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Feminization and Stigmatization of Infertility in Malawi

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ABSTRACT

The World Health Organization defines infertility as the inability to conceive after 12 months of regular and unprotected sex (WHO, 1975). Despite research that has shown that 50 per cent of infertility cases can be attributed to the male partner, in many societies the blame is cast on the woman, her voice silenced, and any action taken by the man deemed justifiable. Infertility affects millions of people across Sub-Saharan Africa, and in a socio-cultural context where children are valued as a source of wealth for the family, perceived infertility can result in neglect, abuse, marital instability, banishment, discrimination and social stigma (Barden-O'Fallon, 2005). The topic of infertility is often considered to be a taboo subject, with women being accused of witchcraft, prior abortions or prostitution. Malawi is a small country in Central-East Africa, bordered by Tanzania and Mozambique, with a population of 18 million, 85 percent of which resides in rural areas. Similarly to other countries in the region, fertility is highly desired and valued. Malawi's total fertility rate (TFR) has declined over the years, but still sits relatively high, at 5.49 children per woman as of 2017 (*Index Mundi*, 2018). In demographic discourse, this declining fertility rate is often celebrated as a sign of the country moving towards a more industrialized economic system. However, this rhetoric on demographic transition invisibilizes the social and psychological consequences of infertility, experienced in varying contexts. This thesis will examine the social stigmatization and feminization of infertility in Malawi, and specifically how stigma is understood and managed in the context of socio-cultural perceptions of infertility, within the local ecology of Malawi, as well as its effect on lived experiences and gender identities. Data was collected from four participant groups – infertile women, religious leaders, health workers, and community members through interviews, discussion groups, and informal conversation. The empirical findings demonstrate that infertility does not exist solely as a biological or physiological condition, requiring a biomedical approach, but rather encompasses emotional, social, cultural, religious and economic spheres. As such, the approach to infertility response must also include these spheres, focusing not only on preventive measures but also addressing stigma, patriarchal structures, gender inequality, poverty, and sexual and reproductive health knowledge.

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BOETUMELO JULIANNE NYASULU

Boetumelo Julianne Nyasulu is a Malawian-born writer with life experience accumulated across three different continents – Africa, North America and Europe. She is a dynamic young professional interested in all things social justice, with over six years' experience in development work. When she isn't fanatically writing about gender issues, poverty or human rights, she's reading poetry, self-help books, science fiction and books on Africa, the beautiful Motherland. She has an avid, incurable wanderlust that has taken her to places far and wide, with an

insatiable desire to know more, do more and be more. She likes to use words like “extrapolate”, “exhume” and “adage” in her everyday tongue but hopes her writing will be accessible, relatable and restorative.

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5 Glory to God for the strength and grace to accomplish this.

1. Introduction

1 In this chapter I will provide a background on infertility and how it is positioned and constructed globally, as well as in the context of Sub-Saharan Africa. Additionally, I will provide a description of the study context – the community of Mngwangwa – under the categories of population, religion, marriage, funerals, economy and health, to better contextualize the discussion on infertility.

1.1 Background

2 Infertility is not a discriminatory condition – in that it can affect anyone of any background, race, or culture – while ironically, it is a source of socio-cultural discrimination in numerous societies. The World Health Organization (WHO) defines infertility as the inability to conceive after 12 months of regular and unprotected sex (WHO, 1975). A distinction is normally made between primary and secondary infertility; the first being when a woman has never conceived, and the latter when she has conceived once but failed to become pregnant again despite efforts to do so (WHO, 1975).

3 Infertility exists as a global problem, with statistics showing that 1 in 8 couples struggle with impaired fecundity (*Resolve*, 2019). Sub-Saharan Africa is one of the regions highest affected by infertility, with prevalence rates across the different countries ranging from 7 to 29 per cent (Ericksen and Brunette, 1996, p. 211). The major causes of infertility in Sub-Saharan Africa are infections that arise post-childbirth, post-abortion or through sexually transmitted diseases (Larsen, 2000, p. 285).

4 While statistics can give us an alternative understanding of infertility and its effects, they don't demonstrate the social and cultural consequences of infertility. The rates vary across Sub-Saharan Africa, and even globally, as infertility is influenced by multiple factors including environmental, social, institutional and cultural conditions. An individual's experience of infertility, and the treatment they receive, are affected by the availability, acceptance and utilization of care systems, assumptions about childlessness, and a society's emphasis on pronatalism (Greil, McQuillan and Slauson-Blevins, 2011, p. 740-742). In Sub-Saharan Africa, infertility exists within a socio-cultural context where children are valued as a source of wealth for the family; as such,

infertility can result in neglect, abuse, marital instability, banishment, discrimination or social stigma (Barden-O'Fallon, 2005, p. 2229).

5 Unsurprisingly, over the last few decades reproductive responsibility has disproportionately fallen on the woman. As such, the inability to reproduce is constructed as both a bodily and a social failure, due to an inability to enact the socially constructed role of motherhood. While there have been developments in Assisted Reproductive Technologies (ARTs), in the developing world, the Sub-Saharan African scene has been left fairly untouched by these advances, creating a problem space in this area.

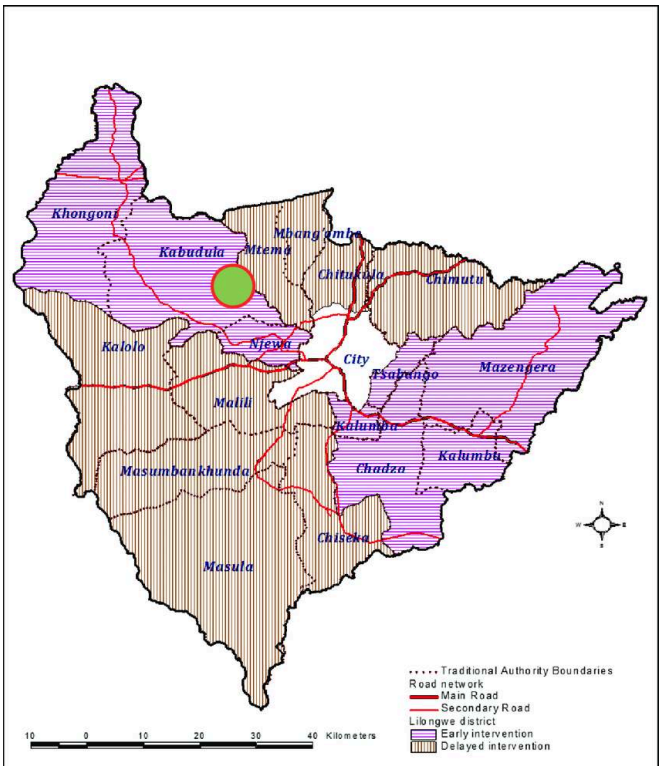
6 There is a need for further research on the effects of infertility on an individual, on communities and on a wider national level, the better to give insight into people's needs and experiences, and in turn develop culturally sensitive and contextualized effective reproductive health programs. In Malawi there is a high secondary infertility rate, but a lack of any form of ARTs or Invitro Fertility clinics. The construction of infertility thus results in various social, physical, emotional, financial and psychological consequences for those suffering from it. The topic of infertility is often considered to be a taboo subject, with the woman being accused of witchcraft, prior abortions or prostitution. Despite research that has shown that 50 per cent of infertility cases can be attributed to men, the blame is cast on the woman, her voice silenced, and any action taken by the man is deemed justified. This includes physical or emotional abuse, financial isolation, divorce, banishment, or the taking on of an additional wife (Barden-O'Fallon, 2005, p. 2229).

7 This study investigates the feminization and stigmatization of infertility. The stigma perpetuated around reproductive failures, such as infertility, can be most pervasive in pronatalist and patriarchal societies, such as Malawi, where motherhood is valorised.

1.2 Research Area

8 Malawi is a small country in Central-East Africa bordered by Tanzania and Mozambique, with a population of 18 million, 85 per cent of which resides in rural areas where – similar to other countries in the region – fertility is highly desired and valued (World Bank, 2018). Malawi's total fertility rate (TFR) has declined over the years but still sits relatively high, at 5.49 children per woman as of 2017 (*Index Mundi*, 2018).

Figure 1: Map of Research Area (Mngwangwa in green)



9 Mngwangwa, the case study area, is in the Central Region of Malawi (Mteza, Lilongwe Northwest). Records from a community worker in Mngwangwa indicate that there are 807 families living there, each of which typically includes 7 to 8 people.[1] This would place the estimated total population at 5,649.

10 *Religion*: The Chewa tribe is the predominant tribe in Mngwangwa. The tribe's most significant cultural marker is the Gulewamkulu – which translates as "the great dance" (Mtonga, 2006, p. 59). The origins of Gulewamkulu can be found in a Chewa creation myth that stipulates that Chauta (God) lived on earth harmoniously with men, women and animals until man sought to equal God's grandeur and wisdom by creating fire, and set all the grasslands and forest aflame (Curran, 1999, p. 68). This angered God, who withdrew from earth to go live "in a village in the sky" and all the animals ran away; this marked the beginning of chaos and discord on the earth (Mtonga, 2006, p. 60). Gulewamkulu dancers wear nyau (masks) that hide their identities and adorn themselves with trimmings of fur and sacking while engaging in song and dance to represent the spirits of the animals and ancestors who temporarily visit from the spirit world to try to reconcile with mankind (Curran, 1999, p. 68). In Mngwangwa, community members reported that Gulewamkulu dancers perform at important events in the community, such as funerals, weddings or celebrations, but also guard certain pathways around the village demanding money or certain signs that are emblematic of one's part in the society. Gulewamkulu emerged with an "ameliorating role" (Kachapila, 2006, p. 328) for men when the matrilineal social and political system of the Chewa tribe valorised women and gave them power and authority in village life. This disparity in social relations led to the creation of Gulewamkulu; a secret brotherhood, it allowed men to showcase their power and control, and protest against the women. Behind their masks, their actions and offences were justified as actions of the spirits and considered above court jurisdiction (Mtonga, 2006, p. 63). This immunity allowed,

and still allows, for "the physical intimidation and degradation" (Kachapila, 2006, p. 334) of women, and indeed many Gulewamkulu members commit atrocities in the form of insults, sexual jokes and in some cases even acts of violence or assault (Mtonga, 2006, p. 63). Invasions by other tribes that culturally influenced the Chewa, as well as the arrival of Christianity, shifted the Chewa's matrilineal structure into more patrilineal practices, however they struggled to eliminate the practice of Gulewamkulu. The elevation of men's status in the community transformed Gulewamkulu from a secret society of men on the margins into a male initiation rite performed by a larger group of men (Kachapila, 2006, p. 335).

11 Despite the existence of Gulewamkulu practices, Christianity is the most predominant religion in Mngwangwa, at an estimated 90 percent of the Malawian population (StudyCountry, 2019). The coexistence of Christianity, Gulewamkulu and witchcraft in the Mngwangwa community is evidence of its dynamism, and its ability to incorporate indigenous and foreign forms in an almost symbiotic manner (Kachapila, 2006, p. 321). Christianity was brought to Africa in the nineteenth century, and was met by many Africans with a response that author Mlenga refers to as "dual religiosity". Dual religiosity refers to the choice individuals make to practice two different religions or parts of those religions simultaneously (Mlenga, 2016, p. 10). Unlike the concept of syncretism, dual religiosity does not require the creation of a new religion from the combination of two different ones, but rather allows for both religions to be practiced "[either to] supplement or complement the other, or as a way of life" (Mlenga, 2016, p. 10). This concept is imperative to understanding many of the inhabitants of Mngwangwa, who practice Gulewamkulu and Christianity concurrently. In this context, many Christians make use of elements of other religions or practices – i.e. Gulewamkulu or witchcraft – without intending to be less Christian, or even regarding themselves as such (Mlenga, 2016, p. 10).

12 *Marriage*: In Mngwangwa, generally people get married at the age of 16, although the revised marriage law of Malawi now declares 18 to be the minimum age (*Girls Not Brides*, 2017). If there are no purely judicially registered marriages in Mngwangwa, three types of marriage are common practice:

1. For a religious marriage, everything is prepared with the involvement of the church, and a clerk presides over the marriage. The marriage certificate itself is provided by the church (Mawila, 2019). The church prohibits divorce from this type of marriage, in reference to the scriptures (Matthew 5:32). This type of marriage is rare; when someone gets married through the church, they become the talk of the neighbouring villages and many people attend the wedding (Mawila, 2019). It is an exciting event for the community that is often grandiose (Mawila, 2019).
2. In a traditional marriage, the couple picks *nkhoswe* (representatives from their families), who come together and discuss their potential marriage (Phiri, 1983, p. 260). The two families come together when the husband's family brings a hen (representative of the bride) and the bride's brings a cock (representative of the groom) (Phiri, 1983). The elderly members of the family exchange the hen and cock, cook the food and then feast and drink to signify the completion of the marriage ceremony.
3. The third and most predominant type of marriage is the *kubachikumu*, which translates as "stealing with the help of an insider" (Kapulula, 2015, p. 99). The

allusion to theft refers to the man 'stealing' his spouse from her family and nkhoswe. A community worker described the events that unfold in a kubachikumu: the man sneaks the woman out at night, and then shows up at his home with the woman to declare their marriage. People cite this form of marriage as occurring when the man is pushed by his "untamed sexual urges", or when he lacks the financial means for a traditional marriage with nkhoswe, where he is expected to fund gifts and the costs of the celebration (Kapulula, 2015, p. 99). Once the man has brought his desired spouse to his home, his family must conduct certain services to officialise the marriage (Kapulula, 2015, p. 100). The woman's family is contacted and alerted about the kubachikumu and invited to the man's family home. There are penalties for the kubachikumu marriage; when the woman's parents arrive, they demand a first payment (*chamlolo*), as a recompense for speaking to the man's family, and thereafter a second payment (*chaminga*) as a recompense for the inconvenience caused by the search for their child (Kapulula, 2015, p. 100). Then a conversation begins as to what happened, and the marriage is officially recognized by both families.

13 *Funerals*: Funerals are normally used as an opportunity for meeting or gathering to discuss community issues, as they assemble large numbers of the community together (Manda, 1987, p. 35). Funerals and weddings are big celebrations in the community; life literally stops for these events, shops are closed, and everyone gathers together (Manda, 1987). There are four types of funeral ceremonies, with the first two being the most predominant: a Gulewamkulu funeral, a church funeral, a funeral without a ceremony and an mntayo (baby funeral).

14 The mntayo funeral is held when a baby is stillborn or dies prior to reaching 2 months of age (Manda, 1987, p. 35). No man attends this funeral, and instead women from the neighbourhood and community gather together (Manda, 1987, p. 35). A community worker added that if there is a chief in the area who is a woman, she leads the funeral. The child is carried by a designated woman, who wears a cloth wrapping to carry them (Manda, 1987, p. 32). The community worker explained that there is no singing or talking during the funeral procession to the cemetery. A small hole is dug for the baby and the child is buried. A word of prayer or comfort is said, and the procession goes back to the deceased's home.

15 *Economy*: As an agrarian economy, 90 per cent of Malawians are employed in the agricultural sector, which accounts for 40 per cent of the country's GDP and 88 per cent of export revenue (Odekon, 2006). The main exports are tobacco, tea and sugar (Nations Encyclopedia, 2019). More than half of the population lives under the poverty line, with more than 50 per cent of children suffering from acute or severe malnutrition (FAO, 2015). In Mngwangwa, people earn money mostly through agriculture focused on crop production (Nations Encyclopedia, 2019). Maize is farmed predominantly, and tobacco is cultivated as a commercial crop, the second being ground nuts (Nations Encyclopedia, 2019). The majority of the population earn their money through tobacco farming, while maize is predominantly used for food, with a surplus for business. Family subsistence farming is most common (Nations Encyclopedia, 2019).

16 *Health services*: The 5 central hospitals in the country are tertiary-care facilities and are understaffed, poorly equipped and under-stocked (World Bank, 2013). The distance between health care facilities and poor communities is significant, compared to the distance found in wealthier communities. 80 per cent of children in Mngwangwa are

born in hospitals, nonetheless in Malawi there is only one doctor for every 50,000 individuals, putting a heavy burden on the healthcare sector (World Bank, 2013). There are two main hospitals located 10-15km distant from the Mngwangwa community – the Area 25 hospital and Mbavi clinic.

17 Infertility stands as a critical public health issue in Malawi, one of the poorest countries in the world ranking 171 out of 189 countries on the Human Development Index (UNDP, 2018). There is currently no form of infertility treatment in Malawi, with several myths circulating around its causes.

18 Malawi's HIV prevalence is the 8th highest in the world, at 9.2 per cent, and with a significant prevalence of other STIs (*Avert*, 2015). A doctor from the interview sample provided various Mngwangwa-specific health statistics: STIs in Mngwangwa predominantly affect the 12-15 age group; out of 10 people in this group, 2 or 3 would be infected by an STI. Syphilis is the most common STI, with gonorrhoea as the second. This means that infertility and its intersection with STIs represent a significant burden on the already strained health care system.

1.3 Research Question

19 This thesis will examine the social stigmatization and feminization of infertility in Malawi, and specifically how stigma is understood and managed in the context of socio-cultural perceptions of infertility, within the local ecology of Malawi, as well as its effect on lived experiences and gender identities. Social theory thus far has focused on a Goffmanian analysis, and on delegitimization in the local moral world. However, in the local ecology of Malawi, what does it mean to say stigma, and how does this Euro-American concept fare in the context of Malawi? This research explores Fertility and Reproduction Studies in the field of Medical Anthropology, as well as the Anthropology of Sexuality and Reproductive Health, and will focus on literature that examines experiences, perceptions and the management of infertility. The theoretical approach of this thesis will include Goffman's theory of stigma and Kleinman's theory of delegitimation. The Goffmanian theory of stigma analyses the social construction of stigma and its effect on tarnishing the identity and image of an individual, often through subtle manifestations that are embedded in social processes. However, stigma cannot be analysed in isolation from the socio-cultural context in which it occurs. Kleinman's approach to stigma will provide a deeper examination of experience, by offering lenses focusing on how illness is constructed by culture and society, and how the body is embedded in social, political and moral worlds.

NOTES DE BAS DE PAGE

1. Records by Malawi's National Statistic Office only cover district and regional statistics. As such, official statistics for Mngwangwa could only be extrapolated from the broader statistics of the Lilongwe district. More specific information was provided by the community worker.

2. Literature Review

1 Chapter Two reviews the relevant literature on infertility, both globally and that which specifically looks at countries of the Global South, as well as infertility studies for Malawi. The chapter situates the discussion of infertility within an analysis of the value of children, in order to better understand the social and personal effects of the absence of children. The studies included will provide insight into both differences and similarities in experiences, perceptions and treatment of infertility.

