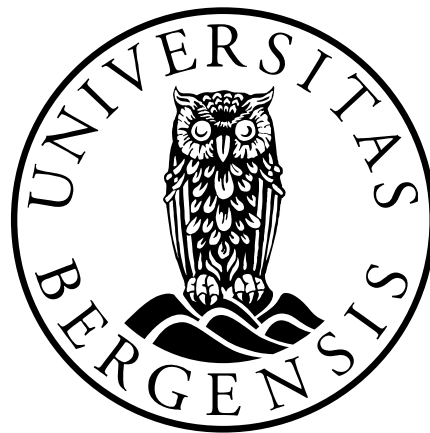


# **Socio-cultural Perceptions of Infertility and their Implications:**

A Study of Women Experiencing Childlessness in South  
Gondar, Ethiopia

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## **List of Abbreviations**

CSA	Central Statistical Agency
EDHS	Ethiopian Demographic and Health Survey
FAO	Food and Agriculture Organization
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HDR	Human Development Report
HIV/AIDS	Human Immune-deficiency Virus/Acquired Immune Deficiency Syndrome
IVF	In vitro fertilization
NABC	Netherlands-African Business Council
NRTs	New Reproductive Technologies
NSD	Norwegian Social Science Data Services
PID	Pelvic Inflammatory Disease
RHO	Reproductive Health Outlook
STDs	Sexually Transmitted Diseases
UK	United Kingdom
UNDP	United Nation Development Program
USA	United States of America
WADP	World Anti-doping Program
WHO	World Health Organization

## Abstract

*Infertility is a global problem affecting a considerable number of people. However, perceptions on the causes and treatments of infertility vary across societies. This study was conducted to assess the socio-cultural perceptions of infertility and the implications of these perceptions on the lives of childless women in South Gondar, Ethiopia. The study specifically focuses on exploring the perceived causes and treatments of infertility from the perspectives of childless individuals, religious leaders, and community members. It also examines the experience of childless women, their coping strategies to the problem, and the socio-economic and emotional consequences of childlessness.*

*Data was collected through in-depth interviews with 17 childless women and 2 childless men, semi-structured interviews with a nurse and a doctor, a group interview with religious leaders, and 3 focus groups with community members. The data was analysed using “three bodies approach”, “social stigma theory” and “coping theory.”*

*From the perceptions of childless individuals and community members, this study found out that there is limited level of awareness about the medical causes of and solutions to infertility. It was found out that besides the severe stigmatization on childless women, childlessness has socio-economic and emotional consequences. Childless women are not passive victims as they have developed different coping strategies to seek solutions for their childlessness and to deal with stigma.*

*Based on the major findings, the study recommends the importance of raising public awareness on the medical causes of and treatments to infertility, incorporating infertility treatments as maternal health component, and planning old-age security programs.*

**Key words:** infertility, childlessness, stigma, discrimination, coping strategies, value of children, old-age security.

# CHAPTER 1

## INTRODUCTION

### 1.1. Background

Infertility is a global problem that affects the social, economic and psychological wellbeing of couples. The definition of infertility may vary across professions as different experts employ definitions that are convenient for their purpose (Larsen, 2005, p. 208). However, the definition by the World Health Organization is widely used (ibid). The World Health Organization (WHO, 2011) defines infertility as an inability of a couple to conceive within two years of regular and unprotected sex. Infertility can be of two types: primary and secondary infertility (ibid). While primary infertility refers to the inability of a couple to conceive a child at all, secondary infertility implies inability to conceive again after a previous pregnancy (ibid). According to Reproductive Health Outlook (RHO, 2003), infertility is a global problem affecting about 8-10% of couples worldwide. Among these, about a third of the problem is female infertility, another third is male infertility, and the remaining third affects both partners or the cause is unknown (Inhorn and van Balen, 2002).

Infertility affected 186 million couples in the majority world<sup>1</sup> By the year 2002, excluding China, (Rutstein and Shah, 2004, p. 53). Reproductive Health Outlook (2003) noted that Sub-Saharan Africa has the highest infertility prevalence ranging from 7% - 29%. In sub-Saharan Africa, the prevalence rate varies greatly among countries and even within a country (Ericksen and Brunette, 1996). This is because of the fact that infertility is strongly associated with social, behavioural and cultural factors that expose women to the risk of infertility due to sexually transmitted and other reproductive tract infections (ibid, p.209). Ericksen and Brunette (ibid) conducted a big survey that included twenty-seven African countries to identify patterns and predictors of infertility among women. This survey found out that there were high (16.7%-21.4%) infertility rates in the Southern African countries of Namibia, Zimbabwe, Botswana and Lesotho (ibid, 213). However, the Eastern African countries of Rwanda, Burundi, Uganda and Tanzania were characterized by a relatively low (9.8%-12.2%) infertility rate (ibid). The study also found out that, those who started having

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<sup>1</sup> The name “majority world “ is used in exchange for the so called third world or developing countries.

sex at very early age (at or below the age of 13) are found at greater risk of infertility (Ericksen and Brunette, 1996, p. 216).

Cultural, environmental and economic factors influence the prevalence of infertility especially in countries where poverty and infections are widespread (Leke *et al.*, 1993). The major preventable cause of infertility in many parts of the majority world is Pelvic Inflammatory disease (PID) which is caused by sexually transmitted diseases (STDs) and post-partum and post-abortion infections (RHO, 2003). In addition, more specific local or regional factors of infertility may have something to say. For instance, in Egypt, exposure of men to occupational toxic agents, water pipe smoking practices of men, and close cousin marriage contributed to infertility (Inhorn and Buss, 1994). Garenne (2008) noted that infertility is still growing in some of the “infertility belt” countries (example Congo and Mozambique), in “late marriage” countries (Lesotho, Namibia and South Africa), and in other countries such as Ghana, Mali, Rwanda, Senegal, Tanzania and Ethiopia.

The above mentioned statistics give us a sense of the magnitude of the problem, but tell us little about what it means to be infertile and how infertility is recognized, perceived and dealt with among people in a given socio-cultural context. A socio-cultural approach may help us to understand the problem of infertility from the perspectives of childless individuals and community members, and thus tell us beyond statistics and medical or technical definitions.

While men and women are assumed to have equal probability of being infertile, in many societies of Africa the problem of infertility is perceived mainly as women’s problem (Deribe *et al.*, 2007; Inhorn, 1996; Kimani and Olenja, 2001). In such societies, women suffer severe stigmatization since they are assumed to have failed to conceive (Ombelet *et al.*, 2008). Besides, in many societies bearing children are valued as the main purpose in life. In these cases, fosterage and adoption will not substitute real motherhood and are only seen as temporary solutions to childlessness (Gerrits, 2002). In many societies of Africa, own children give significant socio-economic contributions to their families and are the ultimate sources of old-age security for their parents (Dyer, 2007; Hollos *et al.*, 2009).

All these factors make childlessness totally unacceptable and thus it is up to the women to accept every advice and try every solution to get a child. If a woman remains childless after whatever trials, such a woman will often be considered as worthless and even not to be considered as a woman at all (Inhorn, 1996 and Kimani and Olinja, 2001). Because childless



women have few options to lead a meaningful life, it is important at this stage to wonder what is left for the childless women. What are the personal experiences of such individuals, and how do they cope with the challenges of a childless life? As it is better to have firsthand information from women, let us listen to their voices!

## **1.2. Statement of the Problem**

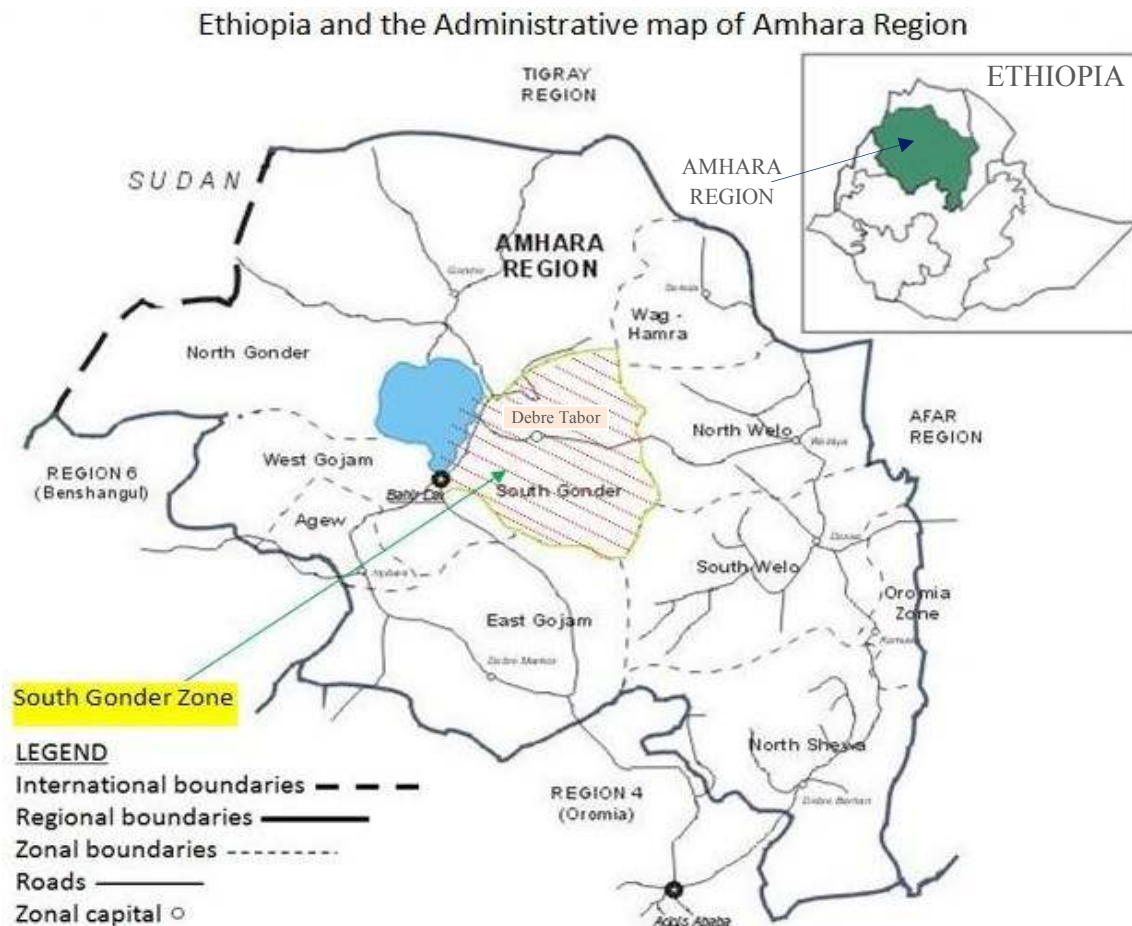
Ethiopia is the second most populous country in Africa next to Nigeria. According to the 2007 population and housing census, the total population of Ethiopia is about 73,918,505 (FDRE, 2008). Given the high birth rate of Ethiopia, the government wants to reduce the fertility rate and provides access to contraceptives even to remote rural areas of the country. However, the fact that the fertility rate per women is 5.38 shows that the government strategy of reducing the fertility rate has not been successful so far (ibid).

In most rural parts of Ethiopia, children are considered as assets and having many children is a symbol of high status. In the Ethiopian context, giving birth is considered as a main purpose in life for couples. As children are assumed to be God's blessings, life is meaningless for couples who fail to have children. Fertility has thus a great value in Ethiopian context (Deribe *et al.*, 2007). However, most Ethiopian research on reproductive health issues focused on the problems of how to reduce the fertility rate of the country and what factors contribute towards a small family size (Alene and Worku, 2008). The other side of the story, infertility as a social and personal problem, is almost ignored. Despite the existence of a high fertility rate in the country, infertility as a social and personal problem has many dimensions in rural parts of Ethiopia.

This research explores the socio-cultural perceptions of infertility in *South Gondar*, an administrative zone of Ethiopia, and the implications of the perceptions on the lives of childless women. As we will see in the literature review chapter, the few existing studies on infertility in Ethiopia are clinically based and researchers recruit their informants from those who undertake infertility treatments. My research focuses on the socio-cultural aspects of infertility and my informants are women identified as "infertile" in the study area. Most of these informants are rural individuals who do not get medical treatment and are hence not found at health centres.

