how the infertile couple coped with infertility. The themes for interviews with the family members included the family members' views on (a) the history of infertility, (b) causal explanations, and (c) the role family members played in helping the infertile women and their partners deal with the impact of infertility.

Each interview session lasted 30 to 90 minutes. The interviews were tape-recorded either in the respondent's own language or in English according to the respondent's preference and level of fluency in English. Written notes were made simultaneously. Four follow-up interviews were conducted since two couples initiated psychotherapy, and information from the assessment interviews in the psychotherapeutic process was used as additional information. Other follow up interviews (three interviews) were spontaneous and occurred when I visited the participants' homes to interview the partner or the family member of the infertile women who were initially interviewed. Only notes were taken with the follow-up interviews, no tape recording was conducted since most interviews were spontaneous. All the recorded interviews yielded transcripts that could be analysed. The ethical issues and informed consent are discussed in section 5.7.2 below.

5.5 Transcription and Translation of Data between Languages

Two assistants (two Masters students in linguistics, one Northern Sotho first language speaking and the other Xitsonga speaking first language speaking) and I were involved in transcribing and translation of interview data. We transcribed the interviews from the language of interviews directly into English to minimise data loss, keeping the original phrases and key words used by the respondents. According to Brislin (1980) there are four useful sets of categories or different purposes of translation: (a) Pragmatic translation, which refers to the translation of a message with interest in the accuracy of the information that was meant to be conveyed in the source language form. Pragmatic translation is not concerned with other aspects of the original language version, for example, aesthetic form that would be considered as part of the other types of translation categories. The translators would have no concern other than getting the information across in the second language. (b) Aesthetic-poetic translation, in which the translator takes into account the affect, emotion, and feeling of an original language version; the aesthetic form (for example, sonnet, dramatic dialogue) used in the original language; as well as any information in the message. (c) Ethnographic translation, which introduces the importance of context in translation. Its purpose is to explicate the cultural context of the source and second language versions. Thus, the concern is on how the people themselves (not the anthropologists studying them) use the terms and the context in which the terms would be used.

However, Brislin (1980) contends that any one translation can rarely be categorised into only one of the four types of translation. Therefore, questions concerning quality of translation depend on which of several purposes the translator chooses to emphasise. A combination of pragmatic translation, aesthetic translation, and ethnographic translation types has been used in this study. Although it was considered important to remain true to the factual content of what was being said (pragmatic translation), in many cases the concern was also to capture the particular personal and cultural inflections (aesthetic and ethnographic translation) that participants brought to the situation. This is demonstrated in the next three chapters involving the findings of this study.

There are four basic translation methods that can be combined for the special needs of any research project. The methods are back translation, the bilingual technique, committee approach, and pre-test procedure. The committee approach, in which a group of bilinguals translates from the source to the target language (Brislin, 1980), was used in this study. The advantage in this study is that the team involved with the translation was not bilingual but multilingual with knowledge of all the languages used in the interviews for this study. Another advantage of this method is that others can catch the mistakes of one member on the committee. The weakness of the method is that committee members may not criticise one another, and may even unify against the researcher. One way of overcoming this weakness was borrowing some elements of back translation. In cases where team members would during the translation, come up with apparently incompatible translations, these were translated back to the original language, and back again to the second language until consensus was reached.

5. 6 Methods of Data Analysis

The analysis was grounded in an interpretive approach. It involved the interpretive feminist epistemological standpoint, acknowledging that patriarchal culture silences and obscures women's experiences by providing the listener with an organised way to respond to the coded or indirect language of men and women. This was imperative, especially on the topic of infertility, in which women have usually been blamed (Grbich, 1999; Sewpaul, 1995; Tolman & Szalacha, 1999).

According to Grbich (1999) there is a considerable overlap among the four ideal modes of qualitative data analysis. That is, the enumerative modes, the investigative mode, the iterative mode and the subjective mode. The four modes are identified on the basis of the researcher's position in regard to data collection, the types of data collected, and the different interpretive approaches. The enumerative mode is characterised by the approach in which the recurrence of particular aspects is recorded, the researcher inhabits a distant position, and data are collected as a complete entity prior to analysis, like in content analysis. Although the researcher in the investigative mode collects documentation, the form of analysis searches beneath the superficial words or other forms of evidence to uncover the meaning, rather than enumerating pre-defined categories as in content analysis. Historical methods, discourse, and semiotic analysis fit into this mode. The iterative mode involves an interpretive/iterative field-based approach, in which the researcher collects data from the field by interviews or observations, reflects upon it, and notes emerging themes, which are used to inform further forays in the field. Diary records from the field are used to facilitate development of the researcher's subjective, reflexive views. Methodologies within this mode include grounded theory, phenomenology, ethnography, oral history, case studies, action, and evaluation research. The subjective mode engages the researcher to either be highly involved in the lives of those under research (like in heuristic phenomenology or memory work), or targets him/herself as research focus (as in some feminist, narratives, and post-modern approaches); both the researcher and the participants' voices are usually heard.

An integration of the iterative mode and the subjective mode were used to analyse the data. The data analysis process followed involved going out into the field, collecting information by interviewing, transcribing the information gathered, reflecting upon it and subjecting it to an initial analysis to determine 'what is going on', then using the information gained to guide the next venture into the field. These linked processes occurred before data collection, during research design and planning, during data collection as preliminary analysis was carried out and after data collection as a final product was approached and completed (Denzin & Lincoln, 1994; Grbich, 1999; Miles & Huberman, 1994; Terre Blanche & Durrheim, 1999).

5.6.1 Steps in the Analysis

The levels of analysis undertaken in the course of the study were ongoing preliminary analysis, thematic analysis, coding, and interpretation. Preliminary analysis was aimed at critiquing the data as it came in, identifying gaps in information, and to start utilising various concepts and frames to see whether they shed further light on the issues being identified in relation to the research topic (Grbich, 1999). Summaries of emergent themes were attempted with every interview. Preliminary analysis continued to inform data collection until all the data were in and I was convinced that a broad picture of the topic was gained and the data became saturated (Grbich, 1999). Tentative themes developed from the preliminary analysis were examined. Each theme was contextualised and notes about it placed within a separate file/unit. The levels of analysis fell into five major steps, that is, data organisation and reduction, thematic analysis, coding, interpretation and conclusion drawing. The sequence of data analysis followed in the study is described according to the following steps.

- **Step 1: Data organisation and reduction**

Miles and Huberman (1994) define data reduction as the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in transcripts. The first step in the data reduction process is data preparation. It involves assembling, transcribing, unitising, judging data for relevance and reorganising it before the analysis proper can begin. Using a computer, I opened four major folders that contained transcripts of the different groups of respondents. Each file was named according to the transcripts of a group it contained. That is, (a) transcripts of women, (b) transcripts of infertile women's partner (c) transcripts of infertile women's family of origin, and (d) transcripts of women's family in-law. Data was cleaned for irrelevancies that can impede the analysis. These irrelevancies include descriptions unrelated to the phenomenon under study, repeats, and side-tracks (Barker *et al.*, 1994). However, care was taken not to be too strict about removing apparently irrelevant material, as this can sometimes in retrospect be found to have contained important material for analysis. I read through the interview transcripts several times to familiarise myself with the data

and to come to a preliminary understanding of the experience under study.

- **Step 2: Thematic analysis**

The data was broken down in an analytically relevant way by printing out the transcripts and highlighting with coloured marker pens, different sections of the transcripts in which common themes appeared to be emerging. These highlights sorted the data into provisional categories or clusters on the basis of look-alike characteristics. The data was put into one or more categories as needed. These resulted in a visual map of the different layers of experience in a narrative as I worked on the sorted data. The way in which each voice mapped in relation to the other voices (cluster) and other clusters was observed and recorded as specific themes.

Then each unit was examined for theme typologies (classification schemes) such as responses relating to a theme. Each typology was examined in order to generate propositions. The propositions were laid across all other identified themes and typologies to see whether there were more complex aspects and associations that needed to be incorporated. Once I was convinced that there was nothing more to be found in the data, I amalgamated the themes, typologies, propositions and concepts that have been identified to begin with the stage of coding.

Psychological reflection and the comparative method were useful for developing themes. Psychological reflection entails the process of 'entering and dwelling', in which the analyst attempts to immerse him or herself in the informant's world (Barker *et al.*, 1994). In this process, I tried to slow the story and dwell on its details and meanings, setting aside (bracketing) the assumption that I already understood what is being described. At the same time, I tried to step back from the description, attending to meanings rather than matters of truth or falsity.

Often this process incorporates a dialogue with the data, in which the analyst interrogates each unit, asking questions such as, "What is really meant here? What kind of thing is being described? How does this relate to the phenomenon I'm trying to understand?" (Barker *et al.*, 1994, p. 227-228). This method is interpretive in that it generates a deeper understanding by allowing the analyst to explicate the informant's implicit meanings and assumptions.

♦ Step 3: Coding

In the generation of codes, preliminary analysis and thematic analysis are usually undertaken first to develop a broad range of themes, typologies, propositions, and concepts. Codes are tags or labels assigned to particular units of text (Miles & Huberman, 1994; Smith, 1999; Terre Blanche & Durrheim, 1999). The labels were derived from numerous sources, including the informants' own words, the literature and metaphors. The research took cognisance of the fact that assigning labels runs the risk of developing an off putting jargon that can act as a barrier to communication of the findings (Barker *et al.*, 1994). The process of coding involved condensing the bulk of data into analysable units by increasing categories with and from the data. The codes were drawn from the data through the process of inductive reasoning. Thus, the categories emerged inductively. The developed codes were used to frame the remaining data, while I continued to check carefully for examples of negative cases or data that did not fit; which was not ignored. The coding process accounted for all data in such a way that data were not forced into predetermined frames, but the frames emerged from the data.

The categories or themes were not mutually exclusive; a particular meaning unit was assigned to a number of different categories. In open coding, one should develop labels for the emerging categories (Barker *et al.*, 1994; Smith, 1999). Thus, I left open the possibility of continually reformulating the codes. The generated themes and categories existed in relation to other categories, often in hierarchical or outlined structure, with more descriptive, lower-order categories functioning as properties, defining features, alternative forms or examples of higher-order, more abstract categories. The codes were ultimately grouped to facilitate interpretation and writing up.

♦ Step 4: Interpretation and Conclusion Drawing

Interpretation attempts to spell out the implications or broader view of one's findings. Moreover, the process of interpretation and conclusion drawing implied deciding what things mean (Barker *et al.*, 1994; Miles & Huberman, 1994; Terre Blanche & Durrheim, 1999), sifting and choosing

among meanings and construing the best possible meaning (Giorgi, 1999). This process consists of two main parts. The first part involved assessing the strength and weaknesses of the study to see whether it can support the interpretations. That is, checking whether the results are substantial or trivial. The second part involved assessing the implications of the results in a larger scientific and professional context. That is, checking how the results relate to existing research in the area, and the practical and professional implications (Barker *et al.*, 1994).

Thus, I was engaged in a range of tasks including comparison and contrasting, noting regularities, patterns and themes, clustering, and triangulation. The triangulated data highlighted individual variations within each group of women and men, couples and their family members so that exceptions to patterns could be examined and understood as part of the diversity of experience for each group (Tolman & Szalacha, 1999). Thus, data on the same issues collected from the different respondents was converged into one consistent picture and variations in results yielded by the different groups of respondents was analysed as additional source of data (Neuman, 1997).

Another task was to transfer the themes and the underlying parts of the narratives into a separate document, so that interpretations could be made for what the participants were saying in close proximity to their actual words. This is why some of the data is reported verbatim while describing the findings of this study. The idea was to allow own expression of the respondents' world in which they live. This is also in part based on the linguistically oriented approach to psychotherapy, where own expression forms a starting point for the theoretical dialogue (Sundby, 1994). Moreover, by providing ample text in reporting results of such analyses, I would enable others to develop alternative interpretations informed by different theoretical perspectives. This also enabled me to create a trail of evidence for the interpretations that were developed (Gergen & Davis, 1997; Merrick, 1999).

I listened to the tapes again, after write-up, to check any nuances of themes that could have been left out. No other themes were generated from re-listening to the tapes but in a number of cases the ways in which themes were presented and interpreted was slightly adjusted.

5.7 Challenges in the Methodology

5.7.1 Research Paradigm Shift

Proposal writing marked the beginnings of this study. The naivety that with proper literature review, proposal writing would be a smooth process was suddenly challenged. Having previously conducted objective studies, the plan was to administer a series of questionnaires on infertility related constructs and conduct a statistical analysis. It became apparent that little was known about infertility in the black South African context, and that what was a reality in western culture might not be a reality for Black South Africans. The realisation that the qualitative research paradigm could not be excluded struck. In order to do justice to my positivistic background, I decided upon conducting the study from both the qualitative and the quantitative background and conduct method triangulation.

Armed with a series of questionnaires, scales and the interview guide, I entered the field, only to realise that what is a reality in the proposal writing phase was not the same as in the field. The reality in the field was that some potential participants did not want to be involved in the study. Moreover, some of the participants, especially women, who were interviewed did not want to involve their spouses. It seemed the infertility issue was so sensitive in interpersonal relationships that some partners feared that the referral could trigger conflict in their relationship. The sensitive nature of infertility also caused women to choose which members of the family I could interview for the study. It seemed that not every one in the family was allowed to get into the private space of infertility.

Most partners of the women refused to participate in the study. In some instances, the women insisted that they be interviewed but refused to involve their partners. Their insistence stemmed from the women knowing that I am a psychologist and from their wanting to gain 'something' from the interviews. It seemed that the women were aware of the potential therapeutic value of the interviews.

Although most gynaecologists contacted to act as networking figures were interested on the study, they too found their patients not interested in becoming 'research subjects'. Community key figures were also reluctant to act as networking figures between myself and the infertile individuals. Their concern was that infertile people would assume that the community key figures were 'laughing' at their infertility and talking to strangers about their infertility. It seemed, people in the community did not know how to talk about infertility - it was a 'no go' area. Consequently, the snowball sampling method, which I initially assumed could be an effective strategy, met with only limited success.

The initial plan was to have the bulk of the study oriented towards the qualitative research paradigm, using the interviewing method to gain in-depth unrestricted information on the infertile women, their partners', and their families' frame of reference to infertility. The quantitative research paradigm was to use the Ways of Coping Scale and the Social Support Questionnaire for Transaction to measure how the infertile couples cope with infertility and perceive the available social resources respectively.

However, it soon became clear that the sample size would not be enough to allow for particularly meaningful statistical data analysis and although it would have been possible to use themes developed from the interview to boost the sample size (Tolman & Szalach, 1999), the study was no longer oriented towards making the kinds of links implied by quantitative analysis. Thus, the analysis of the completed questionnaires was excluded from the study.

Although the quantitative part of the study was dropped, issues such as the infertile couples' ways of coping with and perception of social support resources in dealing with infertility were still studied from the qualitative point of view as planned. The only missed opportunity was the triangulation of the quantitative and qualitative methods with regard to these themes.

The kinds of sampling challenges encountered in this study are not unusual for research in the area of infertility. Sewpaul (1995) and Miall (1989) experienced a similar challenge, and Sewpaul (1995) ended with 8 infertile men and 24 infertile women who were mostly not couples for her doctoral study. The interpretive nature of the approach allowed me to change the sampling

strategy with continued data collection and interpretation, in response to new findings and lessons from the field (Terre Blanche & Durrheim, 1999).

5.7.2 Ethical Considerations

Appendix A consists of request letters and a consent form as part of the ethical considerations in this study. The dimension of research ethics ranges from protecting the rights, dignity, and welfare of research participants to active endeavours to improve their lives (Barker *et al.*, 1994; Grbich, 1999). The central ethical principles in psychological research include (a) informed consent, (b) minimisation of potential harm/deprivation of benefits, and (c) confidentiality and protection of privacy (Barker *et al.*, 1994; Grbich, 1999). To ensure that no ethical issues were violated, the study was guided by these ethical principles as follows.

Informed Consent

Informed consent involves both full information and freedom of choice. The research participants need to be fully informed of what will happen during the study and of any other information that might affect the person's decision to participate. In this regard, prospective participants are able to make a free and informed decision about whether or not to participate in the study (Barker *et al.*, 1994). I discussed the purpose of and described the procedure involved in the study with the networking persons who helped to identify prospective participants. Only infertile women, their partners, and family members who were willing and gave consent to participate in the study were approached for data collection.

I explained the research project, its purpose and my position as a Clinical Psychologist to the respondents before the interviews took place. I also explained that although I am a clinical psychologist, the interviews were not intended as therapy, but as a way for me to learn more about infertility. I made it clear to the participants at the beginning of the study that any need for counselling would be addressed after the research interview (see section 5.7.3 below). Therefore, there was a clear distinction between the research interviews and any subsequent psychotherapeutic interviews.

Harms and Benefits

Harm in psychological research usually comes from stirring up painful feelings or memories, threats to one's self-image and embarrassment (Barker *et al.*, 1994). The participants were given an explanation that participation in the study could trigger psychological distress especially from those participants who found infertility to be distressing. Since infertility is a sensitive issue, the interviews evoked distress in some participants. As stated by Barker *et al.* (1994) the researcher's clinical skills become useful in detecting the presence of distress and in being able to respond to the distress by giving reassurance and by not pursuing overly painful issues. None of the participants became distressed to an extent that data collection had to be suspended or terminated.

In order to ensure that the participants were not harmed by their participation in the study, I debriefed the participants after the interviews. This involved asking participants about their experiences of and feelings after their participation in the study. Some participants seemed to have agreed to participate in the study in order to find a way of getting help. Other participants needed psychological help outside the study, and referral sources, especially social workers, were provided. Due to a scarcity of psychologists in the areas where the study was conducted, I became a psychotherapist for some of the participants after data collection.

Privacy and Confidentiality

It is common sense that all psychological research invades privacy, otherwise it would not be finding out anything new. However, there is a need to be aware of participants' right to limit the disclosing information to myself (privacy) and to third parties (confidentiality) (Barker *et al.*, 1994). These were ensured in the study as follows.

To ensure confidentiality, participants were informed that information obtained from one partner or a family member would not be discussed with the other. My experience with psychotherapeutic interviews helped me avoid letting the interview information from one participant slip into the interview with another family member. Anonymity was ensured by identifying the participants by assigning numbers to the gender for infertile women and their partners, and to the family members. For example, the first woman interviewed is identified as Woman 1 or W 1, her partner is identified as Man 1 or M 1, and her family as FO 1 (for member of family of origin 1) or FI 1 (for

member of family in-law 1). These labels are used to identify the recorded audio-tapes and the transcripts. The initial part of the interviews conducted to obtain the identifying information of the participants was not tape recorded, but written down on paper. Verbal and written consent was obtained for conducting and taping the interviews. I explained to the respondents that taping was necessary for accuracy and that it enables the interview to proceed more naturally (rather than slowing so that I could take verbatim notes).

The participants were informed that I would keep the audio-tapes and only destroy them after the successful completion of the degree that required the conduct of this study. The audio-tapes were kept in case the promoter or the external examiners needed to access them. Thus, participants were also informed that the promoter and the external examiners would have access to the audio-tapes if they so required. The persons who helped with transcription of audio-tapes and with translation of interview data and a work colleague involved with debriefing also had controlled access and the participants were informed accordingly. The case material reported verbatim has the participants' identifying information altered.

The request letter and the consent form (see Appendix A for a consent form) included the following information as guided by Barker *et al.* (1994) and Grbich (1999): (a) Request for assistance with sample identification/participation in the study. (b) Personnel involved (myself and my position). (c) An explanation of the study procedures and why the research is conducted. (d) Maintaining anonymity and confidentiality to ensure privacy. (e) Description of the possible outcomes. This included an explanation that participation in the study could trigger psychological distress especially from those participants who find infertility distressing, and the referral sources for help. I made an offer to answer questions after the research interviews. Clarification that the participant is free to leave the study at any time and is not obliged to answer any question they feel uncomfortable with was also included. (f) Request to audiotape. The signatories kept a copy of the informed consent form. Verbal consent based on the written informed form was requested and obtained from those respondents who could not sign the form due to illiteracy.

5.7.3 Anticipation and Interaction

Feminist qualitative research shares with interpretive work in general, the assumption of inter-subjectivity between researcher and participant and the mutual creation of data. In a certain sense, participants are always 'doing' research, for they, along with the researchers, construct the meanings that become data for later interpretation by the researcher (Denzin & Lincoln, 1998).

In recognising the impossibility of assuming a neutral stance (Gergen & Davis, 1997), I had to consider the implications of my interaction with the informants. I had talked to some participants over the phone while making the interview appointment. Others were not talked to since the networking figures made the interview appointments. Anticipation to meet with the participants for the interviews was accompanied by apprehension as one entered the world of the unknown. Participants who were interviewed in their own homes tended to treat me as their guest – serving tea and traditional South African Sunday lunches where the interviews were conducted on a Sunday.

Although I was uncomfortable about this, such gestures could not be refused, as it would have been 'unAfrican'. Moreover, meals were served without even asking me if I needed some food. One of the networking figures that accompanied me to some of the places where she had made the network, always emphasised that I should eat a little, to show appreciation. Serving food was a way of communicating how welcome I was in the participants' home. Despite being on a weight control programme after the birth of my son, I had to comply and eat.

Some participants asked if I had children, and although I answered honestly, there was some discomfort. Usually, the response was followed by silence from the participants. In an attempt to identify with the participants, I found myself often disclosing about my aunts' infertility. It seemed that this brought a feeling of being understood from participants.

As was the case with Sewpaul (1995) I was surprised that none of the participants objected to the use of audiotape. It seemed that there was a trusting relationship. Some participants were very articulate while others were not. Men tended to give fewer responses than women and, some

women were more articulate than others. A potential problem in this regard is what Miles and Huberman (1994) call 'elite bias'. That is, a situation in which there is overwhelming data from articulate, well-informed, informants which becomes a focus, and thus under-representing data from intractable, and less articulated ones. Although woman 4 was most articulate and her narratives were cited more frequently than others in the analysis, there was a balance of those more articulate and those less articulate. Moreover, more articulation and less articulation represented another different nature of reality within the context of the interview. Men were interviewed by a woman (myself) on an issue which some men felt was a woman's problem while for women the interview could have been a 'woman to woman' talk, creating an imbalance for the men. Re-balancing was attempted by declaring my professional stance as a Clinical Psychologist where in that instance I was a professional seeking information that could be used in future to help both men and women affected by infertility.

The research paradigm allows for an interactive relationship between the researcher and the participants (Grbich, 1999). Using this approached helped with the process of empowering participants and coaching in problem solving skills immediately after the interviews. Most participants needed advice regarding how to deal with the problem of infertility. Some needed to find out how they could go about seeking specialised treatment. Others wanted to know how they could pursue adoption. Some participants felt that they had exhausted all the avenues available and wanted any advice that could be of help.

The following list of concerns, comments, and questions that participants asked illustrates the needs of participants and how participants benefitted through having their questions answered: "Give me advises." "What could be the solution?" "When can I see you to get help?" For some, the interviews were a cathartic experience: "I am just happy for you to have come and talk to me about this." "I am grateful." "I am not used to people where I live, so talking to you was great." "I think a lot about this when I am alone. Therefore, talking to someone like you makes me feel better." Others felt the need to leave the door open for possible consultation with me in my position as a Clinical Psychologist. "If there is anything, I will contact you".

Conducting separate person to person interviews with the couples seemed to have created curiosity among the couples. Some participants wanted to know what the other partner said in the interviews. I had to guard against asking questions to clarify information obtained from either the partner or the family member of the participants, or to give the requested information about the other, especially because one to one interviews were conducted.

Although feminist research is about empowering research participants, I had to guard against the research interview turning into a therapy interview. Thus, I flagged the research interview and the therapeutic interview by telling the respondents that I will give information only after the research interview. After, the research interviews, I responded to the participants' questions. The interaction involved information giving, and provision of referral sources, while also showing empathic understanding.

Within the psychology of gender, feminists have objected to the manner in which advantaged women have claimed to speak for all women, without considering differences among women. Social constructionism has been liberating to those who struggle with the difficulties of being defined by others without suggesting that there is only one proper way to be defined. There are multiple ways of giving words to create worlds, and no one way is the only way (Gergen & Davis, 1997). Therefore, I was able to reformulate other modes of my identity shared with the participants in order to address the power imbalance between us; as described in section 5.7.4 below.

Far from attempting to hide my own involvement in this study, I reflected on my own position with respect to the context of this study. To allow for reflexivity, I was guided by questions posed by Gergen and Davis (1997). (a) Who am I with respect to the respondents, how do I understand the social customs described here? (b) What are the consequences to others if I present information in a particular fashion? This reflexivity enabled me to participate with subjects in relationships with a high degree of openness, and to use these experiences to help organise my understanding with a sense of commitment to their values about gender relations.

5.7.4 Validity and Reliability

The analysis of one's role and position as it affects one's understanding and the research process has been identified (Brink, 1993; Gergen & Davis, 1997; Merrick, 1999) as an important strategy in conducting feminist research and qualitative research in general. Social reality is constructed by human beings, including social scientists, using cultural categories and language in specific situations or contexts of meaning (Denzin & Lincoln, 1994). Therefore, in this section, I examined and declared my values and assumptions in the light of the context of the research situation that can be considered when reading this thesis.

I have a personal experience of infertility within the extended family. My two aunts (my mother's younger sisters) or 'young mothers' were infertile. Some people who were infertile have conducted studies on infertility, for example, Sewpaul (1994) believes that personal experiences of infertility lend richness and depth to their studies, that someone from the outside would find difficult to achieve. Although the experience was not direct and personal, being a 'child' in that context of the three families (my two 'younger mothers' and mine) has its own way of experiencing which could be influenced by and influence the research process. For instance, I found it difficult to interview the families of my two aunts despite their enquiring about the progress of the study and the scarcity of research participants.

One crucial issue about feminist oriented research is a concern that feminist researchers have taken a position of becoming the spokespersons of the researched. The concern here is that some of these feminists, because of different social and economic statuses for instance, are not 'qualified' to be spokespersons for people who have different experiences (Tolman & Szalacha, 1999). As a black woman, I have certain experiences that gave me an understanding and insight to 'speak', to a certain extent, on behalf of other women less privileged than myself in terms of education, for example. I was in some ways, for example race, close to the participants, but in other ways, such as gender for some of them, not close.

As a Clinical Psychologist I have experience of working with infertile patients either for infertility or other conflicts. My midwifery qualification and experiences as a trainee midwife brought memories of the labour ward as well as those patients who sought treatment for pseudo-pregnancy. All these experiences somehow sifted into the research process. On the one hand, these experiences were useful because I already knew a lot about the experiences of infertility, but on the other hand, they may have hampered my understanding as it tended to be from a professional perspective.

Interviewing as a method of data collection assumes that the interviewer and the participants understand one another. I, myself a Xitsonga first language speaker, lived with the Northern Sotho speaking people for a period of seven years, and with the Setswana speaking people for about ten years, and speaks these languages adequately. I can also converse in IsiSwazi. It was her choice for the Swazi speaking woman to be interviewed in a combination of English, IsiSwazi and Xitsonga. Understanding and commonalties in terms of language and culture (Nzimande, 1996) could thus be achieved. Possible communication problems lay not so much with language differences, but rather with differences in class and education for some and status as a clinical Psychologist for all, especially as, most participants expected to gain some means of help by participating in the study.

One basic assumption of interviews is that the response to a question bears some relation to the 'truth' of the person's understanding. Thus, there could be disturbances caused by the interview focusing on one aspect of the person's understanding and knowledge of the issue to the exclusion of other aspects. Other disturbances could be caused by the interview focusing on only one aspect of the person's life experience. This could result in the following: (a) A protective 'front', where only the first few layers might be revealed. (b) Public rather than private views of the topic under study might be exposed. (c)The participants undertaking a reassessment of their experiences, leading to complete reconstruction, which may either favour them or be what they think the researcher is seeking (Grbich, 1999). For example, woman 17 did not reveal her extra-marital affair during the research interview; it only came out as a reason for referral for psychological intervention thereafter. This indicates that she perceived having an exra-marital affair to be socially undesirable. Woman 12 stated that she did consult traditional doctors and she used traditional

medicines, but she reported her dislike of this type of medicine because it would damage her kidneys - again a social desirable response.

It can also be argued that there is no validity of the interview method as such; it is the results of an interview study that must be validated in particular situations (Kvale, 1996:1983). The issue in any qualitative research is not whether another investigator would discover the same concepts to describe or interpret the data but whether the findings of an inquiry are worth paying attention to (Guba & Lincoln, 1989).

The validity of the study was both enhanced and reduced by the refusal of some men to participate in the study. The validity of the study was boosted because the refusal of some men to participate led to the sample being studied to a certain extent, as men and women and not as a couple. Greil (1997) contends that studies on gender differences in infertility based on couple systems may miss the real extent of male and female differences. His bases for this argument emanates from the findings of Link and Darling's (1986) study which found that women whose partners refused to participate in their study were more distressed than the other women in their sample. However, it was a disadvantage to miss the experiences of those men as it could have given a holistic understanding of infertility from a couple's perspective for those cases.