2.1 The Value of Children in Society

2 Globally, motherhood is valorised as a milestone of adulthood for women (Riessman, 2002, p. 166). In certain societies, an environment of pronatalism prevails, even with changing ideas around marriage, family forms and the economy. In these societies, the expectation for women is that they marry and reproduce, and any postponement in this phase of life is tolerated as a temporary delay rather than accepted as a permanent choice (Riessman, 2002, p. 166). In Agadjanian's study, he demonstrates that social interaction influences the regulation of fertility, and as such argues that reproductive matters ought to be analysed in the context of the broader societal structure in which they occur (Agadjanian, 2001, p. 292). He conducted interviews with 84 women and 60 men in Maputo, Mozambique, interviews that centred around issues tied to their reproductive histories and experiences. Through these conversations, he found that Maputo's socio-cultural context, similarly to other Sub-Saharan African nations, lies at the intersection between indigenous Bantu cultures, colonial cultural heritage, and post-colonial indigenous interpretations (Agadjanian, 2001, p. 294). Bantu tradition, which can be found at the origins of a number of traditions in Southern African countries, roots a woman's status in her fertility. This, merged with colonial heritage, which has a history of exalting women as reproducers of the nation, this has resulted in these societies equating the value of women with their ability to reproduce (Agadjanian, 2001, p. 295).

3 For decades, large families and a high fertility rate have been economic and social mechanisms for survival in Sub-Saharan Africa (Caldwell and Caldwell, 1987, p. 409). Feldman-Savelsberg similarly examined Bangangte women's perceptions of infertility

vulnerability through discourse and metaphors. Her findings demonstrated that children are constructed as socio-economic symbols of value for the family, and as symbols of "group continuity, strength, pride and honor" (Feldman-Savelsberg, 1994, p. 471) for the kin group and for the community as a whole. She explores the Bangangte women's understanding of infertility as vulnerability through cooking metaphors. Through culinary imagery, the Bangangte women relate their experiences or perceptions of infertility to plundered kitchens, and use metaphors of cooking to cast an abundance of food – or children, as a source of wealth – in opposition to fears of poverty and empty wombs. The conclusion finds that Bangangte women link infertility to feelings of vulnerability in a broader social context of increased migration, high poverty levels or economic dependency, that in turn place a high social value on children (Feldman-Savelsberg, 1994, p. 471). This high social value implies that producing a higher number of children equates to higher income returns for the family, increased labour for subsistence farming and increased social status in the community (Caldwell and Caldwell, 1987, p. 422).

4 Throughout Africa, marriages occur often and at a young age, and often with the purpose of producing children, rather than for love (Dyer, 2007, p. 70). In fact, the presence of children often acts as a confirmation of conjugal ties for the couple (Dyer, 2007, p. 75). As such, the inability to have children can often lead to marital instability, whether that be divorce, polygamy or extra-marital affairs. Additionally, in African rural communities where land is owned by men, the only economic return women can gain from the land is through their children, who either inherit it, submit land claims or carry out subsistence work on the land (Dyer, 2007, p. 70). In Hollos and Larsen's study analysing 2,019 women and their partners through a Tanzanian household survey (Hollos and Larsen, 2008), they expand on this assessment by highlighting six economic advantages children bring to their families, which are identified as: the labour children provide in producing goods, the services they provide when young, the contributions they make to family or community activities, the care they provide for the elderly, and the education they provide for their younger siblings. Children thus participate in generating an instant form of wealth for the family, but also contribute towards the accumulation of a continual intergenerational wealth, thus furthering their value for the family.

5 The value of children, however, lies not only in an assurance of economic security, but also in emotional and religious security. In Dyer's broad literature review on the value of children in African countries, he aligns with many of the previous findings while adding insight from the various studies he reviews. Dyer maps out informants from studies carried out in Nigeria, Mozambique and South Africa, who all relate their infertile status to feelings of unhappiness or unfulfilment (Dyer, 2007, p. 75). In a sense, children are portrayed as bringing a type of emotional security to the home that the husband cannot. For religious societies, children are represented as gifts from God that introduce a moral imperative, whereas couples without children are deemed unworthy or sinful. The consequences that women without children are faced with thus convolutedly bring together emotional, religious and economic imperatives.

6 The intimate ties between human reproduction and socialization within communities creates a relationship between the achievement of the status of womanhood and the achievement of a high social status through bearing and rearing a child (Hollos et al., 2009, p. 2068). Significantly, in the case studies examined in several articles (Upton,

2001; Riessman, 2002; Inhorn and Van Balen, 2002) both primary and secondary infertility, the inability to become pregnant or carry a child to term after previously giving birth to a baby (*Mayo Clinic*, 2017), resulted in equal, if not similar, social consequences. In fact, in Upton's article on a community in Botswana, many of the women interviewed were actually referring to secondary infertility when talking about infertility (Upton, 2001, p. 357). In Dyer's analysis of several studies, women with either primary or secondary infertility were shown to be excluded from participating in or conversing about traditions that concerned fertility, childbirth or motherhood. The symbolism of social security, social power and social permanence represented by children thus come together to perpetuate complex experiences of maltreatment, stigma and their consequences for women who are infertile or childless (Dyer, 2007).

2.2 Experiences and Perceptions of Infertility

7 In 2009, 72 million women globally had self-reported as infertile, with a majority living in the Global South (Naab, Brown and Heidrich, 2013, p. 135). In Africa, the prevalence ranges from 20 to 46 per cent in the West, and is at 30 per cent in the Sub-Saharan Region (Naab, Brown and Heidrich, 2013, p. 135). Ericksen and Brunette's comparative study of 27 African nations found that the most common cause of infertility in Africa was STDs, resulting in Pelvic Inflammatory Disease (PID) (Ericksen and Brunette, 1996, p. 214). Studies in Gambia also indicated that malaria and malnutrition are other possible causes (Meera Guntupalli and Chenchelgudem, 2004, p. 250). The STDs most implicated include gonorrhoea, chlamydia and syphilis, which can cause damage through the scarring of fallopian tubes, and then lead to foetal loss through spontaneous abortion or stillborns (Ericksen and Brunette, 1996, p. 214). In fact, the findings demonstrate that in Africa 70 per cent of PID cases are attributable to STDs, with abortion and unsafe delivery practices accounting for the remainder (Ericksen and Brunette, 1996, p. 214). Higher rates of infection are concentrated among young girls whose low immunological resistance can often result in permanent sterility (Richards, 2002, p. 87).

8 Several articles have approached the theme of causes and consequences of infertility under an anthropological demography approach (Upton, 2001; Hollos et al., 2009). Upton's article, for example, explores the question "What makes a woman infertile and why are such labels so significant socially?" and Hollos et al. ask "What are the meanings and consequences of infertility?" Both authors utilized ethnographic methods for their studies; Upton's article focused on qualitative data – formal interviews, informal discussions, participant observation – while Hollos et al. applied a combination of quantitative and qualitative methods through in-depth interviews and surveys. The authors criticize the tendency of demographic explanations to assume that women are hyper-fertile individuals "in need of reproductive regulation" (Upton, 2001, p. 354), which consequently silences any discourse on infertility and renders invisible those individuals who are infertile. Upton demonstrates that despite a demographic discourse on numbers that indicate an overall decline in the total fertility rate (TFR) in Botswana, there is still an increasing extramarital fertility rate that has a direct correlation with the cultural construction of infertility and the significance placed on children (Upton, 2001, p. 350). In Botswana, childbearing has been constructed as a key aspect of the female identity – so much so that bearing a child

prior to marriage does not seem to create problems for the woman's social status, because of the value of reproduction (Upton, 2001, p. 352).

9 In Gerrits' qualitative study on the social and cultural aspects of infertility in Mozambique, she conducted interviews with 34 infertile women, six cured women, ten fertile women, and traditional healers, to compile data on infertile women's treatment seeking behaviour. Prior to divulging the study's findings Gerrits introduces two categories of discourse, originally coined by Foster and Anderson, used by the interviewees to explain their infertility: personalistic and naturalistic. Personalistic explanations include "acts of people, spirits or witches" that cause infertility, while naturalistic explanations include biological causes of infertility, such as STIs or a low sperm count (Gerrits, 1997, p. 44). In many African societies similar to the Mozambican one studied by Gerrits, it is not uncommon for personalistic and naturalistic explanations of infertility to be used in tandem, as mixing culture, traditions and biomedicine are not considered to be mutually exclusive. However, it is important to note that biomedical explanations and information about infertility is often largely inaccessible to poor and rural areas, particularly in developing countries (Meera Guntupalli and Chenchelgudem, 2004, p. 256).

10 The causes of infertility and experiences of it should not only be understood from a medical standpoint, but are also influenced by socio-cultural contexts, just as health and illness are socially constructed categories (Greil, McQuillan and Slauson-Blevins, 2011, p. 737). Neff's study on the matrilineal Nayars of South India examines how constructions of fertility and gender shape the construction of infertility. Among the Nayars, fertility satisfies social interests to extend lineage and insure inheritance through the female line (Neff, 1994, p. 475). Several rituals conducted by the Nayars venerate and emphasize the importance of fertility, such as a puberty ceremony, a pre-puberty marriage ceremony and a formal marriage ceremony (Neff, 1994, p. 475). The Nayar women are described as having a feminine power known as 'sakti', a procreative force that is understood to proliferate in other areas of society (Neff, 1994, p. 475). Sakti is released for the benefit of the group when a woman is finally able to marry and bear children – without this step, her sakti is contained and accumulated and can bring on misfortune and disharmony for her kin group and society (Neff, 1994, p. 478). When a woman is infertile among the Nayars, it is believed that it is a result of the wrath of the gods on the kin group and signifies curses that have befallen its members. Such beliefs mean that the infertile individual faces extreme vulnerability; she faces a stigmatized position as a barren woman, the loss of support from her kin group and social exclusion from her community (Neff, 1994, p. 477).

11 Just as the Nayars explain infertility as being caused by an external force, Inhorn's study on threatened fertility in Egypt revealed a similar concept, where infertility is understood to be caused by 'kabsa' – when a polluted individual enters the room of a reproductively vulnerable woman (Inhorn, 1994b, p. 487). This "reproductively vulnerable woman" can be a woman who was recently circumcised or devirginized, or who has just delivered a child (Inhorn, 1994b, p. 487). During this vulnerable state, a woman is isolated in a room for 40 days and is meant to be separated from contact with "polluting substances", which can include blood (vegetable blood, menstrual blood), unwashed substances (semen, breastmilk, urine), death or wealth (Inhorn, 1994b, p. 489). Fertility is deified in two ways – through its capacity to ensure the continuation of a lineage, and to satisfy a man's greatest creation in Egyptian society – a child. As such,

the consequences of infertility far outweigh the burden, embarrassment or fear of de-polluting healing rituals that infertile women go through to subscribe to Egyptian rituals, and to distance themselves from accusations of infertility.

12 Many African societies have spiritual and social explanations for infertility. Richards' ethnographic study on definitions and responses to infertility in Cameroon records interviews that attribute it to "God's will", contraceptive use, lack of tradition and witchcraft (Richards, 2002, p. 88). These causes are commonly cited throughout developing countries; for instance, Meera's qualitative study on the Chenchu tribe of India revealed that infertility was attributed to supernatural powers, God, black magic, body heat and nutrition (Meera Guntupalli and Chenchelgudem, 2004, p. 253). While witchcraft and spirit possession are referenced as the most commonly perceived causes of infertility in several African countries, the next most common causes include women's sexual promiscuity, blood incompatibility, abortion and STDs (Hollos and Larsen, 2008, p. 161).

13 The intersection between the value placed on children, and perceived causes of infertility has several implications for experiences of infertility in African societies. Fledderjohann conducted 107 semi-structured interviews in gynaecological and obstetric clinics in Accra, Ghana, to analyse the social and gendered experiences of infertile women. Upon discovery of a woman's infertile status, a marriage often either suffers from high conflict and instability, is riddled with extramarital affairs, transforms into a polygynous marriage or ends in divorce (Fledderjohann, 2012, p. 1384). The findings from the Gambia study showed that while 99 per cent of the sample of infertile women were now presently married, 26 per cent had been previously divorced or abandoned, 35 per cent had been married before, and in this latter group 16 per cent had also been married once before that (Sundby, 1997, p. 33). Additional sexual partners for either member of the couple causes an increased risk of exposure to STDs or reproductive tract infections, which can thus compound the infertility problem in future relationships (Fledderjohann, 2012, p. 1384).

14 In most cultures in Sub-Saharan Africa, there has been a tendency for infertility talk to fall into a discourse of blame, where women are attributed sole responsibility (Hollos et al., 2009, p. 2062). Dyer et al.'s study on men's infertility treatment seeking behaviour in South Africa conducted 27 interviews with men in Cape Town and found that infertile men suffered from stigma and abuse, and that generally while awareness of male infertility existed it was rarely admitted. One interlocutor expanded on this by saying that "In society today man cannot be the problem" (Dyer, 2002 p. 962). Infertility in several societies across Africa does not exist as a health problem alone because of its social and interpersonal dimensions. It bears the social consequences of exclusion, discrimination, and marital instability, as well as economic insecurity, and affects mental health and stress levels (Sundby, 1997, p. 30).

2.3 Distress and Stigma

15 Several studies have shown the direct impact of infertility on psychological wellbeing. Dyer et al. conducted 30 in-depth interviews with involuntarily childless women seeking treatment in urban South Africa and noted experiences of stigmatization that in turn caused psychological suffering for the women. The women described experiences and feelings of loneliness, desperation, deep sadness and bitterness; they

also described experiences of abuse in their families or communities where they were shouted at, cursed at or outcast (Dyer et al., 2002, p. 1664; Fernandes et al., 2006, p. 871; Edelmann and Connolly, 2000, p. 366).

16 While Hollos et al. also explore infertility through a demographic approach, they examine the differing rates of two communities in Nigeria and demonstrate how the meanings and psycho-social experiences attached to infertility are shaped locally through lineage structure and community mechanisms. Women in Lopon had less serious consequences for infertility than their counterparts in Amikiri, owing to the matrilineal structure of their community and the presence of community structures that economically or socially involved and supported infertile women (Hollos et al., 2009, p. 2061). Hollos et al.'s findings demonstrate that community mechanisms and family structures are crucial for mitigating the effects of stigma, and the negative experiences of infertile individuals.

17 Fernandes et al.'s in-depth interviews with two infertile women revealed the complexity of the experience of infertility, in its intersection between the physical, the social and the emotional. Physical pain and suffering of the body inherently affect the emotional state, which then impacts social interactions – the links between the three are indubitable (Fernandes et al., 2006, p. 871). Fernandes et al. thus frame suffering as a struggle in which an individual fights to maintain control over their physical, emotional and social domains and at times may become so overwhelmed with suffering that returning to their previous, normal state is unthinkable (Fernandes et al., 2006, p. 872). The results of the study emphasize that suffering can be a deeply personal experience, and as such is affected by different layers of identity – personality, past and present experiences and the environment (Fernandes et al., 2006, p. 851). The authors highlight that the experience of suffering can be diverse – existential for some and meaningless for others; perceived as punishment by some and a mystery to others – but always in pursuit of answers for the question 'why me?' (Fernandes et al., 2006, p. 852).

18 The visibility of motherhood or pregnancy can make it hard to avoid the probing and interactions of community members. For many of the women who stay in virilocal residence, the pressure they feel from the family is direct and every-day, as they live with their in-laws and attempt to assert their status in the household – often only elevated through the status of motherhood. As Fernandes et al. state, "[motherhood is constructed as] a woman's crowning glory, the pinnacle of achievement: what we are all destined for and ultimately the only means of true fulfilment" (Fernandes et al., 2006, p. 861). The conflation of womanhood and motherhood, as well as the female body and female identity, creates a sense of failed purpose or body that translates to a failed identity for those women who can't bear children. Inhorn argues that this infertile identity creates a complex experience of stigma, particularly in poorer communities where the woman faces disempowerment or stigmatization because of her "barrenness, femaleness [and] poorness" (Nahar and Richters, 2011, p. 335). For many women in African societies, barrenness further complicates their position, as the husband's family can claim back the bride price previously paid for the wife with the expectation that she would bear children (Dierickx et al., 2018, p. 8). Reclaiming the bride price not only brings on feelings of shame for the woman and her family, but also places her family in a precarious economic position if they have already spent it. Having failed to bear a child, the woman often encounters social stigma from her family or wider community, where she is denied a higher social status or ostracized to

levels that may even reach divorce, banishment, economic isolation or accusations of witchcraft (Hollos et al., 2009, p. 2068).

19 A significant challenge for women in several countries in Africa is what Dyer et al. call a "culture of silence" around the issue of infertility, which renders talk about infertility a taboo subject, and often isolates infertile women, thus placing a triple burden of secrecy, fear and stigma upon them (Dyer et al., 2002, p. 1667; Dierickx et al., 2018, p. 9). Dierickx et al. report that within these communities, infertility talk often circulates around gossip, jokes, rumours or even claims that infertile women are witches or "eating their own children" (Dierickx et al., 2018, p. 7). The blame for barrenness is attributed to women either through accusations of witchcraft, of immoral extra-marital sexual behaviour, of abortions or use of contraceptives (Dierickx et al., 2018, p. 8).

20 The combination of these feelings and experiences of stigma were found to result in a state of emotional distress in Donkor and Sandall's survey, conducted with 615 women in South Ghana. The authors developed a stigma measurement tool originally used for stroke patients and conducted regression analyses to map those women who experienced either no stigma (36 per cent), moderate stigma (23 per cent) or severe stigma (41 per cent) (Donkor and Sandall, 2007, p. 1688). The study concluded that the presence of a polygamous union, the lower the education and the higher the number of years spent seeking treatment, the higher the infertility-related stress level (Donkor and Sandall, 2007, p. 1688). Expanding on this, a compelling finding from a longitudinal study analysing fertility-specific distress among a sample of 266 infertile American women found that feelings of low self-esteem, sadness or isolation often continued for as long as twenty years after suspending treatment (Greil et al., 2011, p. 87).

21 A shortcoming of many of the articles looking at distress is their focus on individuals seeking treatment, which largely excludes those for whom treatment is inaccessible or unaffordable. As such, people from marginalized economic backgrounds, ethnicities or classes are often excluded from these studies. In terms of psychological correlates of infertility, there is an over-abundant focus on Western societies, which is quite disappointing considering Dyer et al.'s findings that participants in developing country studies on infertility exhibited "a significant" and "arguably greater" level of distress, than those in countries in the developed world (Dyer et al., 2005, p. 1942). Added to this, there have been calls to consider the socio-cultural context and how it affects the experience of infertility, and this approach can also shine a spotlight on a demographic and context that has traditionally been ignored by the medical research agenda.

2.4 Treatment and Coping

22 In a study on the choices and motivations of infertile couples in the Netherlands, Van Balen et al. present statistics from a 1992 national survey they conducted with 3,295 women. In it, they identify five treatment seeking options that couples may explore when facing infertility: (1) medical help, (2) adoption, (3) fostering, (4) alternative medicine and (5) other life pursuits (Van Balen et al., 1997, p. 19). Davis and Dearmen's study conducted in the US found similar coping strategies, with the addition of avoidance, sharing the burden or searching for explanations (Donkor and Sandall, 2009, p. 82). Van Balen et al.'s research found that medical help was often sought within the first year, after attempts to conceive, while the other options followed after failed

medical help (Van Balen et al., 1997, p. 22). Alternative medicine was mapped as a more infrequent option – a last resort when no other medical options existed (Van Balen et al., 1997, p. 24). Interestingly, those women who coped through avoidance strategies or acceptance were shown to experience higher levels of distress than those women who relied on support networks, highlighting the importance of social support in the experience of infertility (Richards, 2002, p. 82). Several studies emphasize the importance of the spousal relationship in providing support for coping with feelings associated with infertility (Richards, 2002; Donkor and Sandall, 2009).