### 1.3. Research Area

This study was conducted in *South Gondar*, North-west Ethiopia (see Figure 1). *South Gondar* is an administrative zone of the *Amhara* Regional State with a total population of 2,047,206. Its capital, *Debre Tabor*, has a population of 55,157 (FDRE, 2008). Almost all of the zone population belongs to the Amhara nationality which is the largest Semitic group in Ethiopia. In this section, I will present aspects of the social, economic and health situation of the study area which are relevant to fully understand the empirical findings of the study. Almost all of the research participants are from a number of different villages in South Gondar and few of them are from the town, Debere Tabor.



**Figure 1: Map of the study area**

*Religion:* The Amhara population is predominantly Orthodox Christian (83%) but some Muslim communities are also found (16.8%) (FDRE, 2008). Religion has a great value in

people's everyday life. We can find at least one church in every single village. Most people start their day by going to the church for Morning Prayer. People have frequent communication with priests. Each family has one spiritual father (*yenisiha abat*) who is responsible for teaching the church doctrine, accepting their confession, praying for them, giving them counselling, and other spiritual services. Many of the thirty days of the month are named after God, angels and saints, people can't do farming activities in these days, especially on the days of angel Michel (12<sup>th</sup>), Virgin Mary (21<sup>st</sup>), and God (29<sup>th</sup>), Saturday and Sunday as well.

*Marriage:* Customary and religious marriages are commonly practiced in the study area. The customary type of marriage is not judicially registered. The family of the bride and the groom contribute property (*macha*) such as land, animals and cereals for the start up of the new family. The religious type of marriage is held at the church and the church gives a certificate. Since religious marriage strictly prohibits divorce<sup>2</sup>, most people prefer the customary type of marriage which is not strict when it comes to divorce. As scholars argue, divorce is common in Amhara region and it is not followed by a high level of stigmatization or shame (Mammo and Morgan, 1986; Tilson and Larsen, 2000).

Marriage is a big festival, and in most cases, the woman moves to her husband's family after marriage (patrilocality). In the past, arranged marriages of young girls even below 10 years were common. Dagne (1994, p. 36) in his article *Early marriage in Northern Ethiopia* identified fear of stigma and need to ensure daughter's virginity among the important factors that sustained early marriage in Northern Ethiopia. He found out that, if the girl was not married before adolescence, she and her family became the subject of public gossip. The girl would be stigmatized as 'cheap', 'left over', or unwanted for marriage. Besides, a girl who was not a virgin at first marriage was not considered as trustworthy and the marriage would be dissolved automatically. To avoid these risks, marrying girls off at their early age before they started 'roaming around' with boys was seen as a solution (ibid). However, the practice of early marriage is decreasing these days mainly due to government actions. The revised family law of Ethiopia (FDRE, 2000) declares 18 as the minimum age of marriage for both boys and girls. Article 7 of this law says: "*Neither a man nor a woman who has not attended*

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<sup>2</sup> During the holy matrimony vow, the groom says: "I will not leave her even if she becomes infertile"-my translation

*the full age of 18 years shall conclude marriage.*” The criminal code of the country also clearly states early marriage as a criminal act (FDRE, 2005). Article 648 of this code says that if the age of the bride or the groom is below 13 years, it imposes rigorous imprisonment for up to seven years on those who arranged the marriage.

*Funeral:* A person is honoured on three occasions of his/her entire life: when born, married and buried. Funeral is a big ceremony attended by people from different villages. During the funeral ceremony, a “professional” paid person (*aslekash* or *woyebay*) presents poems that praise the accomplishment of the deceased so that the people will cry more and more. While a deceased man is usually praised as a great hunter, warrior and generous, a deceased woman is praised for being a good housewife and mother. The Ethiopian Orthodox Church also performs religious services (prayers) for the dead, like *teskar* after forty days, *fitihat* on the day of death every year afterwards. Children or close relatives of the deceased prepare food and drink for priests, relatives, neighbours and the poor, usually by slaughtering an ox, a sheep or a goat.

*Economy:* The Ethiopian economy is generally characterised as agrarian. The majority of the active labour force (82.4%) is engaged in agricultural activities (FAO, 2004). The agricultural sector also constitutes more than half (52.3%) of the country’s total GDP (ibid). In terms of livestock population, Ethiopia is the first in Africa and among the first ten in the world (NABC, 2010). A mixed farming system of crop cultivation and livestock production is dominant in the north, north-eastern and central parts of the country (ibid). In the study area, mixed subsistence farming is common. We can find cattle, sheep, goats and poultry in most of the households. In addition to household consumption, animals and animal products (egg and butter) are sources of cash income. The by-products (manure) are used for fertilizing the soil and as sources of energy for cooking.

Poverty is widespread in Ethiopia. According to the Human Development Report of 2010<sup>3</sup>, Ethiopia ranked 157 out of 169 countries when measured in terms of health, education and income. The percentage of population that suffers deprivation in the above three indicators was 90%, and 39.04 % of the country’s population were living below \$1.25 per day (ibid).

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<sup>3</sup> Retrieved on 15.04.2011 from <http://hdrstats.undp.org/en/countries/profiles/ETH.html>

The current social insurance system includes only public sector employees (that is, it does not include the self employed and unemployed citizens)<sup>4</sup>.

*Health services:* In Ethiopia the general reproductive health service provision is very low. According to the Ethiopia Demographic and Health Survey of 2005 (CSA and ORC, 2006), the number of women who received antenatal care, safe delivery and postnatal care was very low. While 28% of mothers received antenatal care from health professionals, the majority of births (94%) were delivered at home attended by a relative or some other person (ibid). Thus, only 5% of mothers received postnatal care within the critical first two days after the delivery (ibid).

The government population policies and strategic health plans don't give attention to infertility treatment as a maternal health component (Deribe *et al.*, 2007). Certain kinds of infertility treatments are available at clinics and hospitals, together with other treatments. Infertility treatments range from simple counselling to tubal surgeries, but high-tech infertility treatments such as IVF are not in place yet. Kitilla (2000), who did a quantitative study to determine the proportion of infertility treatment dropouts at the clinic of Family Guidance Association of Ethiopia, found out that there is no specialized infertility management centre in the country. Unavailability of such specialized institutions forced women to shift from one health service institution to the other in search of better treatments (ibid). A decade after Kitilla's study, I couldn't find any document confirming the existence of such infertility management centres in the country.

There is only one hospital (Debre Tabor hospital) in the study area. It provides infertility treatment together with other treatments. There are also outreach clinics in a distance of approximately 10km for most of the villages. As Rangunathan and Solomon (2009) noted, in rural areas of Gondar district religious healing practices (for different diseases) are very dominant because of lack of modern health care facilities. Religious healing practices are economically as well as geographically accessible for most of the rural population since the ratio of orthodox priests to population is significantly denser than that of physicians to population (ibid).

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<sup>4</sup> Retrieved on 25.04.2011 from <http://www.ssa.gov/policy/docs/progdesc/ssptw/2008-2009/africa/ethiopia.pdf>

## **1.4. Research Objectives**

The main objective of this research is to assess *socio-cultural perceptions of infertility and the implications of these perceptions on the lives of childless women in South Gondar*. In addition to the main objective, this research has the following specific objectives:

- To assess the perceptions of childless women and different community members of the causes and treatments of the problem of infertility.
- To assess the experiences of childless women, with particular focus on the question of social stigma and discrimination.
- To explore the coping strategies childless women have to deal with infertility related problems.
- To explore the socio-economic and emotional consequences of childlessness.

The main focus of this research is childless women. However, during my field work I came across two childless men who are known as infertile by the community. I got the opportunity to talk to them and have thus included them as informants.

## **1.5. Organization of the Thesis**

The thesis is divided into 8 chapters. Chapter 1 is a description of context and the general background of the study. Chapter 2 reviews relevant literature on infertility and points out the gap that this research tries to fill. Chapter 3 presents the theoretical framework for the research, which consists of Scheper-Hughes and Lock's three bodies approach, theories on social stigma and selected aspects of a coping theory. Chapter 4 presents the research methodology. Chapters 5, 6 and 7 discuss the empirical findings. While Chapter 5 describes the perceived causes and treatments of infertility, Chapter 6 emphasizes the stigma and discrimination related to childlessness, and Chapter 7 presents the socio-economic and emotional consequences of childlessness. The last chapter (chapter 8) includes summary of the major findings, recommendations and topics that need further research.

## CHAPTER 2

### LITERATURE REVIEW

Infertility is rarely acknowledged as a serious public health problem in the so called over populated non-Western world (Inhorn, 2003). In the majority world, infertility is even sometimes considered as a solution to overpopulation, particularly by some Western observers (ibid, p.1841). In recent years, however, there has been a growing interest in studying the problem of infertility also in the majority world. This in turn enables, to a certain extent, to create a better recognition of infertility as a reproductive health problem among policy makers (Dyer, 2008, p. 48).

There are some recent infertility studies from sub-Saharan Africa. Most of these studies are quantitative in nature and are based on big surveys. The major focus of the studies include: the prevalence of primary and secondary infertility, perceptions of causes and treatments of infertility, and experiences of infertile women. Most of these studies have documented somehow similar results regarding these themes. According to the studies, the perceived causes of infertility in many parts of Africa are mainly nonmedical and are commonly associated with supernatural or evil powers, and the treatment often involves traditional healers and spiritualists (Deribe *et al.*, 2007; Gerrits, 1997; Pearce, 1999; Runganga *et al.*, 2001). Women's experience of infertility are documented to be multi-dimensional and includes stigmatization, ostracism and neglect, marital instability, abuse, loss of social status and security (Hollos and Larsen, 2008; Hollos *et al.*, 2009; Kimani and Olenja, 2001; Orji *et al.*, 2002; Samuel N, 2006).

In this chapter, I will review infertility studies from Africa in general and from Ethiopia in particular. I will also include some studies from other parts of the world in order to capture variation and similarities. It is good to first look at the value of children so that we can have a better picture on the seriousness of infertility related problems especially in the African context. To fully understand the problem of infertility in a given community, we have to know what values are attached to children which the infertile are deprived off. After discussing the value of children I will proceed to the review of relevant literature on perceived causes and treatments of infertility. This will be followed by an examination of

literature on the experiences of childless women. Finally, I will present the contributions of my study to infertility studies and the gaps that I hope to fill.

## **2.1. The Values of Children**

The reason for having children varies widely across cultures and social classes. While some societies value children for their contribution to parents' emotional wellbeing, other societies emphasize the economic value of children (Lancy, 2008). By reviewing infertility studies in African countries, Dyer (2007) identified six major values of children: (1) marital stability, (2) social security and domestic support, (3) gender identity and parenthood, (4) social status and stigmatization, (5) continuity and religious beliefs, and (6) emotional values. Let's have a closer look at these values as they are described by Dyer and also documented through various studies from the African continent.

*Marital stability:* In many parts of Africa the dominant purpose of marriage is to have children since marriage without children is incomplete and insecure (Dyer, 2007). Infertility studies documented multi-dimensional impacts of childlessness on marital life which include polygamy, divorce, remarriage, abuse, neglect, and abandonment (Deribe *et al.*, 2007; Hollos *et al.*, 2009; Inhorn, 1996; Orji *et al.*, 2002; Pearce, 1999). For example, Orji and colleagues (2002, p. 61) conducted a quantitative study on the impact of infertility on marital life in *Ile-Ife* Nigeria which included 236 women. The study found out that 38.9% of the respondents had divorced and remarried because of infertility. A study in Southwest Ethiopia by Deribe and colleagues (2007) noted that some infertile women were divorced due to their childlessness. Others reported that their husbands had lost interest in them. Some husbands on the other hand told that they were planning to marry another woman to get a child (*ibid*). These practices of divorce and remarriage exposed childless women and men to STDs and HIV/AIDS (*ibid*). This problem was also noted in other studies. For example, in a hospital-based study in Tanzania, Favot *et al.* (1997, p. 417) found out that the HIV prevalence was considerably higher among infertile women compared to child-bearing women since infertile women had more marital dissolutions, life time sexual partners, and STD's than fertile women.

*Social security and domestic support:* "In African communities, land is commonly owned by men and land claims are negotiated through the number of their children" (Dyer, 2007, p. 73).