Women participants usually decided who I could contact for the family interviews. This could have brought information bias since women would have been more likely to select those family members they were on good terms with. Those women whose fathers or fathers in-law were alive seemed reluctant to involve them.

Bias against social desirability was counteracted with follow up interviews which some women and couples initiated, as they needed psychotherapy. The information from the follow up interviews was not different from the research interviews except for one case where the woman found it difficult to reveal during the research interview that she had an extramarital relationship. The husband's discovery of the extramarital relationship prompted her to call me for psychological intervention whereby the extramarital relationship was presented as a problem.

Several techniques were used to ensure that credible findings would be produced. These techniques included prolonged engagement, reflexivity, peer debriefing, negative case analysis, and member checking. The process of peer debriefing involved discussing the interview data with a colleague who was also busy with her thesis using a similar population of study. This included clarifying meanings, information sharing and provision of advice. Providing ample text in reporting the findings enabled me to create a trail of evidence for the interpretations that were developed, boosting both the reliability and the validity of the findings.

Another way of improving the reliability and validity of the findings was to declare values and assumptions for those reading the findings of this thesis (Brink, 1993; Merves-Okin, Amidon & Bernt, 1991). When other's lives or actions form the research focus, the author's voice has a range of possibilities (Grbich, 1999). This calls for the process of separating out the self and decentring one's position as a researcher. I analysed my responses to all the interviews, both prior to and during the interviews. This process enabled me to come to terms with my own responses and to distance them, while using these insights to facilitate a more sensitive interpretation of the data. The self in this study was connected to the participants within the contexts of culture and societal structures in an overlapping and interconnected fashion. In addition to findings about the participants, I included my experience of the research process as a finding. I described here my reactions, social location, and my own development during the study. The latter included considering my race, class, professional position, my fertility, experience of infertility within my extended family, and its influence on my analysis and interpretation of the research.

According to Grbich (1999) the researcher, using the interactive mode of analysis, should critically evaluate the data in order to ascertain his/her effect on the collected data, the range of data sources and the types of responses (directed/spontaneous). He/she should ensure that his/her own beliefs, values, and prejudices have been adequately exposed. This is one of the aspects where the iterative mode of data analysis overlapped with the subjective mode in this thesis. In subjective analysis, the researcher moves from a distant role taken in other modes to the position of involvement in the research process. Those researchers who take the position of involvement have

depended upon the concept of reflexivity to actively construct their experiences in the research process. Reflexivity varies in definition from an apolitical awareness to radical consciousness of the self. At the awareness level, the researcher continually checks his/her biases in the interpretive process. The concept of radical consciousness presumes the deconstruction of power differences (gender, race, status, culture and attitude) between the researcher and the researched in the field, as well as those boundaries between the researcher and the reader (Grbich, 1999).

The problem with the emphasis on power differences can be located in the underlying assumption that the researcher has greater power and that she/he has both the capacity and the desire to empower others. Grbich (1999) suggested some techniques to reduce the researcher's authority. These are: researching, as in memory work; acting as an advocate to facilitate change (where power differences are evident); and passing on knowledge, which has the capacity to empower others. In order to reduce the researcher's authority, the latter two techniques were applied in this study.

Using the interpretive method of data analysis allowed for a more 'psychological' approach to data analysis as the interpretive method is explicitly relational. I brought my self-knowledge and relational skills to the process of listening by using clinical methods of empathy to contribute to my understanding of what women were saying (Terre Blanche & Durrheim, 1999; Tolman & Szalacha, 1999). This relational practice increased my listening ability to avoid bias or voicing over the respondents' stories with my own reactions, much like a skilled therapist can use countertransference to inform rather than overwhelm psychotherapy (Tolman & Szalacha, 1999).

5.7.5 Generalisation of Findings

The extensiveness of the sample in qualitative research is more concerned with depth of analysis than number of cases, and it may not be beneficial to sacrifice analytical depth and scope for additional cases. However, some qualitative work seeks to represent diverse groups to achieve transferability. The diversity of the sample in this study can be observed in that participants ranged from illiterate to highly educated professionals residing in both rural and urban areas, with diverse choices of infertility management options. Therefore, to a certain extent the findings of

this study can be transferred to apply outside the population of study.

5.8 Conclusion

Qualitative research, grounded in non-positivist paradigms that include interpretivist, constructionist, feminist, and post-modernist perspectives that focus on gathering and analysing non-numerical data in the form of text was used in this study. Qualitative data collection proceeded until a point of thoroughness where new data contributed no substantial added insight was reached. The challenges met in the research process were an enriching experience. Despite the challenges, I was able to obtain data that could be fruitfully analysed. The outcome of this analysis is discussed in the following two chapters.

CHAPTER 6
INFERTILITY AND THE AFRICAN WORLD VIEW

6.1 Introduction

This chapter is devoted to participants' beliefs and values related to the existential problem of infertility, as the constructionist position attests that there are many world views, and also many African world views. These beliefs and values are examined in relation to the family's cultural identity. That is, the family's structural properties, its self-representation and how these influence marriage and family life within the context of infertility. The chapter also describes the cultural ways in which African families define and explain infertility crisis and distress, how they respond to it and, their help seeking attitudes and behaviour.

6.2 The Families' Cultural Identity

The findings of the study support Nzimande's (1996) assertions about the structure of black South African families. Modern African families are and include both nuclear families and extended families that consist of such combinations of relatives as cousins, uncles, parents, siblings, and grand parents. The family structure, defined as a set of rules or programmes regulating relations of proximity and leadership among the family members (Shlomo, 1999), reflected this diversity. In particular, there was diversity in regard to who belonged to the nuclear and extended family. Some nuclear families consisted of married couples without children (man 5 and woman 13) and others with an adopted child (woman 1 and man 1). Others consisted of an unmarried woman and her adopted son (woman 4); unmarried woman, her niece, and her mother (woman 14); or married couple living with the woman's in-laws. Some blood relatives were not considered as members of the family because of infertility related conflicts (woman 12).

The residential arrangements of the families were also diverse. Woman 9 and her husband lived together while their adopted child lived with the woman's brother's family. The couple consisting of woman 18 and man 8 each lived with their family of origin; woman 8 visited her partner and in-laws on weekends and when on leave. This couple lived in the same homestead with the

extended family of the woman's parents and siblings in-laws one of whom was married with two children. There was a territorial demarcation for the family of a couple consisting of woman 7 and man 3 in the sense that the two wives of man 3 had separate houses in the same homestead. The rule of descent was patrilineal. Most participants except for woman 11- who was IsiSwazi speaking and married to a Xitsonga speaking man - were engaged in endogamous marriages and relationships in that they belonged to the same cultural community. Most families tended to exhibit cross-generational cultural discontinuity especially regarding beliefs about traditional healing.

6.2.1 The Importance of Blood Ties

One of the most prominent themes in the interviews concerns the central role blood ties play in family identity. Participants reported blood ties to imply an existence of a relationship due to biological ties which were patriarchal in nature. The theme involves how identity is explained in regard to blood ties, how lack or presence of patriarchal blood ties causes or buffers family conflicts, the impact of blood ties on reproductive technologies and adoption decision making, as well the influence of blood ties on the need to experience pregnancy.

Motho ke ao madi.

Motho ke ao madi is Northern Sotho for "you are part of a person because of blood ties". The participants reported that blood ties defined how human beings are perceived as persons. One was "of a person" if there were blood relations. It means that one would not rely on just anybody for support but rather on those persons where there were blood ties. The ways in which this world view is enacted in the context of infertility are reviewed below.

'There is a conflict among my daughters'

Lack of patriarchal blood ties caused family conflicts. The following narrative reflects how lack of blood ties caused disharmony in one family.

> The hatred started after my husband told my daughter (Woman 4) that she was not of his blood and the others were not told anything. They said I should take this hated child to my family (family of origin). There is this thing called *motho ke ao madi* (Northern Sotho for you are of a person because of blood). I was amased because my husband knew that I already had two children before we married. My

> elder daughters took one side and the other two daughters the other. They believed that each of the two groups is of the same father. When I tell them that the two young ones are also not my husband's children, they do not believe me. They say I mention it because I want to separate them. Therefore, my daughters have formed alignments according to how they believe their fathers to be, but we are having family counselling sessions for that (FO 1).

The fact that the family is getting psychological help indicates the extent of distress caused by the blood-ties issue in this case, but is also suggestive of a potential willingness to re-frame the issue in non-traditional terms.

'There is nothing they can do because I am of their own blood'

Just as blood ties may cause conflict, it may also buffer conflicts between family in-law and family of origin. For instance, man 3 had been experiencing conflict with his family in-law. He married his cousin (uncle's daughter). He reported that his partner (woman 7) usually told her family of origin lies about the couple's interpersonal relationships and decisions regarding with whom to seek help for infertility. However, he felt confident that, because of blood ties, his family in-law would be bound to co-operate and support the couple in the search for treatment as reflected in the following extract.

> At the end of the day, we still work together. There is no way they can decide that they do not want me any longer. They will come back so that we work together. If it failed it failed. She will just go and marry a wife there. That is our culture (man 3).

Blood ties influence familial adoption decisions

The importance of blood ties was more pronounced in situations where infertile persons and their families had to decide about fostering and adoption. There was a belief that it was only a biological child that could make one a parent. When asked how important it is for her to have her own child, FO 1 responded: "The difference is that this other one (adopted/fostered child) is yours, you have raised her, and the other one is your own blood (FO 1)." It seemed that familial adoption was mostly embraced. One would be adopting a child where there were blood relations. Therefore, FL 1 did not have a problem if his brother and sister in-law adopted a child, as long as there were blood relations. When asked what he thought would happen if his brother and sister in-law did not have a biological child, FL 1 responded as follows: "He does not mind raising my

kids. I do not know about adopting a child who is not 100% of our blood. I never touched that area" (FL 1).

Participants gave many different reasons for wanting to have a child of one's own blood. The following are the themes related to a strong need for a "blood child" .

Owing the child to the clan

The couple consisting of woman 7 and man 3 had a mandate to bear a chief. Man 3 married woman 7 specifically so that they should bear a chief. In fact, woman 7 was chosen and married to the clan as *makgoshi* (Northern Sotho for chief mother). Thus, strictly speaking, the clan rather than the chief married her. The desire to bear a child was beyond the couple, but was a requirement from the clan. "I owe it to the clan. *Sechaba se batla kgosi* (Northern Sotho for the clan needs a king)." In this case, although man 3 was in a polygamous marriage and his other wife had children, those children could not take a kingship position, as the woman was not married to bear the king.

Need to experience pregnancy and childbirth

Women's desire for blood children was in several cases based on the need to experience pregnancy, child-birth, and child rearing. It was not enough for some women to read about these experiences in magazines. For woman 5, who associated vaginal examination procedures to being cut with a broken bottle, said, "those who know say it is the same as labour pains." It seemed making such associations helped her satisfy her need to experience childbirth at an unconscious level.

Expanding the family tree.

Men faced a demand to carry the family name to the next generation. There was a cultural demand for extension of the family tree. The couple consisting of man 7 and woman 17 had the need to ensure continuity of life especially because man 7 was the only child whose parents were dead. Therefore, having a biological child would satisfy the perceived cultural demand for him to expand the family tree.

'What if the doctors use someone else's sperm?'

The need for a blood child was so strong that man 3 refused to have an IVF. He did not trust doctors, fearing that doctors might use someone else's sperm to fertilise his wife's eggs. Despite reassurance from the doctors and his family in-law, he believed that it was possible for the doctors to use some other man's sperm without his consent and knowledge. The uncertainty of blood ties of a child born from IVF made him decide against the IVF. His stance indicates the extent to which a blood child is valued, especially because the couple was under pressure to bear a future chief/king.

The strong need for a blood child seems to be incongruent with the notion that in African culture a child belongs to the clan (Kayango-Male & Onyango, 1994; Nzimande, 1996). One possible explanation for this may be that there has been a weakening of broader social ties, such as clan ties, and a consequent increased emphasis on immediate blood ties.

6.3 Marriage and Family Life

A broad theme that emerged from the interviews concerns the nature and experience of marriage and family life. Included in this theme are issues such as the meaning of marriage; practices and experiences regarding courtship, polygamy and sexual fidelity; infertility and family economics; marital breakdown; and the value of children.

The meaning of marriage and family

The family cultural identity is closely related to the meaning attached to family and marriage. For some participants, childbirth was associated with the start of a family. There was a belief that a couple without a biological child, whether married or not, was not a family as indicated in the following extracts:

> "My in-laws do not understand why we are not starting a family (woman 13)."
> "At first we did not think there is a problem because she was still at school. We only realised that there is a problem when we wanted to start a family (the couple has been married for six years when they wanted 'to start a family') (man 5)".

This signifies a traditional notion where life cycle stages are correlated with childbearing and reproductive events (Upton, 2001).

However, a contrary view also emerged in that some participants believed that marriage was grounded in a loving relationship and that children were only the products of that relationship. It seemed to these participants that children were not the only important thing in building the marital relationship. Instead, a loving relationship built the marriage:

> "The big thing is, marriage is for lovers and children are fruits of love (woman 9)."
> "I accepted it and continue with life because our marriage is not only based on children but also love (woman 3)."
> "When I ask him (asking why he was not serious about having children), he says to me, whether marriage has kids or not, is not an issue. As long as they love each other (FL 1)."

This contrary view can be seen as a means of counteracting traditional pressures to bear children. It seems to be based on the Western notions of romantic love. The perception confirms the changes that have occurred in marriage and child bearing from an African perspective. For some black people in sub-Saharan Africa, marriage is certainly no longer primarily designed for bearing children.

Another indication of the extent to which marriage and child bearing have become separate domains of life can be found in the increasingly widespread belief that one need not be married to have a child (Upton, 2001). It can be seen from the demographic characteristics of the respondents that some women who identified themselves as infertile were not married, but needed to conceive even before marriage. Some of the women in this study were expected to prove their fertility before marriage could be proposed. For example, Man 4 was in conflict with his wife (woman 11) because she used contraceptives before their marriage without his knowledge. He expected her to prove her fertility. His reaction to the knowledge that she secretly used contraceptives, was to withdraw social support and to no longer accompany her to the doctors for infertility treatment.

Some participants were in fact not interested in marriage at all, but simply wanted to have children. Thus, in the particular cultural context of the participants there is a clear loosening of the connection between marriage and child bearing, supporting Preston-Whyte's (1993) and Upton's (2001) conclusion that fertility before marriage among Africans was not an issue to be concerned with and that procreation within marriage was less important to them than for white people

(Preston-Whyte, 1993) who consider children born out of wedlock to be illegitimate. Thus, one may conclude that the family models (that of nuclear family and that of polygamous marriage) currently recognised by the state are unable to serve the diverse, heterogeneous South Africa. The state tends to disregard the single parent family model to the extent that infertile single women are excluded from IVF programmes, as explicated in 7.2..2.4 below.

Courtship

As described above, it seems that African societies have a high degree of tolerance for pregnancies or birth occurring prior to marriage (Lesthaeghe, 1989). Thus, the African tradition encourages premarital sexual relationships to ensure that a woman can conceive. In some cases, pregnancy was even seen as a pre-requisite for entering into a marital relationship, with partners cohabiting, and waiting for the conception of a child before they decide to marry. Woman 3, woman 8, woman 10 and woman 14, each of whom were cohabiting at the time of the interviews, indicated how on several occasions the promise of marriage was broken because they were not able to conceive. It seemed their partners were unwilling to marry them for fear of disapproval form their families. Families did not want their sons to marry an infertile woman. This is illustrated in the following extract:

> The problem is that a person will live with you for a long time. Then you end up asking yourself why are you not getting married. You find that it is not that he has financial problems. You understand that he is looking at that it will be a shame for family when there is no child in the family (woman 3).

Woman 3 had three failed promises of marriage. She was currently in the fourth courtship. She hoped to conceive so that she could marry her current partner. Her shattered hope for marriage is illustrated in the following statement:

> ... The other man did not say anything he just left me. After some time you hear people saying that the person was getting married to someone else while you knew nothing about it, whereas you thought you will build a family with him (woman 3).

Family members, especially mothers, took an active role in discouraging their sons from marrying a woman they suspected could be infertile. Instead, infertility was used as an excuse to break the promise of marriage so that the two families would not fight thereafter, because of the conflicts

which infertility could bring into the marriage:

> He is a bit of a relative. Therefore, you understand that relatives are people who are supposed to support you. Sometimes when I visited his family, we started to sneak in and I did not understand why we had to sneak in because I used to go there freely. Then I suspected that there could be a problem. One day we were sitting in his hut, his mother knocked at the door. He told her that he would not come out, it was at night. His mother asked him what he put in there that made him not to open for her. While he was still preparing to go out, his mother came in shouting. She said that what he was doing was not right "we will fight because of you two while we are relatives." She said that you could not marry this person "I will not compromise that the family will not grow because the family is grown by children. You cannot marry this person." She started telling me their secret that he is having a child somewhere, "so where are you going with a person who cannot have children" (woman 3).

The families in-law tended to discourage their sons from paying *lobola* (bride-wealth) for a woman whom they cohabited with when there was infertility. In this regard, there would not be marital commitment to an infertile woman. Some women themselves refused marital union because they wanted to avoid conflict in a marriage where there would be no children:

> I cannot allow a person to marry me when I am like this. I have been sensitive and I told myself that I will not accept a proposal for marriage because when you are married, you will experience problems when a person wants a child who is not there (woman 14).

Others warned their partners that they were having an infertility problem. In most cases, the male partner will persevere and still when no child comes, terminate the relationship. Consequently, some women forewarned their potential husbands about being infertile.

Moultrie and Timaeus (2001) found a significant difference of living arrangements for mothers and infertile women. Childless women were more likely to be living with their parents, with other relatives of their parent's generation, or with relatives of their own, than women who have children, even after partially controlling for age. Childless women were far less likely to live with their husbands than women who have become mothers were. This could be an attributed infertility factor like fear to marry an infertile woman, especially because few people do not equate having children with being married (Walker, 1995).

Polygamy

Traditionally, a husband of a childless couple could marry a second wife who could bear children. Two of the interviewed women (woman 7 and woman 9) were in a polygamous marriage. Although both were second wives, the clan chose woman 7 specifically for the future chief bearing role. Therefore, woman 7 was addressed as the elder wife, queen or chief mother in the community. These women seemed to have accepted being in a polygamous marital relationship. It seemed her position as chief mother made woman 7 accept being in a polygamous marriage. For woman 9 it seemed that acceptance of being in a polygamous marriage was based on her previous experience of marriage. This woman was in her second marriage. Her first marriage failed because of her infertility problem. Her in-laws from the first marriage wanted her ex-husband to marry a second wife. Her ex-husband refused stating that he could not afford to support two wives - the infertile one and the child bearing one. Therefore, he divorced her and married someone else. Woman 9 embraced polygamy, stating that it was part of her tradition that a man could marry as many wives as he wishes.

There was a strained relationship between the co-wives who were jealous of each other and seemed to compete for affection from their partner. Woman 7 believed that her co-wife was bewitching their husband so that he developed sexual impotence when he was with woman 7, thus making it impossible for her to conceive. The strained relationship made it impossible for woman 7 to discuss the sexual impotence of their husband with her co-wife.

For woman 9, however, it seemed that infertility was an advantage, as she believed that their husband was showing her more affection than the co-wife because she did not have children and that their husband hated supporting his other wife and children. She saw love and not child bearing as the key factor in a marital relationship. The following extract illustrates her perception of infertility in a polygamous relationship.

> It is possible for him to go back to his family, which has children, but he loves me. He loves my household, so he stays in it. I have realised that this man is not just impressed by the mere fact that the other wife has children. It depends on how much he loves his wife. At times, men leave women with children and go to those who do not have children. It is all because of love and appreciating family

planning. They hate paying (woman 9).

However, the co-wive who had children was also able to gain advantage from this over her infertile co-wife. The fertile co-wife would , for example, sing hurtful songs about infertility. Thus, the fertile co-wife had her own way of avenging the romantic privilege enjoyed by the infertile co-wife. It appeared that it was difficult for the co-wives to share one household since woman 9 moved to live in a different place because of the conflicts. It seemed that their husband moved with her and only visited his other wife.

However, consistent with what Lundgren and Paulson (1997) found in their study, most women were not willing to be involved in polygamous marriages. Some women expressed feelings of uncertainty related to their partners' frequent statements of wanting to marry another wife as a way of dealing with infertility. In some cases the in-laws who felt that their sons should be polygamous or divorce the infertile wife and marry someone else exacerbated the situation. Polygamy seemed acceptable for the older generation and was seen as a cultural norm:

> Culture helps a lot if there was tolerance between a husband and wife. The infertile woman should give permission because she can not bear children. She must allow her husband to go ahead and marry the second wife. She should also be prepared to take care of this woman's children (FO 1).

Infertility and sexual fidelity

The findings suggest double standards for men and women in regard to sexual fidelity. There was tolerance by both men and women of the idea that a man can have an extramarital relationship while a woman cannot. Some men's (e.g., man 4 and man 2) extramarital relationships were an open secret. Two other men (man 7 and man 8) kept it as a secret from their wives but readily talked about it during the interviews. Women (woman 11 and woman 5) on the other hand, kept their extramarital relationships as a secret, and did not reveal it during the research interviews. Woman 11's brother (FO 2) revealed the existence of her extramarital relationship during the interview with him. Woman 5 told me a few months after the interview, when she called in need of psychological help, when her partner discovered that she was having an extramarital relationship. Other partners trusted that they were each not involved in extramarital relationships.

The extent of women oppression and male domination in this regard can be seen by the way in which women, even in those circumstances that allow them to have extramarital relationships, still conduct the relationship with fear and circumspection while men are more brazen about their affairs. Although African culture allows that women in an infertile marriage can have extra-marital relationships, the relationship is supposed to be kept a secret. FO 1 stated that her four children were of a different father and that it was possible for a woman to have an extra-marital relationship to bear children in case her husband did not have 'a seed'. She also stated that she could not discuss with her husband that he did not have a seed because 'he was a man' and that, therefore, one had to have a secret extra marital sexual relationship.

The most common reason that held women back from having extramarital relationships was the fear that the affair could be revealed if they fell pregnant in cases where the women's partners knew that they were incapable of making their partners pregnant. In case of migrant labourers, the duration of pregnancy might not correlate with the dates in which the male partner visited his wife. Although not reported in the current study, the solution to this problem comes in the form of a situation called 'sleeping foetus' in Botswana. In this context it is said that gestational period was 'longer' because the foetus has been sleeping, taking longer than the expected date of delivery to be born. The problem arises where the current generation of young women is no longer able to utilise this cultural construction of the 'sleeping foetus' to their advantage (Upton, 2001). The absence of any reference to the 'sleeping foetus' by the participants in the current study could be a reflection of acculturation processes regarding Western and African beliefs.

The stated reasons for involvement in extramarital relationships were to try and conceive a pregnancy for both men and women and, 'for pleasure and, not for the baby' (man 7 and man 8). Man 4 blamed his wife (woman 11) for his involvement in extramarital relationship. He felt that the interpersonal conflicts with his wife caused him to become involved in an extramarital relationship. When asked, "how did the fertility problem affect your life," the attribution of blame took the following pattern of response:

> It affected my life a lot because part of the silence between us resulted in me fathering a baby outside. The openness is different. Outside you can talk anything and you become spiritually close. At home everything is in the form of an

argument. So I feel closer with the outside person than with my wife (man 4).

Men, including those who were involved in extramarital relationships, did not want their partners to be similarly involved. Man 4 and man 6 suspected that their partners could be involved in extramarital relationships. When asked about the trust in his marriage, man 4 responded as follows: "The problem is, we both want to prove ourselves outside and the consequences will hurt the other most". Although his partner accepted his extramarital relationship, man 6 became angry and insisted on separation from his partner after discovering that she was having an extramarital relationship as well. The woman felt guilty and she became suicidal. It seemed that although the couple consisting of man 2 and woman 5 became involved in extramarital relationships for a similar goal, that is to try and achieve pregnancy, it was not acceptable for the woman, at least from her partner's side. Her family in-law had encouraged her to 'steal herself outside' as indicated under familial ways of managing infertility in section 6.5.1 below.

The women whose partners were engaged in extramarital relationships reacted differently from their partners to the extramarital relationships. For example, woman 5 was so accepting that she went to congratulate her partner's extramarital partner for conceiving a child with her partner. She envied the woman and wanted to know how the woman managed to conceive while she tried and failed to bear the child 'for' her partner. Unfortunately, for all, the pregnancy miscarried. Woman 11 on the other hand, found her partners' behaviour unacceptable. It seemed that her involvement in an extramarital relationship was a way of getting back at her partner by whom she felt cheated.

It seems that having a child in an extramarital relationship was used as a justification to maintain the extramarital relationship. Thus, a woman in the marital relationship is expected to comply as explained in the following extract:

> She has a problem that I love my kid and I can't hate my kid. I would rather separate with her if need be. ..., When I visit my baby it is not only for the baby, but the mother as well. ... She insists on separation because she does not want to be attached with the other person (the woman he is having an extramarital relationship with). ...I don't know how we will solve this. Whether she gets a baby or not, if she does not change her ways (accepting his extramarital relationship and the child), she won't be able to cope (man 4).

Unlike in most of the cases in this study where the in-laws encouraged their sons to divorce the infertile woman and marry another one who will bear children, woman 11's in-laws disagreed with their son and supported her. They did not support their son in his plan to divorce and marry the woman he was having an extramarital relationship with because, as he argued, the woman had proved her fertility. Instead, they saw this as a pretext and insisted that he remain married to his current wife. Woman 11's in-laws may have been influenced by their religious beliefs not to support their son, and this consideration would appear to have weighed more heavily with them than traditional African practices regarding fertility. Woman 11 indicated that her mother in-law was a Christian, who always insisted that they pray for help with this problem.

Thus it is clear that in negotiating their way around issues of fertility, the men and women who participated in this study were strongly influenced by (and made use of), traditional African and patriarchal cultural constructs, but that their engagement with these constructs were mediated by other influences such as Christianity and the idea of romantic love.

Infertility and family economics

Infertility played a role in how the family finances were handled. Married men who were planning for an IVF (as discussed in the next chapter) with their partners felt that an IVF was costly and placed a heavy financial burden on them. Consequently, most of the men interviewed complained of financial problems. Educated unmarried women who had a steady income were able to save for infertility treatment including an IVF while also paying for the advancement of their careers at the same time. Although woman 6 was married, she did not enjoy the necessary financial support from her husband in regard to infertility treatment. She was saving for an IVF and paying for the advancement of her studies, just like the unmarried women. Most women with low educational levels and who were unemployed were economically dependent on their husbands for financial support and it was these women's husbands who were reluctant to pay for the IVF.

Although a couple consisting of woman 19 and man 9 received financial support from the man's younger brother, the younger brother was surprised that his brother did not want to involve him in financing an IVF treatment. The man (man 9) stated that he wanted his wife to save money as

well, so that she would feel involved in the treatment. It seemed that he did not want to risk his and his younger brother's money because he had stated that the IVF was a financial risk and that he did not mind not having biological children. It appeared as if he wanted his partner, whom he accused of being the one who wanted a biological child, to provide for the treatment. He reported that he had always asked his partner how far she was with the savings as an indication that he was concerned about getting the infertility treatment.

Several of the families in-law of infertile women were concerned that their sons were financially supporting their wives who were unable to bear them children in return. It seemed from their perspective, that women in infertile couple relationships do not deserve much financial support from their partners. This finding supports Pick, Ross and Dada's (2002) assertion that women who are infertile are less likely to have the economic support of a male partner, because of the ostracism that these women suffer at the hands of their families and the community. It is noteworthy, however, that Pick *et al.* (2002) contend that infertile women do also benefit from infertility in the sense that they are less handicapped by children and can spend longer hours earning an income.

Another theme in this regard, was the sharing of finances between co-wives where one of the wives had children and the other one was infertile. There were conflicts between co-wives in that they argued about the budget, with the fertile co-wife feeling justified in getting more money from their husband than the infertile co-wife because she had children to take care of:

> She would say that this man should not equally share money between us because I don't have children. She would say that she should get a lot of money because she has children and that I should get very little because I am childless (woman 9).

The infertile co-wife on the other hand, felt that the money should be split equally irrespective of whether one has children or not.

In others cases having an extramarital child caused conflicts in running the family budget. Woman 11 was constantly worried about how much her partner spent on the extramarital child, especially at times when the family was experiencing financial difficulties. Her partner (man 4) on the other

hand, found it difficult to convince his wife of his responsibility to financially support the child.

Fertility is often equated in African culture with economic stability in that children are seen as an investment in the future who will ensure the continuation of the family and the clan. Over and above its other meanings, infertility therefore represents a potential economic crisis for people immersed in traditional African culture. As can be seen from the above, however, infertility manifested as a financial problem in more complex and diverse ways for the participants in this study, who had to contend not only with traditional ideas about the value of children, but also with gender biases, the costs of modern technology and the need to make a living in a market economy. This is discussed in more detail below under the heading 'value of children'.