23 While various treatment options and assisted reproductive technologies (ART) have emerged in the Global North, many of these options remain unavailable or undesirable for infertile women in the Global South. Treatment seeking behaviour and coping strategies among women in African societies can vary from doctor's visits, religious support or practices, to visits to a traditional healer – in many instances, women may try a combination of strategies as they do not stand as mutually exclusive (Richards, 2002, p. 90). Of course, the option of modern medicine also exists in African countries – infertility cases are often treated with contraceptives or antibiotics for the STDs causing the infertility (Gerrits, 1997, p. 44). This is due to a lack of resources, medical personnel, drugs, equipment and infrastructure in the health care services of many of these countries (Van Balen and Gerrits, 2001, p. 215).

24 In contrast with van Balen et al.'s study on the Netherlands, in most African rural societies, alternative medicine is often sought out as a primary option rather than a last resort. Most women seek out a traditional healer for health problems, as they provide not only health support but also therapeutic and social support (Mariano, 2004, p. 267). Considering that about 60 to 80 per cent of the population of developing countries live and/or work around the borders or rural areas, it comes as no surprise that traditional healers are more accessible both economically and geographically (Chipfakacha, 1997, p. 418). In her study on the socio-cultural aspects of infertility in Mozambique, Gerrits found that if some of the 34 infertile women had visited between twenty to thirty traditional healers each, and others had gone only once or twice, all of them had turned to a traditional healer prior to seeking out other treatment options (Gerrits, 1997, p. 43). In these rural areas, healers are generally well distributed geographically, and are regarded with respect in their communities (Chipfakacha, 1997, p. 418). Their lived experience in the community, identification with the culture, and fluency in the local language gives them good knowledge of the socio-cultural contexts in which they work (Chipfakacha, 1997, p. 418; Van Balen and Gerrits, 2001, p. 217). Treatment methods can include herbal teas, balms, baths, exorcisms or prayers to the spirits (Gerrits, 1997, p. 44).

25 In many developing countries' culture of silence surrounding infertility, some women may adopt a strategy of secrecy in an attempt to deny or avoid the label of infertility. Papreen et al. showed that, in order to appear fertile to their community, women in Bangladesh adopt this strategy by faking miscarriages (Dyer et al., 2002, p. 1666). Avoidance strategies for women in close communities in developing countries can often be near-impossible, as their lack of children is seen and noted at community gatherings, hang-outs or daily activities (Nahar and Richters, 2011, p. 333). In some African societies, the practice of giving a child from one family member to an infertile family member can be common practice – especially for those families struggling to provide for their existing children (Sundby, 1997, p. 34). While this may not necessarily

be explicitly labelled as adoption or fostering, it is often a solution for resolving infertility issues or childlessness, or a form of coping for the infertile individual.

26 For many men in several African societies, a solution to their wife's infertility is often found in extramarital affairs, the taking of a second wife, or divorce (Gerrits, 1997, p. 45). The patriarchal nature of most of these societies places women in a vulnerable position when faced with these situations, and often supports men in their efforts to keep their infertile status a secret. However, there are some societies in which women also seek out extramarital options – such as the Macau in Mozambique, as noted in Gerrits' study (Gerrits, 1997). Riessman has specifically examined how married women manage or resist definitions of family, and how the strategies they use can be interpreted as forms of resistance. Riessman takes a different approach to the other studies, in that she focuses on poor women who are *voluntarily* childless, where the decision is made owing to the lack of material or social resources. She unpacks the idea that, for lower-income women, motherhood often represents an improvement in status within their husband's family and within the village, and that "being a mother is a master status for village women [that] overrides other identities" (Riessman, 2002, p. 114). Riessman's discussion of resistance strategies is unique in that she contextualizes and localizes forms of resistance by these women – speaking out, refusing deviant labels, strategically avoiding people or rejecting motherhood. Her study and analysis add nuance to the literature on stigma by providing a localized Global South perspective of resistance strategies, within a rich contextualization and from a unique perspective.

2.5 Infertility Studies in Malawi

27 There is far less research and literature on infertility in Malawi, in comparison to the literature on other African countries. Earlier articles on infertility or the health sector in Malawi focus on a more quantitative approach. The pioneer article discussing infertility in Malawi is Ericksen and Brunette's 1996 country-wide survey of infertility across 27 nations. The study sought to provide a comparative study of infertility across nations utilizing a multivariate analysis of 27 of the most recent World Fertility Surveys (WFS) and national Demographic Health Surveys (DHS) (Ericksen and Brunette, 1996, p. 210). Similarly, Larsen's 2000 study utilized Malawi's and other countries' DHS to examine primary and secondary infertility in Sub-Saharan Africa. Both studies took on a quantitative approach and focused on data from the birth histories of women between the ages of 20 and 41 who had been exposed to conception for at least five years. The studies were limited by the data collected in the WFS and DHS, which focus on a narrow age group, do not differentiate between contraceptive and non-contraceptive users, and whose definition of infertility is insufficient. This last criteria, defined as an absence of birth in the five-year period of exposure to conception, disregards women who were intentionally preventing childbirth in that time period (Ericksen and Brunette, 1996, p. 210; Larsen, 2000, p. 286). Nonetheless, the availability of the data from these two surveys allowed the researchers to take up a different approach from those taken in the past, which focused on regional low total fertility rates (TFRs) to measure infertility (Ericksen and Brunette, 1996, p. 209).

28 Ericksen and Brunette's study found that in 1992, Malawi's primary infertility rate levelled at 1.1 per cent, and that 15.8 per cent percent of fertile women had had

previous periods of infertility (Ericksen and Brunette, 1996, p. 212). One of their major findings was the role of STDs in causing infertility, specifically gonorrhoea, chlamydia and syphilis through the scarring of fallopian tubes or foetal loss (Ericksen and Brunette, 1996, p. 214). Their second major finding concerned the negative implications of sociocultural factors on infertility, such as culture, marital status, history of multiple unions, sexual initiation at puberty, and urban residency (Ericksen and Brunette, 1996, p. 214). While there is no direct causation between these factors, the analysis stressed that such factors could increase the chances of disease acquisition. For example, an individual's place of residency can affect availability of health services, or increase the likelihood of encounters with infected men (Ericksen and Brunette, 1996, p. 216). Cultural beliefs could also affect the acceptance of multiple marriage unions or of polygyny, and thus through multiple partners, the increased risk of an infected sexual partner (Ericksen and Brunette, 1996, p. 216). These findings tie into the article's conclusion that the transmission of diseases most linked to infertility causes are also affected by sexual histories, place of residence and a country's sociocultural context. Ericksen and Brunette surmise that this explains the diverse infertility rates across Sub-Saharan Africa, and emphasize the need for culturally and socially appropriate health services that contribute to the diagnosis of STDs and Pelvic Inflammatory Disease (PID) – the major causes of infertility.

29 Barden-O'Fallon expounds on this in his study on infertility treatment seeking in a rural district in Malawi. Similar to Ericksen and Brunette's findings, he notes that various factors contribute to fertility impairment, which he separates into three different categories. The first of these is demographic, and includes age, marital status, residence area, religion and education level (Barden-O'Fallon, 2005, p. 2229). The second is health, focused on and including sexually transmitted infections – and specifically chlamydia, trichomoniasis, syphilis and HIV, considering that correlations between these conditions and infertility had been noted in the region (Barden-O'Fallon, 2005, p. 2229). His final category is sexual behaviour; taking account of multiple partners and the age that the interviewee had their first sexual experience, as these behaviours can increase the risk of infection acquisition (Barden-O'Fallon, 2005, p. 2229). O'Fallon uses these categories to distinguish between how men and women self-report fertility problems. He found that men typically associated fertility impairment with sexual behaviour, while women associated fertility impairment with a 'child deficit': the difference between their actual and ideal number of children (Barden-O'Fallon, 2005, p. 2234). Thus the process of self-reported infertility in women was more of a subjective and emotional experience. Barden-O'Fallon notes that, while one in five women reported having difficulty becoming pregnant, fewer reported being infertile (Barden-O'Fallon, 2005, p. 2224). He concludes that participants may make a distinction between perceived fertility difficulties and actual infertility; either owing to an unwillingness to self-label as infertile, or the desire to have additional children (Barden-O'Fallon, 2005, p. 2229). Owing to this, Barden-O'Fallon finds that it may be more comprehensive to measure fertility problems in African populations through analysis of those having self-reported difficulties getting pregnant, rather than self-reported infertility. Were he to follow this approach, his results would actually record 60 per cent of individuals with self-reported difficulties getting pregnant and seeking treatment (Barden-O'Fallon, 2005, p. 2234).

30 Eriksen and Brunette's study, and that of Larsen used Malawi's 1992 Demographic Health Survey. However, while Ericksen and Brunette provided an analysis of primary

infertility rates, Larsen went a step further by providing deeper insight into secondary infertility in Sub-Saharan Africa. The study found that while primary infertility prevalence rates were quite low, at an average of about 3 per cent across the region, high secondary infertility rates predominated throughout the region (Larsen, 2000, p. 289). With respect to Malawi, the study demonstrates that the secondary infertility rate of couples aged 20 to 44 sits at a high of 17 per cent (Larsen, 2000, p. 290).

31 The last available study from the late 90s and early 2000s with an insight into infertility is a 1998 cost-comparison of sexually transmitted disease (STD) treatment in Malawi. The study used a nationwide survey to collect data on drug prescription practices for STD patients in 39 healthcare facilities across the country (Costello Daly et al., 1998, p. 88). Notable findings that impact the understanding of infertility in Malawi are the high HIV and STD rates of Malawi in the late 90s, with a 23-32 per cent prevalence in urban antenatal women, and 42 per cent of urban antenatal clinic patients having been diagnosed with at least one STD in 1989 alone (Costello Daly et al., 1998, p. 87). Costello Daly et al. sought to compare the cost of Malawi's clinical diagnosis of STDs – that is, when treatment is conditional on confirmation from laboratory testing, which can be costly and cause delays – shown to be largely ineffective in comparison with a syndromic approach to STD treatment – that is, when two antibiotics or more are provided to a patient, based solely on a patient's symptoms. A shortcoming of the study was that its analysis included an overrepresentation of commercial clinics and hospitals, to the detriment of the health centres found in most rural areas, as well as its strong focus on two STDs: genital ulcers and urethral discharge, which are shown to represent only 50 per cent of new STD patients (Costello Daly et al., 1998, p. 92). Nonetheless, the study not only found that the syndromic approach would add no additional cost and cut laboratory and personnel costs, but also that at the time patients with more than one STD were highly undertreated, with more than 31 per cent of patients surveyed receiving inadequate treatment (Costello Daly et al., 1998, p. 92). Not only does this point to the grim reality of STD treatment and management in Malawi, but it also provides a clearer picture of the environment in which infertility rates prevailed at the time.

32 Of the few articles found on infertility-related studies in Malawi, the most recent one by Fiona Parrott differed in its qualitative approach. Parrott analysed male infertility in rural northern Malawi to examine how infertility diagnoses through semen analysis contributes to the visibility of male infertility and shapes gendered relationships. She conducted 55 interviews with men of different ages and marital statuses from the Karonga District (Parrott, 2014, p. 177). Parrott establishes that infertility diagnosis for men can initiate feelings of shame or secrecy, while threatening their sense of self-worth, owing to discourses of weakness and emasculation that situate infertility as "a lack of sexual strength (*nkhongono*)" and "conflate virility with fertility" (Parrott, 2014, p. 177). Causes of infertility are variably attributed to biomedical problems – the obstruction of tubes, menstrual irregularities, abortion – or the realm of the spiritual and witchcraft (Parrott, 2014, p. 178). Causation thus ties into treatment, as individuals often turn to traditional healers (*sing'anga*) or religion to offer solace or deliverance from spirit possessions or bewitchment; problems that are perceived to lie outside of biomedicine's knowledge and expertise (Parrott, 2014, p. 179).

2.6 Thesis Rationale

33 In demographic discourse, declining fertility is often celebrated, as the country is said to be moving towards a more industrialized economic system. The rhetoric of the demographic transition invisibilises the social and psychological consequences of infertility experienced in varying contexts. Malawi's primary infertility rate lies at 2 per cent, and it has a secondary infertility rate of 17 per cent (the inability to become pregnant or carry a child to term after previously giving birth to a baby), which puts the country in the upper-middle range of infertility rates in Sub-Saharan Africa (Barden-O'Fallon, 2005, p. 2229). This study seeks to add to the literature that has so far focused on childlessness, by including a sample of secondary infertile women. The prevalence of social, emotional and psychological consequences, even with secondary infertility, provides an indication of the high premium placed on children. In rural areas especially, children are a symbol of economic and social value for the family, and a promise of continuity for the kin group and community. In the village's social context the child is seen as the link that ties the woman to her extended family and larger community. In an economic context with minimal social welfare mechanisms, the child also acts as an economic security for the elderly, while for wealthy families the child ensures the transfer of inheritance or property (Riessman, 2002, p. 112). As such, motherhood offers several benefits to the women of the community, and a lack of children often leads to a woman suffering from confusion or harassment from the community. The intimate environment of the village often makes it difficult for women to avoid interactions with their own communities, where there is high likelihood to encounter acquaintances in public transport, on journeys to the shop, or while collecting water at the pump (Riessman, 2002, p. 118). This proximity makes it difficult to hide the fact that you have no children, and gives the space for village gossip over those who don't (Riessman, 2002, p. 166). The Malawian rural context thus provides insight into women's experiences, perceptions and interactions around infertility, in a community where individuals encounter challenges concealing or managing their infertile identities.

34 Despite its significance, infertility is a severely under-addressed problem in many Sub-Saharan countries, Malawi included. The demographic discourse that celebrates a decline in fertility in less developed countries invisibilises the negative experiences of infertile individuals, and silences their voices on the research and policy level. While literature in the developing world often focuses on declining fertility rates as an outcome of empowerment or autonomy at the individual level, and economic improvement at the national level, this study will offer a different perspective to that of the demographic field, in highlighting the negative social consequences of declining fertility rates.

35 The findings of the study will provide information on how stigma is experienced or perceived and in what physical or relational context it occurs, opening the discussion for the proposal and development of different preventive or mitigating measures. It contributes to a literature that currently stands at a minority, by focusing on the contextual consequences of infertility, rather than infertility as an isolated event. By engaging with the infertility conversation, these findings could be used to measure the quality or lack of infertility health care in Malawi, and contribute to improvements in the quality management of infertility, and the broader service areas of health,

education and social security. The study will also give insight into a bottom-up approach that can be taken into account when building social and medical support systems for women, an approach that emphasizes the need to prioritize the impact of infertility and its consequences on women's wellbeing.

36 The descriptive study of experiences of infertility and stigma in the Global South has been a growing field in the past years. However, when it comes to the region of Southern Africa, many studies tend to focus on a narrower and more specific range of countries, such as Botswana and South Africa; leaving a research lacuna in many other countries, including Malawi. Inhorn's groundbreaking work, *Quest for Conception*, was one of the first few trailblazers in the literature that focused on descriptive experiences of infertility in the Global South. My own thesis will add to this field by focusing on the question of how stigma is understood and managed in the context of the local ecology of Malawi, the socio-cultural perceptions of infertility, and its consequences on lived experiences and gender identities. A literature search revealed that no study has discussed coping strategies specific to Malawian individuals dealing with infertility. The qualitative data drawn from the interviews in my own research will offer a rich account through the different groups interviewed: infertile individuals, religious leaders, community workers, health workers, traditional healers, and doctors. This approach also acts as a form of empowerment, allowing the voices of those included in my study to be heard, and highlighting their needs rather than silencing them – as tends to happen when broader national population policies are drawn up. It will focus on the perceptions of causes, the social meanings and the consequences of infertility, to contribute to the limited knowledge that exists in this area in the context of Malawi. This contribution will also respond to the growing call for a social approach to the field of health psychology, one that prioritizes the emotional and interpersonal influences on people's behaviour.

3. Theoretical Framework

1 Chapter Three introduces the two theoretical frameworks that will be used to analyse and explain the empirical findings of the study. Goffman's stigma theory will be used as a grounding framework, while Kleinman's delegitimation theory will be used to build on the Goffmanian approach, to capture the dynamic nature of stigma and its inextricable ties to the social context in which it occurs.

3.1 Stigma Theory – Goffman

2 In Goffman's seminal work, *Notes on the Management of Spoiled Identity*, he explains that the word stigma has its origins in Greek, and defines it as "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (Goffman, 1986, p. 1). These signs indicate that the individual is either a criminal, a slave, or has been "ritually polluted", and that they should be avoided in public (Goffman, 1986, p. 1).

3 Goffman asserts that the original definition of stigma is more widely used today, except with the concept of shame or disgrace attached to it. He separates stigma into three categories: (1) physical deformities (2) individual character blemishes (e.g. mental health disorder, homosexuality, addiction) and (3) tribal stigma (e.g. race) (Goffman, 1986, 4). Cultural and gender assumptions attached to reproduction assign the responsibility for fertility to women. Consequently, infertility is often attributed to the category of individual character blemishes, owing to the fact that it breaks with the group norm.

4 Stigma acts as a "discrediting attribute" that presents a person as tainted or discounted, but can only be defined within the context of relationships (Goffman, 1986, p. 3). Goffman identifies two ways in which stigma can be experienced: the first is when a difference is evident or visible (discredited stigma) and the second is when a difference is not known or immediately perceivable (discreditable stigma) (Goffman, 1986, p. 4). Globally, perceptions of womanhood that equate it with motherhood and define females by their reproductive capabilities, construct childlessness or infertility as discreditable and stigmatizing (Miall, 1994, p. 34). People with discreditable stigma can often adopt what Goffman coins as "passing" – living and interacting without

visibility or discovery of the stigma (Goffman, 1986, p. 48). However, individuals of the discreditable type are tasked with managing information about their stigma and often encounter a tension between revealing and concealing, or determining the context in which they feel safe enough to reveal (Goffman, 1986, p. 48). Goffman emphasizes that revealing the stigma also brings with it its own risks. It can affect future paths, reputation and appearances, or cause trauma and anxiety when exposed unintentionally (Goffman, 1986, p. 65). Additionally, there is the psychological burden of maintaining the secret of the stigma, and at times this leads to self-imposed isolation from the stigmatized group to avoid associating with them, as well as feelings of isolation from general society (Goffman, 1986, p. 87). The majority of literature on infertility places it in the category of the discreditable, but most of this literature is not contextualized in the locale of a rural community in the Global South, where intimacy does not afford the invisibility of infertility.