Children are also seen as old age insurances and guarantors of generational continuity. For example, women in certain communities of Kenya receive land through their children and in this case, the inability to bear children means loss of livelihood (Kimani and Olenja, 2001). Similarly in Yoruba, only children inherit property after the death of the husband and as a result, a childless wife cannot be considered for inheritance (Pearce, 1999). As Lancy (2008) documented, children especially in the majority world, contribute to the household through child-minding, selling products in the market, tending livestock, fetching water, cooking, and farming. Besides their labour contribution to secure parents' and families' survival, children support aging parents in the absence of social support systems for the elderly (Inhorn and van Balen, 2002). A study in southwest Ethiopia found out that most of the childless respondents are worried about not having helpers in their old age (Deribe *et al.*, 2007).

*Gender identity and parenthood:* In many African communities, having own children is the only way to achieve full adult womanhood and manhood. A research in two communities of southern Nigeria found out that in one of the communities, life stages were based on performance of certain tasks and behaviours (such as performing circumcision and being pregnant) which were the prerequisites for entry into the stage of mature womanhood (Hollos *et al.*, 2009). A study from Zimbabwe found that a man who failed to have children was not considered as a real man but as a boy (Runganga *et al.*, 2001). Some societies also put the gender identity of childless individuals in question. For example, the above mentioned study of southern Nigeria documented that childless women were insulted as “men” by their husbands and in-laws (Hollos *et al.*, 2009). A study in South Africa also found out that a childless man was insulted as “woman” (Dyer *et al.*, 2004).

*Social status and stigmatization:* Having children is related to parents' social status, wealth, and prestige in many African communities. Consequently, infertility results in stigmatization and loss of social status. A wealthy person without children might not get recognition in a community (Dyer, 2007). This issue will be elaborated in my discussion on the experience of childless women.

*Continuity and religious beliefs:* “In African communities, children continue the family name and lineage, inherit family land and wealth, and confer a sense of continuity and belonging” (Dyer, 2007, p. 74). From a religious perspective, children are often seen as a gift of God and

consequently, inability to conceive may be seen as resulting from a sin or that the infertile is unworthy to receive God's gift (ibid).

*Emotional values:* Inhorn and van Balen (2002) argue that the existence of strong socio-economic reasons for having children in many non-Western settings doesn't mean that personal happiness and the joy of having children are not motivating factors too. Affectionate parents are found throughout the world and are, of course, abundant in non-Western settings too (ibid). Several studies support this argument. For example, a study in Zimbabwe (Harare and two villages) about the cultural meaning of reproductive failure found out that children are seen as a sense of purpose to life, offering companionship and providing emotional support (Runganga *et al.*, 2001, p. 325). Childless women also believed that children fulfil the need to love and to be loved (ibid). Dyer *et al.* (2002) noted that the main reason for wanting children in an urban community in South Africa was to give life a purpose and to be able to give love to the child. Similarly, a study in five major Ethiopian cities (Addis Ababa, Nazareth, Bahir Dar, Jimma and Harar) found out that children were considered as sources of happiness (Sahleyesus, 2005).

In general, children have multidimensional values and are seen even as the purpose of life in Africa and Ethiopia is not an exception to this. The ways children are valued have some relationship with the perception of infertility in a given community.

## **2.2. Perceived Causes of Infertility**

Medically, there are different causes and risk factors for male and female infertility. According to Eisenberg and colleagues (2009), infertility for men is most often caused by low or no sperm count and blockage of the tubes that transport sperm. Infertility in women, on the other hand, is caused by a range of other factors such as problem with ovulation, blockage of fallopian tubes and physical damage to the uterus (ibid). STDs, advanced age, smoking, and excess alcohol use are also mentioned as risk factors of infertility (ibid).

However, a considerable number of people in the majority world have limited level of knowledge about the medical causes of infertility. The problem is thus usually perceived as caused by other factors than medical ones. Some associate infertility with supernatural powers and others associate it with diseases or with the absence of reproductive organs. A study by Oknofuaa *et al.* (1997) on the social meaning of infertility in Southwest Nigeria

showed that there are several traditional beliefs regarding the causes of infertility. Kimani and Olenja (2001) in their study *Infertility: Cultural dimensions and impact on women in selected communities in Kenya* found that different communities in Kenya associate infertility with different things. For example, while the *Kikuyu* community perceived infertility as being caused by the breaking of taboos such as non-payment of bride wealth, the *Luhya* community believed that if a baby is born by blood relatives, it causes secondary infertility for the mother and brings a curse to the other members of the family (ibid p.205). Infertility is also perceived as caused by menstrual problem; too thick, too thin, too much or too little blood is believed to be unfavourable for conception (ibid).

Pearce (1999) conducted an ethnographic study on the social construction of infertility and childlessness in women among the Yoruba of southwestern Nigeria. This study revealed promiscuity, physical diseases (in the abdominal, reproductive, or intestinal tracts), and spiritual powers or evil spirits to be the perceived causes of infertility. Similarly, infertility in Southwest Ethiopia (*Illubabor Zone*) is commonly attributed to God's wrath (Deribe *et al.*, 2007).

Moving beyond the African context, Adashi *et al.* (2000) conducted an international survey on how infertility was perceived by the public in Western countries (included Belgium, France, Germany, Italy, Sweden and UK, USA, and Australia). The survey found out that the awareness about the definition and incidence of infertility was relatively low. For example 38% of the participants perceived infertility as a disease. From this, it is possible to say that there is limited awareness about the problem of infertility even in the Western countries.

The limited level of knowledge about the medical cause of infertility in a certain community affects the perceptions and choice of treatments as indicated in the next section.

### **2.3. Ways of Dealing with the Problem of Infertility**

Treatments used by infertile individuals around the world vary from being traditional and spiritual to the latest and advanced medical treatments. When people face the problem of infertility in most parts of Africa, they try traditional and spiritual practices rather than medical treatment. A study by Okonofua *et al.*, (1997) in Nigeria, Yoruba, for instance, showed that many infertile couples use a variety of traditional and religious treatments, while medical treatments are less often used. Another study in the same community by Koster-

Oyekan (1999) found out that infertile women prefer to seek treatment from local herbal and spiritual specialists and churches. A study from Malawi also revealed that there is strong cultural pressure to bear children that leads infertile people to visit traditional healers who are assumed as having the ability of curing infertility (De Kok, 2008).

When it is not possible to have one's own child, adoption or fosterage is commonly practiced by many all over the world as a mechanism to satisfy parenthood needs. Adoption and fosterage are solutions for infertile couples to avoid public discrimination and to fulfil parenthood needs (Jenkins, 2002). However, while some people consider adoption as equivalent with biological parenthood, others consider it as of less valuable and incomparable with biological parenthood, arguing that the adopted children cannot be real children for adopters due to their felt needs of biological generational continuity. A study conducted in Canada by Miall (1996, p. 315) showed that parenting experiences between adoptive and biological families as well as paternal and maternal feelings of adoptive and biological mothers and fathers were similar for the large majority of the respondents. What mattered most was commitment in the families, not biological relatedness (ibid).

However, voluntary childlessness and adoption are unacceptable in many parts of the majority world (Inhorn, 2003). In Egypt, for example, one of the reasons that make adoption unacceptable as a substitute to real motherhood, is the fact that birth parents may come to reclaim the adopted child and thus feelings of emotional affinity and kinship between adoptive parents and adopted children will not emerge (ibid, p.1843). Moreover, as a woman should have a child of her own body in order to achieve the real womanhood identity, substitute mothering (fostering or adoption) can never take the place of "normal" motherhood in Egypt (Inhorn, 1996).

Similarly a study by Hollos and colleagues' (2009, p. 2068) in two Southern Nigeria communities demonstrate that foster children are considered as a valuable source of labour but they cannot be compared to biological children in terms of social status, emotional satisfaction, or old age security. A study on *social and cultural aspects of infertility* in Mozambique showed that most childless women didn't see fostering as a permanent solution (Gerrits, 2002). Two reasons making fosterage unacceptable in Mozambique were biological parents' accusation of foster parents for mistreating and exploiting foster children, and children's disobedience for a woman who was not their real mother (ibid).

Despite such deviations, adoption and fosterage are still world-wide practices as a means to cope up with the problem of infertility. In Ethiopia too, there are cultures in some regions encouraging adoption or fosterage regardless of the adopters' fertility status.

Another means of overcoming the infertility problem is the New Reproductive Technologies (NRTs). NRTs are becoming a widespread means around the world since the birth of world's first test-tube baby, Louise Brown, in 1978 (Inhorn and van Balen, 2002). This technique is found world-wide, including the petro-rich Arab countries and North African countries (ibid). NRTs have brought 'new freedoms' by preventing unwanted pregnancy and birth and the birth of 'undesired' ('wrong sex', 'unhealthy') children through prenatal diagnosis technologies (Gupta, 2006). Moreover, it has given the possibility of motherhood to infertile women and single lesbian women through artificial insemination or IVF. However, NRTs have also created a 'new dependency' on technologies and service providers. Besides being expensive, they also have side effects on women's health (ibid). In the majority world, access to NRTs is determined by people's economic status. For example, the elites in Egypt who are able to access NRTs are able to bear test-tube babies while the infertile poor didn't get the chance (Inhorn, 2003).

In the context of many African communities, we can notice that most treatments of infertility are designated for women. This is associated with the perception that infertility is women's problem. The consequences of such perceptions on women's life, and the social status of childless women are reviewed in the section that follows.

## **2.4. Experiences of Childless Women**

Although infertility is a problem of both sexes in a couple, it is the woman who is mostly blamed for the reproductive failure and suffers the negative consequences of being childless. Consequences of being childless for women include disrespect and social exclusion, name calling, mocking, evil eye accusation, denial of means of livelihood (especially access to land), and violence in some instances (Deribe *et al.*, 2007; Feldman-Savelsberg, 2002; Hollos and Larsen, 2008; Hollos *et al.*, 2009; Inhorn, 1996; Kimani and Olenja, 2001; Riessman, 2000).

In their study on the experience of women who under take infertility treatment in an urban setting of South Africa, Dyer *et al.* (2002) found out that most of the infertile women

experienced negative consequences such as marital instability, stigma, and abuse. The level of abuse even pushed some women to the extent of thinking about committing suicide (ibid). Studies in Nigeria and Malawi also showed that women were more likely to suffer the social and psychological consequences of infertility such as physical and mental abuse, neglect, abandonment, economic deprivation, social ostracism, and marital breakdowns (Okonofuaa *et al.*, 1997 and De Kok, 2008).

The childless *Ile-Ife* women of Nigeria reported that they have experienced abuses by husbands' family, accusations of being a witch, husbands taking another wife, and exclusion from some social activities (Orji *et al.*, 2002, p. 61). The *Yoruba* infertile women experience social exclusion as they were often accused of being a witch and of having 'devoured' their own children (Pearce, 1999, p. 73). A qualitative study in *Macua* of Northern Mozambique revealed that childless women were excluded from certain social activities and ceremonies (Gerrits, 1997, p. 46). For example, they were not allowed to assist deliveries, to involve in conversation about such events, and to be around the bodies of the dead (ibid).

While a number of infertility studies explored childless women's experience, the male partners of infertile women are most often not included in the studies. This is partly because of the fact that infertility is seen as women's problem and men are unwilling to participate in studies (Lloyd, 1996). However this doesn't mean that childless men are not negatively affected by infertility. For example, a clinical based quantitative assessment on *psychological distress among men suffering from couple infertility in South Africa* found out that the male partners in a childless marriage experienced significantly more psychological distress compared with male partners of pregnant women (Dyer *et al.*, 2009, p. 2823).

In some cases, infertility has been documented to have a positive impact on couple's life. A quantitative study on 2250 women and men who were undertaking infertility treatment in Denmark revealed that infertility had enabled some of the infertile partners to strengthen their marriage relations and improve mutual connection in their attempts to manage the stressful situations of being infertile (Schmidt *et al.*, 2005).

While infertile women in the majority world suffered a lot due to their involuntary childlessness, there is an increasing trend of voluntary childlessness among women in European countries (Bentley and Mascie-Taylor, 2000). For example, among women born in 1959, 26% in Germany, 21% in England and Wales, and 19% in Netherlands have remained

childless (ibid). Such a trend, however, does not mean that the women in the respective countries are not worried about infertility. Although infertility is not an issue for those who are voluntarily childless, still the majority of the women in these countries want to conceive and infertility is definitely an issue among these.