Marital breakdown

Unlike with Gerrits' (1997) findings, infertility related conflict caused marital breakdown among couples in the current study. As was also found in a previous study (Mabasa, 2000) participants in this study were under no illusion about the fact that women could be divorced for no better reason than their (presumed) infertility. In several cases the women's families in-law encouraged their sons either to divorce and marry someone else who would bear them children or to enter into a polygamous marriage.

FO 1 summarised the fate of an infertile married woman in the following extract:

> It is our tradition for this man to marry another woman to be the second wife. The childless one will take care of the kids. At the end the childless woman may be divorced, go back to her family, or erect her own house and stay there. *O feletsa a lahlegile* (Northern Sotho for she ends up a lost person (FO 1).

While it is true that there has been a weakening in the practise of polygamy among Africans (Lundgren & Paulsson, 1997; Lestheagate, 1989), polygamy or divorce remain among the possible consequences that an infertile woman has to contend with.

Value of children

Marriage and family life in African culture is centred on children. Therefore, there were several emergent themes related to the value of children. The themes on the value of children confirm

much of what has previously been written on this topic (Kayongo-Male & Onyango, 1994; Mabasa, 2000 ; Ndaba, 1994; Nzimande, 1996). In the first place, as has already been alluded to, the economic value of children is closely tied to a sense of security in old age. Children are idyllically depicted as helping in the fields and looking after their elders when they reach maturity, and although this pastoral vision no longer applies to the life circumstances of most South Africans, it still has some influence.

A more immediate and potentially divisive theme that arose in the interviews, concerned issues of who will inherit the family's wealth. Family members were worried that there would be no one to inherit the wealth of an infertile child (son or daughter) when the child (son or daughter) was dead. There was an interesting gender division in this regard. Women's talk about children tended to centre around wanting small babies while men tended to take a 'death perspective' - they wanted a child who would carry the family name when they themselves were no longer alive.

Another theme regarding the value of children related to a sense of family 'completeness'. Participants felt that children brought social status and a sense of identity. Children affirm womanhood and manhood. Children were valued because they easily engaged in conversations and helped to prevent loneliness. They also helped when there were squabbles between the couple by initiating a conversation that would involve both parents, and in that way bringing peace in the family (Mabasa, 2000).

The extent to which Africans value children became apparent in the way in which infertile participants were put under pressure to have children. The pressure was both environmental and biological in nature. The infertile were usually asked: when are you going to have a child? They found themselves racing against the biological clock. To rub salt into the wounds, family members reminded them that time was running out. Women felt under-pressure to conceive because they felt that time was against them. With age, women became more desperate to conceive. Men similarly became worried when they did not conceive as they and their partners grew older.

The couple consisting of woman 7 and man 3 felt under pressure to conceive a child who was supposed to inherit the kingdom and rule the clan. The only relief for this couple was that no one

in the clan could raise the issue with the man, because of his status as a chief. He was the only person who could open the issue for discussion. However, the man nevertheless felt under pressure as indicated in the following:

> The clan has no problem yet. I don't know when it is going to start having a problem with this because they can see that she is getting old. Even if they were having a problem, it is not easy for them to say why do not this and that happens. It is not easy. They will just wait for me to announce that they can also see (man 3).

Both men and women found their family members were putting pressure on them. Mothers wanted grandchildren, siblings wanted nieces and nephews. Thus, family members usually asked, "when are you going to start a family?" One of the women found the family pressure to be her most severe source of stress. Her mother and her siblings kept pressurising her to conceive a child which reminded her that she was growing old. The following extract indicates how she experienced the pressure:

> Now the problem is I get pressure from the family, especially now that I am old. ...It is difficult in that my mother is one kind of a person who will persist in things even when I tell her that I do not want to talk about it. She will keep on saying that whether you want to talk about it or not we will. So, there is a lot of pressure from my mother. The other thing that frustrated me was that they will always discuss it, all of them, including my elder mothers (aunts, that is, her mother's sisters). They will assemble at my mother's place for a meeting with me. I ended up deciding to visit my mother on Fridays and leave on Saturday instead of staying the whole weekend (woman 4).

Besides the family pressure, men and women had their own pressure to conceive. With regard to her pressure, the woman reported that:

> I had my own pressure in the sense that I have a very big house. I realised when I moved into that house that it is empty. I realised that I am alone here and, the reality just struck. So to say: there is this house, but there is no one to live with (woman 4).

Single infertile women felt that they were under more pressure to conceive at times when they had partners than at times when they did not have a partner. A woman who was pursuing other life

goals as a way of resolving infertility found that her engagements made her family put more pressure on her to try and bear a child. She reported that:

> It is just that people, well, my immediate family does not understand. They do not understand why I do not stay at home. They think that if I can have a child, the child will pin me down, just to sit at home, it is out. When I spell out that I no longer want one, two and three, they revolt. I also want my freedom. I should also get my 50% and I demand it (woman 4).

Although she explained to her mother that she did not want a child any more, because of her advanced age, woman 4 was under constant pressure from her mother, who always nagged her about having a child. Man 9 seemed to be getting pressure from his younger brother in finding treatment for infertility. It appeared as if man 9 was not on good terms with his mother. Therefore, his mother usually phoned FO 1 to put pressure on man 9. The following extracts indicate how families applied pressure on infertile persons to bear children.

> I told her a long time ago that she should ask for a child from relatives and, she refused, saying that she will bear her own child. Now she complains that she is too old to bear her own child. She complains that she is about to retire from her job, so the pension money will not be enough to take the child to schools so that the child gets better education. I said it is OK, the pension money is enough, and you will share whatever you have with the child of your own blood. As long as you can give birth to a child, all will be OK (FO 1).

> I went up to my brother to find out how far exactly they are because the wife is growing old; she is almost 33 years old. He told me that she has been seeing a gynaecologist and that the final option is to have an in vitro fertilisation. I asked him why they have not done it so far. He said they were still trying to save some money. I asked him if money was really the problem because if that was the issue, we could have long solved it. He said he wants the lady to be involved in raising the funds so that she can feel to be part of it. I felt that was not enough, I could not buy the story. I emphasised that it was very important for the wife to have children more than it was for him. Thereafter, he took the matter seriously. How far they are going, we cannot ask on a daily basis. We do not know how much to be involved in this (FI 1).

Most family members interviewed believed that applying pressure to infertile persons could help in making infertile persons take the initiative of getting professional help even though they weren't always sure to what extent they could interfere as illustrated in the following statement.

I feel he is now probably pressured to do something because he got pressure from his wife and from my mother. Even from my side because, I keep pestering, asking: "What are you doing? (FL 2)?"

6.4 Explanatory Models of Infertility

6.4.1 Revisiting the Definition of Infertility

The variety of ways in which some participants defined their infertility reflects the different systems of medical and other knowledge within their cultural context. A common belief among participants was that an infertile person is a woman who has never fallen pregnant. Therefore, some women participants with a history of having been pregnant, a history of an ectopic pregnancy or a miscarriage did not see themselves as infertile. For example, woman 11 questioned whether she should be participating in the current study. She did not regard herself as infertile, because she had an ectopic pregnancy. She stated that she did not think she met the criteria to participate in the study during our telephonic contact prior to the interviews. Although the study was presented as being about fertility problems rather than infertility in order to exclude the perception of the finality of the diagnosis, the woman still felt that she did not have a fertility problem. During the initial phase of the interview, she reiterated her understanding of infertility, as is illustrated in the following extract:

> As I said before, I do not believe that I have a problem because, before I met my husband, I conceived and lost the baby. ... I did not see my period last month. The doctor said I am pregnant, unfortunately it was an ectopic again. That is why I wonder if I could be helpful to you (woman 11).

The following extracts also indicate how women conceived infertility.

> This problem of not having a child did not cause me to go up and down. I never thought I would not have children. I have been a person of miscarriages. I had two miscarriages (woman 2).

> I cannot say that I have a fertility problem, because I had conceived in 1987 and

> in 1990 and I got an ectopic pregnancy and a miscarriage. ...That was never my problem because I conceived (woman 12).

This definition of infertility does not appear to accord with traditional understandings of the problem, in terms of which infertile persons are typically described as *a nga veleki* in Xitsonga or *ha belegi* in Northern Sotho (Mabasa, 2000). This implies that he/she cannot give birth, not that he/she cannot fall pregnant or conceive as implied by the participants. Differences in defining infertility also occur from the modern medical point of view. Some definitions focus on failure to conceive after one year of unprotected sexual intercourse while others focus on failure to give live birth (Larsen & Raggers, 2001; Sundby, 1994; U.S. Congress, Office of Technology Assessment, 1988).

In terms of Brockington's (1996) psychodynamic conception of pregnancy, for some people, pregnancy does not have motherhood as an ultimate goal, but is an unconscious means of confirming a female sexual identity or adult physical maturity. Thus, pregnancy may have met the need for sexual identity and physical sexual maturity for some of the women in the current study, at least to the extent that they did not feel that they were infertile. Therefore, those who fall pregnant are able to enter the developmental stage of adulthood, but are unable to continue their pregnancy to become mothers and bring a live child into the world. Infertile women are usually considered to be not 'adult enough' in their community, such that they are usually excluded from some rituals that are deemed to be performed by 'adult women' (fertile women) only (Mabasa, 2002).

6.4.2 Causal Explanations

Consistent with Gerrits's (1997) findings with Mozambicans, the results in this study suggest that the explanations most participants gave came from traditional healers rather than from the hospital or medical doctor. This is in contrast to Goosen and Klugman's (1996) finding where almost two third of their sample attributed infertility to biomedical causal factors. One can conclude that Goosen and Klugman's (1996) were biased because of approaching infertility from a western medical perspective while the current study included a socio-cultural position.

It is noteworthy that participants switched to English when mentioning the cause of infertility from a Western medical perspective, when the interview was being conducted in an African language. Participants also tended to emphasise, by giving a statement that: *"hi Xinchangani/ ka Sesotho"* (in Xinchangani [Xitsonga]/ in Sesotho (Northern Sotho) when talking about and categorising infertility from an African traditional perspective. This was stated even when the interview was being conducted in Xitsonga/Northern Sotho. This reflects participants' acceptance of an African world-view as well as the shift towards accommodating the Western world-view, as described under the different categories of causal explanations below.

Infertility is categorised as an illness in both traditional and Western systems. Infertility has been described as a disease, disorder, disability, handicap, illness, syndrome, condition or condition caused by a disease and traces of these ways of thinking about infertility could be found in how participants spoke about it. Regarding infertility as a disease has both advantages and disadvantages from the Western perspective. It is a disadvantage to call infertility a disease because falling pregnant does not necessarily 'cure' infertility. It is possible for one to fall pregnant and bear a child using reproductive technological methods (U.S. Congress, Office of Technology Assessment, 1988) without being 'cured' of infertility.

The advantage of regarding infertility as a disease is that it is thereby placed within the medical model, which could benefit infertile individuals in that they can more easily obtain insurance cover for its treatment. Not surprisingly, there has been considerable argument for and against viewing infertility as a disease. One way of avoiding this dispute, is to consider infertility as a clinical problem for which the medical community can sometimes offer a remedy. Thus, it becomes unnecessary to ask whether infertility is a disease and which partner has the disease (U.S. Congress, Office of Technology Assessment, 1988).

In their study of causal explanations and adaptation to infertility, Tennen, Afflect and Mendola (1991) found that women who attributed their impaired fertility to biomedical causes encountered greater distress than those who attributed it to non medical causes such as God's will. Causal explanations given by participants in the current study can be grouped into three broad categories: western medical explanations, ethnomedical explanations and those that hinge on religious issues.

6.4.2.1 Western medical explanations

A fallopian tube blockage was the most frequently given Western medical causal explanation for infertility. This is consistent with the notion that reproductive tract infections account for most causes of infertility in sub-Sahara Africa (Goosen & Klugman, 1996; Mayaud, 2001). Other given explanations in this category include natural or genetic infertility, endometriosis, and fibroids. The given explanations seemed outside most participants' world-view and were obtained from the medical doctors participants consulted for infertility. Participants would typically say *ka segoa bari/hi xilungu vari* (meaning that 'from the Western perspective they say' in Northern Sotho and in Xitsonga respectively), before giving the causal explanation of their infertility, then would 'code switch' and mention the causal factor in English. Therefore, one can conclude that the implication in this regard is that the Western causal explanations were foreign to participants' world-view.

Most participants seemed not to believe in and lacked an understanding of the given Western medical conditions. The lack of understanding could not be explained by the educational level or socio-economic status of participants since some of the participants were highly educated. Moreover, some participants who showed the lack of understanding were nurses and midwives. Other participants, especially those who were in the medical field were able to combine the western medical explanations with the socio-cultural ones explained under the ethnomedical and religious explanations below to have an integrated explanation of what caused their infertility.

6.4.2.2 Ethnomedical explanations

The following themes emerged as ethnomedical causal explanations of infertility:

(a) *Sekgalaka,* which implies sores in the uterus in Northern Sotho. The sores have no physiological bases and cannot be observed from a Western medical perspective.

(b) *Noga e swara e lesa,* which literally means that the snake holds and leaves in Northern Sotho. The word *noga* is referred to in almost all the African languages in South Africa as a figurative for organs that take snake-like form in the abdominal cavity, like the fallopian tubes and the intestines. The uterus too is often referred to as *noga*. Having diarrhea is referred to as having *noga* while constipation would be referred to as *nyoka yi bohile* (the snake has tied up in

Xitsonga).

(c) *Rigoni,* is a Xitsonga medical condition identified when a new-born baby develops some redness on the nape.

(d) *Madi ga hlakane/tingati a ti hlangani,* which literally means that 'the blood does not meet' in Nothern Sotho and Xitsonga respectively, implying that the blood is incompatible.

(e) *Xilumi/Silumo,* which means dysmenorhea in Xitsonga and IsiSwazi respectively.

Sekgalaka.

Most Northern Sotho women (see Table 6 below) attributed infertility to *sekgalaka,* a condition characterised by sores in the uterus. These sores erupted on the skin or genital area usually once per month after menstruation. S*ekgalaka se se holo* (many sores) could not be cured. Its 'seeds' could spread to other parts of the body where it would be sown. *Rigoni* as referred to by Xitsonga speaking people is also sometimes called *sekgalaka* among the Northern Sotho speaking people.

Noga e swara e lesa.

Noga e swara e lesa implies that 'the snake' (meaning the fallopian tubes or the uterus) is unable to contain the fertilised egg. In this regard, the participants attribute infertility to a miscarriage where the uterus was unable to keep the pregnancy. A number of women referred to *Noga e swara e lesa* as a possible causal explanation, but only one seemed to believe that it applied in her case .

Rigoni.

The redness that appears on the nape of a new-born baby is considered a symptom that the mother has *rigoni.* The belief is that if the new mother remains untreated, the new-born baby will die and she will never conceive a child. Woman 5 stated that traditional doctors told her that she is suffering from this condition which in turn, caused infertility. This was expressed by the Xitsonga speaking participants. The Northern Sotho speaking people usually refer to this condition as *sekgalaka.*

Madi ga hlakane/tingati a tihlangani.

A number of older family member participants of different language groups believed that infertility was caused by incompatible blood of an infertile couple. This is similar to what Gerrits (1997) found with a Mozambican sample.

Xilumi/Silumo.

Some women (see Table 6 below) believed that dysmenorhea caused their infertility. Conversely, the history of dysmenorhea in menarche was also attributed to infertility.

6.4.3 The Impact of Religion on the Understanding of Infertility

Culture creates beliefs and values that serve the family and the society at large in its attempt to struggle with existential problems like infertility. The family's modes of coping with infertility are influenced by how it interprets it. The interpretations are, in turn, derived from the family's basic premises and its beliefs and values (Shlomo, 1999). People usually apply religious beliefs in circumstances like infertility because they have a sense of loss of control (Sewpaul, 1999). The causal themes of infertility from the religious perspective are grouped into (a) Christianity and (b) African religion.

The Christian perspective

Infertility as punishment by God.

A few participants expressed a belief that infertility is God's punishment or a curse for one's wrong doing. This confirms Sewpaul's (1999) finding with participants of Eastern, Western and African traditions. However, Christian leaders in Sewpaul's (1999) findings expressed a view that God is benevolent and not punitive. This view is different from that of some Christian participants in this study, for example:

> I often pray and ask: What have I done to deserve this? When will this end (Man 6)?

In a similar vein, FO 2 suspected that her daughter could have committed abortion and that her infertility was God's punishment for that.

Infertility as God's will

Most participants saw infertility as a phenomenon in which people can decipher God's will or His state of mind. Infertility is described as a gift from God. This is related to the view that God is non punitive and confirms Sewpaul's (1999) finding where Christian leaders believed that God's gifts, even one such as infertility, come in many forms. The reason for infertility is related to its meaning and purpose. For instance, woman 6 and woman 9 saw their infertility as God's way of using them to prove his power to make miracles so that they can conceive and bear a healthy child at old age. This type of understanding can be seen in the following extract:

> I prefer and I believe that there are many ways that God can solve your needs. At times, you may find that you pray, like with my problem of wanting a child. God might know the reason of you not having a child up to so far. The only thing is that He will not be able to come to you directly to say: "At this point, you will not be able to bear a child." He (God) would say that I give you so many years before you can bear a child. This would make people realise that things are possible and everything has its time, according to God's plan. Maybe He wants to show people that he has power. There is this thing in which people say that if you reach 40 years of age or after 40 years, you will not have children or you will give birth to an abnormal child. Maybe God wants to show His power that all things we believe in, might not be in that way (Woman 6).

Woman12 saw her infertility as God's way of protecting her from miseries. She was frustrated that her relationship with her husband was in constant turmoil while at the same time being happy that there were no children in her problematic marriage, which could have made matters worse.

The African religious perspective

Infertility because of personal transgressions

Several participants attributed infertility to personal transgressions of various traditional customs or taboos. Man 5 reported one of the traditional doctors he consulted explained that their infertility was caused by a curse from the ancestors. He said: "there were some of our ancestors who were not happy about our marriage, because they were not informed when we got married."

In one case, infertility was seen as an ancestral calling to become a traditional doctor. Woman 4 stated that her grandmother, who was a traditional healer, wanted to train her to become a

traditional healer too. Infertility was seen as a way in which her ancestors communicated with the woman to become a traditional healer. She believed that she would not conceive unless she became a traditional healer.

Witchcraft

Most participants in one way or another attributed infertility to witchcraft. This finding is consistent with the perceptions of people in Botswana (Upton, 2001) and other findings from South Africa (Mabasa, 2000; Ndaba, 1994). Women were usually seen as the ones who had been bewitched. One of the emergent sub-themes related to witchcraft was the belief that a woman was not able to conceive because she either lost or had her panties stolen. The witch performs a ritual on the panties to 'close' the woman's reproductive capacity. Some believed that this type of witchcraft worked if the panties were 'worked upon' when stained with the woman's menstrual blood. Another sub-theme related to witchcraft was *segadikane* (Northern Sotho for co-wifehood). Conflict as a result of jealousy and competition for affection from the husband could lead to the co-wives bewitching one another to be infertile. Woman 7 suspected that her co-wife could have bewitched their husband so that he became impotent when he was with her. This, she believed, was to prevent conception of the future chief. She believed that her co-wife was jealous because her (co-wife) children were not going to be a chief. The following extract demonstrates beliefs in witchcraft as causal factor of infertility:

> I once lost my panties while I was menstruating. I searched thoroughly and became convinced that the panties were not there. The traditional doctor pointed my aunt (my paternal grandmother and her mother are sibligs); she agreed that she took them. She was instructed to bring the panties back, but they had been washed when she brought them (an indication that she took the menstrual blood from the panties and 'worked on them' to cause the woman's infertility) (woman 6)."

6.4.4 The Question of Who Carries the Diagnosis

Although the academic literature argues that infertility is a couple's problem and that the prevalence of infertility is equal for men and women, there was a strong preoccupation among participants in the current study with the question of who carries the diagnosis in a couple's system. One of the emergent themes is the belief that a woman always carried the diagnosis of infertility and that a man never carries the diagnosis of infertility within the couple system. The

invisibility of male infertility seems to be a trend among Africans (Boerma & Mgalla, 2001; Mabasa, 2000; Upton, 2001). Evidence from the researcher's clinical practise shows that where it exists, male infertility is often ascribed to women's use of contraceptives (pill, condoms and injections) that are believed to make the men 'sick'. A similar belief seems to prevail in Botswana (Upton, 2001).

Some women in the current study collaborated with this form of patriarchal attribution and accepted blame for infertility even when they knew they did not carry the diagnosis. For example, the infertility in the couple consisting of man 2 and woman 5 could be accounted for by both male and female causal factors. Although woman 5 suspected that her partner too could be infertile, she stated that she preferred not to discuss it with him in case he became hurt. The couple consisting of woman 15 and man 6 on the other hand, agreed not to tell people that it was the man who carried the diagnosis of infertility, for fear that people would laugh at him. It seemed the woman felt she could bear the stigma more easily than her partner. Thus, the belief that a woman always carried the diagnosis of infertility resulted in denial and secrecy in cases where the man carried the diagnosis. However, there were some women who were averse to being blamed and articulated the injustice:

> A man will never see any problem from his side. He will always see a woman as having a problem. The in-laws will never say that it is their child who has a problem. Instead, they will say that you, the wife was the one who was infertile (woman 14).

One way in which men's unwillingness to bear their portion of the burden of infertility manifested, was in a tendency to refuse to accompany their partners for consultation. Men's stated reason for refusal was mostly that they did not have a problem. All the women who participated in the study had initiated the contact with the helping system. It seemed this was based on a tacit understanding between them and their partners that women should carry the diagnosis of infertility. In some cases, men never went for medical examination, continuing to insist that they did not have a problem.

The health system perpetuated the notion that infertility was a woman's problem. Man 2 reported that some specialist preferred to first check the women and rule out the possibility that she carried

the diagnosis of infertility before they checked the man. In one instance, the woman was the first to consult a gynaecologist. After the painful diagnostic procedures, it was found that there was nothing medically wrong with the woman. Then, the specialist advised her partner to seek help, and he was found to carry the diagnosis. The following extract demonstrates how medical specialists contribute to perpetuating the notion that infertility is a woman's problem by focusing on the woman as probably the source of the problem:

> We have been seeking help for two years. We are now seeing a specialist. He/she has not started checking me. Thereafter, he will take further steps and check me. He has not said that he exhausted all the means of checking and treating her (man 2).

However, there was also some evidence of a shift from the norm of woman blame to acceptance of responsibility for infertility. Of the ten men interviewed, two accepted that they carried the diagnosis of infertility. Although it is of course impossible to make a medical diagnosis on the basis of participants' accounts, it seems likely that several of the remaining men may also have been infertile. For instance, man 2 and man 8 had low sperm counts, but the diagnosis of infertility for the couple consisting of woman 5 and man 2, and couple consisting of woman 18 and man 8 was attributed to female factors. Man 7 was somewhat unique in that he went beyond acknowledging that he carried the diagnosis of infertility. He explained the situation to his family so that his family should not blame his partner. The following statement indicates how he clarified who carried the diagnosis: "Culturally, it is believed that women are the ones with the problem. So, I explained to my family that I am the one with the problem (man7)."

A conflict arose between the two families in cases where the family of origin supported their daughter and the family in-law supported their son in the argument over who carried the diagnosis of infertility, as was the case for woman 8:

> Isn't that the in-laws will say it is I who am incapable of having a child? My family would say it is that man because I once fell pregnant (had a miscarriage, the conception was from a different man before she met her present partner) and that man never brought anything on this earth (woman 8).

6.5 Management of Infertility

This section is concerned with the management strategies used by infertile men and women and their families from a traditional perspective. The way in which the families of infertile men and women become involved in managing the infertility is also discussed.

6.5.1 Management Modalities

The reported family modalities include the following:
(a) *Tlhatswa di rupi,* which literally means "the one who washes the thighs" in Northern Sotho. It is a term applied to a surrogate woman.
(b) *Go e kutswa ko ntle/ku ti yiva ehandle,* which means to "steal oneself outside" in Northern Sotho and Xitsonga respectively.
(c) Family rituals. Certain other family rituals were also used as a means of managing infertility.

Tlhatswa di rupi

Tlhatswa di rupi, "the one who washes the thighs," involves a process in which a woman or her family of origin seek/provide another woman (usually a sibling) to be married with her as co-wives. This could be done in a case of infertility or as a replacement of a bride to a man whose wife died. In case of infertility, *tlhatswa di rupi* usually acts as a surrogate more than being a mother to the born children. The infertile woman is expected to "marry" a woman from her family of origin who will bear children for the couple. In one couple (man 3 and woman 7), a niece (a child to the woman's brother) was identified. The identified niece was still young and the woman felt that she might not enjoy being married to an old man (her partner). Therefore, the woman concluded that her niece could just bear the child and leave. It seemed her family of origin agreed with this arrangement.

However, the woman still wanted to seek further treatment before she could go to her family of origin to finalise the arrangement. It appears that in this case the woman was largely in control of decision making regarding seeking *tlhatswa di rupi* and that this is often the case with regard to this particular traditional form of managing infertility.

Go e kutswa ko ntle/Ku ti yiva ehandle

Go e kutswa ko ntle/ku ti yiva e handle ("to steal oneself outside") relates to becoming involved in extramarital relationships as a strategy to manage infertility. When a man carries the diagnosis of infertility, his partner can, in terms of this custom, seek an extra-marital sexual relationship with another man for the purpose of bearing children. The family in-law typically advises their *makoti* (bride) without the partner's knowledge. Hence, it is called to 'steal one self outside', and the partner would not be aware that the children born from that extra-marital relationship are not biologically his.

All the women interviewed in this study reported at one time or another being advised by friends or by family (both the family in-law and the family of origin) to have extramarital relationships in order to conceive a child. This is in contrast with Mozambique, where traditional healers are usually the ones to give such advice (Gerrits, 1997). Some of the women in the current study reported that they were indeed practicing or had practiced *go e kutswa ko ntle* for the purpose of falling pregnant

Other women were reluctant to engage in this kind of relationship. One of the reasons for their reluctance was their commitment to their marriages. They felt too committed in their marital relationships to be involved in extra- marital sexual relationships as illustrated from the following:

> I started going out with one man whom I am now married to. I won't go out for a baby (woman 17).

Other reasons for the reluctance to engage in extra marital relationships were fear and the practical disadvantages of having extramarital relationships. There was a fear that the woman might become so involved with the other man that her marriage could be threatened. In some cases, the man knew about the suggestion that his partner should go 'steal herself outside'. Man 3's uncle, for example, discussed the issue with him before he advised the woman. In this case, the woman (woman 7) had approached the uncle about the problem. Although man 3 agreed with the idea, he no longer trusted his partner. Woman 7 reported that whenever she went out with friends, he would accuse her that she was seeing other men.

This led woman 7 to conclude that her partner had given in to the idea reluctantly. "He knew that it was not possible for me to do it" (woman 7). She expected her partner to make a decision and tell her that she could be involved in an extra-marital relationship.

> The person himself must tell you to go outside and look for a man. He may even send someone. He tells that person that I am unable, may you enter (woman 7).

Friends advised woman 8 to 'steal herself outside', but she was ambivalent about this because she suspected that the partner may have consulted a medical doctor and was diagnosed with infertility. She suspected that he was aware that he was infertile, but did not want to tell her. Therefore, she feared that there could be a problem if she fell pregnant:

> When a man has a problem of infertility, they always blame a woman. I have got a friend who divorced because she was accused of not being able bear children. The moment you say live this thing forget about the fear *go e kutswa ko ntle* and enjoy your life (meaning *go e kutswa ko ntle)* they bear children. You find that conflicts develop and they start to be harassed (woman 4).

As mentioned previously, Upton (2001) found that people in Botswana used a concept of 'sleeping foetus' to explain an extramarital childbirth. An infertile woman who becomes pregnant and whose gestational period does not correlate with the dates in which the migrant partner visited would insist that the child was the husband's and explain that the baby had been a 'sleeping foetus'. Interestingly, the idea of the 'sleeping foetus' was not mentioned by any of the participants in the current study. The sleeping foetus and *go e kutswa ko ntle* share a similar phenomenology in that they are a means of managing infertility which appear to depend on the man having to be kept in ignorance of or to signal explicit approval of what would otherwise be construed as sexual infidelity.

A different situation prevails with the Macua women in Mozambique. A traditional healer would advise a woman to have an extra marital affair in order to check whether the blood of another man was more compatible. Should the husband find out about an extramarital child, the women would not be afraid of the consequences even if it lead to a divorce since her actions have been sanctioned by the traditional healer. The main goal was to have a child and not to remain married, and the child remained with the woman after the divorce (Gerrits, 1997). This is in contrast with

the more overtly patriarchal situation in South Africa where women are often afraid of their partners finding out about the extramarital relationship and where the child usually remains with the husband after divorce.

Family rituals

The family of woman 4 dealt with the fertility problem by "calling *malopo*". *Malopo* is a term in Northern Sotho for a ritual practised in African culture in which relatives and people who are possessed by ancestral spirits in the community are invited to a dance that involves beating the drums and other rituals in order to appease the ancestors. In this case, the purpose of calling *malopo* was to identify the cause of the woman's infertility and what could be done to correct the wrong so that the woman could bear children.