5 Goffman describes four patterns by which an individual can be socialized to a stigma. In the first pattern, the individual learns of the disadvantages of their stigma while living through it – an orphan, for example (Goffman, 1986, p. 32). In the second, an individual with a stigma is protected from society by their family or those close to them (Goffman, 1986, p. 33). The third pattern constitutes an individual who only develops their stigmatized attribute at a later stage and is faced with having been socialized to understandings, meanings and perceptions of the stigma from a young age (Goffman, 1986, p. 34). Owing to this, they can often encounter challenges defining their identity, or challenges resisting the definition of their attribute as a deficiency (Goffman, 1986, p. 34). The last pattern is that of a foreigner who is socialized into a new community with different ways of knowing and being that he must conform to. Goffman makes note, for the third pattern, that it might be applied to an infertile individual – someone who discovers their infertile status at a later stage not only deals with challenges self-identifying because of their socialization, but also deals with challenges in their relationships (Goffman, 1986, p. 34). An individual who discovers a stigmatized attribute at a later stage has to deal with new acquaintances seeing them through the lens of that 'deficiency', and the possibility of old friends treating them differently because of new knowledge, and attachment to the person that the stigmatized individual once was (Goffman, 1986, p. 34).

6 A stigmatized person is constructed as a deviation from the norm, and as such, a non-human (Goffman, 1986, p. 4). Attributes that are constructed as markers of stigma are indoctrinated in community members, creating an environment where both the group and the stigmatized individual regard the marker as a failing, which can lead to discrimination as well as self-hate. Goffman describes the various discriminatory methods employed as actively reducing the life chances of the stigmatized individual (Goffman, 1986, p. 4). Interactions between the individual and the community can provoke feelings of anxiety, hostility, suspiciousness or depression, because they lack knowledge of the thoughts of those around him (Goffman, 1986, p. 13).

7 The interactions, experiences and perceptions of a stigmatizing attribute are socially constructed, and thus these attributes can be different things in different contexts. The management of stigma will occur in any society that has identity norms and expectations (Goffman, 1986, p. 130). As Goffman notes, "the normal and the stigmatized are not persons but rather perspectives".

3.2 Delegitimation Theory – Kleinman

8 In his book, *Writing at the Margin*, Kleinman explores concepts of pain, resistance, stigma and delegitimation. He categorizes illness as socially constructed – modelled by cultural patterns, social interactions in the family and workplace, the psychophysiology of the individual, and diverse intersections of gender, class and ethnicity (Kleinman, 1997, p. 122). An illness is thus a disruption of the norm – the moral structure imposed by a dominant group – and of the normative – that structure embodied by an individual – in a society (Kleinman, 1997, p. 123). These multiple factors conjoin in the construction of illness to create what he refers to as an "intersubjective experience of suffering" (Kleinman, 1997, p. 122) – one that is influenced by the individual's identity and the network of their social world. This intersubjective experience of suffering is seen in certain societies where culture and tradition make meanings of illness that often affect not only the patient, but their family's lives, goals, opportunities and emotional wellbeing (Kleinman, 1997, p. 163).

9 Kleinman's approach emphasizes the importance of developing an understanding of local knowledge and daily practices around the body, suffering and misfortune in order to analyse pain and illness as both biologically and culturally established (Kleinman, 1997, p. 125). Pain and suffering draw on concurrent religious, medical, somatic and social experiences, erasing the mutually exclusive divides between these categories (Kleinman, 1997, p. 133-4). His concept of delegitimation asserts that an individual's experience of pain and suffering delegitimizes their previous experience of their social world. Perhaps, prior to the illness the individual might have experienced a social world in which they were characterized as confident, happy and successful. The onset of the illness – for example, infertility – however, transforms their perception of themself in their social world to abnormal, lacking or distressed. The experience of delegitimation is furthered by a state of incurability, where practitioners or healers deem the situation as "too extreme, too troubling [or] too difficult to control" (Kleinman, 1997, p. 133).

10 Delegitimation is marked by a loss of control of one's identity and perception in the local world, and this loss is compounded by a lack of resources for those in environments of poverty, insecurity or oppression (Kleinman, 1997, p. 139). Often symptoms of bodily pain and experiences of chronic pain can be a physical manifestation of this loss of control. The source of pain and bodily pain can often converge and routinize the transformation of the individual's local world into a world of suffering – a delegitimated world (Kleinman, 1997, p. 139).

11 Building on this background of pain and suffering, Kleinman's theory around stigma builds on the Goffmanian approach by contextualizing stigma in its social, cultural and moral worlds. The socio-cultural world intermediates personal and societal relationships, while the moral world constructs regulations around beliefs and behaviour (Kleinman, 1997, p. 124). By embedding stigma in the social world, Kleinman acknowledges that it does not exist solely as an individual and psychological condition, but also affects and is affected by social life and relationships (Kleinman and Hall-Clifford, 2009, p. 418). Owing to power relations embedded in the social, political and economic world, stigma is experienced differently depending on the background and identity of the stigmatised person (Kleinman and Hall-Clifford, 2009, p. 418).

12 Contextualizing stigma in the social world that it exists in brings an understanding that an individual's experience of stigma can affect their social life and what it is composed of – relationships, networks, opportunities, wealth acquisition and other elements (Kleinman and Hall-Clifford, 2009, p. 418). Essentially, Kleinman accepts Goffman's theory that stigma labels certain conditions as culturally or socially devalued, and whether it is discredited or discreditable, this stigma spoils the identity of the individual who has been labelled as such. Kleinman, however, furthers the theory by localizing this socio-cultural devaluation and acknowledging that the way in which it is experienced and expressed is locally distinctive (Kleinman, 1997, p. 148). Stigma experienced in an African context, for example, brings with it beliefs about the polluting nature of an illness, accusations of witchcraft, traditional healers, and reactionary families – a complexity and diversity of social processes that is largely overlooked by the Goffmanian approach. Kleinman's approach to stigma centralizes analysis on local settings of informal and formal health care, the network of relations and connections, opportunity for resource mobilization and the capacity of an individual's social circle to support emotionally and financially *or* to exacerbate suffering (Kleinman, 1997, p. 163). With Kleinman's theory, stigma is not individual, it is interpersonal; and its contextualization in local contexts creates a diversity of experiences.

4. Methodology

1 Chapter Four will cover the relevance of qualitative methodology for this study, and will also discuss the methods chosen for recruiting interlocutors, data collection and analysis, and ethics. I will conclude with the challenges I encountered as someone who is Malawian-born but perceived as foreign, and mediating between using NGO networks while interacting with interlocutors independently.

4.1 Qualitative Methodology

2 The data collection and analysis methods that I utilized for this thesis were subjected to a feminist methodological lens. Giving centrality to a gender-sensitive research methodology entailed taking gender into account as a significant variable, and in this case specifically focusing on women's voices through this study, to highlight the discrimination and inequality they are confronted with at home or in their communities. The feminist methodological lens not only offered ethical guidance in the study and evaluation of a gender issue, but also encouraged reflexivity on my part, as the researcher. As such, I was conscious of my own positionality as a Malawian-born but foreign-residing woman, as well as of how my positionality influenced interpretation of the results. As my thesis focuses on socio-cultural perceptions and explanations of the infertile identity, as well as the anxieties or stigma that may surround it, a qualitative approach seemed to be the best fit. The specific tools that I used were in-depth interviews, discussion groups and informal conversations.

4.2 Interlocutor Selection

3 The target groups of my interviews, discussions and conversations included primary and secondary infertile women, religious leaders, health workers, and community members. Primary data was collected from January 3rd, 2019 to February 21st, 2019. I liaised with a local non-governmental organization that works on maternal health, as well as health service workers or assistants to identify my first infertile female interlocutors. Time spent volunteering and working with said NGO in the past allowed me to build relationships and trust among the staff, and allowed for an ease of entry

into the field as well as access to interlocutors. I not only relied on the NGO's records but also employed snowball sampling to recruit further interlocutors in order to have a better balance of recruitment methods. The NGO not only had its own records but also employed health workers working in the study area who had relationships with the women and were able to identify them.

4 Health professionals and religious leaders were selected according to their position in the community, and contacted through information collected by the NGO and community members. I selected health professionals and religious leaders who worked in the community, as well as those who resided in the city, through random selection via word of mouth and snowball sampling. For the discussion groups, informants were randomly selected from community gatherings, and common meeting locations for women such as boreholes and church gatherings.

4.3 Data Collection

5 Data was collected from the four aforementioned participant groups – infertile women, religious leaders, health workers and community members – using interviews, discussion groups, and informal conversation. With the consent of those involved, I recorded the conversations and took notes.

6 Interviews were the main data collection method for my thesis. Fontein mentions the advantage of the blurred line between the interview and casual conversation, that can often occur in fieldwork and create what he coins as a "deep hanging out", and I capitalized on this aspect (Konopinski, 2013, p. 77). However, the distinction between casual conversation and interview – the prearranged questions and preparation – was still maintained as I worked on an interview guide to steer interlocutors towards issues, themes and concerns around my research question.

7 Fontein also highlights the fact that interviews allow the researcher to gather data rapidly and transition from a more basic questionnaire guide in the preliminary stage, to a more specifically contextualized guide at a later stage with more precise questions, that can help to unveil "richer, evocative ethnographic material" (Konopinski, 2013, p. 78). With Malawian society rooted in oral culture and tradition, it followed that the most suitable approach for gleaning information and building relationships would be orally. Additionally, with my focus community located in a rural area, there are lower literacy levels than in the city; thus, relying on oral rather than written methods allowed me to have a wider sample size and avoid exclusionary tendencies. This not only prioritized the informant's voice, but also avoided what could be perceived as a strict researcher-interlocutor structure, in favour of a more conversational and informal environment.

8 *Interviews*: The in-depth interviews included questions related to perceived causes and consequences of infertility, as well as questions related to the stigma experienced, coping strategies and social support or lack thereof. The target group of these interviews was primary and secondary infertile women. 30 interviews were conducted with an average length of 1 hour. As seen from the table below, many of the women married at an early age, had been divorced and had, on average, only attained primary school education. These interviews allowed for a better understanding of the infertility

experience, stigma experienced by the community and how the women perceived or understood those experiences.

Table 1: Basic backgrounds of (pseudonymized) women participating in the in-depth interviews.

Pseudonyms	Interlocutor	Age	Age at First Marriage	Number of Marriages	Gender	Education Level[1]	Children
Mphatso	1	52	28/30	8	Female	Standard 8	0
Madalitso	2	45	14	4	Female	None	1 (22 years)
Chipi	3	61	19	2	Female	Standard 2	0
Fusani	4	33	17	3	Female	Standard 7	1
Mpho	5	59	18	7	Female	Standard 1	0
Theresa	6	35	18	2	Female	Form 1	1
Chikondi	7	31	19	1	Female	Standard 5	0
Dalitso	8	66	22	2	Female	Standard 6	0
Chimwemwe	9	22	18	1	Female	Standard 6	0
Pemphero	10	21	13	1	Female	Standard 7	0
Tadala	11	22	15	1	Female	Standard 7	0
Tiyamike	12	37	15	2	Female	Standard 2	1
Yamiko	13	24	20	1	Female	Form 3	1
Pilirani	14	37	18	1	Female	Standard 3	0
Mayeso	15	22	19	1	Female	Standard 5	1
Takondwa	16	34	18	1	Female	Standard 8	1
Thokozani	17	35	21	1	Female	Standard 8	1
Yamikani	18	47	33	1	Female	None	0
Mayamiko	19	47	18	2	Female	Standard 3	1
Mayeso	20	31	19	1	Female	Standard 8	2
Limbikani	21	38	14	1	Female	Standard 3	1
Fatsani	22	54	23	2	Female	Standard 3	1

Chisomo	23	20	14	1	Female	Standard 7	2
Chiyembekezo	24	33	18	5	Female	Standard 4	3
Chikumbutso	25	53	19	1	Female	Standard 2	1 (one died)
Kondwani	26	45	18	2	Female	Standard 2	1
Kumbukani	27	Unknown	Unknown	3	Female	None	0
Chifundo	28	52	22	1	Female	Standard 2	1
Chifuniro	29	42	26	1	Female	Standard 2	0
Ganizani	30	35	21	1	Female	Standard 7	

9 Three semi-structured interviews were conducted with health workers who had an insight on community relations and perceptions that exist in the community surrounding infertility. The interviews provided information on health workers' perceptions of the problem, and of the stigma related to it.

10 *Discussion groups*: Two discussion groups were organised with community members and religious leaders. This provided an opportunity to analyse the value that the former group placed on children and community perceptions of infertility, and glean insights into the latter group's religious explanations or responses to infertility, as well as the church's response to infertile individuals, and allowed me to examine how this played into experiences and management of stigma. The average length of each discussion group was 2 hours. The discussion group with religious leaders consisted of pastors from different churches including Assemblies of God, Seventh Day Adventist, The Nazarene Church of Malawi, Redeemed Christian Church of God, Destiny International Pentecostal Church and Hope in Jesus Ministry Church. The community member discussion group consisted of three men and four women, none whom were infertile or identified as infertile, with different marital statuses and a diverse number of children.

11 The community group and religious leaders group were structured diversely to ensure that different perspectives and interpretations among the community were heard. Owing to the sensitivity of infertility and 'infertility talk', the questions discussed in the groups started with more of a focus on general questions about children, marriage, and family. This allowed the group to navigate around these topics, and both groups independently ended up steering the discussion towards the topic of infertility. The discussion groups allowed for the examination of people's perspectives when operating within a social network or environment. In other words, the discussion groups allowed for an embedded and interactive environment for understanding how people in the community interact with each other and express themselves differently (Konopinski, 2013, p. 80).

12 Kitzinger emphasizes the value of discussion groups for encouraging participants to express themselves in their own vocabulary and explore issues of importance to them (Kitzinger, 1995, p. 299). As such, the question guide for the groups included more general questions and allowed participants to generate their own questions and

discussion based on these questions. The nature of the group also allowed for insight into different forms of interaction, communication and social realities not only between researcher and participants, but also *among* participants in the forms of jokes, arguments, or anecdotes (Kitzinger, 1995, p. 299). Unveiling these interactions and forms of communication provided an opportunity to observe cultural and normative values (Kitzinger, 1995, p. 300) and thus gain a richer account of people's knowledge and experiences around (in)fertility, health and sexuality, as well as buttressing the information revealed in the interviews.

4.4 Ethics

13 As mentioned before, my positionality plays a role in this research. I am cognizant that I am a middle-class, educated, Malawian-born but foreign-living researcher. My positionality required me to be reflexive during my research and during the writing process – to be cautious of power differentials that exist and how they may affect interactions and responses, as well as to separate my own role as a researcher from that of the NGO I worked with.

14 Owing to the sensitive nature of the research topic, where individuals' personal experiences of infertility potentially extended to sensitive emotional issues – such as sexually transmitted infections, marital relations, stigma, or social exclusion – ethical principles were key to this process.

15 Specifically, the principles of **confidentiality** and **consent**:

- Prior to the interviews, participants were informed that I hoped to ask personal questions of them in order to gain information on their experiences in trying to conceive and any challenges or struggles they may have encountered individually, both within their families and in the community. When I received consent to conduct the interview I maintained openness with my participants in explaining that I hoped to use the data in a document exploring theirs, and others', experiences to produce a sample of experiences in the Mngwangwa community, primarily for my schooling purposes but also for the provision of data and information to NGOs on the ground, government or other organizations and institutions that could utilize the thesis for the benefit of the people.
- All the participants included in my study were informed beforehand of the research objectives and promised confidentiality of any information given to me. The interlocutors were informed of the nature of the study, reasons for conducting it and any emotional or traumatic risks that may come up through talking through sensitive emotional matters. Additionally, the interlocutors were informed that should they not want to answer specific questions if they were uncomfortable, that was entirely acceptable.
- The privacy, confidentiality and anonymity of participants was ensured; in those instances where I used an audio recorder or took notes, the interlocutors were duly asked beforehand. Pseudonyms are used for all interlocutors interviewed to protect their identity, unless they stated willingness for their true names to be made public.

4.5 Challenges

16 Firstly, despite being Malawian, my proficiency in the local language, Chichewa, was only advanced enough for me to understand but not to speak at the level that was needed to ask the interview questions and follow up questions. As such, it was necessary for me to use an interpreter when in the field. This in itself was a challenge as it added a barrier to conducting the interviews. I believe that the use of interpreters may have complicated the perception of me with my middle-class status and accent, adding layers to my perceived foreignness. However, I found that once the interview had begun and the interlocutor began to notice that I only used my translator for my own questions rather than their answers, they understood that I could understand the language; most of the interlocutors began to speak directly to me rather than my interpreter by this point. However, when I didn't understand a response, this was a challenge as my interpreter would often forget that we would need to interrupt the interlocutor for a translation, or they would have forgotten the response, thinking I had picked it up, which would result in their translating a paraphrased response.

17 Secondly, while my access to the field was made easier through my relationship with the local NGO, at times this confused interlocutors and positioned me as someone who could remedy their situation either through emotional or medical resources. My apparent foreignness and approach as an outsider asking several probing medical and health questions perhaps added to this. At times, even despite stating my intentions and the distinction of my study from the activities and identity of the NGO's work or from medical personnel, confusion still remained with the interlocutors. This was challenging, as at the end of the interviews many of the women would ask what I would suggest to remedy their situations: either their marriages, their infertile status, or their health status. Being unable to provide an answer other than mentioning the purpose of my study and my lack of professional expertise in any of those areas at times made me feel helpless. Sensing the earnestness of the interlocutors and their disappointment after the delivery of my answer, repeated each day, was at times disheartening – for me, for my interpreter and for them. As such, my study was challenging not only in terms of academic work but often times in terms of emotional work. Thankfully, my interpreters also worked with health workers and were at times able to offer some health advice or referrals. All in all, however, I understand that reliving trauma or emotions through the interviews was not an easy task for the interlocutors.

18 Ultimately, my hope is that this research was more therapeutic than harmful, through its conversational aspect, and I was thanked for this by several interlocutors at the end of their interviews. After these interactions and conversations, I hope that this study exists not only as a thesis, but potentially for use by the NGO that I worked with or other Malawian organizations to better serve the needs of the Mngwangwa community.

4.6 Data Analysis

19 A thematic analysis was used to establish clear and comprehensive findings for the research questions. This entailed identifying, analysing and reporting themes in the data through 5 phases:

1. Familiarization with the data through close listening to recordings of the interviews, discussions or conversations and transcription of recordings. Thereafter producing of a list of interesting notes on the data and preliminary interests.
2. Reading and re-reading transcriptions while conducting provisional coding of the data – that is, organizing chunks of the data under a category that described it – conducting a search for themes and producing a draft report of coded findings. Thereafter grouping the codes into different data sets for ease of review.
3. Defining and naming themes or sub-themes and placing data sets in them. These themes included a) cultural issues b) perceived treatments c) perceived causes d) recommendations e) religion f) social consequences g) stigma experience h) SRH knowledge i) key quotes, and others.
4. Conducting a detailed analysis of the code sets, looking at content, utterances, pauses, silences, laughter or other discursive strategies. Additionally, identifying differences among interlocutors.

20 Refining analysis through discussion and exchange with thesis supervisor and selecting specific extracts to include in the thesis.