Although the need to have children is universal, it becomes even stronger in African countries like Ethiopia where children are considered as assets and sustainable sources of income as well (Deribe *et al.*, 2007). As Inhorn and van Balen (2002, p.9) put it, voluntary childlessness is not a choice in non-Western societies where there are multiple reasons to have a child. Similarly, Sahleyesus (2005) in his study *attitudes toward family size preference among urban Ethiopians*, found that although the preferred number of children for an urban couple is on average 2.8, voluntary childlessness was not a choice of the respondents.

To sum up some of the findings from the literatures reviewed in the previous sections, we have seen that children in most African communities have multiple values, ranging from economic to emotional. It seems that childlessness is unacceptable in such communities. We can say that such strong attachment of children to the purpose of one's life has its effect on the perception of causes and treatments of infertility. We have seen that people in most communities in Africa have no clear understanding of the medical causes of infertility in the first place. While some associate it with supernatural power, others perceive it as a biological disease. Besides, it is indicated that women are blamed for reproductive failure although men are equally likely to be infertile. Finally, traditional and spiritual treatments of infertility problems are widely practiced in Africa, while NRTs are recently becoming available in some countries.

Although it seems that most African countries have relatively similar perceptions on the causes and treatments of infertility, it is proper to examine the perceptions in Ethiopia (and in the study area). The next section takes a closer look at previous infertility studies in Ethiopia.

## **2.5. Infertility Studies in Ethiopia**

There are very few studies of infertility in Ethiopia compared to the studies in other African countries. The pioneer study in this regard is that of Mamo and Morgan (1986) on *Childlessness in rural Ethiopia*. This study was not based on primary data; rather the data

was taken from the 1981 Rural Demographic Survey of Ethiopia that includes 12 provinces of Ethiopia (excluding Tigray and Eritrea regions)<sup>5</sup>. However, the study found out that high fertility differentials across provinces are largely the result of the prevalence of infertility in those areas. According to their findings, infertility was the highest among the Christian Amhara due to the prevailing divorce and remarriage practices which exposed people to STDs. Another study was conducted by Tilson and Larsen (2000) on *Divorce in Ethiopia: The impact of early marriage and childlessness*. This study was also based on secondary data (from the 1990 National Family and Fertility Survey of Ethiopia) but was not aimed directly on the problem of infertility. The findings showed early marriage and childlessness to be the main factors that lead to divorce in Ethiopia. According to this study, most of the women who didn't have a child within their first marriage (with an average waiting time of 2.8 years for first birth) ended up with divorce.

A quantitative study was conducted by Deribe *et al.* (2007) in *Illubabor zone*, south western part of Ethiopia (Oromia Region) about the way people perceive and experience infertility. The study included 225 infertile individuals (167 women and 58 men). The findings indicated that there was lack of medical knowledge about the causes and treatments of infertility in the study community. While 53% of the respondents reported God's wrath as the cause of infertility, 41.8% replied that infertility will be cured using modern medicine. A childless woman experience all sorts of social discriminations coming from her husband, his relatives and friends, her neighbours, and even from her own relatives and friends. A childless woman is for example, often referred to as "mule" to express the stigma of childlessness.

There are also a couple of recent master's theses from the Institute of Gender Studies of Addis Ababa University dealing with infertility related issues. A study by Mekdes (2008) is examining infertility among women in Addis Ababa who attended the *Family Guidance Association of Ethiopia* clinic. This study found out that illicit abortion, untreated sexually transmitted diseases, lack of information about the negative consequences of contraceptives, and female genital mutilation are major causes of infertility. This study also found out that poor and less educated women are mostly affected by infertility.

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<sup>5</sup> Currently Ethiopia has 9 regions and Eritrea is no longer part of Ethiopia



Another hospital based study by Tinsae (2009)<sup>6</sup> on infertile women's lived experience revealed that infertile women are found to be at risk of getting sexually transmitted infection and HIV/AIDS due to the practice of extra marital relationships, divorce and remarriage. According to this study the reasons women need to bear children include, among others, to gain labour aid, financial support, and old age care support, to carry on ones family's name, and to meet social expectations. This is consistent with the values of children identified by Dyer (2007) as mentioned earlier in this chapter.

## **2.6. My Contribution**

Although the problem of infertility in Africa currently has received some attention of researchers (see Dyer, 2008), infertility studies are very limited in Ethiopia and non-existent in the specific study area, South Gondar zone of Northwest Ethiopia. Based on the values attached to children in rural communities of Ethiopia, we can say that infertility is a serious personal and social problem and that childless women are the centre of this problem. To fully understand the problem and the attached social meanings, it requires a qualitative research that focuses on the perceptions of causes and treatments of infertility. My research will primarily contribute to the existing limited knowledge in this regard.

Among the few existing studies in Ethiopia, some of them are based on secondary data and others are clinical or hospital based. Unlike these studies, my research is based on primary data and gives firsthand information. In addition the qualitative data of this research was gathered from different groups (childless individuals, religious leaders, community members, and health workers) something which makes the data richer. Regarding the research setting, my informants are childless women recruited in local communities using snowball method. Most of them are rural people who do not have access to medical treatment for their infertility problem. This method of recruiting informants is appropriate in the Ethiopian situation since the majority of its population (more than 80%) is living in rural places where access to medical treatments is very limited.

The perceived causes and treatments and the severe impacts of childlessness indicated in this study will hopefully inspire policy makers within the area of health, education, and social

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<sup>6</sup> The study was done on women who follow up infertility treatment in Gondar hospital which is the biggest referral hospital in Amhara region.

security to design programs that take the situation into account. The childless individuals need practical and organized actions focused on infertility treatments and on old age security.

The study will also help anyone who intends to take part in awareness creation and related social work in the area; to understand how the problem of childlessness is deep rooted in the communities and the roles of the different groups in the community (childless individuals, religious leaders, community members, and health workers) in averting the problem.

Finally, this research shows the possible gaps that require the attention of researchers who are interested in infertility related problems.

## CHAPTER 3

### THEORETICAL FRAMEWORK

As Silverman (2005, p. 99) has noted, “theories arrange sets of concepts to define and explain some phenomenon.” So I will use three theoretical frameworks to define, analyze, and explain the empirical findings of my study. Scheper-Hughes and Lock’s (1987) three bodies approach, social stigma theory and coping theory are used as theoretical bases for this study. In the following sections, I will describe each theory and their relevance to my study.

#### 3.1. The Three Bodies’ Approach

The three bodies’ approach by Scheper-Hughes and Lock (1987) represents an attempt to integrate an anthropological theorizing on the body, and simultaneously to challenge the assumptions of Cartesian dualism found in medical understandings of the body. As Scheper-Hughes and Lock (1987, p. 208) noted, dualist ideas rigidly separate “mind from body, self from matter and real from unreal.” The three bodies’ approach views the body as a physical and symbolic entity that is both naturally and culturally constituted (ibid). The approach represents three levels of analysis (Scheper-Hughes and Lock, 1987, p. 209): the *individual body* (phenomenology), the *social body* (structuralism and symbolism), and the *political body* (post structuralism). Scheper-Hughes and Lock do not see these levels of analysis as mutually exclusive but rather as interconnected.

The first level (the *individual body*) refers to “lived experience of the body-self” (Scheper-Hughes and Lock, 1987, p. 209). The individual body experiences health, illness, happiness or sorrow although these experiences are influenced by social, political and cultural factors. The second level of analysis is the *social body* (the body as a symbol). As Douglas noted (2005, p. 78) “the physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society.” For example, in some societies, while left-handedness may be associated with the inferior, dark, dirty and female, right-handedness may reflect a positive, socially acceptable character-trait and a symbol associated with something superior, holy, light, dominant and male (Needham, 1973, p. 109 in Scheper-Hughes and Lock, 1987, p. 215). The cultural dimension of the social body perspective can also be explained by reference to reproduction. Scheper-Hughes and Lock

(ibid) states that women in many societies are symbolized as a child-bearing “animal” (passive and receptive, but responsible for giving birth) in contrast to the Western theory of conception where male and female are seen to contribute equally (Scheper-Hughes and Lock, 1987). The third level is the *body politic* or the *political body*. It refers to “the regulation, surveillance and control of bodies (individual and collective) in reproduction and sexuality, in work and leisure, in sickness and other forms of deviance and human difference” (Scheper-Hughes and Lock, 1987, p.209). Foucault (2005, p. 103) argued that a body is “docile that may be subjected, used, transformed, and improved.” The beautiful, strong, and healthy body is the culturally and politically "correct" body in many societies although the indicators may differ (Scheper-Hughes and Lock, 1987).

Generally, the three bodies’ approach explains how bodies are understood and how different meanings are attached to the bodies, what is regarded as acceptable or unacceptable in the society, and the power and control exercised on the body. The three bodies’ approach is helpful to understand perspectives at individual, community, and structure and dominance levels. In relation to my study, the concept of the *individual body* helps me to analyze the ways childless informants come to know their infertility and the perceived causes and treatments of infertility as seen from the perspective of the individual childless woman and men. The *social body* is relevant to understand the society’s views on who is seen as most responsible for reproductive failure (whether the woman or man), to capture community members’ perceptions about the causes and treatments of infertility, and to understand the consequences of these perceptions on childless informants’ lives (stigma). In addition to this, the *social/symbolic body* perspective is important to see the different representations of and meanings attached to infertile bodies. The *political body* is also helpful to understand the power relations revealed in the social categorization of childless people, the efforts of childless informants to solve their problem of infertility, and who have the power and knowledge to advise them to do so.

### **3.2. The Theory of Social Stigma**

As Goffman (1963, p. 1) noted, the term ‘stigma’ originated from Greek to refer to “bodily signs designed to expose something unusual and bad about the moral status of the signifier.” The social deviants like slaves, criminals or traitors were marked with the signs by cutting or burning of their body so that people with these marks could be easily identified and avoided

in public places. During the last decades, the issue of stigma in general and health related stigma in particular have become the concern of social scientists. Erving Goffman's book *Stigma: Notes on the management of spoiled identity* is classical in the study of stigma and has been an inspiration for many studies related to stigma until today. Goffman (1963, p.3) defined stigma as "an attribute that is deeply discrediting" so that the stigmatized will be reduced in the minds of others "from a whole and usual person to a tainted and discounted one." He also identified three types of stigma: *abominations of the body* (based on physical deformities), *blemishes individual character* (such as addiction, homosexuality, and mental illness), and *tribal stigma* (connected to race, nation, or religion).

Later on, the definition of stigma has been expanded to include other components as well. Sartorius (2006) for example, defined stigma as "a characteristic of a person or an institution - the colour of skin, the type of work or a label, for example - that evokes negative attitudes and feelings (such as fear, disgust or hate) and usually results in discrimination of the person or institution in various walks of life" (ibid, p. 383). Link and Phelan (2001) provided an even more comprehensive definition of stigma. For them, stigma exists when "elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma unfold" (Link and Phelan, 2001, p. 367). They argue that stigma is entirely dependent on social, economic, and political powers. For example, when people think of mental illness, deafness, and having one leg as signs of stigma, there is a power difference between those who are 'normal' and who are not (ibid).

Scambler (1984, p. 215) in his study on the impact of stigma on the lives of people suffering from epilepsy, distinguished between two types of stigma: *enacted stigma* which is "intentional discriminatory attitudes and behaviours of 'normal' people towards the stigmatized", and *felt stigma* which refers to "the shame felt by the stigmatized because of their internalization of the stigma or because of their deviation to live up to the accepted standards of the society." Stigma affects not only the person who carries the stigma but also families, close relatives, and friends as they may face what scholars refer to as *courtesy stigma* or *stigma by association* (Ostman and Kjellin, 2002). Ostman and Kjellin (ibid) defined *courtesy stigma* or *stigma by association* as "the process by which a person is stigmatized by virtue of association with another stigmatized individual" (ibid, p.494).

Stigma has adverse effects or consequences on the lives of the stigmatized. One common consequence of stigma is discrimination or enacted stigma. Link and Phelan (2001) identified three types of discrimination. The first one is *individual discrimination* which refers to overt actions or comments directed to the stigmatized (enacted stigma). The second type is *structural discrimination* which is related to institutionalized practices that hinders the life chances of the stigmatized. The third one is discrimination that operates through the stigmatized person's *beliefs and behaviours* due to fear of stereotyping attitudes (felt stigma).