Woman 4 was also advised to go to *ragadi oa tsone* (her aunt, that is, her father's sister) who was to perform rituals such as providing snuff to the ancestors, so that she could bear children. However, she refused because she did not believe that her aunt, who also did not have children, could help her conceive.

Involvement of the ancestors in the resolution of problems through rituals such as *malopo* is sometimes presented as a common feature of African life, even in urban areas, and it is therefore interesting that in the current study only one woman reported this happening and that she moreover did not fully co-operate with the rituals.

6.5.2 Family Involvement

Unlike in a matrilineal kinship structure, where the in-laws are less likely to interfere with the couple's infertility (Gerrits, 1997), the findings in this study indicate that the family in-law become involved and, in some cases, "take charge" of the couple's infertility. The extended family of parents, aunts (the woman's mother's and father's sisters) and siblings were usually involved in dealing with the impact of infertility. Their involvement differed according to their position or subsystem in the extended family. Both the nuclear and extended families could not be defined in traditional terms of being 'intact'. In some families, present adult family members were involved. That is, the mother, aunts and siblings of an infertile woman will meet to discuss the issue.

As a general rule, women did not have much power to make decisions about the treatment of infertility. Married women mainly considered themselves subservient to their husbands, while some unmarried women considered themselves to be under the control of their parents. Therefore, they felt obliged to cooperate with treatment decisions their parents made:

> They (parents) take me to the traditional doctors. The person (partner) I am living with does not agree to go to traditional doctors. He only believes in church. When they say we go to traditional doctors, I go with them, because I am still under them. So that there be peace in the family. If I don't go, there won't be peace because I am still under them. I am still under their control. In addition, if they say do like this and you refuse, tomorrow when you have problems and ask for help they will refuse. They will say that you are a grown up and don't depend on any other person (woman 3).

Parental authority was not, however, always so readily accepted. For example, woman 4 and woman 14 were in conflict with their mothers because of disagreements relating to how to deal with infertility. The women did not agree with their mothers' insistence that they should consult with traditional doctors.

Married women were, to a large extent, under the control of their partners; it was the partners who made decisions about treatment. Women were restricted by financial dependence on their partners who at times did not want to risk money and pursue treatment with no guarantee of a successful outcome. Man 9 left the decision to consult a traditional doctor with his partner because he did not believe in traditional doctors. This made the partner feel that he was not concerned about the condition.

An area in which the family in-law tended to play quite a prominent role was in the decision that a woman in an infertile marital relationship could have an extra-marital sexual relationship for purposes of conception. The woman was usually advised to have an extramarital relationship without the partner's knowledge. Woman 7's husband's uncle advised her after she complained to him about her partner's sexual function problems. It seemed that the uncle consulted with her partner who, reluctantly, agreed. It appeared as if the advice was based on the understanding that the woman would not be able to conceive, and her partner was waiting for her decision on

tlhatswa di rupi. Her mother in-law's younger sister advised Woman 5. The woman suspected that her parents in-law could have sent her (mother in-law's younger sister). Woman 15 was advised by her mother in-law to engage in an extra marital relationship.

In cases where the women were married, their family of origin had limited rights in helping their daughter to seek treatment for infertility. In one case, the family of origin had requested their daughter (woman 7) from the son in-law (man 3) so as take her to some institution where they believed their daughter could get help. Their son in-law disagreed. Since the family no longer had control over their daughter, the idea had to be abandoned. The family of origin did not usually accompany their daughter and her partner to seek treatment; instead, they gave advice as to where the couple could go for help. Some families in-law encouraged their sons to divorce and marry another woman who could bear a child for the family. Other families in-law were supportive. For example, her sister in-law accompanied woman 7 to a traditional doctor where she was admitted for treatment for a period of a week. She appreciated that her sister in-law stayed with her at the traditional doctor for that period in which she was admitted.

Woman 12 did not appreciate when the family in-law interfered with the couple's infertility, while woman 2 and woman 8, whose parents in-law were dead, missed their support. They felt that their parents' in-law could have helped them seek treatment. It emerged that their extended families in-law were not supportive in helping the couples to seek treatment. The women felt that the extended families were not involved and were not concerned because they were not biological parents, but uncles (brothers to the mother in-law and brothers to the father in-law):

> If he had parents, they could to tell him what to do. Isn't that we would go to such and such a place because my family told me about the place to get help? If we did not succeed, we would try the suggestion from his parents. We cannot go to one place. We must try this side and that side. His parents could also advice us where to go. Then we would receive help from both sides (woman 8).

Others found their extended family in-law to be supportive, especially the aunts (sisters to mother in-law). Woman 19 found her mother in-law supportive and appreciated that she was involved in helping seek treatment. However, she found it stressful that her mother in-law did not communicate with her son regarding their infertility.

In this regard, the findings indicate how traditional African approaches co-exist with the western ones. This includes religious beliefs, where some families used both Christian and African religion. For instance, man 9 who would allow his wife (woman 19) to consult traditional healers with his mother, while he did not want to be involved because he is a Christian. However, there were instances where African traditional approaches contradicted Western ones. It seems that the educational level of some women influenced their disregard of African traditional approaches. For example, woman12 did not want to take traditional medicines for fear that it might damage her kidneys; woman 4 read about and, to a certain extent, understood what caused her fertility, and thus she did not want to follow the family rituals or take traditional medicine. How African traditional beliefs and Christianity clashed can be demonstrated from the family of woman 18. Woman 18 was in conflict with her parents who wanted her to consult traditional healers while her father, a priest, had never consulted the traditional healer or taken his children to a traditional healer.

> They (her parents of origin) told me to try traditional healers and I know they never used them. We never used their (traditional healers) services, because my father is a priest. Therefore, I asked them why do they make such suggestions. I told them that a baby has got its own time, because God knows what he is doing. However, I see that they are not satisfied with my explanations, we end up fighting and arguing about it (woman 18).

6.6 Conclusion

The value of children is so embedded in African culture that infertility becomes an unbearable condition for both the infertile individuals and their families. There are many cultural strategies employed to deal with infertility, but these strategies are becoming increasingly difficult to apply in the circumstances that modern African women and men find themselves. Traditional management strategies are also often problematic in that they are intertwined with a system of patriarchal family values from which many women (and men) are now trying to extricate themselves. In addition, traditional methods and understandings often clash with "Western" ones, resulting in a confused understanding of infertility and its management.

As is demonstrated by the stories of the participants in this study, infertile men and women and their families are not passive victims of these contradictory cultural forces, but show remarkable inventiveness and flexibility in drawing on their multifaceted cultural heritage to find ways of dealing with the challenges of infertility. However, the struggle to make sense of and manage infertility in such a complex environment is often painful and does extract a certain psychological toll. It is this psychological dimension to participants' lives which is discussed in the next chapter.

CHAPTER 7
PSYCHOLOGICAL IMPACT OF INFERTILITY

7.1 Introduction

This chapter is concerned with the process of infertility as experienced by the participants. Infertility is conceived of as struggle, which does not seem to have an ending. The struggle begins with the realisation of infertility, then the difficulties in understanding and accepting the diagnosis, next, difficulties with the choice of healthcare, and finally the trauma of diagnostic and treatment procedures.

This chapter is also concerned with how infertile persons negotiate the transition to biological childlessness and reconstruct their lives. It examines the ways infertile persons have of coping, how they find alternate methods of parenting, and how and when they give up on seeking treatment and begin to accept their infertility

7.2 'This Process is Painful': Struggling with Infertility

The process of infertility is experienced as painful struggle. In this regard, this section serves to answer the following research questions raised during the research process. What are the psychological experiences of African women and their families, in regard to infertility? Some of the specific questions are: When does the experience of infertility begin, and for whom? How do men and women react and adapt to infertility? What are the experiences of women and their families with the health system?

7.2.1 When does the Struggle with Infertility Begin?

All infertile participants identified 'a problem' when they were unable to achieve pregnancy after a period of trying. The time frame was variable, ranging from a few months (about 8 months) of courtship to 9 years of marriage, of unprotected sexual activity. The reason for such a variable duration of becoming aware of the 'problem' is related to socialisation. As young boys and girls, men and women are socialised into the primary roles of becoming fathers and mothers. Therefore,

participants did not foresee the possibility of infertility. Consistent with other findings (Sewpaul, 1994; Sundby 1994; Wirtberg 1992), infertile persons took some time before realising that they may be infertile. Several themes emerged as factors that influenced the awareness of the infertility crisis.

The way in which some women participants defined infertility (see section 6.4.1) made it impossible to realise that they were faced with infertility as defined from the Western medical perspective. The cultural expectation that a woman should prove her fertility before marriage can be proposed contributed to the differences in the awareness of infertility for the couple consisting of man 4 and woman 11. Man 4 expected his partner to conceive during courtship, whereas Woman 11 was using contraceptives without Man 4's knowledge. Consequently, Man 4 started doubting himself, thinking that he could be the one carrying a diagnosis as indicated in the following statement.

> It took us three years without realising this problem because we were not prepared. You find that there are secrets between couples, one is expecting something (a pregnancy), the other is preventing (using contraceptives) while the other one is not aware. When I noticed she was preventing, I was shocked. ... I didn't like it, for her to prevent without my knowledge. It was just confusing the seriousness of the relationship. I thought the problem was with me because we didn't talk about such things (contraceptives) (the man had confirmed that he was not carrying the diagnosis by having an extramarital child) (man 4).

Thus, for man 4 the process of struggling with infertility started three years before the marriage. Another three years into the marriage (the couple had been married for six years during the interviews for this study) his partner (woman 11) still did not see herself as having an infertility problem (see section 6.4.1). Consistent with other findings (Sewpaul, 1994; Sundby, 1994; Wirtberg, 1992), it was difficult for infertile persons to identify where the crisis of infertility began, and the awareness of the presence of the crisis of infertility came at different times for couples and their families. As in Wirtberg's (1992) study, the awareness of infertility in this study often crystallised out of a relationship with family members who first recognised the possibility of infertility.

Once the couple became aware of the problem, there were, again as in Wirtberg's (1992) study, differences in who first identified the crisis. However, in Wirtberg's study men tended to be the first to identify the crisis, whereas in the present study it was usually women who took the lead in this. The reason for this may be that in the current study, most participants believed that infertility was a woman's problem, and not a couple's problem. Consequently, women tended to see the crisis coming as it was perceived to be their crisis anyway.

Therefore, some women (woman 10 and woman 14) whose dreams of marriage were disrupted when their partners realised during courtship that the women were infertile, prepared their new partners for the fact that they were struggling with infertility. Initially, the pre-warned men would not view infertility as a problem that could interfere with the relationship, but later they too terminated the relationship. This indicates that the women were already struggling with infertility when they got into relationships, while their partners were not. Furthermore, the men opted out of the relationship instead of joining the struggle with their partners; an option which, the women did not have.

Postponing childbearing and focusing on other life goals contributes to the understanding of when the struggle of infertility began for some couples. For instance, Woman 18 attended school for the first six years of her marriage. Although the couple was not using contraceptives, they were not worried when they did not conceive because the woman was still at school. They realised that there could be a problem three years after completion of her studies.

The findings of this study confirm Wirtberg's (1992) results stated above, that infertility often crystallises out of a relationship with family members who at times first recognise the possibility of infertility. Woman 4 reported that her parents knew that she had infertility before she realised it. The family became aware of woman 4's infertility before her menarche because her immediate younger sister started menstruating before she did. As a result, her family gave her traditional medicines and encouraged her to focus on conceiving and not her education as seen from the following extract.

> They persuaded me to have a child and told me that education was nothing. I did not understand why they talked like that. They asked me questions like why should I go to school (woman 4).

In contrast to other members of the family, FO 1 (mother of woman 4) had been aware of the possibility that her daughter could be infertile as indicated in the following statement.

> From the beginning, this fertility problem did not bother me that much, because I also had a problem conceiving a child. I conceived very late, my sisters also, so we were called *diphathse* (a Northern Sotho derogatory term meaning an infertile person). I thought it was a family thing to conceive late in our age. It took me the whole six years in my marriage without a child. I believed time would come that she will still be able to bear children (FO 1).

Therefore, FO 1 encouraged her daughter (woman 4) not to have a child - neither before marriage nor while she was not working. After completing her basic education and finding work, she started consulting "to find out what was wrong with me". The findings suggest that the process of struggling with infertility began for some of her family members (like her aunts) when she was about fourteen years old, for herself at the age of twenty-three years, and probably at the age of about 30 years for her mother.

7.2.2 In Search of Diagnosis and Treatment

Participants undertook efforts to discover the underlying causes of their infertility as they embarked upon medical intervention, whether traditional or modern.

7.2.2.1 Uncertainty of the diagnosis

Table 6 summarises the different diagnoses which the infertile participants obtained as they went around searching for a diagnosis. Modern medical practitioners, traditional healers, faith healers, family members, and participants themselves framed these various diagnoses. It can be seen from the table that individuals fall into different diagnostic categories, reflecting differences in opinion among the various role players. This clearly caused a feeling of uncertainty among many of the participants.

Another cause of uncertainty could have been the failure of both medical and traditional healers to arrive at a confirmed diagnosis. A single practitioner would keep on changing the diagnosis while different practitioners gave widely divergent diagnoses causing much uncertainty for the couple and their families. A few examples of how participants struggled to obtain diagnostic certainty:

> The doctor said her tubes were blocked. She then had an operation. They said she does not ovulate. Then she had an ectopic (man 10).
>
> We even went to inyangas, although I did not believe in them. I personally never trusted them. They were contradicting themselves. Some were saying my wife had been bewitched, others were saying that there were some of our ancestors who were not happy about our marriage because they were not informed about it (man 5).
>
> I have been to traditional healers who told me that I have *xilumi* (Xitsonga for dysmenorhea). After dysmenorhea they changed the story and said I have *rigoni* (Xitsonga for a viral infection, which causes redness on the neck of a baby) (woman 5).
>
> The doctor told me that I could have children and it was my husband who was not right. He cannot have children. Dr… tested him and told him that his sperm was weak. Again, I was not sure because, Dr… told me that my tubes were not OK, and that my hormones were weak. Therefore, I do not understand what the problem really is (woman 5).
>
> At first I did not see it as a serious problem. After three years of seeking help, and getting different diagnosis from different doctors, and not understanding what the diagnosis meant, I started becoming stressed. I was always tense (woman 4).

Lack of confirmation of diagnosis caused much frustration. For instance, man 9 was frustrated when the doctor could not point out to him what exactly the problem was. He assumed that "doctors were not 100% sure of what the problem was". He became especially frustrated when he was first told that his sperm count was low, then that it was within normal range and that the doctor had seen people with similar counts conceiving, and finally when his partner was operated on, but without success. Thus, besides struggling with the presence of infertility, participants were engage in a struggle to understand what the cause of infertility was.

In some cases participants' confusion was exacerbated when biomedical diagnoses appeared to conflict with their traditional belief systems. Some respondents were torn between the two explanatory models while for others their traditional beliefs made it difficult for them to understand biomedical information presented to them, sometimes leading to denial of infertility on the part of participants. For example, man 7 was diagnosed with low sperm count. He indicated that his urologist told him that he could have contracted an infection while he was still young. Unfortunately for him, both his parents had died and, therefore, there was no one to clarify whether he had such an infection or not. His urologist's causal explanation brought some confusion into his understanding of the cause of his infertility. He believed that his infertility was due to natural causes. His extended family told him that he could have inherited the infertility from his father since he was the only child and that his father too was the only child.

Another example of confused understanding can be demonstrated from woman 4, who, as a result of previous experiences, found it difficult to maintain intimate heterosexual relationships. Her mother and her siblings advised her to have a male partner and conceive a child. They believed that her infertility was caused by her lack of an intimate partner. The woman on the other hand, gave a different explanation. She said that she read medical journals to understand what was wrong with her because her modern medical doctors were not able to give her a specific diagnosis. Her grand mother, on the other hand, told her that she needed to be trained as a traditional healer to be able to bear children. Her confusion and need for certainty amidst this melange of contradictory positions is illustrated in this extract:

> It is the adhesions. I know what the problem is; the bottom line is they (her family) will not understand even if I explain. Even myself, I do not just understand you see. I just understand that it sometimes becomes painful here (touched her abdomen). It becomes soft. These muscles become soft (woman 4).

Table 6: Different types of diagnosis of infertile participants

Diagnosis	Participants
Women:	
Blocked tubes	Women1,4,5,6,14,18&19
Hormonal problems	Woman5
Ovulation problems	Woman19
amenorrhea (not menstruating)	Women3,8&15
Irregular menstruation	Woman7
Adhesions(Endometriosis)	Woman4
Fibroids	Woman13
Surgery (operations)	Woman2
Genetically inherited	Woman4
Dysmenorhea	Women3&11
Sekgalaka (sores in the womb)	Women3,6, 7, 8&10,
Ancestral disregard	Woman4
Witchcraft	Women3, 6,7,10,11,15
Men:	
Genetically inherited	Man7
Low sperm count	Men2,7&9
Couple:	
Ancestral punishment	Woman10 Man5
Incompatible blood	Woman8

7.2.2.2 Choice of health care

Participants sought almost all the available treatments in their attempts to deal with infertility. Table 7 summarises the types of health care system from which participants sought help. Participants sought treatment and healing from spiritual healers, traditional healers, and modern medical doctors. From the faith healing perspective, participants consulted the Zion Christian Church (ZCC), the Apostolic Church, International Pentecost Church (IPCCC), which the participants referred to as the *Ntate Modise* (Sesotho for Father *Modise*) Church, and the Charismatic Churches. From the traditional healing perspective, participants consulted traditional doctors and herbalists. Modern medical practitioners consulted were general medical practitioners, gynaecologists, and urologists in private practice. Both government and private fertility clinics were consulted. Here is a typical account of how participants migrated among the different treatment providers:

> I did not use western doctors only. I also went to traditional healers, that is, where I started. They gave me traditional medicines, *tsa go tshumela* (Northern Sotho for to burn), *bo o oretsa ka tsona* (Northern Sotho for a procedure in which a person, covered with a blanket, is made to inhale the smoke of the burning herbs). I drank some medicines, *ka kapa ka fetsa* (Northern Sotho for self-induced vomiting). Then I went for western doctors, gwa pala (Northern Sotho for it failed). I went to *masione* (Northern Sotho for 'people of Zion', that is, faith healers) and they told me the same thing that my tubes are blocked (woman 14).

While seeking medical help is considered a 'natural' first choice in the West (Van Balen, Verdurmen & Ketting, 1997; Daniels, 1993), some participants in this study had not consulted medical doctors for infertility. The finding is consistent with Gerrits's (1997) study with Mozambican infertile women where all women had visited traditional healers several times, while only half of them went to hospital and clinic. Thus, seeking traditional help is often the first choice in Africa. Beliefs in witchcraft as a cause of infertility influenced some participants to seek help with traditional doctors.

> We (herself and family) tell ourselves that if people caused it (witchcraft), then we will also go to people (traditional healers). We will end up getting help (woman 3).

In many cases there was conflict among individuals, couples, and family members regarding the choice of available treatment. Parents tended to advise their daughters to consult traditional doctors and at times consulted traditional doctors for their daughters who thereafter refused to use the traditional medicines. For example, woman 18 was annoyed when her parents advised her to consult traditional doctors. Her father is a priest and the family never consulted traditional doctors. She did not understand why they then advised her to consult traditional doctors. This conflict could have been frustrating for FO 1 since she had a fertility problem that was treated by a traditional doctor. It appeared that she wanted her daughter to get a similar type of treatment for her infertility. When asked whether she tried traditional doctors with her daughter, she reported that her daughter refused to consult the traditional doctors. Her daughter (woman 4) reported that she used traditional healing while she was still dependent on her parents. Currently, she just accepts traditional medicines, given by her mother, but later throws it away without using it.

There were also negative connotations associated with consulting traditional healers. Some Christians found it difficult to consult traditional healers. It seemed consulting traditional healers was perceived as sinful. There was a belief that Christianity did not allow them to consult traditional healers. Educational background contributed to some participants not using traditional healing. For instance, her nursing background influenced woman 12 not to consult traditional healers. However, woman 12 despite being quite highly educated did consult traditional healers with her husband in the beginning phase of her infertility. It seems that traditional beliefs superseded the educational background, and educational background became salient for her again after the traditional treatment failed.

In contrast, some participants did not want to use modern medical treatment modalities. Lack of trust in the modern medical system resulted in man 3 no longer consulting with modern medical doctors. The medical specialist he had previously consulted suggested in vitro fertilisation (IVF). He suspected that the doctors might use somebody else's sperm to fertilise his wife. It seemed the man, who was a chief, feared that this could interference with bloodline kingship and did not want a 'donated' future chief. He was, however, caught in a double-bind in that tradition prevented any of his blood children with the other wife from being anointed as a chief.

There were cases where an individual in a couple system refused to seek a similar treatment modality. This resulted in conflict among couples. Woman 8 was frustrated because her partner refused to consult both modern doctors and traditional doctors. She was frustrated because she felt she could not seek treatment individually, but that they should do so as a couple. Furthermore, the man was in financial control, making it difficult for the woman to go and consult on her own. She feared that her partner could suspect that she could seek potions from traditional healers to harm the man if she consulted alone as indicated in the following statement.

> He is the only one who is working. If he says let's go this way, I must listen and I must go with him where-ever he says we should go. I do not deny the fact my family could give me money and that I could go, but it is not possible for me to go alone. He will think that I want to do something bad to him if I go alone. Why should I go to the doctor alone, and not with him? Isn't that we should go there together so that they check both of us to see who has a problem (woman 8)?

It appears that her suspicion that her partner could be carrying the diagnosis of infertility prompted the need to consult as a couple. This could also be an indication of the awareness that infertility was a couple's and not an individual's problem.

Table7: Types of treatment sought

Types of treatment sought	Participants
Traditional doctors	Women1,3,4,5,6,7,8,10,12,14&15
Western medical	Women3,4,5,6,7,10,11,12,14,15&18 Men2,7,9
Faith healer	Women6,11,12&14
None	Woman2

7.2.2.3 Traumatic diagnostic and treatment procedures

Participants found it traumatic to undergo various diagnostic and treatment procedures. There was, in the first place, a concern that operations (surgery) could cause bodily damage. Some women and their mothers even believed that the infertility was caused by damage done to the reproductive organs during diagnostic and treatment procedures for infertility. Woman 2 believed that the laparatomy caused her infertility. Her belief was related to her explanation of infertility. She had a history of miscarriage, which implied that she was fertile, and had stopped menstruating after the operation, which to her meant that the operation had caused infertility. Although she knew, from talking to other women, that she could have reached early menopause she considered this a less likely explanation. The bodily damage is also expressed for her in the form of somatic pains in cold weather. Another woman described the trauma of diagnosis and surgery as follows:

> The doctor operated me and he could not see that my tube was missing. Only one doctor noticed during the operation. I do not feel well that the doctor did not see that my tube was missing. You know that operations are painful. Another doctor did not operate me, but he examined me painfully. I don't know what they call it (the procedure) but it is painful. It is like being cut with a broken bottle. Those who know say it is like giving birth (woman 5).

Consequently, most infertile women were reluctant to go for further surgery. The women's partners too, were reluctant that the women should under-go further surgery. The following statement, reflects such reluctance:

> I am not prepared to have any operation because the ones I had were worse. It is also too risky, one would end up dying (woman 13).

Man 2 told his partner that:

> It happens that he operates you and you find that you are condemning yourself. I do not want you to go for an operation because I feel for you (man 2).

Not only biomedical procedures were experienced by women as traumatic. The treatment of *rigoni* experienced by woman 5 was a very painful procedure. She explained the procedure as follows:

> They smear you with black stuff (herbs), then cut you between the anus and the vagina. It is very painful and, you are not supposed to scream. ... I have been cut but it is the same. ... That is why I say I have lost a lot of money (woman 5).

Another painful procedure is undergoing *ku sweka xangule*. *Ku sweka xangule* in Xitsonga is a steaming procedure in which a naked person covers himself/herself with a blanket over a large bowl of boiled water mixed with herbs, and puts hot stones into the hot water to produce the steam. At times, mentholated spirit is mixed with the boiling water. The procedure can cause burns. One other reported painful procedure was self-induced vomiting, using herbs.

It was a struggle for most participants to take traditional medicines. Woman 12 was reluctant to use traditional medicine for fear that the medicine could damage her kidneys. She decided to stop seeking treatment after she exhausted most of the available modern medical treatments. She reported she could still go to traditional doctors. However, she wanted to protect her body from harm. She said: "I felt that I am not going to follow those things because I am afraid, I do not want to spoil my kidneys (woman12)." Her background as a nurse influenced her decision. At some point in the process of infertility, woman 4 started refusing to take traditional medicines brought by her mother. Her mother, too, became frustrated and then gave up as demonstrated in the following response. "It hurts me very badly (that her daughter refuses to take traditional medicine), but because it is her body and her choice, there was nothing I could do (FO 1)."

The findings suggest that some participants stopped using a specific treatment modality because of disappointment with lack of positive outcomes. For instance, woman 1 who is also a nurse only stopped consulting traditional doctors after being promised that she would conceive and becoming disappointed. The following response indicates frustration with treatment outcomes after several different consultations.

> People advised us that there are prophets, who are able to change the situation, we went there, and we were given holy water. Others prayed for us, very powerful preachers prayed for us. Others promised us that God is able to open the womb of the barren woman. After some of these sermons, we would go home with the belief because of God's promises the preachers gave us. As far as I'm concerned we went to different places seeking help, but it is like we are not getting any help (man 3).

7.2.2.4 Availability and access

Van Balen *et al.* (1997) state that infertility treatment seeking is influenced by several factors such as structural conditions concerning the supply of infertility treatment and financial factors. These issues certainly played a role in the experience of infertility of the participants in the current study as well.

Reproductive technologies and marital status

Problems of availability and access to modern medical treatment are evident, for example, in the process which woman 4 went through in her search for treatment. She reported that she discovered about IVF in medical journals, which she read to understand her condition of infertility. It seemed IVF was not made available to her because she was not married.

> When I went to ... hospital, they told me that they would not help me because, I do not have a husband. The big problem was that if I have money, you would find that I did not have a partner. If I have a partner, I would not have the money. It kept on like that (woman 4).

A gynaecologist eventually referred her to a private clinic in another province but she again found that access to IVF was blocked by her non-marital status. She seemed not pleased with the suggestion that would have enabled her to gain access:

> They had given me a referral letter. I did not open the letter. Therefore, I did not know its contents. When I got there, the doctor explained what the problem was and how the IVF will work. He told me that I should buy a ring. He said he is supposed to treat me as a Mrs ... (her maiden surname) and, I did not agree to that. It hurt me. Do I really have to? Why can't I get what I want because I can afford it? Although the price was very high, money buys what you like. Moreover, the problem was not having money. I had money at that time and I had a partner at that time. The system was just making it difficult. Then I became depressed (woman 4).

Woman 4's experiences illustrate the importance of Gergen and Davis's (1997) questions with regard to social biases in favour of a certain kind of family unit: (a) How can a single model family adequately serve a diverse, heterogeneous society? (b) Who gains power by supporting this model for family life? (c) Will those who do not fit this definition be considered sufficiently unworthy that valuable resources will be withheld from them? (d) What opportunities does adherence to this model open or deny to women? (e) What other ways of viewing the world become invisible?

Some answers to these questions are immediately apparent. Adherence to a single model family by South African policies on reproductive health denies the richness and diversity of the culture. Woman 4's failure to meet the standards of the correct family values resulted in punishment by being eliminated from the medical care benefit accorded to infertile married couples.

Some non-married women who were planning to go for an IVF treatment were in agreement with their partners that the partners would act as 'husbands'. Woman 6 did save money before, but her husband refused to go for an IVF treatment with her. She used the money for other things and was now saving again with the hope that her husband would then agree to go for an IVF. It seemed lack of co-operation among couples made it difficult for women to access IVF treatment and even where their partners were willing to cooperate, they had to play the role of husband even where

the couple was not married.

Gaining access to traditional healing presented some participants with a different set of challenges. For example, access to traditional healing may be blocked in circumstances where there are blood relations between the traditional healer and the infertile person. For example, Man 7 was disappointed that his 'elder mother' (mother's sister) who told him that she was successful in treating others, could not treat him. The taboo was associated with gender and cultural sexual inhibitions that could interfere with treatment rituals.

Cost

The cost of infertility treatment made its effective treatment inaccessible for most participants. It appeared that even the basic available treatment from both traditional and modern doctors was expensive. There was usually a negative assessment of the treatment, especially when treatment failed. The treatment was frequently described as expensive and a waste of money. This brought resentment towards the health care system, which was then perceived to be interested only in profit making. The following narrative indicates how one of the respondents expressed how the cost of treatment affected the couple.

> We went to different specialists, especially gynaecologists, who nearly broke us. We now have financial problems. This problem dealt harshly with us financially. We spent each and every cent we had on consultations. Even if we have money, we are unable to buy things that we are in need for. It would not be nice without kids. Therefore, we are still trying to accumulate more money for IVF. The tests have already been done, but we do not have money that is required for the whole process (man 5).