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1. The Malawian education system comprises of eight primary school grades, from Standard 1 to Standard 8, followed by four secondary grades from Form 1 to Form 4

5. Perceived Causes and Treatments

1 This chapter demonstrates that in Mngwangwa the interplay of culture, witchcraft, Christianity and biomedicine creates unique perceptions of causes of infertility and experiences of treatment. In a community where infertility diagnoses are limited to gynaecological exams for STDs, sperm analyses or a review of the individual's reproductive history, when biomedical explanations for infertility remain incomplete or unknown, the unknown is best mediated through personalistic explanations (Gerrits, 1997, p. 44). However, in the interviews for this study it was quite uncommon for an interlocutor to provide only a single categorical explanation, as often both traditional and biomedical factors were considered.

5.1 Perceived Causes

5.1.1 Contraceptives

2 Many of the women interviewed mentioned their use of contraceptives as a reason for their infertility. The majority of them had frequented family planning clinics around the Mngwangwa area in efforts to either prevent unplanned pregnancy or to space out future children. The contraceptive most commonly cited was Depo Provera, the brand name for medroxyprogesterone, an injectable contraceptive that is effective for three months. This comes as no surprise, considering that Depo is the highest-funded and most commonly supplied contraceptive for various clinics and health centres around Mngwangwa. One doctor at Mtema Health Centre – one of the two most frequented health hubs near Mngwangwa – mentioned that his own clinic was only stocked with 5 IUDs annually, without sterilization equipment, making it near-impossible for this solution to be offered, leaving Depo as the most feasible offer.

3 In addition to this, similarly to other Southern African countries, Depo seemed to be the most preferred contraceptive owing to its low cost in comparison to other methods, a decreased need for vigilance and the "invisibility" of the method, as its application and consumption was less likely to be noticed by husbands or extended family members (Kaler, 1998, p. 369). This oppositional experience of the method's benefit cast

against its future cost was evidenced in Yamiko's story, who had secretly taken Depo only to struggle with conceiving at a later stage:

> What was your husband's reaction?
>
> "He was very disappointed that I took a contraceptive without his knowledge and kept him from having children, so he did not eat or bathe for two days, but later he just accepted it."
>
> What year was this?
>
> "It was in 2015."
>
> What happened then?
>
> "When the time frame of the injection I got was over, I still didn't get pregnant even after accepting the need of my husband to have another child – because my mother advised me that what I was doing will give my husband thoughts of getting another woman. Since 2016 I was never able to conceive, then we were advised we should try seeking help as maybe the injection I took was still working in my body."

4 Consequently, despite Depo's family planning benefits, various interlocutors felt that the hormones from the injection delayed or even permanently prevented the ability to have a child. Especially for the few interlocutors who mentioned having received the dosage twice or three times, in the belief that this would allow the birth control to work for longer. Adding to their frustrations, the women's visits to the hospital only seem to have been met with instructions to continue to wait, as my interview with a nurse demonstrated in her response to my question on the correlation between Depo and failure to conceive:

> "Yes, there are some people who have problems conceiving after using some contraceptive methods, not only Depo Provera, so they feel they are failing to get pregnant because of the method they used, but in due time they get pregnant."

5.1.2 Sexually Transmitted Infections and Reproductive Issues

5 Barden-O'Fallon's findings on causes of infertility in Malawi was very much in line with Dr. Kalanda's list of infertility causes in his interview:

> "There of course is a male factor, which is hardly talked about. About 40-60 per cent of the cause for infertility falls upon the male, with a low sperm count as a contributing factor. But in most cases men don't want to get tested. In other cases, sexually transmitted diseases as an obstruction can be a cause. The most common for women is tubal blockage due to sexually transmitted diseases or pelvic inflammatory diseases; other causes are hormonal issues and others have an unknown cause, where we're not able to find out what is causing the infertility."

6 Another doctor from Mtema Clinic mentioned STIs being the largest cause, with syphilis as the primary affecter. In line with this, several women mentioned visits to the hospital where they were given medication for *msungu* (candidiasis), *chibelekolo changa anachitembenuza* (blocked fallopian tubes) or would directly mention an STI, although many were unable to identify exactly which STI they had been diagnosed with, or what medication they had been given. Visits to the hospital would be prompted either by no sign of conception or by symptoms of an STI that would vary from itching, vaginal discharge or sores on the individual or her partner, pain during sex and other symptoms.

7 Kumbukani's visit to the hospital not only marked the discovery of her infertility, but also the surprising cause of it:

Did you try seeking help from anywhere?

"We tried going to the hospital."

What did the hospital say?

"They said I had syphilis but that my uterus was okay; so, they gave us some drugs, but nothing happened."

Who did the doctor say had syphilis?

"The both of us, but we found out because I was the one sick."

What did you feel?

"I felt itching, but I think my husband also had the disease and just did not tell me."

Did the doctor tell you how you got the syphilis?

"No."

How do you think you got it?

"I think my husband gave it to me."

8 There were of course those affected by complications from other infections, iatrogenic infections, reproductive abnormalities and unsafe abortions (Parrott, 2014, p. 175). While only three interlocutors mentioned having an abortion, none mentioned going to the clinic to have it done. The socioeconomic status of the majority of women in the Mngwangwa area forces many of the women to resort to unsafe abortions either performed by traditional healers, non-medical personnel or the purchase of an oxytocin-drug. One nurse expanded on the use of the drug

Are those drugs over the counter?

"No, they are not over-the-counter, it is an illegal drug... not really illegal but it's not supposed to be sold, but some pharmacies sell them, so people access them. So, if people come here because of an abortion it means that someone is providing them."

Does the pill cause complications for the uterus?

"That drug is the same one available here at the hospital. Let's say someone has had an abortion but it's incomplete, so we use it to get the rest out. Or if someone is in labour and the baby is struggling to come out, we use it to induce labour. But regular people don't know the correct doses and timing."

9 Both this health centre and the Mtema Health Centre had large numbers of women coming in having had abortion complications or incomplete abortions that later affected their fertility status. One pastor in the Religious Leaders Community Discussion Group told the story of a woman he knew who "went to South Africa to find out why she was having problems having a child. At the hospital was when they revealed the woman had gotten pregnant and had an abortion eight times. The constant abortions are what eventually led to her infertility. And this is the same for many cases. Unsafe abortions."

5.1.3 God's Will

10 In several African communities, children are seen as a gift from God or the gods, and the inability to have children is thus explained as 'God's will' for the individual – either as a result of their sin or unworthiness (Dyer, 2007, p. 74). As mentioned previously, Christianity is the most predominant religion in the Mngwangwa region, with 70 per cent of the population listed as practicing Christianity.

11 Every interlocutor mentioned God in their interview, either when speaking of reasons for their infertility or the possibility of having a child in future. When mentioning God as the cause, however, it was more with an attitude of acceptance than of anger, as seen in the responses below:

> What do you think are the reasons you are infertile?
>
> "I think it's just the way I was created and that in God's time things will get back to normal."

12 And Mphatso, when asked for her sources of support added: "The person who knows everything is God, so sometimes, I just pray. He is the one who decided that I am to be this way." A religious leader speaking about supporting people with infertility mirrored this view, stating that "Sometimes we church leaders misdirect people in our church. We try to tell our people that all things are possible with faith. But some situations cannot be changed even with faith. Barrenness is something that has happened because God has willed it."

13 Of the interlocutors who did mention 'God's will' as a cause for their infertility, only one perceived it as a punishment for past transgressions, while others rested on the idea that God's will can often be undecipherable and without need for explanation.

5.1.4 Witchcraft

14 Studies in other African countries have revealed the prevalence of perceptions of witchcraft as a cause for infertility. Evans-Pritchard's ground-breaking work on witchcraft among the Azande explains that beliefs in witchcraft are used to explain unfortunate events and regulate the responses to those events (Evans-Pritchard and Gillies, 1976, p. 18). While misfortune is often explained with a plurality of causes, more serious cases are often attributed to the action of witchcraft (Evans-Pritchard and Gillies, 1976, p. 18). Witchcraft is often instigated by feelings of greed, jealousy or envy (Richards, 2002, p. 88); consequently, interlocutors cited a diverse range of examples of witchcraft or curses that took on different forms. Madalitso explained that her infertility was a result of the ill conduct of her mother-in-law:

15 "After the birth of my first child, my mother-in-law took the after-birth and told me that she was going to dispose of it. Because the place we stayed in was temporary, just for us to settle down for a bit, it had no toilets. So, my mother-in-law told me that she would dispose of them in the bedroom, burying them under the ground. After some years, when I realized I wasn't able to conceive again I went to seek help from the sing'anga (traditional healer). The sing'anga told me that if I go and find my after-birth and remove it from the house then I would be okay. But when I went back to the house, I found that it was gone – that my mother-in-law had not in fact buried it in the bedroom that day. When I went back to the sing'anga, that is when I was told that my

mother-in-law used my after-birth for her own rituals and benefits, and that is why I was infertile."

16 Two other interlocutors described a similar situation as the cause of their infertility, except that the after-birth was substituted with an umbilical cord for the one, and a cloth used during a menstrual cycle for the other.

17 Those most exposed to your riches or successes are those closest to you in a community, and thus have a higher propensity for feelings of jealousy or envy. Several interlocutors felt their own family members had bewitched them, out of jealousy for their wealth or fertility:

"I think my cousins are responsible."

Why do you think that?

"They sometimes come to my house and enter my bathroom, kitchen and toilet but do nothing. Then they just leave. So, I think they are witches and have brought this misfortune on my family. Other people know they are witches too."

What exactly do they do?

"They might pass by a house and touch it for no reason or go into a house and not do anything then leave. And once a neighbour's young girl died and they told the parents that they could kill another child in the neighbourhood as revenge."

Why do you think you are infertile?

"I think someone is responsible for my infertility and bewitched me out of jealousy."

Who do you think that person is?

"I think my aunt is responsible."

Do you know why?

"I think she is just jealous. She was also jealous of my mother, which is why she struggled to have more children."

Why doesn't she want you to have children?

"She never wants to see my mother happy – because my mother didn't have many children it would have been possible to make her happy if I did. But because my aunt was jealous and bewitched me that was never possible."

18 Another interesting form of witchcraft occurred in the dreams of two interlocutors. Chipi described her dreams of seeing herself crossing a river or seeing a house burning. She had the dreams several times after becoming pregnant, and right after the dream she would wake up with heavy bleeding and eventually miscarry. She believed that because she saw her in-laws in the dream helping her cross the river, they were responsible for her losing her baby and essentially 'crossing' into an infertile phase.

19 Intriguingly, even if the interlocutors had suspected someone of bewitching them, they rarely, if ever, confronted their assailant. Evans-Pritchard offers a hypothesis that this could be due to the risk that an accusation of witchcraft against a family member might implicate other members of the family as witches (Evans-Pritchard and Gillies, 1976, p. 7). The inferior social position of an individual – in this study's case as a woman, and further as an infertile woman – might also affect the gravity of their accusation, and in particular be framed as an insult if their potential accusee is of a higher social status (Evans-Pritchard and Gillies, 1976, p. 10).

5.2 Perceived Treatments

5.2.1 Traditional Healers or Hospitals

20 Visits to either the *sing'anga* or hospital were cited in all of the interlocutors' treatment seeking. Most interlocutors averaged between 2-3 hospital visits and 5-6 visits to a sing'anga, often in efforts to seek out different opinions or treatment options.

21 One of the thirty infertile women interviewed only visited the hospital, explaining that "I did not see any benefits of going there (to a sing'anga) as sometimes sing'angas also lie and can't really be trusted." Contrastingly, 2 out of 30 only visited the sing'anga and not the hospital, with the former explaining that this was due to a lack of finances, and the latter saying she had not gone to the hospital "because my husband believes the help will be found in a sing'anga." The remaining 27 women visited both the sing'anga and the hospital, often multiple times, and saw the traditional and biomedical systems as complementary and re-affirming rather than mutually exclusive. This was apparent in several interviews, where the sing'anga would often give a diagnosis that was repeated in hospital, or vice versa.

> "I was given some tablets from the hospital which I was to insert in the vagina, which they said would help wash me in the inside. The sing'anga gave me some herbs and roots to soak in water and to drink that would cleanse me inside and allow for things to be released through urine."

22 In fact, in a few instances interlocutors were advised by a hospital attendant to visit a sing'anga, as the hospital had no way to help them:

> "The sing'anga gave me some herbs that would help me conceive and told me to wait as I had no fertility problems. I went to the hospital in 2013, where after screenings they found that I had no problem and advised me to seek help from a sing'anga. I explained that I had gone to a sing'anga once and nothing happened, and they just told me to go again."

23 Research indicates that traditional healers see 70 per cent of African patients, as they are often the first line of contact (Chipfakacha, 1997, p. 418). Traditional healers are well-suited to forms of diagnosis and treatment that acknowledge this diversity of perceived causes of infertility, ranging from the biomedical to the supernatural (Van Balen and Gerrits, 2001, p. 217). Consequently, in instances where a hospital gives a confusing or incomplete explanation of the cause of infertility, interlocutors were often able to gain clarity through a visit to the sing'anga, as demonstrated by Tadala's visit:

> Did they (the hospital) explain?
>
> "They said this happened after the birth of my first child, but this was explained by a sing'anga who said someone had bewitched me and moved my womb to the wrong place."

24 Contrastingly, if the cause of infertility was not identified as witchcraft, the sing'angas visited by the interlocutors did not seem to offer any other explanation, nor was any information given on treatment methods, or medication provided, and it was this lack of information that would often prompt the interlocutors to seek help from the hospital.

25 The methods of diagnosis of sing'anga cited in the interviews ranged from "seeing into other realms", to bodily examinations with their hands, to conversations with the

patient. In some cases, the sing'anga were even able to provide information on the person who was infertile:

> "We tried to have a baby for four years and then we decided to get help. We went to a sing'anga who gave us some herbs. He said that the person who would sneeze was the one who was infertile but when we took it, we both sneezed so we went back to the sing'anga and he gave us some herbs to take together."

26 This same ritual was described by different interlocutors substituting sneezing with coughing or vomiting, or even an action that would occur later in the day (for example, an individual removing a stick from the interlocutor's gate).

27 Treatments from the sing'anga would include herbs to drink for one or both members of the couple, or herbs to insert in the vagina. When an explanation was given, these herbs were said to clean out the insides of the womb, heal sores or pains in the vagina or womb, or simply to "help them get pregnant". Similarly, at the hospital interlocutors were often given medication in the form of tablets instead of herbs. The majority of interlocutors stated they did not know the function of the medication, unless they were antibiotics for STI treatment. Other services the hospital offered that the sing'anga did not were X-rays, STI diagnosis, semen analysis or contraceptives to correct or initiate the menstrual cycle.

5.2.2 God

28 While 'God's will' was cited as a cause for infertility, interlocutors would also touch on their turning to faith when efforts by the hospital or sing'anga were in vain. Interlocutors would mention praying for the gift of a child from God or visiting a religious leader or church in search of help. In one instance, an interlocutor even mentioned imploring her husband for them to stop seeking help from hospitals and sing'angas and instead *"just wait upon the Lord because we were just spending money over things that did not bring results."* The most commonly cited answer given by the religious leaders or church members to "wait on God". As one religious leader explained:

> "God answers in three ways, which is YES, NO and WAIT, so when they see their answers being delayed it is either a NO or WAIT. There are times when God tells you directly that the person cannot be helped, but if you tell the person that God has told them NO they will not have children ever, he/she might just stop worshiping God and might seek help from elsewhere, like the sing'angas."

29 The church has a disregard for sing'angas that stems from the belief described by one religious leader: "[sing'angas] have a certain power, but not a power that is good. It taps into something that is evil – that Satan can take advantage of." He added that a visit to a sing'anga when one is Christian confuses what source is truly responsible when a child is successfully conceived:

> "In the story of Abraham and Sara [in the Bible], Sara was told to wait. In the time that she waited imagine if she had gone to the sing'anga? Then she would have birthed a child and assumed that the birth of the child was the result of the visit to the sing'anga and not the promise from God."

30 Prayer was the most common, if not only form of treatment offered and encouraged by the church. One religious leader mentioned praying for three infertile women and declared that all three presently had a child. Along with prayer, two elements were emphasized – that of faith and of wisdom.

> "Faith comes by hearing and hearing by the Word of God. With a certain level of faith, anything is possible – you can move a mountain. Anything is possible. But faith goes with reasoning. If God wants to do something, of course he can do it. But he created us with a brain to reason about certain things. So, it's not just about believing that certain things will come to pass."

31 This religious leader and half of the discussion group believed that while faith is necessary, a certain level of wisdom needs to accompany it. He went further to provide an example:

> How do you see infertility issues in terms of faith?
>
> "It needs both prayer, faith and wisdom. I remember from the story that my mother narrated to me that they had problems with my birth, it took them years for my mother to get pregnant. She heard from friends that, from what she was explaining, she could get help, and when she went to the hospital she got help and got pregnant after some months. Faith and wisdom go together. God will work in your circumstance if you also apply wisdom to it. He has the ability to give a child if he wills it, but you must be wise. When your faith is low also, go to the hospital and get help there. As religious leaders we should be able to discern those cases that need either wisdom or need faith."

32 While half the group of religious leaders stood behind this argument, the other half believed that faith did not always require an element of reason. One religious leader summed up their thoughts by responding that "In many instances that is true but at other times God can tell you something, some solution that you should do, where your reasoning would not make sense of it. Human reasoning is not applicable to all that God tells us."

33 All in all, however, the religious leaders were careful to emphasize that not all prayers for infertile people would result in conception. Whether one had unshakeable faith, or one applied an element of wisdom to pursue other forms of treatment along with their faith – in the end, God's will still prevailed.

5.2.3 Remarriage or Polygamy

34 Western literature has examined experiences of marital stress when couples are faced with infertility, but very few cover cases of male-initiated divorce as a result of female infertility (Greil et al., 2011; Greil, McQuillan and Slauson-Blevins, 2011; Van Balen and Gerrits, 2001; Van Balen et al., 1997). However, this outcome is present in several non-Western societies around the world, and has been cited in studies in countries like India and Egypt (Inhorn and Bharadwaj, 2007, p. 14). Similarly to the findings from the study of infertility in India mentioned previously, in Mngwangwa infertility is viewed as a valid reason for divorce or abandonment. All of the interlocutors had been divorced and remarried between two or seven times, and many of them were or had been part of a polygamous union. Often times, the added vulnerability and stigma of being not only an infertile woman, but an abandoned or divorced infertile woman would be enough motivation for the woman to accept a transition into a polygamous marriage. Other interlocutors accepted the union owing to their feelings that they were the ones to blame for, because of their inability to have a child, as expressed by Chifuniro:

What was your husband's reaction?

"He told me that he would get another wife but that I did not need to leave and could continue staying with him as his wife."

How did you feel when he said that?

"I just accepted it, as I knew I was the one who had the problem and could not bring us children. After a month, he went and got another wife who got pregnant after five months. She gave birth."

35 If these women have to deal with the discovery of their infertile status, they also have to manage it in the context of another fertile woman married to their husband, and the latter often takes a higher social status in the household upon bearing a child.

36 Interlocutors spoke of their divorces as an almost obvious result of a husband discovering his wife's inability to conceive; similarly, in a community group discussion one man stated, matter-of-factly, that "If she is infertile you either leave her or get another wife."