In more specific terms, stigmatization damages self-esteem, leads to status loss, and creates stress (Deacon, 2006; Sartorius, 2006). Disbelief, shame, terror, grief, anger, social withdrawal, hopelessness, and lack of prospects are also mentioned as consequences of stigma (Gray, 2002). However, the stigmatized groups are not always passive victims as they also actively resist stigma (Link and Phelan, 2001).

Generally, the theory of social stigma is useful for my study to understand the experience of childless informants as 'deviating' from the social expectation of parenthood in general and motherhood in particular, and the consequence of this experience on the lives of the informants. The various types of discrimination will help me to explain what kinds of discriminations my informants receive from others, how informants feel about themselves, and what structural discriminatory factors are there.

### **3.3. Coping Theory**

A theory of coping was developed by Lazarus and colleagues starting in 1960s and was refined over time (Folkman *et al.*, 1986). The theory was mainly used to measure the distress level of people who experienced different social and health problems or people who faced stressful encounters such as mental health problems, breast cancer, infertility, and divorce. According to Lazarus (1993, p. 237), coping refers to "ongoing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Infertility is seen as a stressor that exceed a couple's personal coping resource (Jordan and Revenson, 1999).

Coping has two major functions: to regulate the stressful emotions (*emotion-focused coping*) and to change the problematic person-environment relation that cause the distress (*problem-focused coping*) (Folkman *et al.*, 1986). Folkman *et al.* (1986, p. 995) distinguishes eight

different ways of coping namely: confrontive coping, distancing, self-control, seeking social support, accepting responsibility, escape-avoidance, planful problem solving and positive reappraisal. The level of distress a person experiences is influenced by his/her choice of coping strategies.

*Confrontive coping* refers to aggressive efforts to change the situation with an inclination towards risk-taking and hostility. The efforts include: struggling to get what one wanted, trying to find the responsible person that caused the problem, expressing anger towards the person who caused the problem, and doing something even if it does not seem to work. *Distancing* refers to efforts to detach oneself. It may imply that one doesn't take the problem seriously, refuses to think about it too much, or tries to forget the whole thing. *Self-control* refers to the attempt to regulate one's own feelings and actions, while trying not to let others know the feelings and the intensity of the problem. *Seeking social support* has to do with making efforts to seek informational, concrete, or emotional support. *Accepting responsibility* means acknowledging one's own role in the problem and trying to correct it. This includes blaming oneself for the problem, making an excuse, and promising to change things in the future. *Escape-Avoidance* refers to wishful thinking and behavioural efforts to escape or avoid the problem. This includes wishing that the problem will go away, avoiding being with people in general, and excess eating, drinking, smoking, and sleeping to feel better. *Planful problem-solving* refers to deliberate efforts to change the problematic situation which includes making a plan of action, identifying different solutions, and increasing the efforts to make things work. *Positive reappraisal* implies efforts to create a positive meaning by focusing on personal growth. This strategy includes changing or growing as a person in a good way, to come out of the experience better than was in the past, founding new faith, and praying.

Coping theory is mainly used for quantitative studies and it provides a checklist of specific coping strategies under each way of coping described above. However, my research is qualitative and in my interviews, I did not provide checklists of coping strategies for my informants as I did not intend to measure the stress levels of the informants. However, as the coping strategies came up at different stages of the in-depth interview, I decided to employ coping theory to recognize and distinguish the coping strategies used by informants to solve *external* problems of stigma and discrimination and *internal* emotional problems of their childlessness. One informant might use a combination of coping strategies and his/her choice

of coping strategy might be influenced by his/her understanding of the body. Although the eight ways of coping seems relevant, the specific coping strategies might be culturally specific, differing from those mentioned above.

The three theoretical approaches described in this chapter are interrelated and employed throughout my empirical chapters with the three bodies' approach as a main theoretical framework. The *three bodies approach* will be used to analyse the perceptions of individual childless women and men, community members, religious leaders, and medical personnel on causes and treatments of infertility (chapter 5). It is also relevant to understand nuances of body symbolism (chapter 6) and the emotional experiences of childless informants (chapter 7). The *social stigma theory* will be used to analyse the experiences of childless informants due to their deviation from the 'normal' life (chapter 6). Terminologies such as enacted stigma, felt stigma, and structural discrimination will be important to define certain experiences of childless informants. Finally, I depart from a presumption that childless informants are passive; they have their own ways to solve their infertility problem and to cope with stigma. I have therefore, chosen to use *coping theory* to analyse the social support-seeking behaviour of childless informants (emotional, informational as well as concrete support) (chapter 5) and to define the ways childless informants have to cope with stigma and infertility related problems (chapter 6). It is also important to analyse childless women's relation with pregnant women and young children in general and to define the future expectations of childless informants (chapter 7).



## **CHAPTER 4**

### **RESEARCH METHODOLOGY**

This chapter focuses on discussions about the relevance of qualitative methodology to achieve the objectives of this research, the methods used to recruit the informants and to collect and analyze data, ethical considerations, and challenges faced during data collection.

#### **4.1. Qualitative Methodology**

The main objective of this research was to *assess socio-cultural perceptions of infertility and the implications of these perceptions on the lives of childless women in South Gondar*. In this inquiry, I didn't seek to study the relationships between dependant and independent variables, nor did I want to test hypotheses. What I want to explore was the socio-cultural meanings of infertility in South Gondar (Ethiopia), about which little is known. Understanding these socio-cultural meanings of infertility required me to get inside the community's world. Thus, the underpinning philosophical perspective in my work is interpretive, and the methods used were qualitative. Qualitative research methods enable researchers to study social and cultural phenomena and are more suited than quantitative methods to understand people's subjective interpretations (Myers, 2009). As the focus is on the social contexts on infertility, qualitative research is a good fit for the research. Thus, qualitative research methodology was used in collecting data to achieve the research objectives. Qualitative data gathering tools such as in-depth interviews, semi-structured interviews, group interview, focus group discussions and informal conversations were used in the process.

#### **4.2. Recruitment of Informants**

The primary data was collected from 25<sup>th</sup> May - 15<sup>th</sup> August 2010 from childless women and men, religious leaders, health workers, community members and some individuals who have a close relation with childless women. Since there is no vital registration system that identifies childless individuals in the communities under study, *snow balling* method was used to recruit childless women informants. I used rural health extension workers to identify these women and to get their consent for the interview. As health extension workers work in rural areas, they have close interaction with the rural communities and know who is who.

As I started to get in touch with childless women through the assistance of the health extension workers, some more childless women were motivated to come to my place, as they thought I could help them with their problem. They thus mistook me for a medical person who can give them some sort of help for their infertility problem. Even if I immediately told them that I am a student who cannot at all treat infertility, all except one of these women were willing to participate in the study after I explained to them the purpose of the research. The other groups of participants such as health professionals, religious leaders and people who know childless women well were recruited *purposively* as these informants were recruited on the basis of their respective positions. Participants of the focus group discussion were selected *randomly* from church gatherings and farmers' association meetings.

### **4.3. Data Collection Methods**

Qualitative data was collected from five groups of participants through different research methods: from childless individuals through in-depth interviews, from health workers through semi-structured interviews, from religious leaders through a group interview, from community members through focus-group discussions, and from people who have close relation with childless women through informal conversations. I used to take notes during the interview.

Bryman (2008, p. 700) noted that the use of more than one method or source of data, called *triangulation*, is useful to crosscheck findings in the study of social phenomenon. In my case, the use of more than one method was useful not only to crosscheck the findings, but also to expand the data material itself.

Interview was the major data collection tool in this research as it has many advantages for undertaking research on sensitive topics such as mine. According to Gorman and Clayton (2005), "individual and group interviewing can obtain detailed, in-depth information from subjects who know a greater deal about their personal perceptions of events, processes and environments" (ibid, p. 41). In addition, open ended interviewing has also the advantage of getting unexpected insights (ibid). The personal contact between the interviewer and the interviewee may also have special importance to address question related to matters that are confidential, unflattering, embarrassing, or sensitive (ibid, p.125). Since infertility is a highly sensitive topic that touches upon personal experiences of people, face-to-face individual interview was the most appropriate method to get trust from informants.

### ***In-depth Interviews:***

In-depth interview was used to gather qualitative data from seventeen childless women and two childless men to explore their perceptions of causes and treatments of infertility, and their experience of being childless. Informants were first introduced to the research objectives and were asked if they were willing to be interviewed. Among the childless women I approached for interview, three of them were not willing to be interviewed; they said that they do not want to talk about the issue.

Interview guides were used as advised by Kvale (1996) which indicate the topics to be covered and the sequence of the interview questions. During the in-depth interview, questions related to the perceived causes, treatments, and consequences of infertility were addressed. In addition, questions related to social support and stigma, the role of adoption and other coping strategies, childless people's relation with other people's children and with pregnant women, and the future plans of childless women were included. The average length of each interview was one and half hour. I have made two contacts with six of the childless women informants of this study, but I contact the others only once.

The basic backgrounds of informants of the in-depth interview are summarized in Table 1.

<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Education</b>	<b>Age at 1<sup>st</sup> marriage</b>	<b>No. of divorces</b>	<b>Present marital status</b>	<b>Work</b>
Debre	F	60	Illiterate	13	4	Married	Housewife/farmer
Wude	F	35	Grade 3	13	-	Married	Housewife/farmer
Desta	F	60	Illiterate	20	2	Married	Housewife/farmer
Maritu	F	40	Grade 8	18	2	Married	Community worker
Abebu	F	60	12 complete	9	3	Divorced	Gov't Employee
Bertukan	F	60	Illiterate	17	2	Divorced	Handy craft
Yemata	F	40	Illiterate	15	2	Married	Housewife
Tibebe	F	35	Illiterate	13	3	Married	Housewife/farmer
Berke	F	31	Illiterate	15	1	Married	Housewife/farmer
Masresha	F	42	Illiterate	13	-	Married	Housewife/farmer
Alemitu	F	38	Illiterate	15	2	Divorced	Farmer
Fanta	F	28	Illiterate	14	1	Married	Housewife/farmer
Almaz	F	30	Illiterate	13	2	Married	Housewife/farmer
Worke	F	38	Illiterate	12	4	Married	Housewife/farmer
Asmarech	F	23	Grade 10	8	3	Divorced	Student
Bosena	F	37	Illiterate	12	2	Married	Housewife/farmer
Amsale	F	35	Illiterate	14	1	Married	Housewife
Mengistu	M	40	Grade 7	27	1	Married	Farmer
Hailu	M	45	Grade 4	25	2	Married	Farmer

*Table 1. Basic backgrounds of childless women and men participated in the in-depth interview.*

The above childless informants are living in a number of different villages in South Gondar zone; only three of them are living in the town, Debre Tabor. As we can see from *Table 1* above, most of the key informants got married at an early age (8-15) and have experienced divorce more than once. Except one government employee, one community worker, a 10<sup>th</sup> grade student, and a 3<sup>rd</sup> grade dropout student, all the other female informants had no formal education and are working as house wives and farmers. Lack of education is not the special for these informants since the overall adult literacy rate of Ethiopia is still only 35.9% (UNDP, 2010)<sup>7</sup>.

***Semi-structured interviews:***

As health workers are expected to have close relationships with infertile individuals, it was important in this research to get the perceptions and experiences of a couple of health workers on the problem. Semi-structured interviews were used to gather data from two health workers (a medical doctor and a nurse). During the semi-structured interview, questions related to the overall situation and people's awareness of infertility in the study area were emphasized.

***Group interview:***

A group interview was held with three religious leaders of the Ethiopian Orthodox Church, South Gondar District (Debre Tabor). In my proposal, group interview was not included. Instead, I was planning to use semi- structured individual interviews to address religious leaders. However, when I asked the leader of a church at Debre Tabor to have an interview with him about the topic, he told me that there are two other knowledgeable colleges at the district office who can answer my questions and he preferred to be interviewed together with them.

According to Kitzinger (1995; 1990), while group interviews are used to collect data from several people simultaneously with the researcher asking each person to respond to a question, focus groups explicitly use group interactions by encouraging participants to talk to one another. In the case of interviewing the religious leaders in group, the interview questions were designed for an individual interview. I asked each of the three participants to respond to each of the questions and thus, there was limited interaction among them. Therefore, the

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<sup>7</sup> Retrieved on 10.04.2011 from <http://hdrstats.undp.org/en/countries/profiles/ETH.html>

method I used should be considered as a group interview rather than a focus group discussion.