Some couples expressed the need for an IVF, but it was expensive for them. Other couples and some women were saving money for an IVF treatment. It appeared that men and women who were married helped each other to save money for an IVF while unmarried women had to bear the cost alone. In some cases partners were emotionally supportive and willing to donate the sperm, but they were not financially supportive. In one case, this could have been influenced by the fact that the man was married to someone else and he had a family to support.

Golding (1993) contends that infertility in South Africa is not a middle class problem. Socio-political factors such as migrant labour and influx control laws contributed to split families and increase sexually transmitted diseases (STDs), making infertility common among the poor. The available advanced medical technologies are costly, and medical aid is non-existent for infertility treatment. Personal communications with gynaecologists indicated that in vitro fertilisation is currently done at a rate of about R8 000, 00 to R12 000, 00 per trial. Although there are high rates of infertility (15 to 20%) in the Third World, the emphasis is on population control, with almost no effort to enhance female reproduction (Golding, 1993). The right to parenthood is a privilege reserved for the economically advantaged (Sewpaul, 1995). Even where couples can afford in vitro fertilisation, there may still be problems. In vitro fertilisation has a relatively high rate of successful pregnancies but most of such pregnancies are not completed, leading to emotional and financial difficulties for couples (Eupnu, 1995).

7.2.2.5 Psychosocial intervention

The findings suggest that psychological intervention is not included in the infertility treatment regimen. It seems that there is virtually no co-operation between mental health practitioners and medical specialists. Consequently, infertile persons are not referred for psychological intervention or social work intervention where options of adoption could be discussed further. This confirms that, in South Africa as elsewhere, infertility is still mainly viewed as a medical problem (Lober, 1997; U. S. Congress, Office of Technology Assessment, 1988).

Participants themselves also did not see psychological intervention as existing in parallel with medical intervention, as is reflected in the following response:

> ... At the beginning, you do not think of counselling. I did attend counselling at some stage, but it did not work for me. If I ask questions and a person dodges me, I do not see why I should not go and look for them whichever way. Counselling is necessary. It is just that sometimes you may not pick up the right person. If the person has got his/her own agenda and you have your own agenda, you do not tally (woman 4).

However, the above statement also reflects that the need for psychological intervention has been realised. Woman1 expressed the gap that could be filled by counselling as follows:

> It is like seeing a gynaecologist who just takes blood to check HIV and, if you are positive, they just tell you and leave you. You need to be told about adoption from the point of examination. The doctors just leave you with the pain and it is not easy to announce to the other relatives as well. That is a gap, which needs to be filled by a psychologist (woman 1).

There is an indication that some doctors considered the psychological aspects of infertility and provided some counselling to their patients. It seemed that the doctor was preparing woman 10 for the possibility of treatment failure when he/she told her that his/her work was guided by the power of God and that a child came from God and not him/her.

Psychological support need, of course, not necessarily be provided by a professional. Several women expressed the need to form a support group. They wanted me to help them form such support groups. It was indicted to the participants that I could help them after the completion of the research process. One of the women described her willingness to be of help as follows:

> This infertility problem gave me a thought that I must show support to people like myself. You will find them surprised and *ba sikinyega matswalo* (a Northern Sotho figurative expression literally meaning that the lungs of infertile women become shaken, which means becoming anxious) (woman 9).

7.2.3 Doctor Patient Relationship

'He (urologist) is avoiding me': doctors lacked commitment

Participants' relationship with the specialist not infrequently became strained when specialists who had different practices in different areas did not turn up for an appointment. For example, man 7 was disappointed with his urologist who was often "not available" or missed their appointments. This caused man 7 to doubt the prognosis of his infertility and the commitment of the urologist:

> The doctor I am consulting with does did not keep to his promise. He told me he would come around at a certain doctor's consulting rooms, but for several times, he did not show up. It made me think that he is avoiding me, or there is something he doesn't want to tell me. I called him several times, but he couldn't respond to

my messages (man 7).

Other participants seemed to have developed strained relationships with the medical personnel out of frustration from not getting a clear diagnosis or positive outcome from the treatment process.

'Doctors are quacks'

There was a fairly wide-spread perception among participants that doctors are only interested in making a profit and not in helping infertile patients to conceive. This perception was associated with the high cost of treatment without positive outcome. Participants felt cheated and some, such as woman 4, had no doubt that "Western doctors are quacks". When asked if she was angry with the doctors, she responded: "I am no longer angry because, most of them (modern doctors), I told them their part. Whoever touched my life negatively, I just tell it back, I no longer need it" (woman 4). Her negative experiences in the relationship with medical doctors are illustrated in the following extract:

> I wrestled for a long time. Then, I finally decided that I would settle for IVF and that I would save money. By the time I had money, in 1990, I had depression. I had depression because the doctors were not fair. They did not tell me exactly what was wrong with me. They kept on ... it is like when one gets exhausted with me, would pass me to the next one until I got fed up and said now I am going to terminate. That day caused a lot of friction, I just said that now I want the truth because, I could see from the journal that I was reading that I would not have a child naturally, and this doctors were just taking my money. So one day I confronted one doctor and said you are going to tell me. If you don't, I will write a letter to the medical council. Then he referred me to another doctor. When I got to that doctor, he did not mind his words. He was rude. Therefore, I complained to the minister of health and told him/her that the doctor was rude and, he must be dealt with. The minister did not look at the matter objectively. He/she was trying to protect the doctor. I did not deny that I have a problem and, I do not see why I should kill myself because of that (woman 4).

'Traditional doctors too are just interested in making money'

There seems to be a lack of trust in the genuineness of current traditional doctors' ability to treat infertility. There is a belief that many of the present traditional doctors are interested in making money to the extent that they would not refer to other traditional doctors even when they realised that they were not making treatment progress. Some participants believed that some traditional doctors were not only overly concerned with money, but outright fakes, as is evident in the

following account:

> I do not know how they could help us. Is it not that when you are struggling you have this thought that you will go to a person (traditional doctor) just once or twice, you realise that there is nothing happening and you leave. In the olden days, you would just go to one person (traditional doctor), who would fight the disease. If he realises that he could not help you, he would tell you. However, today's healers do not do that. It would be a person seeking help who decides to seek another help somewhere else. Is it not that they benefit from the whole thing. They have nothing to lose, because when they say it is this much amount of money, you give them with hope that he might help you (FI 2).

7.3 The Emotional Tumult

The question of gender cannot be divorced from how infertile persons experience emotions, how they express emotions and how they think of emotions in relation to themselves and others. Thus, this section centres around answering the research questions: On the individual level: how do men and women react and adapt to infertility? On the level of social network, how are the men, women, and couples' relationship affected?

7.3.1 Individual Experiences

The findings indicate that the infertility experience brought emotional chaos. It tossed individuals from excitement and hope to disturbance and despair. This process can be seen in a response such as the following : "...If one could at least pick up *thoranyana* (Northern Sotho for a seedling) and then proceed to give birth, but it failed" (woman 9). The infertility experience is full of twists and turns, with progress often being followed by despair.

There was some indication that men and women in the current study went through the five stages of grief identified by Elizabeth Kubler-Ross: denial, anger, bargaining, depression, and acceptance. Similar to Williams' (1997) results, infertile participants in this study had not yet completed the final stage of grief, and accepted their infertility. The crisis of infertility is an emotional roller-coaster for the participants. It is possible for infertile persons to accept infertility, only to move back again to a stage of denial. Thus one can conclude that acceptance, as a final stage of grief, may not exist for infertility. It seemed that for the participants in the current study the stages of

grief instead followed a circular and spiral pattern.

The following themes were identified as part of the emotional stages of the infertility experience.

Shock and denial

Most of the participants took it for granted that they will be able to bear children and become parents. Thus the reality of infertility came as a sudden and unexpected shock : "I cannot understand what blocked them (fallopian tubes) I am still shocked, even right now" (woman 14).

Anger

Some women were angry that they were blamed for the couple's infertility. There was anger when women were blamed without medical evidence that they carried the infertility diagnosis. The anger was directed to the partners and at times to family in-law, who continued to blame them. Woman 4 was angry with her parents who knew that she would not have children but were not open with her except to encourage her that she should focus on having a child and not on her education. Woman 5 on the other hand, was angry with what she called 'apartheid doctors' who excised one of her fallopian tubes during an appendisectomy operation at the age of 18 years.

It seems that the belief that infertility is a woman's problem resulted in men blaming the spouse for causing the infertility problem. Man 4 and man 10 were angry with their partners for using contraceptives without their knowledge during courtship. There was an expressed anger in families in-law who believed that infertility was a result of a woman's misdeed. In-laws were angry with daughters in-laws whose infertility was attributed to prolonged use of contraceptives and having committed illegal abortions in the past. The grandmother in-law of woman 11 became angry when no grandchild was born. She accused the woman of aborting the pregnancies.

Woman 12 was angry with her in-laws whom she perceived to be interfering with her marriage. She was angry with her in-laws for encouraging their son to divorce her. Although her husband did not divorce, she blamed her in-laws for her marital problems. Her husband was no longer supportive, and he had an extramarital relationship.

For different reasons, participants were angry at the medical health system. First, the anger was about the failure to come up with definite diagnosis. Second, treatment failure caused disappointment and anger with the doctors who failed to help achieve pregnancy. Third, the medical establishment had some degree of control over infertile women and men and the treatment process. The sense of loss of control brought feelings of anger for the participants. As discussed above, participants were also angry at the medical system for a perceived lack of commitment and an excessive interest in financial gain.

Guilt

Some participants experienced self-blame as a result of associating infertility with punishment for untoward acts or omissions. There was also regret about not having a child earlier:

> I initially regretted that I should have had a child earlier. Still, I understood that it would not have helped because, what was I going to give to that child (Woman 4)?

Guilt feelings were sometimes accompanied by pessimistic feelings.
"I often pray and ask what have I done to deserve this? When will this end? Where is the end-line (man 10)?"

Isolation

Infertile participants tend to avoid contact with the fertile world. They isolate themselves from social events which involve children. It appears that contact with the fertile world is painful and the isolation is used to avoid the pain. Woman 2 recalled a Christmas time when she went shopping with other women. The shopkeeper distributed sweets to women who had children. The pain of being left out because the shopkeeper knew that she was childless seemed to be still with her. Therefore, she tended to avoid social contact, which involved children:

> It affects me because, I could be having somebody, a grown up kid, who will always be on my side, keeping me occupied, busy and concentrating on some other things. At times you find that I have spent a day without any objective. Just sitting, wondering and doing nothing. If I had somebody to stay with, if I had a baby, maybe I will be calling my daughter, my baby or my son. Maybe he would be

keeping me busy (woman12).

Depression

Depression is a common response among women to the pain of being infertile. Men also tend to react to their partners' infertility by becoming depressed. The crisis of infertility for a man also relates to failure to carry the family name forward. It represents mortality of self and family. Interestingly, previous research suggested that self-attribution of responsibility for infertility was not necessarily a source of distress for men (Halman, Abbey & Andrews, 1992). Different meanings attached to the causes and consequences of infertility led to depressive symptoms. For man 8, the reminder of infertility in the menstruation of his partner resulted in *ku nyama* (figurative for a severely depressed mood and literally meaning becoming pitch black in Xitsonga). The reasons for wanting a biological child contribute to the depression as is illustrated in the following extracts: "This is a person (partner) who is supposed to bear a child who is going to lead this clan. It makes me sleepless. I feel unhappy (man 3)." "My main worry is that I am alone at home, so I wanted to be able to extend the family (man 7)."

It is hurtful for men who, as married men, need biological children to affirm their identity as 'real' men and fathers. Depressive states for men are also brought on by a failure to meet the need of being like other men who were biological fathers. Another emergent theme is the feeling of helplessness in some men to support their partners in dealing with the pain of infertility.

> I hate to see my wife cry. It pains me a lot, but there is nothing I can do (man 5).
> I sometimes ask myself: What will it happen that I die like this, without having a child (man 10)?

Failure to meet the financial demands of infertility treatment, especially advanced technologies, brought feelings of hopelessness and helplessness.

Women, on the other hand, are in patriarchal relationships where children carry the names of their fathers. In this regard, women are not responsible for the family mortality. Despite not being directly responsible for the mortality of the family, women may be depressed due to guilt feelings of failure to bear children 'for their' partners. The chief-mother (woman 7) felt guilty and depressed that she was not able to bear the chief:

> *E ntshwara bosaedi* (Northern Sotho for I feel bad). It is heavy on me, considering that I am supposed to bear a chief (woman 7)."

Anxiety

Participants displayed intense anxiety from their responses. Anxiety in some women was brought on by the possibility that their partners might leave them for women who could bear their partners children. Other women fear that their partners could leave because they were always fighting about the infertility and the lack of a biological child in the family. Woman 4 became anxious when after three years of seeking help, she was still unsure of what the diagnosis was and that she was not conceiving. Menstruation became an emotional roller-coaster for both men and women. There was anxiety about the wish not to menstruate when the expected dates of menstruation approached. The arrival of menstruation brought 'painful' or depressive feelings. Sometimes the man would become furious with the woman for menstruating.

The uncertainty of who would take care of woman 2 and woman 10 in old age was threatening. The belief that a child provides a sense of security in old age made them feel uncertain about the future. Both women went to the hospital to apply for a government welfare grant, and that is how we met. Woman 2 presented with psychosomatic complaints which she attributed to the laparatomy that she had as part of the diagnostic and treatment process for an ulcer. She wanted a disability grant. It transpired that her husband was sick at the time of her initial consultation, a factor which could have prompted her to seek a disability grant as she felt that no one would take care of her in case her husband died, as he indeed did. Woman 10 on the other hand, felt that her employed sibling was not taking care of her and she wanted a social welfare grant.

Grief

Woman 1 was mourning the loss of experience of the birth process. Her interpretation that the birth process was a transition to womanhood made her question her identity in terms of what she would be like during the birth process.

> I felt partially satisfied that I succeeded in helping a person give labour. You saw the procedure as it is. However, you do not feel how the person feels. You do not know the pain. At times, you might think that she does things deliberately especially because of the individuality factor. This other one give birth in a smart way, with no problems, and the other one is so crazy that she cannot even understand what is going on. I often ask myself where I would fall between the two if given an opportunity. I will be becoming a woman (woman 1).

Man 2 expressed the sense of loss when he said: "I feel I am at loss. It is like there is something missing. It is as if my hand was severed (man 2)." It appears that this man was mourning for the loss of control over the infertility experience. The findings indicate that infertility brought a sense of loss, which made infertile persons helpless.

Envy

There was an envious feeling when other women had babies as expressed in the following extract.

> I become disturbed when someone give birth to a child. I just wish the child were mine. If it was possible for that person to give birth to a child and give it to me. I envy her with all my heart. ...I only have one friend. Now she has a baby and, because I envy her, I am even afraid of going to pay her a visit. (What are you afraid of?) ...I am not afraid of anything. I just envy the child. We are in good terms and I have raised her two children, but at times, I feel that if her child were mine, I would feel much better (woman 15).

It appears that women whose partners refused to participate in the study did not show as much distress as the other women participants. This finding is contrary to Link and Darling (1986) who report that women whose husbands refused to participate in their study were much more distressed than other women in their sample were. The differences could be accounted for by differences in sample frame. Unmarried women, some of whom did not have partners at all, were included in this study, making such comparisons futile. Moreover, some women served as gatekeepers, refusing to invite their partners to participate in this study.

Contrary to Berg's (1994) finding that infertile men did not admit to their psychological distress, I found infertile men in this study to admit to their psychological distress. This is consistent with Edelman and Connolly (1996), who, using quantitative measures, found no evidence that feminine women or masculine men were more distressed by infertility. Instead, those men and women who had undifferentiated sex role identity were distressed. The findings in this study suggest that men had difficulties with emotional expression of the infertility experience. However, it is important to consider the extent to which differences in findings might be a function of the sample studied and the methodology used (Edelman & Connolly, 1996).

Difficulties with emotional expression could be ascribed to the socialisation process. The patriarchal orientation of South African society could have influenced men not to show emotions. According to Brody (1993) emotional experience and expression are influenced by the need to meet the implicit demands of the societal context. Therefore, as much as infertile men experienced intense emotions, society did not allow them to express the emotions explicitly. Hence, men participating in the study were able to identify their partners' intense emotional response and worried about the emotional reactions of their partners.

7.3.2 Family Members' Experiences

The emotional impact of infertility appears to affect not only an infertile individual, but also family members. The following are emergent themes about the family members' emotional reactions to infertility.

Guilt

Parents, who attributed infertility to delayed child bearing, felt responsible for their daughters' condition because they encouraged their children to postpone child bearing.

> I did not encourage her to bear a fatherless child because of my own personal experiences. She has now grown up and I feel bad. I do not know why my child does not have a man so that she could have a child. ... I do not know whether it is because of how I suffered in raising them. Maybe she thinks that is how her kids are going to suffer too. The idea of a fatherless child, maybe it is because of her own personal experience of being raised by a stepfather (FO 1).

Depression

There seems to be a chronic depressive mood related to the inability of one's child to bear a child.

> ...Now, my heart hurt so much. If only she could bear a child. It does not help, but I feel hurt inside when she does not have a child. ...The family members are hurting because she is infertile where as she is working. She has her own house. Who is going to take care of her in old age? Who is going to take over her house (FO 1)?

> I cannot sleep because of this problem. If a person was never like other people since birth, as a parent of that person, you will never fall asleep. You will always worry and ask yourself, where would this come to and end? What is going to happen to her at the end (FO 2)?

Anger

At times, family members perceived the infertile person as not making enough of an effort to have a biological child. These kinds of perceptions made family members to become angry towards the infertile person. Mothers were angry with their daughters, whom they perceived to be not interested in following traditional methods of treatment. It seemed that the assertion by infertile women, who made decisions not to take traditional medicines (woman 4 and woman 14) and not to pursue other forms of treatment (woman 4), made their mothers frustrated and angry.

> I have decided I am no more going to talk about this problem. I am actually fed up. She frequently said that she does not want to hear anybody mentioning that she should drink this and that medicine or go to this doctor or anything about the child (FO 1).

Another example of family members' anger can be found in the way in-which FO 3 blamed her daughter for the problem of infertility. She suspected that her daughter (woman 14) could have had an illegal (back-street) abortion which led to the complication of infertility. It seems that FO 2 was angry that her daughter did not confide in her about the abortion. There seems to be ambivalent feelings in that her anger because of blaming her daughter for having committed an abortion was accompanied by guilt feelings about being angry towards her daughter.

Anxiety

FO 4 was uncertain about the future of her sister's (woman 13) marriage as expressed below.

> I know that there is no issue that should make people break up, in our culture. Nevertheless, in the new culture that we live in, if something is not working out, you leave for new or for better pastures. There are people who define that marriage is held together by kids. I do not know about this one. I fear that my sister may be divorced, and she will not be able to take it (FO 4).

7.4 Identity Crisis and Loss of Control

Developmental theories suggest that identity crystalises during adolescence. However, the findings in this study indicate that for some gender identity can only be affirmed with child bearing or biological parenthood. In this regard, one can conclude that although gender is biologically determined, failure to fulfil gender roles threatens gender identity. Upton (2001) found that infertility, at any stage in life, whether married or not, is a risk to an individual's identity formation, to such an extent that it could result in infertile individuals becoming 'invisible' in their social circle. This certainly appeared to be the case in the current study as well, with many of the participants struggling with feelings of personal inadequacy. Infertility threatens the gender identity of both men and women, preventing transition to manhood and womanhood. This notion seems inculcated in everyday discourse. For instance, while expressing her frustration about the conflicts she had with her partner, a woman said:

> I have a problem with this boy that I am living with. Most of the times, we have arguments about a child. I feel bad when he starts blaming me. I end up telling him that you are blaming me alone where as I once did something (she once had a miscarriage; the pregnancy was conceived before she met the present partner). The problem is you have never done a thing (made a woman pregnant) (woman 8).

The value ascribed to fertility and the fusion of meaning around motherhood and womanhood has persisted as a major feature of African women's social identity as women, despite the very different circumstances under which the capacity to bear children is realised (Walker, 1995). According to Tong (1997), in our society a mother is a woman who is defined and defines herself in terms of a nine months pregnancy, a twenty four-hour or so delivery, and eighteen years or so of child rearing. Infertility prevented women from achieving the status of womanhood. There was a belief that an infertile woman was not a 'woman' until she gave birth. Woman 1 saw giving birth as the only way in which a woman could transit from being a 'non woman' to being a 'woman'. Black South Africans' attitude towards motherhood indicates that motherhood is seen as synonymous with womanhood to an extent that woman's fertility lies at the root of a mother's status and identity (Potts & Marks, 2001; Walker, 1995):

> ...By giving birth, I will be becoming a woman (Woman 1).
>
> I will feel a woman when I become a family woman. Presently I am a woman, but I am not a real woman yet (woman 19).

This view is supported by a study by Preston-Whyte (1993) which suggested that teenage mothers did not view their pregnancies as shameful disasters, but rather, as an affirmation of their womanhood. It seems that becoming a 'real woman' is not the construction of infertile women only. Pregnant women also express their happiness at becoming a 'real woman' through pregnancy and having a child (Harrison & Montgomery, 2001) which says much about their roles, gender norms and male control over fertility (Harrison & Montgomery, 2001; Potts & Marks, 2001).

Motherhood has been used by progressive political organisations as a powerful weapon to fight apartheid and white supremacy in South Africa. The failure of progressive political organisations to distinguish between 'woman' and 'mother' (Walker, 1995) has severely disadvantaged infertile women. Thus, the empowering nature of motherhood takes place within the confines of patriarchy, rendering it of limited value as basis for challenging gender oppression.

There is a need to understand the complex psychological processes by which women come to accept and internalise an ideology and a practice that is oppressive. Women tend to collude with patriarchy (Walker, 1995). The way in which woman 17 described the meaning of the loss of one of her fallopian tubes as compromising her identity as a woman shows how women collude with patriarchy to their own disadvantage. The lost fallopian tube made her feel defective to such an extent that both she and her mother believed that her womanhood was compromised. Consequently, she was not presentable to her husband.

> I wanted to tell him, but my mother advised me not to tell him because my womanhood is downgraded. When a man cannot produce, he feels he is not a man enough. Therefore, I think he might feel the same about me (woman 17).

The threat to traditional male/father roles becomes worse if a man carries the diagnosis of infertility within a couple. Men who carry the diagnosis seem under pressure to maintain the societal beliefs that infertility is a woman's problem. Therefore, infertile men tend to keep a public

facade that they do not have 'a problem' while on the other hand, they are internally engaged in struggles, among others, of identity crisis and emotional turmoil. When asked, "do you think people outside, like your neighbours, are aware that you are the one having a problem?", the man responded as follows:

> My neighbours, I do not care about them. They do not know this problem. It is only between us. ... Otherwise, people will not respect us. They will look down on us (man 6).

The internal struggles and feeling of loss of control due to infertility in men was expressed as follows: "I feel I am at a loss. It is like I am short of something. It is as if my hand has been severed" (man 2). Therefore, men are 'safe' from the stigma of infertility. Their public esteem makes it easier to assume a 'complete' sense of biological gender identity while keeping their emotional struggles around the issue of gender hidden. There was an emergent theme that reproductive capability was determined by age. Some men and women felt inadequate when "even kids had kids". Their standing in the society became affected when people who were younger than infertile men proved themselves able to bear children.

There are highly prescriptive and restrictive gender roles that continue to prevail among women, especially in rural areas. However, by virtue of social change including greater education, women are beginning to challenge accepted gender roles (Harrison & Montgomery, 2001). Some women indicated a sense of identity and self-esteem when they defined themselves as persons and women and not mothers. In this way, the women have found some constructive ways of dealing with the infertility issue. For example, woman 9 said: "In some instances, I am respected as a woman because I am a person. I am also a living person (woman 9)."

Among participants in the current study, as was the case for participants in other studies (Edelman & Connolly, 1996; Sundby, 1994; Wirtberg, 1992), it would appear that socialisation processes promoted and reinforced different meanings for the role of procreation in men and women. For women, it is the loss of motherhood that is the central issue, whereas, for men the loss is associated with manliness. An important difference from Edelman and Connolly's (1996) study is that as much as men in this study were concerned about manliness, becoming fathers was also a central issue for the men. Especially because some men did prove their manliness with other

women in extramarital relationships or with co-wives, where they were able to produce children. Other men who did not have children outside the infertile couple relationship expressed the need to fulfil both manhood and fatherhood.

Stigma of infertility

Consistent with other findings (Mabasa, 2000; Ndaba, 1994; Sewpaul, 1995; Upton, 2001) women blaming resulted in women being attached with the stigma of infertility. As a result, infertile women are called by derogatory names like *nyumba/moopa* (Xitsonga and Northern Sotho/Sesotho words respectively that means a cow or other animal that cannot reproduce) (Mabasa, 2000). Thus, infertile women were dehumanised, and equated to an infertile animal. As much as people are dehumanised and compared with animals in various non-insulting ways, like "strong as an elephant", calling an infertile woman *nyumba/moopa* is extremely derogatory. "It is like calling a person kaffir" (Sewpaul, 1995). Upton (2001) found a similar trend in Botswana where, infertile women are called *moopa*, a Setswana word for a cow that is sterile.

The use of the word *diphatse* (a derogatory word for an infertile person in Northern Sotho, also called *moopa*) is degrading to infertile women. Language is part of the social propaganda that communicates social roles for men and women in the realm of sexuality, including infertility. A tendency to use sexually degrading language against women perpetuates their lower status by making them less likeable and intelligent (Gergen & Davis, 1997). Sexually degrading language might be described as a form of gender intimidation.

7.5 Impact on Interpersonal Relationships

7.5.1 Couple Relationship

The findings of the present study concur with Chandra *et al.*'s (1991) findings that there was deterioration in the areas of communication, affective expression, problem solving and closeness in couples faced with infertility. However, the findings of this study also indicate positive results in these areas, as discussed below.

7.5.1.1 Communication

Some couples openly discussed the problem of infertility. Others avoided the discussion. This caused the partners to misunderstand each other and to draw their own conclusions about what the other might be thinking about the situation.

> When you try to talk about this problem, you find that she does not want those things. It looks as if she is fed up. So you ask yourself whether she gave up, because it is a long time or what (man 3).

This man's partner drew the following conclusion, because of miscommunication:

> My husband became hopeless and just kept quiet. He would say that we would go (seeking further treatment) and kept on postponing. Realising that he is not bothered, I too decided to keep quiet. Maybe he likes it (the situation of infertility) (woman 7).

There were other cases as well where women interpreted the miscommunication and differences in expression of the emotional experience of infertility in a couple as an indication that men were not concerned about the problem of infertility. Some men were aware of this miscommunication problem and understood it to imply that women thought that they were not concerned about the problem of infertility.

> My only problem is that I am worried about her. She might sometimes think that I don't care, which can affect our relationship. I show her that I am concerned, but I do not have to be worried in order to be concerned. It is a matter of how to deal with it. I co-operate in every way. I go to doctors when she tells me, I talk to her about raising money (for IVF). I tell her we do not have to be worried to be concerned, we have to accept it (man 9).

Women tended to disclose their negative feelings about the infertility experience more than their partners do. This reflects the literature on marital functioning where men and women were similar in verbal expression of positive feelings, but differed in their readiness to express unpleasant feelings - with women more willing to express negative feelings (Merves-Okin *et al.*, 1991). This can be attributed to families and social institutions, which have created certain roles for males and

others for females. The differences in communication patterns may be attributed to these roles. Furthermore, how females and males interpret support in the relationship is dependent on these roles.

Social expectations produce the belief that a similar level of disclosure will occur in close relationships (Merves-Okin *et al.*, 1991). Studies (Merves-Okin *et al.*, 1991) have revealed that both partners are unsatisfied when there are relatively large discrepancies in the amount of self-disclosure between partners. When both partners report either low or high self-disclosure, they describe their marriage as more satisfying. Consequently, women in this study tended to interpret their partners' lower level of disclosure as an indication that he did not care. The men on the other hand, were concerned that their partners did not understand that they too were concerned about the problem of infertility. It seemed that some men were aware of their low level of self-disclosure, and of the fact that it interfered with the marital relationship

Disagreements regarding who carries the diagnosis brought conflict in some couples. Men usually blame their partners for infertility. Consequently, the couple's daily conversation is coloured by the man telling the woman that he wants a baby. Another related emergent theme involved what woman 6 reported about her husband. Her husband would do something good for her, like a gift. While the couple was still talking and the woman appreciating the gift, the man would say "if you could make me a baby ...".

7.5.1.2 Affective response

There were both negative and positive couples' affective responses towards infertility. One of the negative affective responses is anger related to premarital issues. Infertility triggers unresolved premarital issues that influence a couple's reaction to it. For example, man 4, whose partner used contraceptives without his knowledge while they were still in courtship, became angry to hear about that in the doctor's consulting rooms. It seemed he expected his partner to conceive before their marriage. The following extract illustrates this:

> You find that there are secrets between couples, …I realised when she told a doctor that she was once pregnant (had a miscarriage with previous partner). It really disturbed me because I was not aware of it. After six years, she was keeping that as a secret, it was a blow. After that, I don't prefer going with her to the doctors (man 4).

Consequently, this man withdrew social support and no longer accompanied his partner for treatment. Another theme about anger in a couple involved reactions to menstruation. For example, woman 8 reported how her partner became angry at every menstruation.