5.2.4 Fostering

37 The last response or 'solution' to infertility cited in the interviews was to foster, although the interlocutors never labelled it as such. Many of the interlocutors who had not had any children and were divorced and living alone had taken on the care of their siblings or extended relatives' children. This could include those relatives who did not have the economic or spatial capacity to care for all their children, relatives who had passed away, or relatives who sympathized with the interlocutor's feelings of loneliness. In most cases, the children would move to stay permanently in the same house as the interlocutor.

38 There were also instances where the interlocutors in a polygamous union would care for the other wife's children. One husband even moved his other wife's child into the house so that Fatsani could care for them:

Does your first husband not want more children now that you're back with him?

"No because he already has three children and I was taking care of the other wife's youngest in our house, although she died a few years ago."

Why were you taking care of the other woman's youngest child?

"I took her because I loved her character and behaviour."

Was the other woman okay with you taking care of her child?

"We had conflicts over the child but because my husband was on my side, she accepted it."

Why did your husband agree that the child should stay with you?

"He saw the child would grow well under my care."

6. Experiences of Stigma

1 Chapter Six will examine the shifting nature of stigma. Stigma as a category is continuously in a state of flux. It is a truism that stigma will not be experienced by everyone in the same way, but also that the way in which it operates produces a state of exclusion that is delegitimating and impacts all aspects of social intercourse. The empirical data analysed for the theoretical framework underlines the fact that stigma is a very unstable, variable category. It is universal and yet is experienced as a certain disability. There can be two identical situations, and yet the way in which people experience the stigma can be very different, as well as the way in which it is ascribed to them.

6.1 Social Stigma

6.1.1 Pronatalism

2 When asked "Do you think people have a lot of children in Mngwangwa?" a community member in a discussion group responded, "when most people get married they think the greatest achievement of marriage is to have children and people think that the aim of marriage is to bear children." His answer reflects the general attitude of a pronatalist society that venerates reproduction and exalts parenthood (Miall, 1994, p. 34). Miall establishes that two procreative norms exist in such a society – that all married couples should procreate, and that all married couples should *want* to.

3 When motherhood is normative, infertility is not afforded a secretive status and instead becomes a hyper-visible state. Goffman speaks about stigma being a polluting substance that discredits the social identity of the person who possesses it (Goffman, 1986, p. 34). In the same way, the infertile woman becomes stigmatized, or polluted, for her failure to reproduce in a society that constructs gender in such a way that womanhood is equated with reproductive ability. Madalitso encapsulates the pressure of this societal construct in her comment that *"people say that I'm not a person because I can't give birth to a person."*

4 In the context of Sub-Saharan Africa, where a number of economies are on the decline and women's social positions are vulnerable, children exist as sources of wealth,

markers of adulthood and assurance of the obligations of their husbands (Richards, 2002, p. 85). Interlocutors often spoke of *needing* children, as opposed to wanting them, or would choose to mention that they *only* had 'x' number of children when the number was two or lower. The insecurity of the environment and prevalence of poverty and disease often complicates reproductive patterns, further implicating the woman's body as a reproductive machine, as elaborated by a community elder:

> "[Women] give birth to a lot of children because they are afraid of their children dying; so, they feel that when something happens, they should still have children. If they have one or two children and one child dies, they are left with hardly any. But if you have five or six and one or two die, you are still left with children. You see?"

5 Interlocutors recounting their experiences demonstrated that with the high number of children being born in the community, often no distinction is made between primary and secondary infertile women, due to the stark difference between one child and the average of five. With a woman's social status intrinsically linked to her achievement of motherhood, failure to achieve that through infertility can lead to exclusion from her community, friends and family. This is especially felt through her perceived inability to contribute or engage in conversations concerning pregnancy, delivery or parenthood, as Mphatso relayed:

> "I envy the other women who have children in the village. Most of the time when other women are talking about motherhood, they mock me by saying 'hey don't talk about these things while there is someone here who hasn't had a child and who doesn't know what it's like to be a mother.'"

6 Goffmanian stigma theory suggests that infertility exists as a discreditable rather than as a discredited condition, and thus allows individuals to manage their stigma and the knowledge of it (Goffman, 1986, p. 54). This theory of manageable stigma rests on the assumption that it can be maintained as a secret and has no visible, obvious stigmatizing features that would prevent the individual from passing as normal (Goffman, 1986, p. 54). However, this takes on a Eurocentric and problematic assumption that the stigmatized individual is self-reliant and autonomous, faced with a diverse range of options, and lives in a context that allows privacy (Bharadwaj, 2017, p. 70). This also assumes that without a visible physical deformity, there is no sign that marks an individual as infertile.

7 In a non-Western rural context, like that of Mngwangwa, infertility stigma fails to exist as a "secret stigma" and instead exists as a hyper-visible trait and attaches to the body and identity of the infertile individual (Bharadwaj, 2017, p. 70). Beyond that attachment, the community often makes known the woman's infertile status in conversation, passing by, at gatherings or even in the way she is addressed, as one elder explained: "Once you have children a woman is called 'mother of...' and so too the man 'father of...'. With no children the woman would only be called by her clan name." The elder suggests that lacking this reference to their child is almost to lack a sense of belonging to a large group of the community, or to miss the transition from an average clan member to a contributing clan member. She reflected on this as she continued, stating "Without children, people don't regard the couple as worthy of being a family or part of a clan. The family and clan are strengthened because of children."

8 In a society that venerates parenthood and reproduction, there exists a surveillance, at times even a hyper-surveillance, of the female body that often transitions into personal interference, particularly when a woman marries. A community member described the social pressure that is exerted on a couple who has not borne children after marriage,

as parents and those around them interrogate them with warnings and questions such as “what are you doing??”, “What are you waiting for?”, “Are you having problems bearing children?”, “You must have children soon.” An assumption is made that the absence of children cannot be a voluntary decision, or that if it were, it would be irrational.

9 A community member reflected on this irrationality as he commented on voluntary childlessness, stating that “For someone to choose not to have children in our area can’t happen. It is the way of life and culture – you meet someone, you get married, and you have children right away.” The absence of children or the absence of signs of pregnancy thus physically marks an infertile woman, and surveillance of her complicates her ability to secretly manage the mark of stigma.

6.1.2 Patriarchy

10 Infertility stigma in Malawi needs to be understood and contextualized in a social context where men have a dominant status, and where that status is maintained through institutions and systems. In Mngwangwa, social systems exist that consistently disadvantage the woman, whether it be through low representation in the workforce, higher school drop-out rates or even the construction of parenthood as an ultimate life goal. Infertility stigma thus doubles onto the already-existing burden of patriarchal forms of control that affect the social and emotional position of women in society.

11 The tendency for society to extol men and their status often leads to the construction and gendering of infertility as a woman’s disease, which typically results in victim blaming. The gendering of infertility is preceded by the gendering of bodies, in which the responsibility and goal of the female body is prescribed as fertility. Kleinman asserts that stigma as a moral category exists in the West, but in other contexts the moral blame for an illness extends to include not only the patient but also their family, and can bring about accusations of bad heredity, witchcraft, or assumptions of punishment by the gods (Kleinman, 1997, p. 169). With this, the emotional and economic consequences for the infertile woman are high, particularly in a rural context, as Mphatso mentioned:

> “I got bad treatment from my own family and his. My past husbands’ families felt like I brought them no value. That we were doing all this work for no purpose, with no children and that the only thing I would do is just sleep and lodge in the house. Their families would tell them ‘just leave her; she doesn’t bring you any help or success.’ My own family would say that I would die poor because I had no help or children to bring me wealth. Both families felt that there was no point even helping me, for example, take care of a farm, because they felt there was no one who could reap the benefits of the fruits of that labour. I had no help for the work I was doing. I had to do this work on my own for my survival. My past husbands wouldn’t help me. They threw me to the side. I was something that needed to be disposed of.”

12 In many, if not the majority, of cases explained by the interlocutors the husband’s family or the husband himself often blamed the woman for the infertility. Fusani even recalled her husband yelling, “‘I wanted a child, why aren’t you giving me one?’ all the time he kept saying ‘I want another child.’” Placing blame on the woman absolved these husbands and their families of the social and moral guilt that would emerge out of the inability to bear a child in an exceptionally pronatalist society (Van Hollen, 2010, p. 650). Once the blame had been placed, several interlocutors faced challenges seeking

treatment or infertility help with their husbands, who would tell them to "*figure out their problem"* alone, seeing as they were responsible for their infertility. Seeking treatment or support was challenging for many interlocutors, who depended on their husbands and consequently did not have the financial or emotional support to even begin exploring options.

13 Even when treatment seeking is carried out by the couple, hospitals, sing'angas and family members are mindful in the delivery of their diagnosis. Fatsani demonstrated this when describing her treatment seeking visit:

> "After the [first] child was born, some time passed without me being able to conceive. My husband sent me to inquire about this from my grandmother, who gave some herbs for both me and my husband. The herb was initially just for my husband, but she just gave it to both of us so as not to insinuate that he was the one with the problem."

14 If a treatment fails to succeed, the maltreatment towards the wife intensifies as the husband or family scrutinize the wife's past decisions in efforts to place blame. Interlocutors cited families blaming past abortions, promiscuity, use of contraceptives, hospital operations (i.e. Caesareans), or even going so far as saying that the woman had performed witchcraft on the man.

15 Once the blame was placed on the interlocutor, many of them found that their husband would divorce or abandon them shortly after, with little backlash from family or the community, who would see the decision as well-motivated or often be involved in making it. Mayamiko, who was divorced by her husband, was never consulted on his intentions to do so, despite community knowledge of it:

> "He left because he wanted children, but he never told me, yet he was always telling his friends outside or around the house that he wanted children and I wasn't giving him any."

16 In other instances, where the husband's family or the interlocutor's family stood in support with her, the woman was either encouraged to persevere through the husband's ill-treatment, or was encouraged to return home to her family. The families who encouraged the interlocutor to persevere with her husband believed that the couple would eventually be blessed with the "gift of a child" if they continued to wait or sought help, or that those in relation to the woman would eventually accept her. Chifundo decided to stay through her husband's physical and emotional abuse because of her family's input:

> "It was because my family advised me to persevere, saying he would change and sometimes we would live together civilly. Sometimes I would leave and stay at my relatives' place for some time, and then my husband would come and apologize so I would just go back home."

17 When it comes to infertility, the sanctioned blame that is placed on women perpetuates disadvantaging social systems that already reduce women's economic opportunities and social opportunities within Mngwangwa (O'Brien and Broom, 2014, p. 343). In this way, infertility or childlessness becomes another structure that perpetuates 'social marginality' (O'Brien and Broom, 2014, p. 343).

18 While the focus of the interviews was with female interlocutors and their experiences of infertility, a few comments arose in the discussion groups regarding instances when the man was known or assumed to be infertile:

How do you see infertile people in your community?

"Infertile people are never at peace because of the discrimination they face. And most of the people that suffer from it are women, whereas a man uses a friend to cover up for him. If a man is infertile, he will ask his friend or relative to sleep with his wife. Then his wife can get pregnant without anyone in the community knowing. But if a woman is infertile, she can't do anything."

Why is it okay for a man to do that but not a woman?

"It is just the way culture is. If a man is infertile, he can choose someone to sleep with his wife. But if a woman is... our culture just cannot allow a woman to choose someone."

19 As the community member explained, when a man is infertile in the community he selects what is known as a "sexual hyena" – a close friend or relative – who comes secretly in the night to sleep with his wife and impregnate her, so that no one in the community may know he is infertile. There is a stark contrast between what seems to be a 'secret' stigma for male infertility – or a discredited stigma in Goffmanian terms – and the openly ostracized and vilified discreditable stigma of female infertility that can only be understood through the structures and institutions of the Mngwangwa society that favour and allow men to dominate and exploit women.

6.2 Cultural Stigma

6.2.1 Constructions of Infertility

20 In Mngwangwa the words and phrases used to describe infertile people influence interactions and relationships with those people, and construct a stigmatized infertile identity. Many of the interlocutors mentioned hearing "*chuumba* [childless/barren]!" yelled at them when passing by a group of people, whether from strangers or friends, in the community. The pervasiveness of the mockery and marking of infertile individuals in the community makes it challenging for the interlocutors to find a safe space either publicly or privately. This means that for an infertile woman in Mngwangwa there is no opportunity to avoid what Goffman calls "living on a leash", or the Cinderella syndrome. In other words, she remains in locations and spaces where she cannot maintain her disguise, and rest from stigma management tactics (Goffman, 1986, p. 94). This absence of spaces where her spoiled identity is unknown poses higher risks for the mental and social health of an infertile woman in Mngwangwa. Management strategies such as name-changing or 'passing' as normal in the community become near-impossible when the private sphere merges with the public sphere in a rural context, and familial or personal interference in reproductive matters is not only commonplace but validated.

21 The intimacy of rural living makes it easy for strangers, neighbours and friends to identify those without children and those who have remained so for months or years. An elderly woman in Mngwangwa mentioned the numerous ways infertile women are labelled in the community:

"There is name-calling – women are called chuumba and men Gojo or chimbuwira [infertile man/impotent man] – these are derogatory terms. Women are referred to as pupa [rotten or worthless]. Another term for women is ada yala tanthwe [literally, a woman with a rock in her vagina] or ama lavula [she cannot hold in/

> down anything, she vomits it out]. When a woman has one child only, they call her kuumira mwana mmodzi [dried up woman]."

22 It is intriguing that the Chichewa words used to describe infertile men translate directly, while the phrases used to describe infertile women have a certain vileness or violence attached to them – insinuating an un-humanness or a lack of value for infertile women. Metaphors of fruit came up frequently in interviews, with health workers and interlocutors adding other names and phrases to reference infertile women, such as "Anagwa mu papaya" [you fell off a papaya tree (because a papaya tree cannot be climbed)] and "kumangolima pa lubwe" [wasting energy on something that cannot bear fruit].

23 Language is an integral part of culture in that it reflects and communicates the ideas, values and attitudes of a community (Borisoff and Hahn, 1993, p. 254). Consequently, the use of specific metaphors to describe infertility do not occur in a vacuum. The reference of fertility and fruit in the Mngwangwan community can be situated in its religious context – following biblical injunctions referenced in one community discussion group, that God has commanded us to "be fruitful and multiply" (Genesis 1:28). In this way, the inability to do so is even judged on moral grounds, as a failure to fulfil one's divine purpose.

24 Metaphorical descriptions of fruit can also be understood in the community's agrarian context – where rural everyday life circulates around planting, harvesting and animal husbandry to sustain the life of the family and the community (Jensen, 2015, p. 28). Within these contexts and discursive frameworks, the inability of the woman to 'produce' or to bear life is perceived as cutting off the sustenance of the family and the lineage of the community, and in so doing she becomes labelled as 'fruitless' or barren. One community member used this fruit metaphor to explain infertility stigma by saying:

> "When a tree is planted, we expect fruits, and if it does not bring forth fruits it's taken as useless, which is the same with a person – when a man and woman marry, we expect fruits from that marriage."

25 Fruit metaphors position women as consumable and have starkly sexual connotations, where the man engages in eating his lover. Positioning infertile women on the opposite end of the scale – as rotten – positions them as untouchable, inedible and undesirable. The imagery of rotting fruit depicts an attitude towards the infertile woman as something disposable and expired: that no longer serves a purpose. These attitudes seemed to extend towards even secondary infertile interlocutors; describing these women as "dried up".

26 These labels, attitudes and experiences influence treatment the seeking behaviour of infertile individuals, even when deciding to visit a hospital. A doctor at the Area 18 Clinic mentioned that often people who come with infertility problems avoid using direct terms or explanations:

> "The most common way [of explaining infertility] is saying 'lower abdominal pains.' They mention they were trying to conceive and failed and are wondering what is happening. Generally, with men they say they have lower back aches when they want to have sexual relations. Most don't really go as far as mentioning sexual relations though, so you really have to listen for what they're explaining. Most just mention lower back aches – we get that a lot and so it forces you to immediately start thinking of reproductive screening."

27 It is quite revealing that infertility is stigmatized to the extent that infertility talk itself becomes taboo – even in the context of treatment seeking, in a space like the hospital that is typically regarded as safe as concerns discussions of illness and disease.

28 As Kleinman explains, "culture is not a thing [but] a process"; a process in which activities and conditions are ascribed meaning (Van Hollen, 2010, p. 650; Kleinman, 2004, p. 951). These meanings then influence interpersonal relationships and interactions, as well as collective and individual identity. These meanings are perpetuated in the ways people communicate and the words they use to do so.

6.2.1 Institutionalization of Stigma

29 Kleinman's theory establishes that social experiences reflect everyday practices of culture. These practices attach meaning to the body; they contextualize and localize the experience of a certain kind of body (Kleinman and Kleinman, 1994, p. 712). The discourse used by interlocutors, such as *ndimatonzedwa* [I was reproached in society], *wopanda pake* [I was a nobody/valueless/useless], or *kusalidwa* [people shun me because of an ailment] demonstrates the construction of a female infertile body in Mngwangwa.

30 Goffman suggests that an individual with infertility has a discreditable stigma and avoids forbidden or out-of-bounds places for fear of exposure of their hidden stigma (Goffman, 1986, p. 81). Antithetically, in Mngwangwa, interlocutors' infertility exists more as a discredited stigma, and as such they explain that these locations are not forbidden out of fear of exposure but rather due to the reality that crossing into these areas while discredited will result in ostracism, shaming, and vilification. The interlocutors don't battle the tension and anxiety of hiding their stigma, as suggested by Goffman; instead, they battle with the tension that arises out of their stigma being known and the hyper-visibility of that stigma in these forbidden areas. When questioned on how the community knew about their infertility, most interlocutors mentioned that they had been seen without children over the years, or that it had been noted they hadn't returned to their parents' home to announce their pregnancy, as is custom. In one instance, an interlocutor's entire community had knowledge of her infertility, as her husband had begun drinking heavily after years of her struggling to conceive, and would go yelling through the community that his wife was barren. The blurred lines between private and public sphere validate community members' obtrusiveness in matters of childbearing, as described by Mphatso when random people approached her in her day-to-day activities:

> "They see that I stay by myself with no children and realize that I can't bear a child. Other people in the village talk about me so that's how others know. They say, 'that one she has no child.' I'll even bump into people in a farther village who will ask 'oh how are you, people say you don't have children?' and I'll just answer, 'yes I have no children.' The men that I was married to also spread the news that the marriage didn't work out because I couldn't bear them a child."

31 Interlocutors recounting their experiences demonstrated that community talk around children and family affairs is quite common, often positioning infertile people as a topic of concern. Some interlocutors mentioned that while not all community members would mock or discriminate against them, many still felt it appropriate to comment on their infertility, saying *"one day you will give birth"* or *"just keep waiting and praying"*, which ultimately would still add to the visibility of their state. Often the people who

chose to be encouraging or offer some form of pity were the interlocutor's parents, immediate family members and in very rare occasions a mother-in-law:

> "A lot of them do not like the idea that I am still staying in their brother's place, considering the fact that I do not have a child for their brother. But a few of them encourage me, saying that I should not move out of the place as it is not my will that I do not have a child. They say when the time will come God will bless me with a child. My own family pities me a lot and asks questions like what happened for something like this to happen to me. Some of my relatives even encourage me to go out and seek help from sing'angas but I do not agree with that; I say when the time comes, I will have a child through God's will."