As Flick (2006) noted, “group interviews are low cost and rich in data, they stimulate the respondents and support them in remembering events, and [...] can lead beyond the answers of the single interviewee (ibid, p. 190).” Even if unintended from the beginning, the group interview was very productive as the leaders remind each other biblical stories related to the topic. Religious explanations about the causes and treatment of infertility and how the church treats infertile people were themes discussed with the religious leaders. I interviewed religious leaders only from the Orthodox Christianity church because all of the key informants (and more than 80% of the population in Amhara) are followers of this religion.

***Focus group discussions (FGDs):***

As Barbour and Kitzinger (1999, p. 5) noted, “focus groups enable researchers to examine people’s different perspectives as they operate within a social network”. Kitzinger (1995, p. 299) also mentioned that FGDs “do not discriminate against people who cannot read or write and they can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say.” Thus, the method was found to be important for my study to explore the community members’ perspectives about the topic, most of whom cannot read and write. Focus group discussions were conducted with community members to hear their views about the causes and consequences of and solutions to infertility, to reflect on proverbs related to infertility, and to get to know how the community treats childless people. Two FGDs, each having seven participants, were conducted with men. Moreover, one FGD of eight participants was conducted with women. Participants of the FGDs were from different villages who gathered for Sunday holy mass and farmers’ association meeting.

In addition to the above mentioned qualitative data collection methods, I gathered valuable information during informal conversation with a couple of people who are close to childless individuals. I also gained a considerable amount of data using observation and taking field notes. Since most of the interviews were conducted in the childless women’s home, I observed women’s work load in the house, physical appearance and health situation. I also observed their facial expression (fear, eagerness, anger, hopelessness...) when they recalled their past experience and imagined their future.

#### **4.4. Research Ethics**

This research fulfilled all the necessary requirements of the Norwegian Social Science Data Services (NSD) regarding confidentiality of the information, anonymity of the informants, and safe storage of the data. In addition to this, as all research conducted by students or researchers from institutions outside Ethiopia have to get a letter of permission from Addis Ababa University, it was necessary for me to go to the office of the Vice President for Research and Dean of the School of Graduate studies to obtain the permission. In this respect, I have received the permission letter before I went to the field.

Research topics which touch on deeply personal experiences can be considered as sensitive topics (Lee and Renzetti, 1990). Infertility is one of the sensitive issues that touch personal and emotional issues such as marital and extra marital relations, abortion, and sexually transmitted infections. Informants may also feel emotional pain and stress as they are asked to recall their “worst” encounters in life. To deal with this sensitive topic, key ethical principles such as *informed consent* and *confidentiality* were adhered to in relation to the informants (Davis, 1999). Research participants or informants were informed in advance about the purpose of the study, the use of data gathering devices (audio tape recorder), and the exclusive secrecy of the personal information they gave to me. Oral consent was granted to me by all the informants. Pseudonyms were used to protect informants from being identified, except in the case of those who were willing to publicise their names (the health workers). Although only one of the religious leaders preferred being anonymous, I decided to use pseudonyms for the other two too because if I publicise the name of the two, the other one will easily be identified.

#### **4.5. Challenges during Data Collection and My Role as a Researcher**

Recalling our painful or difficult experiences in life may cause bad emotion to arise and thus, we may feel uncomfortable as if the past experiences were happening now. What if the painful or difficult moments are yet not over? How do you feel if you are still living with your bad past and if you do not know when this will come to an end? The issue of infertility can become serious especially in communities where children have multidimensional values. If infertility or childlessness is accompanied with stigma and discrimination, it will then be more painful to recall and tell others about these discriminations.

During my interviews with some of the childless women, many of the above mentioned scenarios came true. Some informants were even crying during the interview. This was heartbreaking and at the same time it gave me an understanding of the extent to which the problem of infertility has influenced women's lives in the community. I tried my best to put my informants at comfort by telling them about the importance of medical check-ups and about the experience of many childless families who get children through adoption. In some instances, I even told them about high-tech infertility treatments such as test tube babies to build their hope although the technologies do not exist in the country.

The data collection environment was not without challenges as there were some instances leading to interruption of the interview or change of the subject to undesirable direction. On one occasion, while a woman was telling me about the stigma or discrimination she frequently faced from her family, one of her step-sons came and sat with us. At that moment, she immediately changed the subject and said: "I haven't faced any discrimination from my family. My step-children give me a lot of support and I will depend on them in the future; I have no one else except them." In another case, a neighbour of the childless woman entered during the interview and, as it was impolite to ask the neighbour to go out, she started listening to our conversation. When I asked the childless woman if she ever faced discrimination from her relatives or from her neighbours, the neighbour started answering the question by saying: "How come we discriminate her? We all feel sympathy to her, and especially I always thought of supporting her but I am also poor to do so. I was her testimony in the court when her husband abused her."

In another case, the husband of a childless woman was unhappy about the interview. He asked his wife what the interview was about and she told him that it was all about infertility. Then he became angry and said: "There is no one infertile here!" However, the wife told him the importance of the interview and the interview continued as desired. She later told me that he himself has children from his ex-wife.

Another problem was the lack interest among women to participate during the focus group discussion, thinking that they are not knowledgeable enough to answer the questions or to provide useful information. However, once they were told that they need no special knowledge to talk about their personal perceptions, someone started talking, others followed with confidence, and subsequently the discussion was completed in a good way.

I was born in the study area but it is about ten years since I left it. Although almost none of the informants know me personally, many of them know either my parents or the place I was born. Being an insider, I have had an advantage of being trusted by the informants and getting their consent. However, the two childless women who personally knew me were not comfortable to talk about some personal experiences like extra marital relationships, abortion, and sexually transmitted infections even if I promised them the confidentiality of the information.

A final problem was the already mentioned impression of some informants who took me to be a medical doctor. After I made some interviews with childless women in different villages, people started saying: “The daughter of Mr. Aseffa has come from abroad to treat the problem of infertility.” Some people also asked my father if I can help them. Almost none of the informants had undertaken medical examination to know the causes of their problem. However, knowing that I came from abroad (“*ferenj hager*” - white-people’s country), they were eager to see me because there is a belief that white people have excellent medical solutions.

Despite all the above mentioned challenges, I managed to successfully complete the interviews. I am confident that I have gathered reliable and valid data that enables this study to contribute new insights to the existing infertility studies.

#### **4.6. Data Analysis**

As should be clear from the presentation above, the data material collected is complex and rich. Detailed and intensive examination of the data has been necessary to bring out interpretations of what lies in, behind, and beyond the material (Strauss, 1987). Interviews were summarized with contact summary forms as suggested by Miles and Huberman (1994). A contact summary is a sheet or form that summarizes interview questions and the responses obtained in a particular interviewee (ibid). It is a qualitative data analysis tool where the researcher makes a preliminary summary of an interview before going to the next interview so that what might be missed in one encounter will be gained in the next interview (ibid). After each interview, I summarize the previous interview on a contact summary in the local language (Amharic) before I go to the next interview. (A translated sample contact summary form is presented in Appendix 2). In addition to this, the transcribed data have been coded



and categorised into themes. The main themes include: (1) perceived causes and treatments of infertility; (2) social support and stigma; (3) socio-economic and emotional consequences of childlessness on women's lives; and (4) the coping strategies of childless women.

All the interviews, focus group discussions, and field notes were conducted in Amharic (the national as well as the local language) and later translated to English. During translation, the longer interviews were condensed without losing their original meaning.

## CHAPTER 5

### PERCEPTIONS OF INFERTILITY: CAUSES AND TREATMENTS

In the study communities, fertility has central value. The problem of infertility is, therefore, the concern of not only the childless individuals but also the community in general. Thus they exert the maximum possible effort to solve the problem. There is an interplay between cultural beliefs, medical understanding, and religious views about the causes and treatments of infertility. Although the authority of the Orthodox Church is found to be high and popular religious opinions of the problem are prominent, individual childless women did not restrict themselves to seek religious treatments only, but tried a combination of different treatments. The following sections present the ways childless women came to know their infertility, the views of childless women and men, community members and religious leaders on the causes and treatments of infertility, and the coping strategies of childless individuals.

#### 5.1. Ways Childless Women Came to Know Their Infertility

Before asking about their perceptions of causes of infertility, it was appropriate to know how individual women came to realize their status. So I asked the question: “*How did you know that you are infertile? Have you undertaken an infertility test?*” The way individual informants come to realize their infertility could be related to their age at first marriage, the strong social pressure to bear a child, and interpretation of religious teachings. As indicated in the introduction, early marriage is widely practiced in the study community (Dagne, 1994). Early marriage (below the minimum age limit 18) seems to have a religious basis in the previous times. For example, Article 24 no.883 and 889 of the first legal and religious reference document called Fitha Negest (Justice of kings)<sup>8</sup> states that girls of age 12-15 and boys of age 20-25 are considered as matured and ready for marriage. However, there had been a long-aged tradition of arranging marriage between children under 10 years in the rural areas, a tradition which is almost terminated presently but which a lot of my informants were victims to.

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<sup>8</sup> Fitha Negest was a legal and religious document before the emergence of the first written constitution in 1931 and is still a considerable reference document for religious canonical rules.

### **5.1.1. Age as a Standard**

Normally, women's reproductive age is within the range of 15-45. However, many of my informants concluded that they are infertile at the beginning of their reproductive age. If they do not give birth at 15, then they start to think that there is a problem. As we can see in their responses, age 15 is considered as the appropriate age limit for giving birth since most of them were married much earlier than the reproductive age.

Fanta point out: *"I got married at fourteen. I concluded I am infertile when I passed fifteen without medical test because for me fifteen is the appropriate age to give birth."* Berke, first married at the age of 15, explain: *"I concluded that I am infertile when I reached 20 without giving birth because I believe 15 is the appropriate age to give birth, if there is no problem with us."*

Debre, first married at the age of 13, recalled:

*At first marriage, I was not matured and was not worried about being infertile. During my second marriage, I started thinking about being infertile because I was matured enough to give birth ,15 years old, and then my husband started complaining by saying: 'Why don't you give birth? I married you not only to feed you but to get a child'. In addition, my neighbours and relatives repeatedly asked me if I am pregnant or not. As a result, I started thinking about being infertile.*

For the above three informants as well as many others, age 15 is mentioned as the appropriate age to give birth under normal circumstances although none of them gave me specific reasons for choosing 15 as the standard age limit. However, Worke a 38- year woman, conclude that she is infertile based on the years she spent without children rather than a specific age limit: *"I realized that I am infertile when I became 22, which means after 10 years of marital life. I believe that after so many years in marriage, it is almost impossible for me to give birth."*

### **5.1.2. Taking Someone Else as a Point of Reference**

Some informants compare their status with other child-bearing persons to reach at a conclusion that they are infertile. For example, the 30- year old Almaz realized her infertility by comparing herself with women of her age who gave birth. She said: *"When I saw my friends giving birth, I also wanted to give birth but I failed to do so. After that, I concluded that I am infertile."* Asmarech, aged 23, also came to believe that she is infertility by

comparing herself with her younger friends: “*I suspect I have some problem because even my younger friends gave birth.*”

For other informants, the fertility status of their partners is used as a standard to know their own status. For example Tibebe, a 35- year woman concluded that she is infertile when she was unable to bear a child from her husband who had a child from his previous wife. She recalled her experience:

*I couldn't get children from two previous marriages. My current husband, who had married two times before me, has one child from his first wife and three from his second wife. As I married him after the conclusion of his previous marriages with the deaths of his wives, I was hopeful to give birth. However, I couldn't give birth from him and then, I concluded I am infertile.*

Hailu, a male informant, came to believe that he may be infertile in a similar way as did Tibebe:

*I divorced my first wife after we spent eight years together because she was infertile. I also divorced the second one after five years of marital life for the same reason. For the third time, I chose to marry a woman who gave birth before to be sure that I got the right birth-giving woman. I thought she would be pregnant immediately, however it has been more than one year and nothing happened. Now I am thinking that the problem may be with me.*

In many societies, infertility is mainly perceived as women's problem (Deribe *et al.*, 2007; Inhorn, 1996; Kimani and Olenja, 2001). Similarly, as we can see from the above cases, childless women easily conclude that they are infertile without medical proof and without questioning the status of their partners. This is not observed in the male informant, Hailu, as he has been relegating the problem to his wives, although slowly coming to realize that the problem may be with him.