> My husband works in town and only comes home during the weekend. He becomes very furious with me when he comes back and realises that I am menstruating. If he comes back and discovers that I am not menstruating, he would ask me when I menstruated, and I tell him. Still, he will be very angry. I don't know whether he suspects that there could be something that I am doing. Another thing is that he knows the dates in which I am supposed to menstruate. Isn't that they could change? So if he realises that the dates have passed and, when he comes back and finds that I am menstruating, he becomes angry. He thinks there is something that I do (woman 8).

Thus, menstruation interfered with the couple's trusting relationship. It seems that her partner suspected she could be intentionally aborting the pregnancy. Besides the anger and trust, menstruation led to feelings of hopelessness (man 7 and man 10) and sadness (man 8) in some men. Another emergent theme involving trust was the way in which men (man 7 and man 4) suspected that their partners could be having extramarital affairs. It seems that man 7 had reluctantly agreed that his partner could be engaged in an extramarital affair for the purpose of sexual pleasure because he had a sexual dysfunction. He became jealous and tended not to trust his partner. This is shown in cases where he started questioning every movement that the woman made.

There was anger and resentment towards woman 19 from her partner. Her partner anticipated that IVF treatment could fail, resulting in financial loss.

> We have to go and finalise it (IVF). It needs money, which we don't have. If she does not get pregnant after all, then we should just live it as part of us. What else can be done? I think there is nothing (man 9).

These findings support Chandra *et al*'s (1991) results that infertile couples in extended family contexts tend to have limited interaction and sharing. This is brought about by the fact that it is usually the elders who make decisions for the couple. When partners rely on external sources of support, they tend to distance themselves from each other.

The positive affective responses related to a feeling of a sense of belonging and of being emotionally supported. The following extract indicates how one of the men appreciated his partner's emotional support.

> I realised that this woman has a heart (patience and understanding). She has no problem (does not carry the diagnosis). If it was some other woman, she would have run away long time ago (man 6).

Men too, were supportive of their partners. It can be deduced from the following that man 9 gave emotional and instrumental support to his partner.

> I show her that I am concerned, but I do not have to be worried in order to be concerned. It is a matter of how to deal with it. I co-operate in every way. I go to doctors when she tells me, I talk to her about raising money (for IVF). I tell her we do not have to be worried to be concerned, we have to accept it (man 9).

7.5.1.3 Sexual relationship

Consistent with several other studies from the West (Ponjaert-Kristoffersen & Baetens, 1999; Williams *et al.,* 1992) and from India (Chandra *et al.*, 1991) the findings in this study reveal sexual problems in couples faced with infertility. Several themes including the stress related to diagnosis and treatment procedures; sexual intimacy viewed as a practical task for baby making; and infertility related conflicts within the couple contributing to the development of sexual problems emerged. Women develop sexual problems such as lack of sexual desire and inorgasmia. The reported sexual dysfunction for men included an erectile dysfunction.

It seems that sexual intimacy served a procreative function once there was a problem of infertility in a couple. Sexual intimacy became nothing more than a physical procedure or an obligation to one's partner.

> When you go to bed (sexual intimacy), and you are not satisfied, you think that the other person is also not satisfied. There are times when we just do it without the pleasure. You just do it because the other person wants it, because at that time I will be thinking that there will be nothing (no conception) tomorrow. ...Although she does not voice it out, I think she thinks about it, that we are just wasting time. End of month when she is on her periods, it does not make me happy. ... We don't really have a problem. We do well in bed. It is just that when one gets tired it is not like I am going to gain something. You, just get tired for nothing (Man 8).

Making sexual intimacy to serve the procreative function could have contributed to men having extramarital relationships for sexual pleasure. Man 8 lost sexual desire with his partner because of seeing sexual intimacy as a procreative function. Thus, he had an extramarital relationship "for pleasure and nothing else. It has not reached a point where I would want another woman for a baby".

Man 2 was impotent and had lost sexual desire with his partner, but was not experiencing sexual problems with his extramarital partner. He believed that he no longer became sexually excited with his partner because he was used to her. His partner (woman 5) on the other hand, ascribed the sexual problems to the medical treatment that her partner had for impotence. She believed that the treatment damaged him. Therefore, she suspected that both could be carrying the diagnosis of infertility.

Infertility made it difficult for infertile women to be in control of using preventative measures against sexually transmitted diseases as indicated in the following extract.

> It becomes painful when one thinks that a child is a product of sexual intimacy. You find that I want to use a condom, and my partner will say why do you use a condom because you know you cannot conceive. I know I cannot conceive but the bottom line is, I should make sure that I do not diminish the slightest chance, maybe of 25%, that I can have a child by means of IVF (woman 4).

One of the important findings to consider in this study is the way in which infertility is a major threat to the expectations of the future and their sense of identity as a couple. Women in infertile relationships are concerned about being abandoned or divorced by the fertile spouse in favour of another fertile partner. In almost all the cases, after all the resources had been exhausted, women were willing to consider adoption as a means of becoming mothers. This is not an option favoured by some of the husbands who felt unwilling to raise a child who was not their own. Again, this concurred with Williams' (1997) study. It is noteworthy that even when the reasons for infertility of a couple are clearly traced to biological defects in the man, women still tend to blame themselves as if it were somehow their fault.

7.5.2 Family Relations

7.5.2.1 Parental context

The themes that emerged within the parental context involve conflicts related to the generation gap, including social changes among women, their partners and families. The findings suggest that there are conflicts related to pressure from parents who needed grandchildren. There are misunderstandings and disagreements about the explanations of infertility and how infertility should be managed.

There are differences between the family in-law and the family of origin on how they reacted to the lack of grandchildren. Although both families may pressurise the couples, the families of origin usually seemed supportive while the families in-law seemed intolerant of their daughter in-law for not bearing a child. Consequently, woman 11 (for example) is accused of not valuing children and therefore not being willing to have children.

> My grandmother asked her if she was aborting (self determined/induced abortion), even now, they are not in good terms. My mother wanted to confront her about this problem, but I stopped her (man 4).

It seems that the desire to have a great grandchild for his grandmother and to have a grandchild for his mother was so great for man 4 that the possibility of infertility was not entertained. Instead, the woman is blamed and accused of deliberately aborting the pregnancy. It appears as

if her history of using contraceptives was interpreted to imply that she did not ever want children.

Families in-law tended to mistreat their daughter in-law because of the problem of infertility. Most women felt excluded when the problem of infertility was discussed within the family in-law. The families involved their sons only. It appeared that the in-laws did not involve the women in the discussions, because what is discussed seems destructive to the couple relationship. Families in-law usually complained to their sons that they are financially supporting their wives so well but the wives are unable to bear the family a child. It seemed that the in-laws believed that the women did not deserve that kind of support. There was a concern that families in-law gossip about the couple's infertility with people outside the family, but could not talk the women directly.

The way in which families in-law mistreated the women resulted in animosity between the woman's family of origin and the family in-law. For example, woman 8 reported that her family of origin were hurt that her family in-law was blaming her for the infertility. They were hurt because they believed that it was their son in-law who carried the diagnosis of infertility. The men who are not supportive to their partners tend to have strained relationship with the in-laws, since the in-laws feel that the men are abusing their daughters.

> We had external factors that affected us, especially his family. They (his family) interfered too much in this affair. They could not explain why he could stay with a woman who cannot have children. Then he stayed away from his mother. My husband was very supportive before he was influenced to come back home (to divorce). ...It created animosity between my in-laws and me, especially when I realised that they were dissatisfied. ...Those people are not my family anymore. It has broken up (relationship). I am no more interested in them, whether they are there or not. They have hammered our relationship. That is their problem now (woman 12).

Unlike in Chadra *et al.*'s (1991) study where the extended family in an Indian context always brought disharmony in an infertile couple, some participants in this study found the extended family to be supportive. Some women found the in-laws to be supportive to the couple's problem of infertility. The women believed that the families in-law are supportive because they had similar problems where one of the sisters in-law also had an infertility problem. These women felt

understood within the family in-law. Being comforted with statements like "a child cannot be mined" (woman 9) and a "child cannot be built" (woman 3), from mother in-law and mother of origin respectively, made the women feel understood and supported in their struggle with infertility.

The findings suggest that most families of origin supported their daughter and sons in their struggle with infertility. However, it appears that the given support caused conflicts instead of bringing harmony. The generation gap and differences in belief systems between infertile men and women and their parents caused conflicts. Showing concern and attempting to find treatment, especially from traditional healers was met with discontent. It seems that the concern was read to imply pressure from the parents. Therefore, parents became frustrated and did not know how to interact 'appropriately' with their children

> We are happy but I am not free to mention that there is doctor so and so, somewhere who can assist her. Earlier on, when my daughter was still young, I could discover experts in the field of infertility through discussing with others and I was able to come back and talk to her about it. Lately, she seems hurt by such talks. I only talk to her about these things because I am also hurting and I want to assist her by any possible means (FO 1).

This made it difficult for her mother to be able to offer social support to her daughter. There is an indication of difficulty in family members communicating social support to infertile persons. When asked, "how do you show that you care about her?", woman 4's mother (FO 1), whom her daughter perceived to such an extent that she limited visiting her mother, reported: "I visit her, cook for her, wash for her in her house" (FO 1).

The following statements indicate difficulties in communication and expression of social support between infertile persons and their families.

> The only support I could offer her is to advise her to go to see doctors, be it modern medical or traditional ones. That is the only support I could offer, but she insisted that she no longer wants to hear anyone mentioning anything about the problem. I do not advise her of such things anymore. She made it clear to all of us (FO 1).

> At times I accompany her (to traditional doctors), and at the end I realised that when she says "I better try this (modern professional help) and leave that (traditional doctors), maybe God might help", and I do not accompany her, she thinks I do not care. I do care. Even you, are a grown up, your parent will not follow you in every step you take. She would then tell me that she will see to it because it is her problem. I realised that this person thinks that I do not feel the pain. At times when we are talking, just having a conversation, I would tell her that I also feel the pain. I would not be happy to see that you are working and every person who works knows who she is working for (implying that she was worried that her daughter was working but she does not have a child to support)(FL 3).

It seems that FO 2 avoided talking about infertility with her daughter because her daughter was short-tempered and usually reacted to the conversation with hostility. There is also an indication that FO 2 resented that her daughter was not married. She believed that if her daughter was married, her daughter and her partner would help each other seek treatment.

There seemed to be a lack of open communication about infertility between men and their families in-law. For example, man 9 who has been married for almost nine years, never discussed the couple's infertility with his in-laws or his mother. He was also not sure whether his partner discusses the problem with her family of origin. Consequently, there is a strained relationship. Man 3 explained that there is a strained relationship with his in-laws. He felt that his partner was misinforming her family of origin about his perceived unwillingness to pursue treatment for infertility. However, blood ties seem to have maintained their relationship. He believed that his family in-law is bound by blood ties (he married a cousin) to support him. Hence, they still have to put the conflicts aside and work together in seeking treatment.

There was a strained relationship between man 4 and his mother, who did not approve of his extramarital relationship and the extramarital child. He did not accept it when his mother did not take sides with him, but supported his partner in her distress about the extramarital relationship.

> She went to explain to my parents, they bought her story and became negative. My mother started accusing me of things and I told them I won't visit them any-more because she doesn't want to listen to my problem, she just takes sides. She takes her (his partner's) side (man 4).

It appears that the long-standing conflict that Man 9 had with his mother prevented open communication between the two. Consequently, his mother tended to communicate with him through her other son (FL 1). His mother would raise her concerns about the infertility problem with FL 1 and ask FL 1 to find out what was happening.

Infertile individuals felt not understood within the parent-child relationship. A couple (man 5, woman 18) felt not understood and pressurised by both family of origin and family in-law to bear grandchildren.

> We have difficulties with both families. We feel not understood in both families. They seem surprised and they do not understand what is happening to us. It could be because there has never been an infertile person in the two families before. They always question us on when are we starting a family because it is long that we have been married. However, they are not that bad. It may be because we are not staying with either of them on a full time basis but we only visit them (man 5).

This seemed to cause interpersonal difficulties to such an extent that the couple (man 5 and woman 18) felt it an advantage not to be living with either family. It seems unmarried women had to strive to prove that they are adult enough to be able to make their own choices regarding infertility management. Their parents, especially mothers, misread this to imply that the women were not doing enough to have children. The women, on the other hand, felt that their mothers were not understanding and supportive.

> My mother did not want to understand why I did not want to adopt children from relatives, to be committed in long term relationships, to talk about the infertility any-more, to discuss about my assets and how it should be divided when I die, and to consult traditional healers. I do not understand why it is difficult for my mother to accept me as I am. This makes me feel stressed especially when I am not in a mood for arguments (woman 4).

> My mother stresses the point that I should get married so that I can have children while my grandmother stresses that I should get/have children. I do not understand why they are so concerned about this problem. They both (her mother and grandmother) do not understand that I have made a decision and I want to stick to it. They are not aware that I need their support to go on with life. I am aware that my grandmother loves me more than she can show. She pretends to love my two sisters more than me, but in reality, she loves me (woman 4).

7.5.2.2 Sibling context

Infertile individuals became worried and envious when their younger siblings had children. There was a feeling that the younger siblings reached the status of manhood whereas the older infertile man remains a 'boy'. Consequently, infertile men developed an inferiority complex as indicated in the following narrative. "They act elderly to you. It is like you are nothing to them. They look down on you (man 2)." The feeling of inferiority was precipitated by family members who told the men that younger siblings were ahead in that they had children.

It seems that during the process of infertility, some men and women were able to relinquish the feelings of jealousy and start to enjoy the company of their sibling's children. Most siblings became worried when their brothers and sisters were unable to conceive. The way in which they expressed the concern tended to create interpersonal problems with their infertile siblings. For example, one of the siblings said: "I keep on advising them (couple consisting of man 9 and woman 19) that time was running out for them to can be able to conceive a child" (FL 1). As a medical doctor and having children himself, FL 1 felt that he was in a better position to advise his brother and his sister in-law, but his brother did not appreciate his constant reminders. His brother (man 9) did not seek support from his medical practitioner younger brother in relation to clarification or reassurance about the diagnosis of low sperm count and the intended IVF. The younger brother was concerned that the brother, whom he helped financially with things like purchasing a car, did not seek financial help about the IVF. It seems his need to help his older brother was misread as intrusion.

Her siblings advised woman 4 to have a boyfriend so that she can conceive a baby because they attributed her infertility to her current lack of a partner. Her response was: "I do not need a boyfriend to have a child. I can just have a donor (woman 4)." However, she perceived her siblings as supportive.

> That also affected my relationship with my mother because she felt that I was keeping her daughters at my house unnecessarily. I felt guilty, but at the same time, I could not chase them away. I needed their company, because when they are with me I feel comfortable, relaxed and at home. They provided solace for me. I gained strength to progress at work and academically. I also encouraged them to

study to avoid gossiping or engaged in other people's affairs (woman 4).

FO 2 was resentful that his sister did not seem to appreciate how much he provided her with emotional and social support.

> At times, it reflects as if nobody cares about her and, sometimes I feel she demands attention from me even if it is not warranted. You can visit there once a week, but she will still complain that "nowadays you do not come as often. I feel lonely here this person (husband) is not in most of the time" (FO 2).

He (FO 2) found his loyalty divided between his brother in-law (man 4) and his sister. His sister had demanded that he should stop associating with her husband. He was close to his brother in-law and at times, his brother in-law would meet with his extra-marital partner while he was with him (FO 2), and his sister did not like it. It seems that woman 11 perceived her brother's association with her husband in a context of her brother befriending her enemy.

> There was a stage, which we were not on talking terms with my sister, almost six weeks. I had invited her to accompany me to a function. Unfortunately, some how, we ended up talking about her and her husband's girlfriend and all that. It culminated into a very tense situation, where she did not want to talk to me for about six weeks. That was very bad, but we eventually talked about it and embraced each other again (FO 2).

When asked, how he went about helping her deal with her fertility problem, his ambivalence and divided loyalty became more apparent. He reported how he suggested the meeting between their family and the in-laws. He had also advised the couple to consult with a psychologist, which the couple did not do. The sister seemed to reject his social support because of his association with the brother in-law as indicated in the following text.

> Every time I try to talk about this issue with her, we always deadlock because she says that: "if you want to help me you help me on preconditions. You must stop associating with my husband's girlfriend or associating with my husband when he is going to do his own things (seeing his girlfriend)" We (with brother in-law) used to be very close. We used to do things together, but now, we associate just there and there. I think our area of association somehow has been redefined. I can't say we are breaking up, but we are no longer associating as often and as close as we used to be, but there is no animosity. I try not to be around when my brother in-

law and his girl friend are together (FO 2).

There is an indication from the findings that his (FO 2) ambivalence was influenced by his belief that one has to accept the fact that there is a child (in the relationship between his brother in-law and the brother in-law's extramarital partner). This reflects the value of children irrespective of whether 'legitimate' or 'illegitimate' and not that the existence of a child necessarily excuses the affair.

> I think she does not expect me to have a close relationship with her husband' s girlfriend. Therefore, I tried to talk to her and said, "look, in that relationship (brother in-law and girlfriend), there is a product (an extramarital child) that one cannot ignore." For me, to try and down play such issues is immaterial. And, her husband came to tell me that he actually included the child in his medical aid, but my sister does not know about that (FO 2).

It appeared that he (FO 2) expected his sister to accept the situation. One can assume that his position about his sister, brother in-law, and the extramarital child is clouded by the assumption that he could have done the same thing in a similar situation. Therefore, besides the issue of value of children, one can also conclude that in this case, blood was not thicker than water, but that 'male bonding' (which in cases such as this can also be read as men conniving to perpetuate the patriarchal order) proved to be the stronger force.

Among female siblings in-law, the picture was mixed. Some siblings in-law were supportive while others had strained interpersonal relations with infertile individuals. Woman 19 reported how she had a difficult relationship with her younger sister in-law (wife of FI 1). She felt that her younger sister in-law, who had two children, went about gossiping about her and bragging that "although she was not educated, she was able to bear children" (woman19). This caused conflicts within the extended family. Her husband (FI 1) understood the circumstances to mean that his wife, who did not have grade 12 and being married to him, a medical practitioner, compensated for her feelings of inadequacy by bragging that at least she could reproduce. Although the conflict bothered him (FI 1), he and his brother (man 9) chose to turn a blind eye and ascribe the conflict to 'women's' problems.

Some family members were resentful of their siblings who did not show concern about infertility to their partners.

> I have my brother who is not concerned with this. I think he is more concerned with his achievements, his studies and work. His personality, most of the time I do not understand his personality. He seems a bit of Type A Personality. If he is not concerned with an issue, it is very much difficult to drive him into understanding it (FL 1).

The following extract summarises the family dynamics within the sibling context for the couple consisting of man 9 and woman 19.

> For a long time, I did not care about whether they have a kid or not, but now, we are a family of four children, I am the second born. It is expected that for the first born to have a family and kids before the second born and my eldest kid is about seven years. He (man 9) does not have a kid. To him it is not a problem. I would say he is playing not to have a problem with that. But I realised that there is a problem in the marriage because my mother called to tell me how devastated her daughter in-law was about her infertility. What aggravates the problem is that my wife and my brother's wife (woman 19) are not on good terms. We are staying in the same homestead (they also live with their parents). This 'women' thing gets out of hand. The wives (his and brother's wife) have bit of squabbles and become angry with each other. She (his wife) is somebody who is not educated; she does not have matric. She is one person who is lazy on doing any schoolwork. Therefore, she always compares my brother's wife's achievements with her ability to bear children. If somebody (his wife) says that I might not have education but I have kids, that is very painful (FL 1).

When asked, "what effects has the fertility had on your relationship with your brother and sister in-law?", his response further indicates the family dynamics within the sibling context:

> I do not think it (his sister in-law's infertility) had negative effects on me as a person. I think my brother's wife loves my kids and she does most of the things for them. She buys them clothes, and all that. Unfortunately, instead of giving the clothes which she bought for my kids to my wife, she gives them to me. She is not on good terms with my wife. Therefore, on my individual relations, I think it did not have any negative effects, but as to my family and me, I think it has, because I mean, she is not talking to my wife. I do not know if they would talk to each other if she had kids. I tried to find out if she was at ease to talk to my wife, she said she is at ease but they are not talking. I have not let their quarrelling to be part of me or actually affect my children (FL 1).

Man 2 found his brother in-law to be supportive. His brother in-law was experiencing secondary infertility and shared his experience of infertility with man 2.

7.5.2.3 Extended family context

The results of the present study support Chandra *et al.*'s (1991) finding that extended family, especially when living with the infertile couple, contribute to family disharmony within the infertility context. For example, the family of woman 4 felt that the extended family and relatives were insensitive to the family problem of infertility. This resulted in extended family conflicts as described in the following extract.

> The hostility between the two families (hers and her aunt's family) grew bigger because my mother kept on complaining. There were some remarks, which were passed whenever my mother was amongst the family of my aunt, by her children, they would count the grandchildren, and that was causing pain for my mother. Then, I requested my mother not to visit the immediate family members because they caused unhappiness. That also interfered with my happiness and the happiness of the family of my sisters. To me that was painful because my sisters would avoid visiting my mother for fear of hearing complaints from mother about the misery of us not having children (woman 4).

Interpersonal relationship with the extended family network was characterised by feelings of hostility. As with parents who wanted grandchildren, participants' grand parents were concerned about the lack of great grandchildren. Conflict arose when the grandparents suggested management methods which were unacceptable to men and women participants. For example, her grandmother wanted to train woman 4 to become a traditional healer. She believed that her granddaughter's infertility was a way in which the ancestors were communicating that she should become a traditional healer. She responded as follows: "I have made it clear that if it is a precondition that I should join traditional healers before I may have children, then I counted myself out (woman 4)."

Some women who were educated and financially stable felt that the extended family was abusing them, when the extended family asked for financial help. It appears that the women felt that the extended family members assumed that the women had lots of money since the women did not have children to support financially.

> Everyone from the family expects that I am their source. They do not see that I have got other needs. They just see me as a source, as someone who has money, someone who does not know what to do with that money (woman 4).

7.5.3 Extended Social Network

7.5.3.1 Occupational environment

Some women reported that the occupational environment was insensitive to their problem of infertility. The pain of seeing other women colleagues take maternity leave was in itself difficult to deal with. Furthermore, it was unbearable when a colleague, with the intention to hurt, asked woman 4 when she was taking maternity leave since all the women at work had taken the leave at some point. She felt that the colleague was vindictive and she became disrespectful and vulgar with the colleague.

> I remember one day one person I work with once said to me that all women have taken maternity leave, when are you taking yours, in front of the other colleagues, men and women. She was an older person, so I kept quiet as if I did not hear her. When she repeated, I told her that my father does not sleep (sexual intimacy) with my mother and with me. It is something I did not want to say, but she pushed me. I understand that the more I persevere with people; the more I suppress myself (woman 4).

Woman 1 felt inadequate in the work environment when her colleagues discussed labour pains. Although she understood that her colleagues were just chatting in the context of their work as midwives, her inferiority complex was worse when the discussion was carried out by those people who knew that she is infertile.

7.5.3.2 Other social networks

The couple consisting of man 5 and woman 18 usually felt out of social context when going out with people who have children. Both men and women developed an inferiority complex around people who have children. The complex was worse in situations where people who have children were younger than the infertile ones. Women felt that they were more badly affected by the impact

of infertility in social relationships than men. The women also felt that fertile women tended to oppress infertile women in their interaction as indicated in the following statement.

> Men are affected but women are worst affected. That is because women are often hurt. When you are with other women, *o kereya ba go hlaba ka diema* (literally means that you find that they stab you with songs (derogatory songs) in Northern Sotho). Those who do not have children feel hurt (woman 19).

Woman 9 and woman 15 reported that men hurt each other by talking carelessly only when they were drunk. Consequently, man 8 and man 10 did not open up to any one. They avoided people's questions about their personal life. In that way, they were not giving people things to talk about. Man 10 also reported that he does not take remarks from his social network seriously since he does not tell them about his problem.

Some participants (woman 1, woman 4, and man 8) did not associate with those people whom they perceived not to accept their problem of infertility. Others, like woman 4, were usually vindictive in their interaction with the social network. It appears that the women felt provoked in their interaction with the social network and reacted by being vindictive.

> I associate with many of them (people who have children), but only those who accept my problem. Those who do not accept it, I do not tolerate them because they always hurt you (woman 19).

> Maybe for those people who do not have a, b, c, and d attached to their status, is not a problem, but in my case, it is hot. People will say you have got money and, what are you going to do with the money if you do not have children. Even if you keep quiet, people will push you. You develop an attitude, which crush everything. It makes me to have a hard heart. If a person tells me dirt, especially if it is about my inability to bear children, I will go all out to find out who this person is, and why he/she is interested in my affairs. People use our inability to have children as an opportunity to gossip (woman 4).

Although woman 12 became happy when her relatives had a baby, she became annoyed when people asked her how many children she had. She tended to lie about her infertility status.

> At times, it annoys me if people keep on asking me how many kids do I have. It really affects me indirectly. At times I do lie whereas I know I do not have any, because some do not understand if you tell them you do not have a kid. If you tell them that you do not have a kid, they would ask why? You have to answer unnecessary questions. Therefore, I just say two and then I am out of them. If they find out somewhere that I do not even have one, it is their problem. I know they will not come back to me (woman 12).

7.6 Responding to the Impact of Infertility

7.6.1 Ways of Coping with Infertility

The findings suggest gender differences in the use of coping mechanisms. Men tended to deny the existence of infertility as a problem more than women do. Schlebusch (1990) suggests that defensive denial is only useful in the short term. If used as a long-term strategy defensive denial can lead to psychopathology. Using defensive denial helped men to deal with the societal notion that infertility in men should be regarded as non-existent (Mabasa, 2000). It seems, as if society is trying to 'protect' infertile men by keeping men's infertility a secret (Mabasa, 2000). However, This deprives men from mourning openly the loss of biological parenthood, which is also socially constructed. The finding confirms Brody's (1993) assertion that emotional experience and expression emerge as an adaptation to one's social roles and goals. Furthermore, because men and women in our culture often have different amounts of and kinds of roles, power, and goals, different emotional experiences and expressions may be differentially adaptive.

Changing doctors

One common coping strategy used by infertile individuals and couples is simply to change doctors. There are different reasons for changing doctors. In some cases the participants were in denial of the diagnosis and shifted from one doctor to another with the hope of finding a doctor who will disconfirm the given diagnosis. Some participants were confused about the different types of diagnosis and felt that consulting different doctors would clarify the diagnosis. Man 7 appeared to want to change doctors because of his difficulty in dealing with the disappointment of being infertile. However, such 'doctor shopping' could be influenced by experiences in the health care system, and are not necessarily always due to denial of the diagnosis.

Denial

Denial was quite a common defense mechanism among participants. Woman 11, for example, refused to accept that her partner fathered a child outside the marriage and insisted on a DNA test despite the partner's confirmation that he fathered the child. It seems the defense mechanism of denial helped the woman cope with the idea that her partner was having an extramarital child:

> I just tell myself that God will give us a child whenever he so wishes. I sometimes feel bad that other people have children and I don't. I end up telling myself that I should not think too much. God will give a child when-ever He deems fit (woman 18).

As suggested by Schlebusch (1990), it seems denial as a coping mechanism worked only in the a short-term. Woman 1, for example, miscarried in the early eighties but did not believe, for some time, that she was infertile. With time, she became worried that she was not falling pregnant again.

Another pattern of denial involves telling oneself that one is still too young to worry about infertility. This theme emerged from both men and women participants. At the age of 42 years, woman 9 believed that she was still young enough to be able to conceive naturally. As a way of providing social support, her family of origin inculcated this belief. There seems to be ambivalence in her denial in the sense that she also believes that, God willing, she may conceive at an old age just like it happened in the Bible. Man 3 too tells himself that he and his partner are still young and that they will ultimately conceive.

Vindictiveness

Those women who felt hurt by fertile women who sang songs with lyrics or metaphoric expression centred around fertility, birthing and children in their presence tended to use vindictiveness as a coping mechanism.

> Such words don't affect or hurt me because although they are able to bear children, this can happen to their children in future. It will be a painful reminder because they might have forgotten how they used to hurt others (woman 17).

There was a feeling of vengeance and triumph from woman 9 who was in conflict with her co-wife. She moved out of the shared household with the co-wife, their husband moved out with her (woman 9) and he only visited his other wife. The woman reported that her co-wife could be bitter because the husband chose to leave with her despite her infertility as indicated in the following statement.

> He stays with me most of the time. She may be bitter to see that this man is not leaving me. She might have thought that this man would leave me if I do not bear children (woman 9).

Vindictiveness as a form of defense mechanism is also evident from the following narative.