32 Goffman's stigma theory postulated that the 'normals' that live around or come into contact with the stigmatized individual feel "direct sympathetic concern" for their condition, and thus enact a kind of "courtesy stigma" that either ignores the part of their social identity that is polluting and attempts to reassure them that they are human, or offers them moral support (Goffman, 1986, p. 20-21). While of course, there are some cases that were mentioned where community members would offer encouragement or pity, the majority of interlocutors described a hostile and superior attitude from other community members:

> "[People] say I can never have children because 'mchombo unagwera munsi' [my navel cord fell inside] and that is why my husband left me. They sometimes sit in circles and talk about me and someone from the group comes and tells me to my face what they're talking about or insults me."
>
> - - -
>
> "I receive a lot of mistreatment and abusive words [from my husband's family]. They sometimes come and tell me that I'm wasting their brother's time and energy. Sometimes when I'm around people they stop talking normally and start talking about me and my situation."

33 Various interlocutors commented on the exclusion they faced in community groups and programs; exclusion that was enforced by community leaders and members, as the words of Tadala, Kumbukani and Tiyamike below demonstrate:

> "There is this other group where they talk of safe motherhood techniques and issues, they used to say everyone who has ever given birth should come but later some people started saying because I have given birth once I am not eligible to gather together with them."
>
> - - -
>
> "Sometimes pregnant women or mothers in the community get porridge from the Chiefs or organizations and I am not allowed to receive. Other times they receive other gifts or services, but I don't know what exactly because they hide it from me."
>
> - - -
>
> "There are, for example, the fertilizer subsidy program and the food for work program. The chiefs organize people on a list who can receive money or fertilizer to sustain themselves, but because I have no children I am normally excluded from these lists. I went to the Chief in the community last year and explained to him, and I was assured that things would change, but nothing has changed."

34 These experiences of exclusion were not limited to the childless women, as secondary infertile interlocutors often repeated the same hardships:

> "When different organizations come, I am not included because I have a single child. World Program, this other NGO from Likuni, and Children of the Nations. When Children of the Nations are gifting families with supplies, food, or clothes they look for families with more than one child because they say those are the families that need things the most."

35 People talk in groups around a woman with infertility, approach her with insults, offer unsolicited advice, pity, encouragement to wait, or even laugh or immediately leave when she visits certain community areas. One community member even mentioned songs that people mockingly sing when an infertile woman approaches:

> *Kachumba iwe, Kachumba iwe* – Barren woman, Barren woman
>
> *Ubeleke wako mwana* – Bear your own child
>
> *Kachumba iwe* – Barren woman
>
> *Ubeleke wako mwana* – Bear your own child
>
> *Oti uzikamutuma* – The one you will be sending on errands
>
> *Kachumba iwe* – Barren woman
>
> *Opita naye ku munda* – The one you will be going to the farm with
>
> *Kachumba iwe* – Barren woman
>
> *Omutuma kumadzi* – The one you will be sending to draw water
>
> *Kachumba iwe* – Barren woman

36 Video 1 (click hyperlink to open): **Kachumba iwe song**

> *Kachumba tiye, Kachumba tiye* – Come barren woman, come barren woman
>
> *Ukamgulire wayilesi* – Buy a radio
>
> *Udzikamvera* – You should listen to it
>
> *Ukamgulire wayilesi* – Buy a radio
>
> *Ukayese mwana adzimvera* – And think that is your child listenin to you

Kachumba tiye, Kachumba tiye – Come barren woman, come barren woman

Mkakugulire wayilesi – I should buy you a radio

Ukayese mwana iwe – You can take it as your child

37 Video 2 (click hyperlink to open): **Kachumba tiye song**

38 Goffman's model of normalization, where the stigmatized individual is treated as if the stigma does not exist is absent in the Mngwangwa context, where the infertile woman struggles to escape her stigma and knowledge of it by the greater public. His theory of infertility and sterility as discreditable rather than discredited fails to recognize the heterogeneity of experiences of stigma, which vary across ethnicities, class and gender. Indeed, he did not consider a context in which the stigma is so entrenched and institutionalized that, rather than receiving sympathy, a stigmatised individual is isolated and avoided and, in that state, becomes almost more polluted than before.

7. Consequences and Delegitimation

1 Chapter Seven will give empirical insight into the conceptual context of stigma. It will identify key aspects in the empirical data, to establish a conversation between Goffman's and Kleinman's theories, and to better understand the experience of stigma as an intolerable, discredited state. Further, it will expand on Kleinman's concept of delegitimation and how it relates to the experiences of the infertile women in Mngwangwa. The chapter will conclude with the localized resistance strategies that many of the women evidenced in discussions.

7.1 Marital Consequences

2 In his analysis of stigma and social interaction, Goffman suggests that vilification and stereotyping are more commonly enacted by strangers towards the stigmatized individual, while those in the closer circle of the individual have a greater tendency to understand and sympathize with them because of a deeper level of intimacy (Goffman, 1986, p. 51). He suggests that there are two groups of support that a stigmatized individual can reach out to – those who share their stigma with them and those he coins as "the wise", "who [are] related to the stigmatized individual through the social structure". Goffman's assumption is that those who are related to the stigmatized individual share his discredited attribute and are thus able to empathize on a deeper level and recognize his humanity (Goffman, 1986, p. 29). Goffman does add, however, that this may not always be the norm, saying:

> "In spite of this evidence for everyday beliefs about stigma and familiarity, one must go on to see that familiarity need not reduce contempt... There are sure to be cases where those who are not required to share the individual's stigma or spend much time exerting tact and care in regard to it may find it easier to accept him, just because of this, than do those who are obliged to be in full time contact with him."

3 While one interlocutor's marriage had survived without children, and two others had supportive husbands despite in-laws who mistreated them, the majority of the interlocutors' descriptions of their experiences within their close-knit social groups and families align more with Goffman's exception. Many of them described volatile reactions from their husband and in-laws after months of the interlocutors being

unable to conceive. Several interlocutors had survived through marriages of emotional and physical abuse perpetrated by their husband or his family members, as recounted by Fusani and Limbikani:

> "[My husband] drank when we got married but he didn't drink so much. But after he saw I was struggling to conceive he began to drink more and more and during that time he would come back to shout at me. He beat me. I would tell the relatives on my side and my in-laws, but I would never see them talking to my husband about it. So, some people would tell me that I should go home to my home village before I lose my life."
>
> - - -
>
> "[My husband] would drag me through the community and hit me, saying he is just wasting his energy on nothing. That he is basically discharging on a rock when he has sex because there are no fruits to show for it. His mother sometimes joins him and tells me to leave her son."

4 Some interlocutors who struggled to conceive but then managed to bear one child still encountered problems in their marriages if they failed to conceive again, highlighting how a wife's role is constructed in Mngwangwa and how the female body can often come to be treated as a reproductive machine. Those women who experienced this highlighted the rollercoaster of emotions they were taken on, from negative reactions prior to them conceiving the first child, to momentary peace and happiness, only to return to a toxic environment once again:

> "My husband changed his character and started having affairs with other women. He also told me to my face that he would rather just marry another wife that will give him a child. By the grace of God, I started seeing changes in my body which were signs of pregnancy, although at the time I did not know it was because I was pregnant. I went to the hospital where they confirmed that I was four months pregnant. I did not believe the news until I gave birth to a girl child in 2005. Since I gave birth to that child I have never conceived again. When the child was four years old my husband started saying that we should have another child, that was the beginning of the problems in my family as he started doing the same things he used to do when we had no child. So, in 2009 we separated, and I went back to my home village."

5 Dyer et al. noted that the stigmatization, ostracism and marital instability faced by infertile women was recorded at a higher frequency and severity in the developing world. They linked these experiences to the tendency for African cultures to venerate children and position them as the purpose for marriage – which then allows for the absence of children to be due cause for divorce and abandonment (Dyer et al., 2002, p. 1666). At times, the focus on children complicated matters for couples who married out of love or desire and later discovered they could not have children; some interlocutors described relationships with men that would begin well, and then suddenly switch after the discovery of infertility. Others described men who would pursue them and initially assure them that their inability to have children was not an issue, only to change attitudes months or years later, as noted by Mpho:

> "I had real problems. Problems with not having a child. My third husband left his first wife and came to live with me in my house. He only stayed for four months. I think because I couldn't conceive."
>
> Did you not tell him you couldn't conceive?
>
> "I did. He had insisted that he had children already and that he didn't care. But after some time, he wanted to try to have children with me."

6 At these points, various husbands would decide to go forward with divorce or to transition into a polygamous union. Many interlocutors described instances where the husbands would give no forewarning of their intentions to divorce them or take another wife, making it challenging for them to discern between moments when their husbands were acting out, and when their husbands were actually abandoning them, as Madalitso mentioned:

> How did your husbands treat you? (she had been married four times)
>
> "In the beginning it was okay with each of them – he would treat me well and buy me things. After some time though he began to ask me what was going on and why I wasn't bearing him a child. From that point, things changed, and he stopped the nicer things he was doing for me. One husband would leave for 3 months, another 6 months, and then eventually they would just leave and never come back. That's how I would marry again."

7 Should the husband decide to stay, in the majority of the situations recounted, he would engage in extra-marital affairs or take on an additional wife. This not only affected the family economically, as resources had to stretch further between members, but frequently placed the first wife in an inferior position to the second, especially if the additional wife began bearing children. Chikondi wistfully told of how her life took a dramatic turn after she failed to conceive a child and her husband took another wife:

> "I have been married for 12 years and I have no child. From the look of things, it looks like I am the one who has a problem because my husband got another wife and has had three children from her. My circumstances changed so much because of having no child; it got to an extent that all the utensils I was using were taken away from me and given to the other wife because I have no child. I had a very big piece of land before my husband married the second wife. He then took a very big portion of my land from me, leaving me with only a small portion and gave the larger portion to the wife that bore children. My husband pays a lot of attention to the other family, so I do everything on my own. He moved into a different house with them and even stopped coming to my house; this is the second year he has not set foot in my house, so I hadn't had a chance to see him in two years. They used to stay at the second wife's home village, but then last month I saw him for the first time in two years. When my husband returned last month with his second family, I was vacated from the house I used to live in with my husband, to smaller, dilapidated quarters. I just accepted what happened as my misfortune."

8 Many polygamous unions also seemed to instigate jealousy between the wives – the infertile woman feeling envious of the children, or the second wife wary of sharing household resources and the husband with the first wife. This can result in the second wife mistreating the first, whose social status has already shifted down once the second wife births a child. Many interlocutors also noted instances where the other wife would engage in direct mockery or witchcraft to push the interlocutor to leave:

> "When I came back from the hospital one day, I found some charms that I didn't know anything about. So, a meeting was called with all three families – the husband's, mine and the other wife's. At the meeting the other wife confessed that she was the one who had left the charms because she wanted our husband and me to separate. So, my second marriage didn't work out because of the other wife."

9 In one instance, Dalitso, despite knowing her infertile status, was still wed by a man in her community who made it explicit that he needed no children from her, as he already had another wife. However, Dalitso found that while her relationship with her husband

was conflict-free, the first wife complicated living together: “I had no problem with my fellow wife, but she was not happy with me because her husband took a second wife. She thought I wanted to take everything she and her husband had worked for. She would tell me that I was responsible for her marital problems. She thought that the husband took all the money they earned from selling the yields and gave it to me, and maybe because he loved me more, he would give me everything.” Consequently, being taken on as a second wife – rather than having an additional wife added to their own union – still seemed to generate a different set of problems for the interlocutors.

10 Whether dealing with emotional or physical abuse, divorce, abandonment, or the transition into a polygamous union, each interlocutor demonstrated a true sense of grit in all that they experienced. This was particularly striking for a sample of interlocutors who averaged two failed marriages. For many, motivations to stick through the negative experiences in their marriage were financial security, pressure from family or the belief that, as Tadala expressed, “marriage is about persevering”, whatever the cost of that might be in Mngwangwa.

7.2 Emotional Consequences

11 Within any social space, everyday feelings and perceptions that are repeated have the potential to become norms that become attached to social meanings and affect biological responses and social relationships (Kleinman and Kleinman, 1994, p. 712). Kleinman describes this process of the social experience transferring into a felt psychological experience, as a socio-somatic experience that delegitimizes the individual. This delegitimation is the experience of withdrawal and alienation in the individual’s social world, resulting in them losing touch with reality (Kleinman and Kleinman, 1994, p. 719). In this process “social relations affect (and are affected by) blood pressure, heart rate and respiration and social loss and demoralization contribute to illness and disease” (Kleinman and Kleinman, 1994, p. 712). In line with this concept, the social experience of infertility affected and was affected by the mind-body state of the interlocutor. One nurse mentioned that at times, the experience of infertility leads people to literal madness, and they are often taken to a mental institute or hospital. She explained that this is often because, “A lot of infertile people suffer psychologically, as every time they see people, they think the people are talking about them. People also speak badly of them or mock them. So, they end up sinking into sadness or depression or isolating themselves, whether or not they encounter bad treatment in the community.” She added that “People with infertility issues are actually considered to be mental health patients because of the mental stress and trauma they go through. I went to a mental hospital when I was in school and there was this lady who was there because of the same issue. She stayed for 14 years without having a child, and was mocked to the point of going mad, and now stays at Zomba mental hospital.”

12 Several interlocutors recounted the hurt, fear and isolation they suffered due to ill-treatment by their community, families and husbands. A large majority of them suffered from emotional and physical abuse from their husbands, or even their family members:

> “There were no problems between my husband and I during the time we were waiting to have a child, but my mother in-law was the one who I had problems with.

> She talked a lot, insulted me and told my husband to get another wife because I was wasting his time since I could not conceive. She would sometimes throw food at my face or throw it away when I cooked for her, and sometimes beat me."

13 Other interlocutors recounted abandonment or divorce by their husbands, and feelings of vulnerability, as they no longer had anyone to depend on and were burdened with an uncertain future. Interlocutors left with children they had previously borne were thrust into traumatic emotional and economic vulnerability, as they became the sole supporter of the child. Some interlocutors who had children faced distress when their marriages collapsed, as the husbands would often take the only child, as was the case for Tadala and Dalitso:

> "I then left on the 23rd of August, and I took our child with me. But [my ex-husband] came this month [January 2019] on the 6th to get the child. He did not tell me anything in advance of this plan though. I felt hurt and I still feel so, but because of the way he came [violently] I just had to give him the child. I was afraid he would hurt me."
>
> "When my brothers heard of what I have been going through, they decided to come and take me back home. So, in the process of discussing the divorce the relatives of my husband just took away my son. My brothers told me to just leave him and that he would return to me when he gets older. I felt hurt leaving my son behind, considering my mother in-law was evil, but I just trusted God for his safety."

14 Conversely, for those interlocutors who did manage to keep their children, upon entering a new marital union they would find that their new husband would not want to care for or keep the children from their previous marriage, and their dependency on him would often force them to send the children away, or consider returning to their previous marriage despite the chances of it becoming polygamous. At times, the women who chose to keep the children even in the new marriage would find their new husband mistreating or abusing the children, as Chiyembekezo explained how in her third marriage her husband "would swear at the children when I was not around, and he would not give food to them and lock them out the house." In this case, Chiyembekezo had to consider the costs against the benefits of remarrying.

15 Polygamous unions bring with them other complexities, as interlocutors described being mistreated by the other wife or her children. One interlocutor described a difficult polygamous marriage experience, as the second wife's children would refuse to obey her, mocking her and saying she did not know how to raise children as she had none of her own.

16 Delegitimization that is directly experienced through the body becomes even more nuanced when an interlocutor experiences bodily suffering, due to their inability to bear a child. In such cases, they experience and express the social consequences of that inability through bodily distress:

> "I was so worried and upset. I have a lot of questions in my head, like why is this happening to me? A lot of people talk bad about me saying I can't have a family because I can't give birth. Most of the time I'm by myself because people talk about me or say bad things to me to my face. I mostly do not have the energy to wake up and work based on what people say about me."

17 Kleinman describes this expression of bodily pain as almost an extended and lived metaphor of the social pains experienced in family and community settings – the social body (Kleinman and Kleinman, 1994, p. 715). In Kleinman's study of the impact of culture on the experience of depression, he notes that in Chinese society the experience was more physical than it was psychological (Kleinman, 2004, p. 951).

Rather than express Western codes of depression, Chinese participants expressed feelings of boredom, discomfort, pain, dizziness or fatigue (Kleinman, 2004, p. 951). The infertile women from this study expressed their responses to the ostracism and exclusion similarly, with a large majority of participants articulating how the negative reactions of community members and family made them feel, using the phrase *mtima kuwawa* [literally, my insides/heart is sore].

18 The work done by Lawrence Langer on Holocaust survivors underlines this connection between bodily pain and social trauma, describing it as "deep memory". He takes Kleinman's theory of an individual feeling delegitimated in their social world to almost feeling out-of-this-world because of enduring pain. Expanding on this idea, he asserts that "Events are relived yet remain permanently unredeemed and unredeemable; unhealed (and unhealable) wounds." As such, rather than the worst outcome of illness and stigma being a spoiled identity, as in Goffmanian theory, it is the experience of delegitimation that is the worst outcome. This is attributed to its effects on family, marriage, livelihood, and social relations as a whole; as Kleinman asserts, "the ruins of social relations ruins lives" (Kleinman, 1997, p. 170). If we apply this concept to the infertile body of the interlocutors, through the way in which they describe their past and present infertile experience, one could suggest that their pained experiences are expressed through bodily or psychological pain. These experiences of pain were articulated when they were asked how they felt about life currently. Many responded in a similar manner: "I am always sad because I still want a child", "I pity myself", "I feel like getting married and that after that I could live happily", or "I miss my children, I feel lonely." The suffering of an infertile person thus doubles as both an experience of individual suffering and social suffering as they are subject to isolation, exclusion and ostracism (Kleinman and Kleinman, 1994, p. 712).

7.3 Economic Consequences

19 To understand the consequences of the experience of stigmatization for infertile interlocutors, one must contextualize and localize their experience as rural women living in Mngwangwa. Firstly, the starkly low level of education, with interlocutors averaging at Standard 4 (the first four years of primary school) and few economic opportunities available to women. Secondly, the lack of a welfare system, thus positioning children as a form of security and wealth for the family – not only through the support they offer but through the leverage they represent in keeping the husband in the marital union and allowing the wife to economically depend on him. Nahar and Richters' study of childless women in Bangladesh found that the women perceived economic consequences as "the most damaging results of childlessness" (Nahar and Richters, 2011, p. 335). Mpho demonstrated how her inability to have children led to the loss of her marriage, as well as the loss of the income-generating business she ran with her husband:

> "I got married in 1977, by 1978 the problems began. I would produce tobacco with my husband to bring in finances for the family. But my husband began to get irritated when we couldn't have children; he began asking 'what is all this money for? Our friends are having children and using the money to support their families, but what is our money for?' He began to say that he wanted to get another wife. So, after five years of trying for a child I was sent back home to my family. My ex-husband took another wife and they had a child."