### **5.1.3. Medical Check-ups**

Medical examination is a universally accepted way of knowing the cause of any disease and to seek a solution to it. There is no exception for the problem of infertility. However, only three informants have tried medical check-ups. Low level of awareness of people about the medical solution of infertility is one factor that hinders people to access health services. The

other factor is inadequacy of health facilities in the vicinity. The nearest referral hospitals are found in Gondar and Bahir Dar towns which are respectively 190km and 140km away from the study area. Besides, before they get access to transportation, they have to walk approximately 20-30kms. Even for those who tried medical treatment to know their infertility problem and to seek solution for it, shortage of time and money forced them to give up without having a solution. Wude's experience is illustrative in this regard:

*I started thinking about giving birth two or three years after marriage because people were asking me by saying 'why you are late? Why don't you give birth?' as if I have a power to create a child by myself. Now I have concluded that I am infertile because I didn't give birth in 22 years of marriage. We tried infertility test at Gondar hospital but they didn't tell us who is infertile, my husband or me? We interrupted the treatment because it is hard for us to go there every month since there is no one to keep our farm and cattle here.*

In this case, we can see that in addition to lack of health services in the vicinity and the repeated appointments, the treatment process is hindered by the absence of family members who can look after their house and cattle. It is to be recalled that children are the main sources of labour in the study area.

Mengistu, a male informant who divorced once and now living with his second wife:

*My wife and me underwent infertility test at Bahir Dar hospital [about 135km away] but we didn't know who is infertile. The doctors promised us we can give birth if we follow the treatment patiently. However, I don't think we can continue the treatment because it needs so much money for transportation, accommodation [...].*

After spending a lot of money and time, infertility treatments might not always be successful. This is Abebu's experience: "*I have been through long lasting infertility treatment. The doctors told me that my tube is blocked and I had to undergo surgery. However, I didn't get a solution even after surgery. I finally gave up and terminated the treatment after spending more than 10,000 Birr<sup>9</sup>.*"

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<sup>9</sup> Birr is an Ethiopian currency. 1 USD is about 16 Birr. According to World Bank (2010) the average annual income of an Ethiopian citizen (GNI per capita) in 2009 is 330 USD. Retrieved on 26.10.2010 at <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD>

Limited awareness about medical solutions to infertility, poverty, and inadequacy of health facilities in the area were impediments to consider medical treatment as a solution to infertility. The fact that the informants have heard no success stories of medical treatments also affected their attitude. My informants were surprised and very eager to hear that there are high-tech treatments to get children such as test tube babies, although such treatment is beyond their reach. As shown in the introduction, majority of the Ethiopian population lives in poverty and it is difficult for people living in the rural communities to access hospitals that are located in towns. As the focus of existing accessible community health services is on family planning and basic health care, the rural childless people remain detached from medical infertility treatments.

## **5. 2. Perceived Causes of Infertility**

We have seen in the literature review that the awareness of infertility problem is found to be very low even in some European countries, let alone in Africa (see Adashi *et al*, 2000). That is why in many parts of Africa, infertility was perceived to be caused by God's wrath, evil spirits, breaking of taboos, and physical disease (Deribe *et al.*, 2007; Kimani and Olenja, 2001; Pearce, 1999). This perception is shared among the informants of this study. As we will see in the following section, the individual women's understanding of the causes of infertility is mainly shaped by popular religious explanations of the problem as well as by particular socio-cultural perceptions of the body.

### **5.2.1. God's Will**

In many parts of Africa, children are perceived as God's gift, and inability to have children may be considered as a result of sin (see Dyer, 2007). Similarly most of the informants believed that children are the gifts of God and that getting a child or not is God's Will. Thus, the cause of infertility is perceived as the determination of God. However, some informants such as Wude mentioned God's Will in combination with other factors as causes of their infertility. She explained: "*I don't know the exact reason of my infertility. I believe God is the only one who gives a child but I suspect that my husband has a big ball-like thing in his stomach and he made a surgery recently. May be that was the problem.*" In addition to her belief in God's Will, Wude associates the cause of their infertility with her husband's sickness.

Debre point out: *“Only God gives you children; it is His will. I faced a miscarriage once and may be that was my only child God gave to me and took it away. I do not know the reason and my wrong deed.”* Debre believes both her miscarriage and infertility is caused by a punishment from God although she doesn’t know her fault which angered God.

For other informants, Gods will is the only reason for their infertility. For example, Masresha feels that God doesn’t love her and sometimes she questions the existence of God: *“My fate makes me barren. I feel God does not love me but I don’t know the reason. Sometimes I disagree with God and I question his existence too by saying ‘is that impossible for you [God] to give me one child?’”*

Almaz, however, believes everything is predetermined and that human beings has very limited chance of changing what God determines as she expressed in the following manner:

*I think our destiny is determined before we are born, and it is difficult to change it. God determines who will be what, who will have children, and who will not. I tried holy water many times for the sake of my husband and friends just to make them happy, but I am doubtful that I will have a baby.*

A similar perception to that of the childless women was reflected during focus group discussion. Participants of the focus group discussion emphasised God’s Will as the major cause of infertility. A 45- year man, for example, said: *“God makes some people poor and some people rich. Like this, God blesses some women’s womb and makes some others barren. Doctors can’t solve this problem.”*

Religious leaders in the group interview, however, emphasised the difference between the New and Old Testament about the cause of infertility. As they explained in the Old Testament, infertility was considered as resulting from a person’s sinfulness and God’s curse. They said infertility is no more considered as God’s curse in the New Testament while some childless informants explained that they are cursed by God for their sin or for unknown reasons.

Kes Haile- Mariam, one of the three religious leaders, stated the Old Testament views on the cause of infertility:

*In the Old Testament, infertile people were considered as cursed because they didn’t share the blessing: “Be fruitful and multiply; fill the earth.” Genesis, 1:28. Other*

*people insult them by saying 'dry breast', 'closed womb', 'relative of mule', 'unblessed and cursed'. In the Old Testament, the tribute of the infertile people was not accepted by the religious leaders for holy services.*

This indicates that in the Old Testament infertility was associated with God's curse. As shown earlier this view is also shared among community members and some childless informants.

Merigeta Yohannes then went on to explain the perception of infertility in the New Testament:

*In the periods of the New Testament, the Church treats all people equally regardless of their status. As the church needs people's faith and goodness only, becoming infertile is no more related to curse. The reason for people to become infertile, poor, unhealthy [...] is not because they are sinful or cursed. Whether one becomes fertile or infertile, healthy or unhealthy, rich or poor [...] it is for the revelation of God's wisdom as manifested when Jesus cured the man who was born blind [John. 9:3]. However, some ignorant individuals insult and discriminate infertile people. After all, since insulting people is a sin by itself, those who insult or discriminate infertile people are sinful and they need to seek God's forgiveness.*

This expression tells us childlessness should not be related with curse or sinfulness in the New Testament. However, community members and some childless women considered curse or punishment as a cause of infertility.

Aba Matiws on the other hand emphasised the importance of patiently waiting for God's time to get a solution for the problem of infertility, by providing different biblical verses:

*What people didn't recognize in the Old and New Testaments is that, most prophets and saints were born from women who were barren for a long time. When barren women pledged or vowed to God, they were able to give birth to God-chosen children such as Isaac (Genesis. 18:11; 21:2), Samson (Judges 13:2-5, 24), Samuel the Prophet (1 Samuel 1:9-20), and John the Baptist (Luke 1:7,13,57). In the Ethiopian Church history also, Saint Gebre Menfes Kidus and Saint Teklehaimanot [well-known apostles in Ethiopian Orthodox Church] were born from women who were barren for long.*



As shown from the above explanation, the religious leader stressed the importance of patiently waiting God's response. However, as will be seen in the next section, childless informants try a combination of different solutions since religion and culture are interwoven in the study area.

Apart from God's Will, being possessed by Zar spirit was also mentioned as a spiritual cause of infertility. Messing (1958) conducted a study on *Group therapy and social status in the Zar cult of Ethiopia*. According to the study, a person who is possessed by the zar spirits has symptoms of "proneness to accidents, sterility, convulsive seizures, and extreme apathy (p.1120)." Similarly, an informant and focus group participants of this study mentioned that possession of zar spirits (*yebet tata* or *tiyishet*) is among the causes of infertility. The personal experience of Masresha illustrates this particular cause:

*The reason to my infertility is 'yebet tata' (zar) and it is a very serious problem. It tied me up not to try any religious treatments, not even holy water. However, my friends advised me to take contraceptive pills and I took 90 pills for three months, but it didn't help me.*

If an individual is possessed by zar, he/she is expected to fully serve the spirit and cannot participate in religious fests and use holy waters without its permission. As Masresha stated, the spirit is believed to control people even from giving birth.

### **5.2.2. Sexually Transmitted Diseases (STDs)**

In the literature review we have seen that STDs are found to be both causes and consequences of infertility. On one hand, the transmission and the lack of treatments of STDs is a major cause of infertility in sub-Saharan women. On the other hand, childless people involve in remarriage, divorce and extra marital relationships in search of solution to infertility and this in turn exposed them to STDs (see Ericksen and Brunette, 1996; Favot *et al.*, 1997; Mamo and Morgan, 1986; Mekdes, 2008; Tinsae, 2009). Informants of this study most frequently mentioned syphilis and gonorrhoea as causes of their infertility. Most of the informants didn't undergo tests and treatments of such STDs, rather they know it from the symptoms of the disease. In this respect, Maritu recalled: "*When I was 16, I urinated in front of the sun on the*

*hot ground. By the time I become sick (“mitch”)<sup>10</sup>. Later it changed to syphilis and gonorrhoea and I suspect that is the reason of my infertility.”*

A related idea was reflected by Abebu although the way she thinks she was infected with STDs is different.

*I was married when I was 9. After five years, I left my husband and migrated to the town, and started working as a housemaid. By that time, the owner of the house raped me and I was infected with gonorrhoea and syphilis. I feel this is the cause of my infertility. My mother claims that the cause is witchcraft (‘metet’) that my first husband did to make me infertile when I refused to live with him. However, I didn’t believe this and I suspect the infections to be the cause.*

Birtukan also believed that STDs is the cause of her infertility: *“My first husband infected me with gonorrhoea and I think that made me infertile. My menstruation was as black as your purse [pointing to my black leather bag].”*

From the above two informants account’s, men are blamed for transmitting the disease. This complain of women is not groundless. As we will see later, it is a common practice for husbands of childless women to be engaged in divorce and remarriage to have children, and such practices could expose men to STDs.

### ***5.2.3. Menstrual Problems and Absence of Female Reproductive Organs***

In medical science, absence or irregularity of menstrual cycle is a sign of infertility problem. According to World Anti-Doping Program (2008)<sup>11</sup>, ovulatory dysfunction is a cause of infertility and the absence of menstruation and irregular menstrual cycle are the signs of this problem. As stated in the literature review, infertility is perceived in Kenya as caused by absence of menstrual blood or blood of “wrong” quality and quantity (Kimani and Olenja, 2001). As mentioned above for Bertukan the sign of her infertility is the colour of her menstruation which is too black due to infection. For other informants, absence of their menstruation or irregular menstrual cycle is perceived to be the cause of their infertility.

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<sup>10</sup> Mitch is an illness which people believe is caused by direct exposure of the body to the hot ground. People believe that when one urinates on the hot ground, such a disease will come to their body in a form of vapour.