> Avoidance does not work for me because I am a people orientated person. The problem is that a person cannot come to me and say rubbish. I simply tell them that, that cannot be tolerated. If a person irritates me…a person can irritate me with other problems, but this one of a child, makes me angry. I do not have a problem if a person talks about something else. A person once angered me saying that I cannot bear children. I told her that what if one day while driving, you got hit by the train with all your children and you all die. It happened that while her children's uncle fetched them from boarding school, they all died in a car accident. People said that it is long that she has been talking nonsense. It was then that she realised how painful it was not to have children. Moreover, she was an older person; she would not be able to bear more other children. She did have children, she handled them like dolls, and now she does not have them. What is life beyond children? It is equal. You end up being similar. It was more painful for her because she has to deal with it at the wrong time. At least you are not going to face the pain. For her they are dead and, for me, I know that they are not there and, it is not an issue because, they would not have been there. They would be there, if I had the mechanism (woman 4).

Avoidance

Men (man 1, man 3 and man 9) tended to avoid discussions about infertility with their partners in case their partners became negatively emotionally affected. Some women understand that their partners were worried, but did not want to share the worry with them. Therefore, women joined their partners in silence. Other women interpreted their partner's silence to imply that men were not concerned about their problem of infertility. It seemed, in this regard, that avoidance, as a defense did not work because some women were frustrated about their partners' silence.

Using Social Support

Most women and their partners drew strength from their social support resources. Most women found their partners to be supportive. The fact that her husband had given up on treatment and was no longer giving her money to seek treatment made woman 7 believe that her partner was not supportive.

Some women were involved in providing social support to others in a similar situation. For example, women who adopted advised others on how to go about adopting a child. It also involved advising others on specialist doctors and on how to move on - focusing on other life goals. Women expressed the need to form support groups. Men who carried the diagnosis found their partners supportive. They could draw strength from a sense of belonging or knowing that they were not alone, but with their partners in facing the problem of infertility. Both men and women tended to seek and be provided with social support from their families of origin. Having extramarital relationships was a form of seeking social support for some men.

Cutting social ties

Woman 4 coped with her stressful situation by cutting ties with the extended family. She also encouraged her immediate family members of mother and sisters to cut ties with the extended family. In this way, she and her immediate family were able to cope with the extended family's insensitive remarks and perceived demand for financial resources.

> Family members want me to live with one of their children. I just want to put my life straight and leave what people are saying because I cannot control them. I made my decision that I am not turning back. I must see what to do, otherwise, they will enjoy me, saying that I should sponsor them. I no longer want to sponsor anyone. It is unfortunate that I discovered it very late. One way or the other, I have to deal with it (woman 4).

Withdrawing and moving away from an insensitive co-wife helped woman 9 deal with the impact of infertility as illustrated from the following statement.

> I realised that we could end up fighting if I could bear the way she was singing hurtful songs about me in mind. Therefore, I left her with her children so that I could not hear anything from her. Now that I am far from her, I do not hear a thing from her. I am free and relaxed now that I cannot hear anything. It is then

that I feel well (woman 9).

Keeping a distance from the extended family helped some participants deal with pestering parents who always wanted to know when they would have children. However, keeping distance from the extended family also meant withdrawal from social support resources. Hence, there was a feeling of loneliness. For example, woman 4, whose extended family usually met at her mother's house to discuss her infertility, decided to stay away from visiting her mother for a longer period, but in the process also lost some of the social support she was getting from her mother.

Releasing oneself from responsibility

One interesting way of coping with infertility used by participants was to release themselves from responsibility for the infertility. This strategy took a number of forms:

Placing God in control of one's infertility.

The belief that infertility is due to God's will helped some infertile participants deal with the impact of infertility as it by implication released them from responsibility in the matter. As woman 4 put it: "I only propose and God disposes" The fact that there was no clear medical diagnosis led man 9 to tell himself that a child is a gift from God. Since he was 'not given' this gift, his only option was to accept. Woman 9 expressed this idea as follows:

> I believe if many things are not going well, it is how God wanted it. God does not give everyone what he or she wants. You can have everything but not have children. It is how God gave you (Woman 9).

Blaming infertility on witchcraft.

Another way of placing infertility beyond the individual's control, is to attribute it to witchcraft. As alluded to in section 6.4.3 above, witchcraft was mentioned as one of the causal factors of infertility. It seemes that blaming their infertility on witchcraft helped participants to cope because infertility was the outcome of the witch's acts and not of their own making.

Putting blame on medical practitioners.

A much more common coping strategy was to blame medical practitioners. For example, woman 5 had an operation to remove an appendix while she was still young. She reported that the doctors

who operated her intentionally excised her fallopian tube and that her gynaecologist discovered the missing tube as he was operating the woman. She felt that the doctors robbed her of her fallopian tube, limiting her chances of conception. She attributed the incident to apartheid and racism. She was angry that the "white doctors" or "apartheid doctors" (the label she ascribed to the doctors) who operated her did not even tell her that they took out one of her tubes. She believed that it was the intention of the doctors who operated on her, to reduce her fertility. Therefore, she felt not responsible for what happened. One can conclude that her blaming the doctors could either be limiting her sense of responsibility for infertility or due to a lack of knowledge since there is medical evidence that appendisectomy is one of the iatrogenic factors contributing to infertility (U.S. Congress Office of Technology Assessment, 1988).

Another emergent theme in this regard is the suspicion that the medical doctors could have conducted a hysterectomy without the patient's knowledge. For instance, woman 2 who had a laparatomy as part of an ulcer treatment procedure, suspected that the doctors who operated her could have taken out the uterus. She also held her husband responsible for her infertility because he took her to the hospital for the ulcer treatment. She used this as a coping mechanism in the face of her partner's aggression who often shouted at her that he wanted a child.

> I told him that all this illnesses (including the ulcer), I contacted them here (after her marriage). It was you, who took me to the hospital. I don't know whether they removed the womb or if something else happened (woman 2).

Concurring with Upton's (2001) finding, the results suggest that placing the explanations of infertility in this context help infertile persons redirect infertility outward. Seeing infertility as a product of God's will or witchcraft or of medical mishaps meant that infertility was beyond the individual's control. It was in this way that infertile persons were able to renegotiate their status in the society. It seems that attributing infertility to the outward forces enabled infertile individuals to re-negotiate their status in the community since they were not responsible for their infertility.

Focusing on alternative goals

Some participant found escape from the problem of infertility by focusing on improving their careers.

> I did not have time for stress. I was engaged in my studies. I did not put that problem in my heart. I even forget what kind of a person I am when it is time to study. I forget I have this particular problem. Once I finished studying, it was then that I would think I have a problem (woman 14).

Others escaped infertility through their employment or by interacting with similar others:

> I like working with women and children in community projects. That is why I end knowing who has children and who does not have. So I go to that person and talk to her, woman to woman. I tell her not to be surprised, we are not alone; it is God's will. Then they will open up. If you group yourself with similar problem, you can solve the problem and save yourself from talking with your heart (worrying), causing yourself mental problems (woman 9).
>
> I want to advice women that they should know that to stay in *bogadi* is not due to children. Children are God's blessing. To stay in *bogadi* is just a matter of you being in love with your husband. You can give birth to ten children and then you may commit suicide because this husband may leave you and go to a woman who has no child or who has two children. Then you remain with a burden that you can cope with. My intention is to advise women who do not have children and those who have children that they must not think that we the childless are desperate and suffering too much. They must know that we are acceptable in the community, the same way as those who have children. The big thing is that marriage is for lovers and children are fruits of love (woman 9).

The findings suggest that both men and women had a family model which includes children in mind when they married. Therefore, pursuing other life goals seems to be some kind of a forced choice, a choice that is mostly made after a long period of infertility (Van Balen *et al.,* 1997). Only infertile women in this study identified alternative roles in order to resolve the crisis of infertility. They identified following a career as an alternate role:

> After two years of seeking treatment, I decided to go back to school. I realised that I could not solve the problem. I wanted to do a nursing degree, but I could not choose a nursing career since the training took longer, which could have limited my chances of conceiving after completion, because I was advised by a doctor to have children as soon as possible (woman 4).

Following a career did not seem to work for some women. It was difficult for them to adapt to alternative gender roles. As Gergen and Davis (1997) pointed out, if people have only one version of family life to follow they become limited in the vision of their lives. Women's deconstruction of their infertility by following other life goals like a career become thwarted, because of viewing

childbearing as the only mandate for women.

> Success is a benefit if you originally wanted to be like that, but if it is by default, it hurts. Like the first time when I had my diploma, it was very painful. It was like, I got this diploma, it pays highly, and the money that I am having, what am I going to use it for (Woman 4)?

Woman 1, who is a nurse, decided to follow a career in midwifery. She wanted to observe the experience of pregnancy and childbirth. It appeared that she found role fulfilment in helping other women during the birth process. It appears that occupational identity is a form of grief work for her.

> As a nurse, I thought of specialising on working with pregnant women and women giving birth. At first, I wanted to close the gap. I wanted to understand the process. That is, how is it like to give birth? What is expected from the person when she is in pains and what she expects from you as a nurse, in return? It came to a point where I realised that if you have not had the labour pain, you are missing a lot. You do not understand when a person is in labour pains. Even if you read books, there is still something that you can still experience from labour to be able to talk about it. Like they say, you can talk much better if you have experienced the issue. ...I felt satisfied that I helped someone else give labour, and I saw the procedures as they are. When in labour, some women give birth calmly others are like crazy. I often ask myself where would I fall between the two, if given the opportunity (woman 1).

Woman 4 became involved in community development projects where she mostly worked with children. She was an ambassador for HIV and she gave motivational talks, therefore, she reported that: "I do not see how my life can be empty".

Minimising

Some participants coped with infertility by minimising the extent of the problem. "I have a problem with my tubes, but it is not a serious problem. I will go back so that they open them (woman 18)."

Normalising

Normalising as a defense mechanism took the form of avoiding interaction with similar others. In this way, the infertile felt normal by interacting with those who are perceived to be normal (the fertile persons). Woman 12 stopped attending a support group for infertile women as a way of

coping.

Another, opposite, form of normalising was through interacting with similar others. Infertile persons felt normal while with other infertile persons. Women tended to associate with similar others. Some men did not appreciate their partners interacting with similar others. It seemed that men perceived the interactions to be emotionally charged, thus, making it difficult for women to cope. Other men found the interactions to have a negative influence on the marital relationship in the sense that women became empowered to challenge their partners. Man 8, by contrast, was concerned that his wife was not interacting with similar others to help her cope with the infertility.

The tendency of community members to see infertile persons as hostile (Mabasa, 2000) could have contributed to some women developing the hostility through the way in which the community members interact with infertile people. It seems that infertile persons became vindictive as a reaction and a way to deal with the humiliation from the social network. Andrews *et al.* (1992) state that there are no purely adaptive or maladaptive coping strategies, only that some may be more adaptive at the time. There is room for flexibility within the stress process framework, in the sense that coping styles may to a certain extent transcend the influence of situational context and time on the choice of coping strategy. This notion gives an understanding as to why some participants used coping mechanisms that could not be socially or culturally explained, such as cutting social ties.

7.6.2 Gender Differences in Coping Mechanism Used

Besides the differences in emotional expression of feeling, men and women differed in terms of their coping mechanisms. Some men tended to play a supportive role, attempting to exhibit strength and to restore equilibrium. They tended to avoid discussions about infertility as a way to maintain the emotional balance. It seemed that avoidance was interpreted as a courageous way to deal with the feelings of helplessness.

> We normally do not talk about this, because she usually gets emotionally affected. I believe we are able to deal with it in that way. I hate to see my wife become affected. It pains me a lot, but any way there is nothing I can do. I can't really tell, but one is supportive and courageous (man 5).

Engaging in extramarital affairs seems to be another way of seeking social support for men. The men stated that they had extramarital affairs for pleasure, and not to procreate. Woman 5, who engaged in an extramarital affair, on the other hand, reported that she was hoping to conceive. Her husband acknowledged during the follow up interview that by having an extramarital affair, his wife wanted to conceive so that she could please him.

Men tended to use defensive denial as a means to cope with the impact of infertility. Even when man 6 had the primary medical problem, his denial of the difficulty was powerful. The findings suggest that having a physical defect made it difficult to cope with infertility. Man 6 who had low sperm count and woman 5 found it difficult to cope with infertility.

> Some advised me that it is God's will. I am trying to accept the situation. The other day I was talking to another woman, she is fine and coping well, but she does not have a child. However, it is difficult to cope for me because of the removed tube (woman 5).

7.6.3 Using Alternate Management Options

Participants tended to look for alternative options as an attempt to resolve infertility after all the avenues (traditional doctors, prayers, and modern doctors) were exhausted.

7.6.3.1 Alternate Parenting

Social reproduction exists besides biological reproduction and has four universal components. These are (a) provision of civil and kinship identity and status (including residence rights and inheritance/succession rights); (b) nurturance; (c) training for an adult role; (d) sponsorship into the adult community as a full member of it. The four components are distinct from each other and do not have to be located in the same adult (Lesthaeghe, 1989). Thus, infertile individuals are not immediately cast as non-persons or invisible, because there are ways to 'remedy' one's social status. One of the remedies available within African culture is to adopt one of several alternate parenting roles (Upton, 2001)

'I will marry a wife to bear us a child': Surrogate parenting

The transfer of sexual and reproductive rights to another member of the descendent group in case of apparent infertility (Lesthaeghe, 1989) is still prevalent. As a potential chief mother, woman 7 decided, as demanded by her culture, that she would find a surrogate to bear her a child, who would become a future chief.

> I will marry a wife. I will take my brother's daughter and marry her so that she could bear us a child (woman 8).

Although woman 7 is a Northern Sotho or a Pedi, she is not from the Lovedu ethnic group who are also Northern Sothos. Woman-marriage has been a common practise among the Northern Sotho people of Lovedu descent (Lesthaeghe, 1989). One could infer from this finding that woman-marriage was not necessarily restricted to the Lovedu ethnic group, as is implied by Lesthaeghe. Moreover, I have also witnessed woman-marriage from the Vatsonga ethnic group. It appeared that in this case the two families (of woman 7) had discussed and agreed upon this form of surrogacy. Her niece was identified to become a surrogate. It seemed to be agreed by all that their cultural heritage allowed for her to marry her niece on behalf of her husband.

It seems in this case, woman 7 gave her niece a choice of either becoming a surrogate or to marry woman 7's husband. She indicated that she would not like her niece to feel tied to the marriage with an old man (her husband). Therefore, her niece could just procreate with her husband and leave. It seemed that the woman had some power, in this regard, to decide after treatment failure to marry her niece. Her partner had given up on treatment and was just waiting for her to give up seeking treatment and act on the surrogate decision.

Vicarious parenting

Some informants experienced the role of parenting vicariously :

> They are so happy when I take their children during school holidays. I become very happy when they visit me. Even the kids are happy with *mmamogolo* (Setswana for elder mother [aunt]) (woman 12).
>
> Last year (1999) we stayed with my sister (younger sister). She has a child and I was happy to take care of the child. I usually forget that I do not have a child

in the presence of a child in my house (woman 13).

> I like my younger brother's kids like they are mine. Even when I go to her family, I treat her younger sister's kids like they are mine. I will not push the situation of moving out of the house because I will be staying by myself. She will only come on weekends (wife works far from home, she comes home for weekends) moreover, I would be moving away from the children. I might feel lonely (man 9).

> I enjoy spending time with my sister's and brother in-law's kids. Doing things for them makes me happy (woman 19).

This form of parenting is relevant in the South African context since only 26.5% of women in the child bearing age (15-49 years old) live with their husbands but no other relatives in the same house hold. The rest (73.5%) are in a position to experience vicarious parenting by virtue of living with other members of the extended family in the household (Moultrie & Timaeus, 2001).

Fostering

The findings suggest that fostering, as a way of managing infertility, is rare in African context. Instead, infertile individuals turn to adoption. However, adoption is typically not a formal legal arrangement, but a traditional one. There is a common theme that the interviewed infertile individuals and family members did not want to ask for a child from relatives for fear that the child might go back to his/her own parents at a later stage. This is indicative of general absence of fostering, since fostering was not seen as a sufficiently permanent arrangement.

Only woman 14 was fostering. It seems that her reason is not directly related to infertility management. She was fostering her niece, whose mother had died. Therefore, the niece came to live with her grandmother. Thus, the child's aunt (woman 14) played the mothering role.

7.6.3.2 Adoption

Lesthaeghe (1989) concluded that adoption is absent in Sub-Sahara Africa. The findings in this study indicate an attitude change on adoption issues. The change of attitude towards acceptance of adoption as a form of alternate parenting also seems to be in resonance with the prevailing acculturation. For example, woman 9 adopted a child outside the family in a formal way, an

indication of change in adoption patterns among Africans. A few decades ago, most references to 'adoption' in the literature seem to refer to the transfer of child rearing rather than the transfer of identity (Lesthaeghe, 1989), as is described below.

Woman 4, woman 9, and a couple consisting of woman 1 and man 9 had adopted children. Woman 4 familially adopted two children, one from her biological sister and the other one from her cousin's sister. Her cousin's sister's child went back to his biological parents and she remained with the child adopted from her biological sister. Couple consisting of woman1 and man 9 adopted man 9's elder brother's child in a familial way. The child went back to her biological parents after living with the couple for almost 10 years. It seemed that adoption in African context refers to a transfer of child rearing or of sponsoring rather than the transfer of identity. The identity that a child acquires at birth is not manipulated (Lesthaeghe, 1989).

This form of adoption cannot be explained by Lesthaeghe's (1989) notion that religious beliefs concerning the importance of the ancestors and the importance of descendants for performing ancestor rites, are probably highly significant factors, especially since woman1 had adopted within the biological family.

7.6.3.2.1 Familial adoption

All forms of adoption was unacceptable to many of the participants, but asking for a child from relatives to live with (familial adoption) was more conceivable as compared to formal adoption. However, it seems that familial adoption was seen not as a permanent arrangement, and hence, it was disagreeable. Familial adoption was equated to having borrowed a child from relatives. There is no sense of ownership of a child since what was just borrowed (meaning the child) as stated below, would at a later stage need to be taken back to the lender:

> If you do not have a child, you can always negotiate with those relatives who have children to borrow you one and that be your gift and you will treat him/her like yours (FO 1).
>
> No one will ever give you a child to be yours. They just borrow you, just to stay with him/her. Therefore, I said I don't want that. Mine will come whenever he/she could come. I don't want another person's child (woman 5).

Some women were agreeable to formal adoption, but their partners were against it. This suggests that women had a need to satisfy their mothering role. Men on the other hand, were not concerned about fathering, but needed a biological child to carry the family name. However, having a biological child or a 'blood child' as the participants called it, was not necessarily restricted to men. It is just that unlike men, women are willing to look at adoption as an alternative. "Every woman is proud of her own child. The love for a blood child and another child (adopted) will not be the same (woman 5)."

The fact that some participants looked favourably on the idea of familial adoption seemed to be closely tied to the fact that there are blood ties in familial adoption. Consequently, men were more agreeable to familial adoption than women. Some could not live with a child provided from the family because the woman (e.g., woman 5) in the couple system did not want to.

It seems that the prevailing practise in which women take the more active parenting role contributed to women refusing familial adoption. It appears that women felt that their parenting skills would always be scrutinised by the child's biological parents to check if 'their' (biological parents') child was well cared for. Woman 5 also believed that instead of a familial child bringing happiness for the couple, the child's presence could lead to marital conflict. She described the situation as follows:

> They gave me a child, but I realised that it would not work. His family brought a baby, but he told them to come back when I am there. I was not going to love the child. He was going to cause problems between us. I would not love the baby as my own because I do not know how to love a child. I would not love the child. I do not want to have someone else's child and abuse them (woman 5).

Adopted children seemed to use this uncertainty to their advantage especially during adolescence where matters of discipline brought conflict between children and their parents. For instance, the adopted child of a couple consisting of woman 1 and man 9 always threatened to go back to her biological parents when her adoptive parents disciplined her untoward dating behaviour.

> The reason they took her away was when I talked to her. I hired her room at school (tertiary institution). I realised she was no more attending school. She was staying with the boyfriend in that room. That is what made us to differ, when I told her that no, you cannot because you are supposed to go to school and attend your sessions regularly so that you can progress. Is it not that when a child is at that stage, if you try to call her to order you become wrong? To her mother, it did not sound like that, it was that I mistreat the child. She did not go very far, now she is pregnant (woman 1).

Thus, other reasons for women's negative attitude towards familial adoption were based on negative experiences. This process hurt the two women (woman 1 and woman 4) whose familial adopted children went back to their biological parents.

> The process is hurting. I have got one son whom I raised from childhood. He is my younger sister's son. I am picking up problems about him. The process is hurting. The one of my younger sister, his father says *ngwana ha rekiwi* (Northern Sotho words meaning that a child cannot be bought). Moreover, he does not tell me directly. He tells other people. I also raised another one of my sister (cousin sister) from my elder mother. I chose to raise him. I went properly to ask for him from the family. When they came to take him, they did not come properly like I did when I asked for him. Imagine when a child is a street kid, smoking glue and all sorts of things. I had to work very hard to make him a disciplined child. They took him behind my back. They stole him. He was not even accepted at school. I had to go all out to make him right (woman 4).

> I cry for the wasted time. I regret, from scratch, I did not push this idea of having a child who is a family. However, my husband did not understand. I thought that would help him or help both of us, but we did not succeed. Instead of bringing joy, it brought unhappiness (woman 1).

Lessons which these women (woman 1 and woman 4) and man 1 learned made them develop negative attitudes towards familial adoption. The following extracts illustrate the women's change in belief system with regard to familial adoption.

> The best method is not to raise another person's child (familial adoption), but it is to go for adoption (formal adoption) from scratch. Not to waste time because you will be hurt unnecessarily. On the other hand, it is what belongs to them (biological parents). They (infertile persons) should learn to deal with separation anxiety when I (biological parents) take my glass that, I (biological parents) loved so much because it is mine. How I (biological parents) take it is not an issue. Some (biological parents) will say: "Thank you" (to adoptive parents), others will say: "Bring my glass" (woman 1).

> I do not want conflicts anymore. I must just deal with myself. Moreover, I have got just one son. He is the only one I will struggle with. Just to see what happens. It depends on what his mother says (woman 4).

7.6.3.2.2 Formal adoption

Formal adoption seems to be a problem to most infertile persons and families interviewed. These negative attitudes towards adoption could in part be due to lack of information and understanding as expressed in the following narrative.

> I do not really appreciate to adopt a child, maybe I never thought about it. I never thought that I would adopt a child one-day because I would not have one of my own. Maybe if I get professional help in this area I will change my understanding, but I do not know (man 5).

Adoption was not an option for the couple consisting of woman 7 and man 3 who was under pressure to bear a future king. The kingship was based on blood-line, and as such only the man's biological child could become a king. It appeared that the decision to adopt was dependent on the reasons for wanting a child. This could be shown from the following expression: *"Ke ka moshate. Go ka si* gonege." Meaning, "it is in the royal house, it won't be possible" in Northern Sotho.

The findings indicate that infertile women were more agreeable to formal adoption than men and family members were. It appeared that women were more concerned with fulfilling their mothering role either way. Fathering was not a primary issue for men. These notions affirm the need to distinguish between gender-ascriptive and gender-bearing roles. Gender-ascriptive roles imply persons of a particular gender (mother, father, son, and daughter). Gender-bearing roles, on the other hand, need not be inhabited by a person of any particular gender but have empirically come to do so (Imam *et al.*, 1997).

Instead, men were concerned about family continuity and affirming manhood.

> As I said, it would be very nice for one to be a father of a child. It is very nice raising your own child. And, I believe in fulfilling one's manhood (man 5).
>
> As a black man, I could not understand (agreeing to adoption) (man 1).
>
> We will live happily until we decide to stay with a relative's child. So far, I do not see a need to have somebody else's child around. I do not even think of adoption, well it is OK to adopt but we wanted our own baby. I can't go for adoption. If need be, I can take my brothers children to stay with (man 8).
>
> What are the reasons for adoption, to have a baby? No, it will not give us our own baby. Whom are we going to tell that now we have a baby, knowing that we don't? We could rather have a relative's child around (man 2).

The concern with having a 'blood child' was not limited to men. For example, adoption did not seem to take away the need to have a biological child for woman 9, who had adopted a child with her husband. She felt that it was only one's own blood child that could make her satisfied. Moreover, there was a concern that one could have adopted a 'wrong gene'. There was also anxiety around the possibility that the 'real' parents would take the child whom the couple had adopted. These justified the continued quest to have one's own blood child.

> You find that you have adopted this child and maybe his/her mother was a drunkard or his father was a thug. The child becomes a drunkard when he/she grows up, where as my husband and I do not drink liquor. Then you develop bad feelings towards the child. This could make the child to feel somehow because you will end up saying it is not ours. You will say, maybe if it were our own blood, he/she would not be this way (woman 9).

Woman 12 had similar concerns, saying: "You will end up getting *bana ba di rape* (Setswana for children of rape). This supports Miall's (1998) finding that adoption is often pathologised. Similar to the western perspective, negative attitudes towards adoption in this study are often linked to the expected deviancy of the child (Van Balen *et al.,* 1997; Mabasa, 2000).

Another issue here is the way in which both the African tradition and clinical practice seem to contain a powerful bias in favour biological parenting. Adoption as an alternate parenting experience is defined as inferior to biologically reproducing and parenting a child and is considered a choice of last resort (Mabasa, 2000; Miall, 1994). Moreover, societal attitudes dictate that there is no solid ground upon which a woman can stand to get a clear fix on what it would be like to

be a 'co-mother' or a 'child-minder' instead of 'real' mother. The societal beliefs here is that a woman is the one who knows what it means to carry a child for nine months 'heavy under her heart,' to bear a baby 'in blood and pain', to suckle a child (Tong, 1997). One can conclude in this regard, that it seems that social parenting and alternate parenting is only acceptable to those women who proved fertility and experienced child birth in the eyes of the society.

However, some infertile women in the current study were agreeable to the ideal of alternate parenting and were practising it. This finding is in contrast with the Western cultures where alternate parenting is not preferred. According to Van Balen *et al.* (1997) alternate parenting is perceived as care giving rather than as pursuit of an (egoistic) desire to have children. One can conclude that this does not mean that alternate parenting is totally rejected in a western context, where there are the same kinds of ambivalence, that is, various kinds of prejudices and fears, but also some pragmatic acceptance similar to those reported by participants in the current study.

7.6.4 'Life goes on': Deciding to Let Go

Deciding to let go could take the form of deciding to stop treatment and acceptance. Some men and women had stopped seeking treatment and others were still speculating about discontinuing seeking treatment. The cited reason for stopping seeking help included financial loss when there was no progress. The experiences with the helping system contributed in deciding to stop seeking help. A traditional doctor told woman 1 that there was nothing wrong with her and promised her that she would conceive. "The anticipation was emotionally taxing ... until I felt it was too much. After the pains I decided to adopt a child from the family (woman 1)."

Factors that contributed to letting respondents who decided to stop/take a break or contemplate stopping included perceiving the risks. These were the cost of IVF and financial risk, risks of becoming a parent at an older age for some (woman 4 and man 2), damage to the body (woman 5, woman 19, and man 2), and losing hope (woman 10 and woman 15). The extracts below illustrate the process and factors involved in deciding to let go.

> We have already accepted the news. It does not make me feel depressed any more. We are not becoming sick or not being able to sleep because of it. We

> have accepted it or else we will keep going to doctors time and again. We will even suffer from heart diseases because of it (woman 9).

> I accepted because I realised that it would be impossible for me to have children naturally. I want to prepare myself to be emotionally stable, so that I can take the life forward. More so that I can do whatever I can because I cannot change things which were not meant to be changed. I did not opt to be like this, so the sooner I accept myself as I am the better (woman 4).

> When it fails (IVF), we will just accept it and continue, life goes on (man 9).

> I have decided to take a break. It is bad to keep on taking medication even if you do not see its function (man 5).

Acceptance signifies the last stage of the grieving process. Both woman 1 and woman 9 adopted a child each, two and three years ago, respectively. Their responses below indicate how they progressed to the acceptance phase of the process of emotional turmoil, and accepted being infertile.

> At first, you will never know whether you will have children or not. You try many times until you realise that I am running at a loss here. ... I started giving up, realising that I am not progressing here. Instead, it was as if I was feeling the pain (painful treatment procedures) for nothing (woman 1).

> I realised that I was failing. I then told myself that there is nothing I can do except to adopt a child. Therefore, I have adopted a boy child because I know and accepted that God knows everything (woman 9).

However, the findings suggest that one can, from acceptance, restart the emotional stages of the infertility experience. Woman 9 had again entered the cycle of hope and potential despair. She had resumed seeking treatment during the interviews for this study. She further stated during the interviews that she was still young and that it was possible that she could conceive. She further reported that she wanted to adopt a baby girl. When asked, "how long did it take you trying doctors until you took a decision to adopt a child?", she reported that:

> It took me a long time; it is about twenty something years. Still, I am from doctors even now. I still have faith. There is a possibility that I can meet with a doctor whom God has chosen for my treatment (woman 9).

Similarly, woman 1's struggle with infertility was not over despite her acceptance of her situation. Difficulty with the acceptance of infertility emerged when she and her family relocated some time after the couple had a familial adoption. She pretended that her familial adopted child was biologically hers.

> The other thing with infertility is that you just do not accept that you have a problem. When we came here with the child, it was as if this child was mine. I was pretending that it was my own child, treating her as such, until I realised that it has leaked that it was not mine, and that I was just lying (woman 1).