20 The contributions of a child to the household are valued in many African societies, particularly for the woman, as the child can provide help with household labour or piecework, or be sent on errands such as market shopping trips, fetching water from the well and various other tasks (Fledderjohann, 2012, p. 1384). In the village's economic context, with minimal social welfare mechanisms, the child acts as an economic security for the elderly, and for wealthy families the child represents a guarantee of the transfer of inheritance or property (Riessman, 2002, p. 112). Traditionally, in many African societies, wealth is maintained through ownership of property or land, and is for the most part owned by the men of the household (Pearce, 1999, p.70). This structure was reflected in one community member's explanation of land ownership and inheritance in Mngwangwa:

> "With 5 acres of land it's a guarantee that a male child will get 4 acres and the daughter 1 acre if the son is even willing to give up land for his sister. Ownership of land by wives depends on the level of education of the husband and whether he would share the land with his wife in the will, but land cannot be divided among them while the husband is still alive. This is why the wife will depend on the children who will inherit the land and support her."

21 When a family has children, the land is distributed among them, while the wife receives nothing, forcing her to depend on her husband during the marriage and her children thereafter (Pearce, 1999, p.70). This bears stark consequences for women who are childless.

22 For a society that upholds children as the purpose of marriage, without them infertile women are often divorced, abandoned or find their husbands taking an additional wife. Being divorced or abandoned in a rural context adds to the economic consequences for the woman, and these consequences can be just as dire for those in a polygynous union. In rural areas, with households already steeped in poverty, the taking of an additional wife can often add to the economic burden. While the husband may keep the infertile woman as his first wife, he often rescinds any responsibility for her economically or emotionally, and may refuse to engage socially or sexually with her. Chikondi's experience demonstrate these very consequences, which she described in her struggle to conceive during her first years of marriage and the aftermath of it:

> Why did you not use your revenue from your garden to see a sing'anga?
>
> "I use the money to buy food as my husband does not support me in any way."
>
> Before the second wife, was your husband supporting you?
>
> "Yes, he was supporting a bit."
>
> How did he treat you after getting the second wife?
>
> "There was no love. He would tell me that even though I have a second wife I will be supporting you, and yet I did not receive anything. I explained to his parents that I planned to go back to my home village, but they told me not to leave as my parents were not even in my home village. He only came to visit me and help me once this other year but since then he has never visited."

23 Chikondi touched on the fact that, after a husband's decision to take an additional wife, the infertile woman may explore the option of returning to her parents' home. However, this option is rarely, if ever, resorted to, owing either to parents moving locations or the potential burden her return might pose by adding to their living expenses (Nahar and Richters, 2011, p. 332). The risk of becoming an added burden and

becoming stigmatized as infertile *and* divorced can often lead a family to persuade the woman to stay, despite toxic circumstances, as Pemphero and Tadala both mentioned:

> How did you feel when your husband took the second wife and essentially left you?
>
> "I thought of moving on with my life but when he came back to take me, my family pressured me to accept him, as a woman who has been divorced is never respected in the communities. I just agreed and went with my husband."
>
> Did they ever encourage you to leave or did you ever think of leaving?
>
> "I thought of just leaving but when I explained to my family, they discouraged me, until one day my husband beat me till I fainted... that's when they encouraged me to leave."
>
> Why did he do this?
>
> "Because we took a loan from a village bank that he said we will use to start a business and pay fees for his sister. He did not pay the fees but instead used it for women and alcohol, so the day I asked him why he was using the money for this he beat me."

24 Tadala explained that she faced emotional abuse and uncovered her husband's extra-marital affairs, but was persuaded by her family to stay with him and keep waiting and believing for a child. Even after the first instance of physical abuse in 2017, when she made the decision to leave after her husband visited her family home to apologize, the opportunity to be economically supported once again re-initiated her family's encouragement to reconcile.

25 The economic costs for an infertile woman are particularly high within poor households in rural areas, where there are less economic opportunities for women and higher dependency levels on the men of the household.

7.4 Resistance Strategies

26 'Resistance strategies' refers to the mechanisms that were adopted by the interlocutors to manage their infertility in the Mngwangwa community. This term is borrowed from Riessman's study examining Indian women's experiences of stigma. Riessman acknowledges that the Indian women's strategies may not fit under the Western feminist form of "ideological emancipation from the sex/gender system" (Riessman, 2002, p. 114) but that they cannot be disregarded simply for not fitting Eurocentric modes of thinking. Similarly, the strategies to be noted from conversations with the interlocutors, exist within the context of Malawi, and challenge Western ways of thinking of resistance by offering a localized perspective. The following five strategies for managing stigma emerged in the interlocutors' accounts of their experiences: blame, avoidance, taking control, acceptance and talking to others.

Blame

27 A more recent work on stigma by Cook and Dickens describes three forms of stigma: perceived stigma influenced by others' views and expectations, experienced stigma that encompasses the discrimination and exclusion faced by the stigmatized individual, and internalized stigma when the stigmatized individual internalizes the expectations and perceptions of others, and consequently reduces their self-esteem and increases

feelings of shame (Cook and Dickens, 2014, p. 89). Several interlocutors demonstrated internalized perceptions of their infertile status, as they blamed themselves for what they saw as a failure to meet their responsibilities. This is exemplified in Chifuniro's comment on how she felt about her life, as she woefully answered, "I have just accepted that I am the cause of my problems."

28 Ganizani, who spoke of her husband engaging in extra-marital affairs after months of them trying for a child, added that she "just accepted every decision he made after I found out I was the cause of the infertility."

29 The interlocutors who had internalized the negative perceptions of infertility by their community and those closest to them would take on the blame for failed marriages, abandonment, their husband cheating, the physical or emotional abuse they suffered, or even the discrimination and exclusion they faced in the community. This internalization is rooted in the normative pressure the women face in their community to have children, and this pressure is exerted either overtly through direct blame for their barrenness, or covertly through questions and interactions with community members (Dyer et al., 2002, p. 1664). For these interlocutors, the inability to be a model member of society was perceived as "a failure to continue that society", and through the interviews was expressed as a personal burden they carried (Feldman-Savelsberg, 1994, p. 469).

Avoidance

30 The close-knit nature of the village often makes it difficult for women to avoid interactions with their community, where there is high likelihood of encountering someone in public transportation, on journeys to the shop, or while collecting water at the pump (Riessman, 2002, p. 118). This proximity makes it difficult to hide the fact that you have no children, and is conducive to village gossip over those who don't (Riessman, 2002, p. 118). Avoidance tactics in Mngwangwa made it challenging for the interlocutors to frequent and use community locations that are necessary for their everyday lives – the borehole, the church, the market, and others. This sentiment was nuanced by different interlocutors:

> "Chuumba [infertile woman], Osa beleka [person who cannot have children], person whose womb has dried up. They would say these to me to my face. But what could I do? I would just ignore them."
>
> - - -
>
> "I just leave the place. Especially if there is a situation where there has been a stillbirth, and there needs to be a burial assisted by other mothers. I leave quickly. I give an excuse like 'ah my feet hurt' and I go back to my home. Because I know they will exclude me or tell me that I cannot join the burial because I am not a mother. Sometimes if I'm alone and people talk ill of me, I just take my hoe and go to my garden to work."

31 While a few interlocutors mentioned explicit avoidance by isolating themselves at home to deal with the fear of running daily errands, the majority of them cited disregarding community members or switching tasks and locations as an 'avoidance' tactic.

Taking control

32 A few interlocutors described resistance strategies in which they seemed to take control of their current or future experiences. Three approaches emerged under this strategy: the first was adopted by those who decided not to get married in future and strove to become financially independent, as Pilirani exclaimed: "I am kind of bitter about marriage now, so I do not want to have anything to do with marriage or care about having children for a man."

33 The second approach, the decision to stop trying for children, was mentioned by three interlocutors. Chipi was one of the three who became voluntarily childless and found happiness in her decision, as she disclosed: "After that one trip to the clinic when nothing happened, I stopped trying to find out what was wrong, especially with my second husband. I didn't go to the sing'anga, or the church or again to the clinic. My second husband just didn't have a problem with it. He said that his children are my children, and my sister's children are my children and that we should just sit with that knowledge and not worry about me birthing a child. My relatives stay well with me and my sister has accepted me like this as well." Mayeso, the second interlocutor, emphatically declared her response to community members: "I respond to them knowing that I have made the decision to delay another child and it is a decision I made with my husband. But really, I try to avoid paying them any attention because our family matters are ours and not theirs." The last interlocutor, Dalitso, chose to stop trying for children and did so without the known cooperation of her husband: "I decided to use the withdrawal method of contraception, but with me jumping off of him before he discharged rather than the other way around – to make sure that his sperm would not come into me and fertilize me. So, I did this every time we had sex, but I did not tell him of this plan. I had gotten married for the second time for the help, I did not want another child considering how many children were already in the household from the other wife."

34 The third approach under the strategy of 'taking control' was mentioned as a reference rather than an experience by interlocutors – the performance of pregnancy. One interlocutor mentioned that some women who are infertile may stuff bundles of material underneath their clothes to feign pregnancy and navigate the hyper-surveillance of women in Mngwangwa society. Several interlocutors also added that some infertile women are known to go to hospital maternity wards and simply steal another woman's new-born from the ward and leave under the pretence that they have just given birth. Mphatso reflected on this with her own thoughts about her infertility, remarking, "I think that if I get a child it will be a gift from God. And if he wills it, I can have it from the womb. But if he desires, I would adopt. Other infertile women have gotten so desperate that they go to hospitals to steal children that are not their own. This isn't the right thing to do. They should just wait upon the Lord."

35 These drastic actions exhibit the intimate ties between human reproduction and socialization, which equate the ability to reproduce as an achievement of motherhood, high social status or high economic status (Caldwell and Caldwell, 1987, p. 434). A Chadian proverb quintessentially reflects this concept: "A woman without children is like a tree without leaves" (Dyer, 2007, p. 70). Several African societies are alike in the immense value they place on children, and with it the responsibility and pressure they

place on the woman – especially the African rural woman with few livelihood opportunities.

Talking to others

36 Talking to community members or even family can at times be risky, as Madalitso referenced in stating her reasons for turning to prayer: "At first, I would talk to this other cousin of mine, but then I stopped because everything I told her, I would hear it somewhere else. So now, every time I hear people speaking badly of me, I go home and pray to God to help me work through my pain."

37 All in all, however, several interlocutors found comfort and solace in talking to friends, family members or church members and leaders. Abbey et al.'s study on the impact of infertility on wellbeing found that the stress experienced due to infertility can often increase an individual's vulnerability to anxiety, illness, depression and low self-esteem (Abbey, Andrews, and Halman, 1992, p. 408). Findings demonstrated that women often suffered from these effects more than men, and stress levels were compounded in instances where they were blamed for their infertility or treated as inferior by other women with children (Abbey, Andrews, and Halman, 1992, p. 416). In analysing how these effects can be mediated, the authors discovered the importance of psycho-social support, which a few interlocutors touched on when describing the interactions and relationships they sought out in their moments of distress:

> "I speak to my in-laws. I realized that I can talk to them because I saw how they encouraged me when my family members talked about me."
>
> - - -
>
> "[I talk to] my husband; he tells me to ignore them and to pray. That they don't understand that we do have children [my sister and her husband's children] and that I am a mother to them. Satan just wants my spirits to be low."
>
> - - -
>
> "I talk to my friends and they encourage me, saying 'you never know, perhaps someday you will give birth. How come the hospital told you to take tablets and come back when they could have told you, you will never give birth? Perhaps one day you will give birth.'"

38 One point of note for the interlocutors who engaged in this study is discussed in Rossetto's work on methodology. He made the comment that, while the "qualitative research interview is not therapy, it is therapeutic in that it offers a space for catharsis through sharing" (Rossetto, 2014, p. 282). A few interlocutors not only mentioned the support and comfort they gained from talking to family members or friends, but also the comfort they felt in telling their story and experiences through the interview process, which was often framed as a conversation. An expression of this was at the end of Fatsani's interview, when she added "I really just want to thank you for meeting with me today. I am very grateful that I had someone to share my story with. I think talking really helps work through things."

Acceptance

39 The experience of delegitimation centres around the key question of 'why' rather than 'how' – it focuses on the meaning of the experience rather than causation, and on the hope for change rather than the failures of treatment (Kleinman, 1997, p. 133). With the acceptance approach, interlocutors responded to their experiences of delegitmation by turning to God and described prayer bringing with it undertones of hope, faith and

possibility. For many, this meant understanding the reasons for their infertile state as God's will and placating their distress around the question 'why?' in the understanding that God's will is at times undiscernible, but always *"for the good of those who love him"* (Romans 8:28). This reliance on a spiritual explanation to mitigate anxiety and understand what seems to be unknown and inexplicable is termed a theodicy. Bharadwaj explains the function of theodicies operating in the biomedical sphere as mechanisms that allow individuals "to make sense of the unknown working of the human body" (Bharadwaj, 2006, p. 458). Theodicies offer an answer to the 'why' question for interlocutors struggling emotionally and cognitively when no reason is found for the cause of their infertile status (Bharadwaj, 2006, p. 462). For the majority of interlocutors who were dealing with their infertile status and identity, who had sought help from doctors and sing'angas to no avail, their spiritual beliefs replaced the absent or incomplete 'rational', or even traditional, explanations from doctors and sing'angas:

> "I also go to church and get encouragement from the word of God. They teach that a child is a gift from God. They know I'm infertile and have told me to wait upon God because his timing is best."
>
> Do you ever get angry at God?
>
> "Angry? No. but in the beginning, I was upset, I felt he wasn't hearing me. In the Bible it talks about family, but it doesn't guarantee a child – a child is a gift that God decides to give."
>
> "Sometimes I pity myself, but I think about it as the infertility not being my fault, it's just the way I am, and I can't do anything about it. The person who knows everything is God so sometimes, I just pray."
>
> "I pray that God should bless me with a child. I know in his perfect timing things will happen."

40 With the belief that God is in control of both the good and the bad, some interlocutors rest in the acceptance of this knowledge, and others even practice prayer constantly in the hopes that God will later "grant the gift of a child". Numerous interlocutors referenced the story of Sara and Abraham, where Sara in her old age had not yet conceived and laughed when a man of God came to tell her husband that they were still to have a son, only for the prophecy to come to pass years later. This Bible story stood as a testimony of hope, faith and possibility for several interlocutors, and allowed them to resist narratives of their status and identity and manage emotions around their infertility.

41 While each strategy was quite different from the next, those interlocutors who did engage in these forms of resistance and infertility management demonstrate a localized and contextualized Mngwangwan understanding of coping. These findings stand as an acknowledgement that infertility treatments, perceptions, reactions and forms of resistance are not homogenous, and in Mngwangwa they occur at intersections such as class, gender and education under broader systems including, but not limited to, pronatalism, patriarchy and culture.

8. Concluding Remarks

1 This study is a qualitative study of infertility in Malawi and used the lens of Goffman and Kleinman's theories to analyse the localized experience and management of stigma in Mngwangwa. The study first analysed perceptions of infertility rooted in causes and treatments, followed by an analysis of the emergence of stigma in cultural and social interactions and practices, and concluded with the social and emotional consequences this has for infertile individuals. In this way, the findings come together to demonstrate how stigma is understood through socio-cultural perceptions of infertility in the local ecology of Malawi, and its effect on lived experiences and gender identities.

2 Two emerging issues in the research warrant further attention and studies. The first of these is the role of traditional healers in infertility, or on a broader level, disease and illness. Traditional healers exist as a critical resource for health education, diagnosis, treatment and care when we consider that treatment seeking behaviour is influenced by accessibility, availability and alignment with perceived causes. Many interviews highlighted the lack of information around general sexual reproductive health by the interlocutors, as well as the limited information provided by the hospitals, clinics or healers they frequented. Traditional healers are in an ideal position for reaching out to a large population of affected people, for participating in sensitization efforts that seek to educate about sexual reproductive health or change customs and traditions that put people at risk (Chipfakacha, 1997, p. 419).

3 The second emerging issue was the silence and secrecy around male infertility in Malawi, despite one doctor's assertion that in about 40-60 per cent of cases of infertility, the low sperm count of men was a contributing factor, and several studies stand behind this claim (Irvine, 1998; Parrott, 2014). Currently, only one study exists on male infertility in Malawi, and it examines the role of diagnosis and how this may contribute to the visibility and discourse around male infertility. The discussions that emerged through the interviews in this study, around sexual hyenas or the role of culture in perpetuating female infertility while hiding male infertility, stand as an intriguing opportunity for further research that could contribute to the broader conversation on infertility in Malawi.

4 A limitation, albeit an intended approach, of this study is its focus on only one member of the couple dealing with infertility. Future studies examining behaviours and

responses to infertility by couples in Mngwangwa could offer valuable insight into how to model education and interventions that include the male partner, as well as offering better approaches to infertility counselling and care.

5 The principal recommendation that emerges out of these findings is the need for interventions that are appropriate to the socio-cultural context in which they are applied. For interventions to move towards success in Malawi, they do not only need to focus on diagnoses of infertility, but also sensitization and awareness-raising, and beyond that, address the experiences of being labelled, stigmatized and ostracized in these communities. This requires careful consideration of the intersectional disempowerment that Malawian women face in their community, owing to the nature of power structures and relations.

6 It is imperative that the government develop a policy around infertility care, and effectively integrate it into the Malawian National SRHR Policy, rather than its most recent policy statement, to "reduce the incidence of infertility among men and women" (SRHR Policy 2017-2022, see Government of Malawi, Ministry of Health, no date), without any measurable indicators. A holistic policy should include an analysis and impact assessment of the current health care system and its current effectiveness, or lack thereof, in addressing infertility, and thereafter incorporate all levels of health services to produce a more cost-effective approach.

7 As identified in this study, STDs, unsafe abortions and reproductive infections have largely contributed to the high rates of infertility in Sub-Saharan Africa. As such, a focus on prevention efforts could certainly lend to a decrease in these climbing numbers. However, it is important to note that infertility does not exist solely as a biological or physiological condition that requires a biomedical approach, but also encompasses emotional, social, cultural, religious and economic spheres, as demonstrated through the findings of this study as well as other previous studies. The solution for tackling, for example, youth pregnancies that often result in unsafe abortions or reproductive problems, is not simply to increase access to contraceptives or legislate on the age of marriage. Instead, the answer should be sought in the question 'why?' Why are young girls engaging in early or pre-marital sex, and how does motherhood contribute towards defining status or ensuring economic stability? (Richards, 2002, p. 86) In asking these questions, we begin to address the root problems, such as lack of access to economic opportunities, community attitudes that venerate children, or gender inequalities that set motherhood a young girl's life goal.

8 As such, the approach to infertility response must also encompass these spheres, focusing not only on preventive measures, but also addressing stigma, patriarchal structures, gender inequality, poverty, and sexual and reproductive health knowledge. Rather than looking at the biomedical natural course of a disease, Kleinman asserts that disease takes on a social course – its experience is influenced by the economic, moral and social structures within which it is set (Kleinman, 1997, p. 171). It thus follows that in responding to illness and disease, a society must marry health policy with social policy, and social policy with social theory (Kleinman, 1997, p. 171). This approach certainly requires the commitment and involvement of health workers, but also calls on teachers, leaders, influencers, community workers and members, and patients to join the discussion table.

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