7.6.5 The Struggle Continues

Most participants had similar stories to tell of on-going struggle. Woman 9 hoped that she could still be able to conceive even in old age, just like Hanna in the Bible. The woman and her partner had adopted a child formally. They were also still seeking treatment as indicated in the following narrative.

> It took me a long time, about twenty something years. Even now, I still am from doctors because I have faith. Isn't that a person could meet a doctor whom God has chosen her for the treatment (woman 9)?

Her husband described the situation as follows:

> We are still trying. A woman will not do that. She insists on saying that she is still young. It is still going to take her a very long time before she could give up and accept (man 3).

One could argue that these participants have 'regressed' from a position of acceptance of their infertility, but again pursuing treatment even when there seemed to be no hope in the eyes of others does not necessarily imply lack of acceptance of infertility. In seemed clear, for example, that in the case of woman 9 infertility no longer caused her much stress, but that her belief system simply did not allow her to loose hope that her God could want to perform a miracle that she would conceive a child at old age. By contrast, woman 3 seemed less clearly to have reached a point of equilibrium. On the one hand she indicated quite clearly that he had accepted her infertility:

> I accepted it and I decided to continue with life because our marriage is not only based on children but also love (woman 3).

However, she broke down during the interview and reported various negative emotional reactions which could indicate that she was not emotionally stable. It seemed that the condition of infertility did not progress through the stages of loss with the final stage of acceptance. Instead, she appeared still to be riding the roller coaster of emotions with no absolute acceptance of infertility. For some participants, it seemed, the struggle with infertility would never reach finality.

7.7 Conclusion

Infertility is a deeply distressing experience for many individuals, couples and family members. In Africa, as elsewhere, social and personal identity appears to be important motives for child-bearing. It seems that infertile persons who place a particular value on biological parenthood are more affected than those infertile individuals who found other constructive ways to contextualise their infertility.

The findings suggest that some individuals who are struggling with the pain of infertility can reach a good resolution of their loss and grief. Through that resolution comes greater self-understanding, commitment to their marriage for those who are married, and satisfying connection with the family-of-origin. There are others who have difficulty in resolving infertility. For them infertility is a continuos struggle characterised by emotional chaos.

CHAPTER 8
INTEGRATION AND DISSEMINATION OF FINDINGS

8.1 Introduction

This chapter presents an integration of major findings of the study, recommendations related to clinical practice, and a discussion of the implications of the research method used in the study. The chapter also provides information on how the findings of this study will be disseminated.

8.2 Integration

8.2.1 Implications of Findings

One of the objectives of the study was to describe and interpret the psychological experiences of infertility of African women, their partners, and their families. The findings suggest that infertility is experienced as exacting both a physical and an emotional toll. The physical toll is experienced in the form of surgical operations such as the hysterosalpingogram (performed to look for blockage in fallopian tubes) or less intrusive but potentially demeaning procedures such as masturbation into cups to collect semen specimens. The experience from the traditional healing context presents itself also in the form of unpleasant operations such as is required for the treatment of *rigoni.* Other treatment procedures such as *ku sweka nxangule* and *ku phalaza* are also physically taxing. In addition to the physical toll, these procedures are often also emotionally and financially draining for infertile individuals and their families. The major emotional toll is a deep sense of loss that engulfs both infertile persons and their families. This includes the loss of self-esteem, sexual identity issues, feelings of loss of control of one‘s life and goals, loss of privacy, loss of important relationships, loss of security, loss of hope to parent a biological child, and loss of continuity of blood line. Other emotional experiences are those of shame, stigma, and feelings of deviance, being labelled as a failure, guilt feelings, anger, and isolation.

Women have tightly controlled roles as biological and social producers, with fertility a central area of control within a broader patriarchal societal structure. Fertility confers social status and allows women to meet societal expectations, but it does not make them autonomous through fulfilling

these roles.

The extended family has evolved along with other changes in South Africa. In the current study it became clear that family economics, financial arrangements, and decision-making rules about family resources influenced the whole process of infertility, from the awareness of the crisis of infertility to struggling with acceptance. The findings suggest that the extended family interfered with every aspect of the infertility process in infertile persons. It seems that infertility threatened the foundation and survival of the extended family as an institution to such an extent those family members felt that it was their responsibility to make sure that infertile individuals and couples have children.

The fact that family members wanted to know when the couple would be having children indicated socialised assumptions that everyone should be able to have children. It also indicted that infertile persons did not usually communicate their infertility with the immediate extended family members. Therefore, as much as the question could be a means of applying pressure, the question, "when are you having children?", could also indicate that family members were initially not aware of the infertility.

Over involvement with the individuals' and couples' business of infertility also took a form in which family members played the role of decision making for the infertile persons. It was the family which encouraged men not to marry an infertile woman and should the man happen to have married the woman, the family would encourage the man to divorce and marry another wife. This happened even in situations where there was a possibility that both partners carried the diagnosis. Infertile persons, especially women, were forced to follow traditional practices of consulting traditional healers, and in some cases were advised to have extramarital affairs.

This caused conflict within the family since some infertile participants were averse to this kind of the family interference. It seems that families were trying to offer social support. However, the generation gap, socio-political changes and different belief systems between infertile persons and their families made it difficult for most infertile participants to see the behaviour of family members as social support. Instead, most of the active behavioural strategies of family members were viewed as an additional stressor. The above findings relate to the study objective to determine the

perceptions and practices of African women and their families with regard to infertility.

Other issues relating to the objectives of the study involve communication patterns about infertility in most families. These patterns were found in some cases to be deviant in that family members avoided talking about infertility, discussed infertility only with one member of the couple or with a sibling. The positive form of family involvement came about when family members offered financial and emotional support to the infertile individuals. Thus, the findings indicate that families could be both sources of social support and stress for infertile individuals.

8.2.2 Implications for Practice

More than a decade ago Mathews and Mathews (1986) called on family life educators to focus more attention on infertility. The findings of this study endorse such a call, especially in relation to psychotherapy modalities. The findings also confirm that there is a place for psychological intervention in the infertility treatment process as advocated by Schlebusch (1990). The findings indicate that in the current medical system there is insufficient emphasis on psychological intervention as an option for those who struggle with the problem of infertility. Mental health practitioners have a responsibility to educate the society to be sensitive and where possible, be supportive to those whose hopes for biological parenthood have not been realised.

Focus of infertility counselling and psychotherapy

The types of counselling required include information counselling; implications counselling, that is, exploring the implications of the options open to infertile persons; support counselling and therapeutic counselling. It should however be noted that some people never need counselling while others need help to adjust to infertility (Bryan & Higgins, 1995). The divergent issues that participants in the study were dealing with and their different ways of engaging with the process of coming to terms with infertility suggest that a variety of different counselling and therapy needs should be catered for.

Therapy should focus on helping infertile individuals reconstruct a meaningful life vision that does not include biological children. There should also be therapeutic support for couples where one partner is fertile and chooses to have children by 'stealing outside', for example. This should

involve re-evaluation of beliefs, needs, and priorities. The goals of psychotherapeutic intervention should involve working through disclosure, examining the pros and cons for disclosure/privacy, and helping the couple to make their own decision. The therapist can help the couple in identifying the threat, appraising the threat and protecting oneself from self blaming and telling others/not telling others.

Addressing individual needs

One of the needs of potential users of counselling and therapy services concerns the reduction of distress and improving communication skills and ways of coping with infertility. The approach should therefore include the analysis of the crisis of infertility, the emotional stages experienced by the individual, and of the communication patterns she or he engages in.

A woman-centred approach to counselling has long been suggested (Daniels, 1993). This study reiterates Daniels' (1993) recommendation for a women centred approach for the following reasons. When infertility treatment continues to be unsuccessful, this study suggests that women may need to be counselled about re-considering their perceptions of a childless lifestyle and their sex role beliefs. Women may need to be helped to redefine various sex-role beliefs or to meet the psychosocial satisfaction of having children through other roles. The women-centred approach is especially relevant in the South African context where, in many cases, single women rather than couples seek treatment for infertility - either because they are not married and do not have a partner or because the partner refuses to accompany the woman.

Emotional needs of the couple

Besides the challenges of infertility to the individual, there are also challenges that face the couple system. The findings suggest that medical infertility treatment should not only be focused on women, but on couples, especially at the beginning phase of treatment seeking. Improved recruitment strategies for seeking psychosocial treatment focusing on depathologisation could be helpful for infertile persons who have marital distress. It seemed that couples with infertility could be helped more effectively if psychological help was not described as 'therapy'. Moreover, the reduction of distress and the improvement of coping skills should not be regarded as the only gaols for counselling, but marital enrichment too, could be encouraged.

The findings of this study confirm Williams *et al.* 's (1992) observation that an infertile couple is faced with a multitude of decisions to be made. These involve decisions about whom to tell about infertility, when to seek treatment and when to stop seeking treatment, and what kinds of alternate management options to choose. Therefore, a couple may need help so that they make informed decision. Where there is dispute, the therapist could use decision-making interventions to help the couple in reaching consensus.

Practitioners working with infertile couples may need to assess how each partner views the other and how each interprets any perceived differences. It should be recommended that couples maintain open discussions with one another on issues related to infertility. According to Tolman and Szalacha (1999), women have the power to care for and to connect, using these traditional feminine abilities to help men change. These abilities in women may open up a space for both the man and woman to talk about their subtle experiences of having different power bases in the family, potentially opening up space for different power bases in the family. This study found how infertility sometimes impairs sexual functioning. Thus, therapy could focus on improving the couple's sexual relationship using sex therapy.

The psychological intervention needs to focus on both members of the infertile couple, with attention being paid to selecting interventions that are sensitive to the particular needs and social and medical realities of infertile women and men. It is also important to support the couple as they negotiate their way through finding solutions that are acceptable to both of them in terms of both traditional and modern African culture. Counsellors and therapists have a tendency to think first in terms of the 'western' nuclear family model, but as this study illustrated, many African men and women use a blend of traditional and modern African understandings and practices in their attempts to deal with infertility

Addressing the family system

Not a single case study could be found in the literature dealing with treatment strategies involving the family and the extended family. Yet, the findings of this study reveal that families and extended families do become emotionally involved when there is infertility in the family. It is an enormous challenge for South African therapists to find ways of conducting therapy that include the extended family in the definition and management of the problem. It is important that such therapy

and counselling should be started at the initial contact with the medical system while everyone in the family is still engaged and has hope; and not to wait until the 'woman' is left alone in her struggle with infertility.

Addressing society

South Africans need re-education in regard to interpersonal sensitivity in many areas of life circumstances. The re-education strategies need not be focused in one area but could encompass a broader perspective. Existing educational and intervention programmes such as those on HIV/AIDS prevention could for example include issues relating to infertility. Youth programmes could likewise incorporate material on fertility. Such educational interventions should include a focus on gender sensitivity and confront cultural prejudices that infertility is a female affair. Programmes should also refer to the specifically African cultural issues around fertility highlighted in the current study.

Self-help and support groups

The reflected value of support groups in this study suggests that counsellors be encouraged to facilitate the setting up of and operation of such groups among people experiencing infertility and infertility treatment. The organisation RESOLVE established by Barbara Menning in 1974 provides telephone counselling, advice and referral, support groups, and educational programmes for the West - and counsellors should be encouraged to refer clients to such organisations. Sewpaul (1995) has also reported on the existence of a support group for infertile individuals in Durban. Beyond these piecemeal efforts, there is a need for a co-ordinated national strategy and implementation of support groups in South Africa.

With limited resources in South Africa, most psychological intervention can be channelled to group psychotherapy or group counselling. Attending support groups or self-help groups can foster a feeling of 'we are all in this together' that helps diminish feelings of social isolation and loneliness.

The multidisciplinary team approach

As sources of social support, medical personnel need to be aware of the perceptions of their patients. Like mental health practitioners who need to be conversant with biomedical aspects of

infertility, medical practitioners too need to be familiar with the psychological aspects of infertility. Daniels (1993) warns against a tendency to view counselling services as an adjunct to the main purpose of infertility clinics. Psychological intervention could involve the therapist as a member of the infertility treatment team or as an independent practitioner in a therapeutic relationship with a patient in which infertility is a secondary treatment issue.

The approach should include the analysis of the crisis of infertility, and the emotional stages experienced by the individual. Clients are often referred to the counsellor in expectation that their emotional needs will be sorted out. Instead, counsellors need to be a vital part of the infertility team from the point of client entry to the point of exit. Educating other members of the multidisciplinary team should be another role of the counsellor. The reported problems linked to the doctor patient relationship and communication in this study could in part be addressed through such educational programmes.

Consideration of the cultural context

Cultural considerations are particularly important in South African clinical practise because of the multicultural nature of South African society. Practitioners, both medical and psychological, must be made more aware of the perceptions of their patients that are informed by traditional African beliefs and practices.

The finding that most participants in this study consulted traditional doctors cannot be ignored. There have been debates on either the collaboration or integration of traditional healing into the modern medical practise, but to date not very much has been done to turn this into a practical reality. The simple reality, as demonstrated again in this study, is that many consult both traditional and modern medicine in their quest for help. This situation can no longer be ignored.

In taking account of cultural issues, counsellors and therapists should not, however, be tempted to fall back on a reductionist view of African culture. It is clear from the current study that cultural practices are in constant flux and often arise in a context of contestation, with partners and their families not necessarily agreeing about what the culturally and personally appropriate ways forward are. Some traditional African practices may, for example, be seen to be in conflict with Christian beliefs or with Western ideas regarding romantic love, and counsellors and therapists need to learn how to mediate in a culturally sensitive and respectful manner when such cultural

contradictions arise.

The financial considerations

Financial issues are one aspect that health care providers involved in infertility treatment will have to deal with. Most of the clients are not able to finance the basic infertility treatment, thus reproductive technologies are a privilege not enjoyed by many. Therefore, the financial burden of infertility is an issue that counsellors and therapists should anticipate to be an important issue for clients to deal within the therapeutic/counselling process.

Consideration of policies and ethical issues

There is a need to reformulate policies on reproductive health, specifically on IVF treatment and other reproductive technologies. Infertility needs to be seen as an important reproductive health issue by policy makers and program makers. However, South Africa is still a developing country with many challenges and it is therefore unlikely that advanced technologies such as in vitro fertilisation can be introduced into the public health system at this stage. Therefore, preventive interventions will have more impact than curative ones and more effort should be expended on them.

8.2.3 Implications for Methodology

Massey, Cameron, Ouellette and Fine's (1998) notions about qualitative research were confirmed in the process of executing this study. As I began coding the data, moments of stress of infertility and challenge as well as expressions of strength and growth were located. The data detailed the contexts confronted in the lives of participants, and exceeded the conceptual boundaries of existing theoretical formulations of infertility. The participants confronted stressors I had not anticipated and responded in ways I could not have predicted. Various contexts – some of which they had to negotiate and others which they chose to negotiate – shaped their process of infertility, both the challenges they faced and the resources they relied on.

Qualitative research methodology was sensitive to the representations of both myself as the researcher and the respondents as the researched, the multiple contexts of the participants' lives, and the shift and changes in their encounters with adversity. The method allowed me to hear

respondents make a meaning of their lives – the transition, contexts, challenges, obstacles, and networks of support and stress without limiting them to the meanings that we as researchers have decided (in advance) are relevant, useful and even healthy. I was able to go beyond meaning making to hear in the narratives, very important distinctions too easily collapsed in quantitative research. It was possible to distinguishing the devastating social and medical reactions to the diagnosis of infertility from the diagnosis itself.

Qualitative research enabled me to track what I might call a trajectory of agency, that is, to chronicle the often confounded process and the decisions for adaptations that respondents make over time. For example, it became clear that woman 4 and woman 9 seem to have moved from a position of passively accepting their oppression to lives of hopeful engagement and to move from a life of isolation to higher education and immersion in a community of activist women. Thus qualitative research paves the way for respondents to narrate and for researchers to hear the many twists and turns in life those individuals make.

Respondents allow us to hear that outcomes of adaptation could be meaningful only within contexts. The literature indicated that in the face of crisis, networking, building family support structures, and reworking old relationships would serve as indicators of adapting. This worked for some participants, but for woman 4 and the couple consisting of man 1 and woman 13, fleeing from what they perceived to be a pressurising and abusive relationship with their extended families could also be a sign of adapting. Thus, I had to unhook from a set of values unwittingly assigned as 'good adapting' and listen instead to the multiple ways in which the respondents' responses could in fact be re-conceptualised as evidence of adapting.

8.3 Dissemination of Findings

8.3.1 Scientific Article

The required scientific article, which is based on the research, is submitted with the thesis. The article is titled 'The role of infertility on gender identity'. This paper discusses the role of infertility on gender identity of men and women experiencing infertility. The data was obtained from the men and women who participated in this study. The paper attempts to answer the following research

questions: What is the role of infertility on the gender identity of infertile men and women? What alternative roles do infertile men and women identify in order to resolve the gender identity crisis of infertility? The article will be sent for publication in an approved subject journal.

Several other articles based on the research, on themes such as the impact of infertility on families with special focus on socio-cultural aspects will also be disseminated in the form of academic publications.

8.3.2 A Booklet on Infertility

A medium-term plan is to develop a booklet aimed at the practitioners and consumers of health faced with the challenge of infertility in an African context. The provisional title of the booklet is as follows: "Facing the challenge of infertility from an African context: a guide for consumers and health practitioners". The booklet will confront misconceptions and conflict areas according to the findings of this study. It will provide guidance in dealing with infertility related problem areas from a psychological perspective. The booklet will guide practitioners and service users on issues relating to patient doctor communication, and sensitivity to emotional needs of their 'patients'.

Dr Johanne Sundby of Norway and Nurse Aileen Jacobus of Zimbabwe (1997) wrote a brochure titled 'Infertility: A guide for patients'. The brochure attempts to guide infertile couples through the diagnostic and treatment process using a scenario. The main issues involved are the explanations of investigations, like laparascopy, blood sample, tuboplasty, and measuring the basal temperature. The guide explains to patients what to expect in an identified infertility clinic in Zimbabwe. Elizabeth Bryan and Ronald Higgins (1995) wrote a book titled 'Infertility: New choices, new dilemmas'. In this book, the authors begin by explaining their own infertility. The book is intended for infertile individuals, professionals and the public at large. The focus of the book is the physiology of infertility, investigation, and causes, psychological and emotional factors, treatment and alternate treatment options.

These two publications are indicative of the kind of publication envisaged, but both suffer from some shortcomings. Although Bryan and Higgins's book (1995) deals with psychological issues, its focus is western oriented. The findings from the current study suggest various cultural

contextual issues relevant for South Africa which also need to be included. Sundby and Jacobus' (1997) brochure, on the other hand, is based on the African context, but it is focused more on the orientation of infertile persons to the medical procedures involved in diagnosis and treatment of infertility, to exclusion of psychological issues.

8.4 Conclusion

The integration of findings of the study in this chapter provides a form of understanding of relations between psychosocial factors and biomedical ones, with biomedical problems the entry point. It is apparent that social and political changes lead to new ways or re-constructions of infertility as reflected on the findings of the study. The findings of the study suggest that the research method used in this study was helpful in creating the form of understanding obtained. This in turn has implications for the types of methodologies that can be used to study infertility in future. This chapter also provided an indication of how these findings may be disseminated.

CHAPTER 9
CONCLUSION

9.1 Introduction

This thesis attempted to synthesise understanding of infertility within the existential context of African men and women. Relevant biomedical, psychological and socio-cultural literature was reviewed and related to what infertile men, women and their families said about their circumstances in open-ended interviews. This concluding chapter attempts to round off the study by providing a consolidation of the thesis, suggestions of areas that require further research and the limitations of the study.

9.2 Consolidation

Infertility is usually taken to health services and treated from the biomedical point of view. However, the psychosocial dimension of the biopsychosocial approach can no longer be ignored. Therefore, the focus of this thesis has been on the psychosocial dimension including how social and psychological factors relate to the causes, care and consequences of infertility.

Psychological causes of infertility have not been demonstrated with any certainty, but infertile persons and their family members suffer from serious psychosocial effects of infertility and its treatment. Most infertile individuals and their family members have repeated periods of crisis with depressive feelings, loss of self-esteem, loss of family identity, impaired gender identity and impaired sexual lives.

Medical treatment from both the modern and the traditional perspective brings the possibility of having a child and further psychological and physical strain. The available effective medical treatment is not accessible for the majority of South Africans and infertile persons are therefore usually dissatisfied with the somatic part of their treatment. The available psychosocial support and counselling during the process of treatment is equally limited and the fact that adoption as a possible solution can only be accessed from the private health sector. Even in the private health sector the psychosocial dimension in treatment and treatment planning is in most cases neglected.

Traditional family methods of infertility treatment such as having extra marital sexual relationships may be functional in certain cases, but could place infertile persons at risk for sexually transmitted diseases including HIV and AIDS. As it is, most cases of infertility in the black South African communities are already associated with sexually transmitted diseases. Although sexual behaviour is difficult to change, information about associations and risk factors should be included in health education. Infertility education should not be a biomedical issue and should form part of family life education for young people. If socialisation allowed childless living to be as common and accepted as living with children, the treatment demands would probably diminish. Furthermore, the emotional burden of infertility, even if still present, might be more bearable.

A complete analysis of infertility and mental health cannot be divorced from gender issues. Contrary to what most people and the literature assume, women are not the only sex to feel the mandate to have children. Gender differences can be found in the meaning attached to the mandate. Men have the responsibility (in terns of current social stereotypes) to carry the family name forward, while women are expected to conceive and do the actual nurturing of children. It became very clear from this study that, like women, men are also emotionally affected by infertility. Gender impacts on infertility through economic circumstances, work and family responsibilities, life style choices, social interaction with family members and others, including health care providers. However, gender differences can be found in the fact that women have less bargaining power in the decision over what to do about not being able to have children. This calls for a need to increase the status of women.

9.3 Limitations of Findings

The interviewing method collects data about events which have already occurred or are not readily available. Thus, interview data is subject to problems of recall because it is a second-order data which is one step removed from the actual occurrence of the situation. Another problem with the interviewing method, like many other social psychological methods, is the large role played by social desirability bias. Clearly, the men and women interviewed for this study in some respects 'played' to the researcher as a particular kind of professional audience, and may frame their circumstances differently in conversation with, for example, friends. Both men and women may

also have had somewhat different stories to tell if the researcher had been a man rather than a woman, or had she been white.

The sample was drawn from volunteers who might have been experiencing different levels of psychological distress than those who chose not to volunteer, especially because some participants stated their need for psychological help during the interviews. This and the refusal rate of some male partners of women who participated in the study make it difficult to achieve any kind of representativeness of the infertile population as a whole. Furthermore, the 'refusal' group could have been more affected by being childless than those who chose to participate in the study. However, it was possible to describe in relatively clear terms how the participants were selected and how this may have affected results. This is of particular interest when one compares it with some American samples that are obtained from advertisements or membership lists of RESOLVE.

Another way in which the sample may have been biased relates to the fact that infertile participants could have chosen family members whom they are on good terms with to participate in the study. None of these participants for example chose their fathers to be interviewed as family members of participants, which may have resulted in some of the complex family dynamics being overlooked. Finally, the cultural inhibition on sexuality issues made it difficult to obtain a more rural sample that followed African traditional practices regarding infertility more closely.

The fact that I am an African and a woman helped me to understand the issues in greater depth than another researcher might have, but this may also have led to particular kinds of biases and 'blind spots' in the analysis of data. However, I tried to counteract these potential problems by (a) following a careful pattern of checking for disconfirming and contradictory evidence whenever I thought I understood an issue and (b) constantly discussing and checking my unfolding analysis with colleagues most of whom were also black women, but some of whom (such as my promoter) were not.

9.4 The Need for Further Research

The following are recommendations for further studies.

There is an increasing argument that gender implies understanding women's experiences in relation to men, and that it is as important to focus on men and masculinity as it is to study women and femininity (Gergen & Davis, 1997). Both men and women were therefore included in this study, but it would also be useful to study men and women as separate groups to further demystify the notion that infertility is a woman's problem. Studies on black men with primary infertility and comparative studies of infertile men and fertile men in an infertile couple relationship are recommended.

The suggestion that distress experienced may be related to a loss of masculinity and an inability to fulfil traditional male roles warrants further exploration. Men could have contributed to the couple's infertility due to low-sperm count, but denied ownership of their sub-fertility. Further research could profitably investigate the experiences of such men.

There is a need to understand how fertility and child bearing versus infertility and lack of children influence the negotiation of one's identity development. It would be informative to conduct studies on infertility medical care-givers and the role they play in constructing the experience of infertility of infertile persons.

It is recommended that there should be studies on the actual interaction between infertile couples/persons and the health care providers and the interaction between infertile couples/persons and their families, instead of reliance on interviews and questionnaires.

There is a need for studies on the relationship between the experience of infertility and the national health care policy as well as socio-cultural issues related to new reproductive technologies.

9.5 Conclusion

The study represents an exploratory investigation of the psychological impact of infertility on African women and their families. The intention of this thesis has been to create a framework for understanding infertility within the African context in order to analyse how infertility today linked with societal factors. Infertility is often viewed from the biomedical point of view to neglect the psychological, social and cultural issues, which are also equally important. Therefore, the focus of this thesis has been on the understanding of social, cultural and psychological issues' influence on causes, care and consequences of infertility. The feminist social constructionist research paradigms applied was useful in obtaining an understanding of the psychological impact of infertility on African women and their families.

The findings of the current study and the literature reviewed in chapter 2 reveal that infertility presents a crisis for both infertile persons and their families. The psychological and the socio-cultural contexts reviewed in chapter 3 provide a lens through which infertility is viewed. These views and the findings of this study in chapters 6 and 7 provide insight on the impact of infertility within the family system. On this basis, one can conclude that the impact of infertility in families brings its own family dynamics that have implications for family functioning.

The ways used to cope with infertility have been presented in chapter 8. Effective biomedical treatment is not widely available and health care resources are not sufficient to provide full investigation and successful treatment for the majority of infertile persons in South Africa. The solution lies in prevention of infertility by addressing risk factors to infertility. Psycho-educational programmes could be used to address societal sensitivity to infertile persons. Infertile persons themselves need information and counselling to be able to handle the faced infertility problem. The proposed booklet will attempt to address these issues. Psychosocial intervention in infertility/fertility treatment programmes can no longer be ignored. Another issue is the need for policy change. Policies on reproductive health, especially on reproductive technologies, need to be in line with the social changes that South Africa is faced with, in order to address socio-cultural diversity.

One important, hoped-for goal is that a better understanding of the impact of infertility on African women and their families would result from reading this thesis. The outcome of this understanding guided the researcher to suggest the recommendations outlined above. Finally, it is hoped that the understanding will help in effective infertility service planning and delivery relevant for the 21st century African context.

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Appendix A: Request Letters

Letter to networking figures:

Dear Ms/Mr/Dr/Prof...

I, Langutani Francinah Mabasa, am a Clinical Psychologist and a lecturer in the Department of Psychology, University of the North. I am currently conducting a study titled: The psychological impact of infertility on African women and their families. The study was chosen for the fulfilment of a doctoral degree in Psychology, registered with the University of South Africa.

I am requesting you to assist by linking me with couples or women and women who have fertility problems for a period of two years or more. I would appreciate if you could tell these people about my study. Then, pass me the contact details (if so permit) of those people who will be willing to participate in the study so I could contact them for the interviews.

I assure that I will maintain anonymity and confidentiality of the participants throughout. The gathered information will only be used for the thesis and, publication of findings in the scientific community. The participants will be given contact details of Psychologists and social workers, in case the interviews trigger psychological distress. The outcome of the research is envisaged to can help develop relevant and culture sensitive psychological intervention programmes for infertility.

I will contact you after a period of two weeks, thereafter weekly, to collect details of willing participants.

Your assistance in this regard will be highly appreciated.
Thank You

Mabasa L. F. (Ms)

Letter to participants:

Dear Participants

I am currently conducting a study about the psychological impact of fertility problem on African women and their families. The study is an independent project for a doctoral degree in Psychology with the University of South Africa. I am a Clinical Psychologist.

I would appreciate your helping with my research by responding to the interview on this topic. Please note that you are free to stop the interview anytime and you are not obliged to answer any question you feel uncomfortable with. Anonymity and confidentiality will be maintained

I seek your consent for tape recording the interview on the attached form, to record the interview, to use the recording in preparing the thesis on condition that your name or identity is not revealed, that the promoter or the external examiners may have access to the tapes if required. I will destroy the audio-tapes after the successful completion of my studies.

There is a possibility that the interview could trigger emotional distress related to the fertility problem. You are invited to contact your nearest health care centre or me where arrangements for psychological counselling could be made.

Please accept in advance my thanks for your assistance.

Ms L. F. Mabasa
Clinical Psychologist (Cell number was indicated here)

Appendix B: Consent Form

I ... ... agree to be interviewed on the topic about the impact of infertility on African women and their families. I am aware that I am free to stop the interview anytime and I am not obliged to answer any question I feel uncomfortable with. I agree that the interview be recorded on condition that anonymity and confidentiality will be maintained

	Signature	Date
Consent Granted	....	....
Witness	....	....