<sup>11</sup> Retrieved on 17.11.2010 from [http://www.wada-ama.org/Documents/Science\\_Medicine/Medical\\_info\\_to\\_support\\_TUECs/Infertility\\_EN.pdf](http://www.wada-ama.org/Documents/Science_Medicine/Medical_info_to_support_TUECs/Infertility_EN.pdf)

Yemata stated: *“I didn’t take an infertility test, but I know my problem. My menstruation does not come on a regular basis. It comes once in every four months or more, but recently it has completely stopped.”* A related issue was raised by Mengistu whose wife didn’t see menstruation for ten years: *“I underwent infertility test with my wife but we didn’t get to know who is infertile. However I am suspecting that the problem is with my wife because she didn’t see menstruation for ten years.”*

Although many participants of the focus group discussion agreed on the above causes of infertility, some said that infertility is also caused by the *‘absence of female reproductive organ’*. They claim that childless women lack some female reproductive organs. For example, a 60- year woman said: *“In a similar way as God didn’t create a womb for the mule, infertile women have no womb at all. They are cursed like the mule to work tiresomely in this world until they die.”* This woman compared infertile women with the “mule” (born from a male donkey and a female horse) which cannot produce its offspring. In most rural parts of Ethiopia, mules are known as hard working animals used for transportation and farming. This perception of having no reproductive organ is somehow related with the perception in Kenya which is stated by Kimani and Olenja (2001, p.206) as: *“Some women are simply formed like males and therefore, physically unable to conceive.”*

#### **5.2.4. Heredity**

A few informants believed infertility can be transmitted genetically from their families. For example, Amsale points out: *“I think my problem has come from my family because my mother gave birth only to my brother and me.”*

Mengistu also has a similar opinion as has Amsale: *“I think the problem is with my wife because her mother gave birth only to three children and she became infertile afterwards.”* In these two cases, secondary infertility of their mothers is mentioned as the cause of their own primary infertility. (Amsale’s mother gave birth to two and Mengistu’s mother-in-law gave birth to three, but both of them are seen as infertile as women in the rural area are expected to give birth of many children). Although almost all the childless informants said that having one child makes a difference and they will be happy if they had one, we can learn from these cases that having only two or three children is also considered as a problem of infertility.

### 5.2.5. Cultural Beliefs

Being uncircumcised and having a *closed vagina* ‘*chinha*’ were also mentioned as possible causes of infertility. These two factors seem specific for the study community since I have not found them documented in infertility literature.

Some focus group participants believed being uncircumcised might cause infertility. However, others opposed this idea strongly. A 45- year man said: “*Most probably, those who are not circumcised can’t give birth.*” However, a 75-year man argued: “*Circumcision cannot be the reason for infertility. If that is so, girls of today who are not circumcised should not have given birth.*” The first man replied by saying: “*Even though some of them can give birth, they cannot deliver in a natural way. Rather, a doctor needs to cut the stomach of the uncircumcised women because their organ is not as open as the ones who are circumcised.*”

Contrary to the views of some community members of this study, Inhorn (2002, p. 1840) found that Egyptian women appeared to be at a significant risk for tubal-factor infertility due to female circumcision. All the female informants of my study underwent circumcision in their childhood<sup>12</sup>. But none of them believe circumcision could possibly cause infertility because almost all women of their age or above who give birth are circumcised too. Almost all childless women and focus group participants consider circumcision as a good practice. Ethiopian criminal code of 2004 prohibits the practice of female circumcision. Article 565 of this law says “*whoever circumcises a woman of any age is punishable with simple imprisonment for not less than 3 months, or fine not less than 500 Birr.*” Even if female circumcision is a criminal act, some of the informants didn’t conceal to me that they still practice it on their children. Fulfilment of religious obligation and reducing female promiscuity were mentioned by community members as reasons to sustain circumcision. It is commonly said that ‘*those who are not circumcised broke household utensils repeatedly.*’ By this they mean to indicate that women’s sexual desires can be high if they are left uncircumcised, and cause “improper” behaviour.

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<sup>12</sup> According to World Health Organization’s classification of female circumcision, the type of circumcision that is carried out on female children in the study area seems to be excision. WHO (2011) defines excision as “partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are “the lips” that surround the vagina).” Retrieved on 02.05.2011 from <http://www.who.int/mediacentre/factsheets/fs241/en/>

Having a closed vagina (*chinha*) was also perceived as a cause of infertility. (*'Chinha'* literally mean unproductive land that doesn't have good soil). It is claimed that there are women who are born with a closed vagina. According to focus group participants, those who are *chinha* have no opening in their vagina so they cannot have sex at all, and then they cannot give birth. People use this term to refer a woman who divorced repeatedly and have no children. During the informal conversation with people who knows infertile people closely, a woman told me about *chinha* and advised me to talk with her distant relative who faced this problem. I approached the woman to learn her experience. She is in her mid thirties and is now a nun, living by begging at the church. I didn't ask her about *chinha* directly because I know how embarrassing and derogatory the term is, rather I asked her indirectly about the reason why she prefers to become a nun in her young age. She answered: "*I don't want to remember my life before I become a nun. I don't want to tell you anything about it. I sat with you because I thought you want to know about the churches and monasteries I have visited.*" She was very sad when she talked to me, I apologised and left her.

One of the health workers interviewed, Sister Ababa, who is born, has grown up, and worked for long period of time in different villages as a nurse, has an understanding what *chinha* means. She says: "*There is a belief about chinha but in medical science it is a type of hymen<sup>13</sup> that can be corrected in minor surgery.*" She shared her knowledge about *chinha*:

*One day, a young girl came to a clinic where I work in need of a solution for her problem. She is a newly married young woman and said that her husband cannot have sex with her. He tried hard but he cannot. As a result she cannot conceive. As her husband said that she was not circumcised, she asked her mother and knew that she was already circumcised while she was a baby. One year passed without having sex, people told her that the problem might be her being 'chinha' and advised her to try holy water, but that didn't solve it. So I saw her problem it was a type of hymen and told her that it will be corrected by a minor surgery. I advised her to go to the nearest hospital [Debre Tabor] and she didn't come back to me again. Her problem was easy and I think it has to be resolved.*

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<sup>13</sup> Hymen is a thin membrane that surrounds the opening to a young woman's vagina. The treatment for imperforate hymen is a minor surgery to remove the extra hymeneal tissue and create a normal sized vaginal opening. Retrieved on 11.10.2010 from <http://www.youngwomenshealth.org/hymen.html>

In summary we can see that the individual childless women's perceptions about the causes of their infertility include a combination of religious, cultural, and medical reasons. STDs, menstrual problem and possession by zar spirit are experienced by childless individuals as possible causes of their infertility. In Scheper-Hughes and Lock's (1987) terminologies, these personal experiences of childless women represent the individual body. In the study communities there are socio-cultural values, norms and practices, such as being uncircumcised and having a closed vagina, which are perceived as causes of infertility this could be referred to as the social body. God's Will is mentioned as the main cause of infertility by informants, religious leaders, and community members. However while some informants and community members associate God's Will with sinfulness or curse, religious leaders associate it with the revelation of God's wisdom. In both ways, religious views that relate the cause of infertility with God's Will are dominant. Thus, we can say that religion is related to the political body, that is "the regulation, surveillance and control of bodies in reproduction and sexuality..." (Scheper-Hughes and Lock, 1987, p.209). In this case, childless individuals as well as community members believe that fertility is controlled and regulated by divine power. The individual as well as the social values and norms are framed around the existence of such divine power.

### **5.3. Ways of Dealing with the Problem of Infertility**

Childless women informants of this study desperately tried every solution and accepted every advice to have a child, the reasons for which will be discussed in chapter 6 and 7. Here, I shall examine the various treatments tried and solutions opted for. As shown in the literature review, traditional and spiritual/religious treatments of infertility are found to be prominent than medical treatments in most parts of Africa (see Okonofua *et al.*, 1997; Koster-Oyekan, 1999; De Kok, 2008). This seems true in my case too. The following section presents the treatments used by my informants.

#### ***5.3.1. Spiritual Treatments***

We have seen in the previous section and in the introduction chapter that religion is deeply rooted in the study communities. However, religion and traditional values and norms are intertwined, and it is difficult to make a clear separation between culture and religion.

Debre expresses her effort in a variety of religious and traditional treatments:

*I tried everything to conceive. I have tried those holy waters that are known to cure infertility like Aba Mezgeb [saint]. I have also tried the well-known Muslim wise man at Kashet [name of village]. He gave me a medicine to be hung on my neck when I sleep with my husband. But all my efforts were not fruitful. I did not try medical treatment because I had no idea about it at that time and still, I did not believe doctors will create children.*

There are different holy waters named after different saints and angels, which are offered specialized treatments to people with different problems. For example, some places of holy water are known for treating specific diseases including HIV/AIDS, some are known to free people from evil spirits, and some are also known to cure infertility.

Desta also says: *“I have tried the nearby holy water but I didn’t try those holy waters known for curing infertility because of my health problem.”* Desta is handicapped as she lost a hand and a foot due to leprosy. Her leprosy problem, added with her infertility, exacerbated her struggle in life to both get treatments and to accomplish her domestic chores (there are no children to help her in the household).

Bertukan tells us how she prefers religious to medical treatments: *“I have tried known holy waters like Wubua Mariam. But I didn’t try medical treatment because first, I didn’t believe doctors can create a child, and second, I didn’t have money to do that. I can’t visit doctors even for common diseases let alone for infertility treatment.”* Maritu explained it in the following way: *“There is no holy water that I failed to try. I didn’t try medical treatment because there is no treatment in the surroundings.”*

Although these two childless women used only religious treatments, the following two used religious as well as medical treatments. Wude, one of the three who had tried medical treatments: *“In addition to the medical treatment, I have been drinking holy water, washing in it, and carrying the book called the Miracle of Mary in front of hundreds of people in Sunday gatherings. All this didn’t bring any change to my life up till.”*

Abebu, who had been for long lasting infertility treatment and undergone tubal surgery, pointed out:

*In addition to medical treatment, I have tried holy water. My neighbours told me about a holy water at Ba’eta. That holy water is known for solving infertility problems*

*as it enabled a 50-year woman to give birth. When I drank the holy water, something like a small fish came out of my stomach. My friends said it is a sign of being cured. However, I was divorced from my husband at that time. My friends pushed me to try from other men to conceive, but I didn't want to marry again.*

The issue of infertility is not the problem of the childless only. Relatives and friends of the childless couples may also try to help in finding solutions. The experience of Hailu, one of the male informants, is an evidence for this:

*I didn't try anything to have a baby but my ex-wives and my friends do. My wives tried holy water and visited traditional healers. My friends vowed for me by saying we can give this and that for saints if I get a child. For example one of my friends promised one pot of 'tella'<sup>14</sup> for Saint Michel and other friends in the mahiber<sup>15</sup> did the same each year.*

Mengistu's mother-in-law and his friends also contributed a lot to help him:

*My mother-in-law went to traditional healer ('awaki')<sup>16</sup> asking for a solution to her daughter's infertility problem. He asked our mother to bring a brown coloured sheep ('dangile beg'), a hen, and three differently coloured 'tibebe'<sup>17</sup>. She tried all but it was not successful. Besides, the traditional healer wanted my wife to visit him, but I refused to send her to him because I didn't 'trust' him. My wife also tried religious solutions. One Sunday at Kidanemeheret Church, she carried the book of Miracle of Mary in front of people. At the moment, she was sweating as she was afraid to stand in front of such a crowd, and people blessed her and we promised to bring a sheep the next year if we got a baby.*

Mengistu's distrust of the traditional healer has had some ground in that women are highly eager to get children and may be willing to accept any request from the healer. Samuel (2006, p. 74) in his study *Extramarital sexual activity among infertile women in southeast Nigeria* pointed out that in the course of seeking solution to their childlessness, infertile women were often in sexual partnerships with spiritualists, traditional healers and medical personnel.

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<sup>14</sup> Tella is a home-made beer.

<sup>15</sup> Mahiber is a local religious association of people. Members of this association are gathered once in a month to eat and drink. Each member has to prepare the food and drink turn by turn. Each association will be named after in the name of God, a saint or an Angel.

<sup>16</sup> Awaki means a person possessed by spirits of zar and assumed having power to solve different problems.

<sup>17</sup> Tibebe is cotton made traditional cloth.



From the above scenarios of the two childless male informants (Hailu and Mengistu), we can see their reluctance in seeking solutions for their problem. This might partially come from the widespread belief of infertility as being women's problem. Kimani and Olenja (2001) found out that while men tend to relegate the problem of infertility to women, women accept the blame almost unquestioningly (p.203). Besides, in many societies, infertility may put ones' male identity at risk, which leads them to claim that the problem of infertility is with their wives. For example, childless Egyptian men were found to be unwilling to seek medical treatment for their problem since infertility is often associated with sexual impotency which threatens men's gender identity and masculinity (Inhorn, 2002).

Focus group participants also mentioned holy water, vowing, and carrying the books of miracles of angels and saints (mostly the book of Miracles of Mary) as potential solutions to infertility. Although none of my informants had their problem solved through the above mentioned treatments, most of them heard about the success stories of others. Community members mentioned that they know infertile couples who gave birth through such solutions.

For example, a 45- year woman point out:

*We know infertile people who gave birth by vowing<sup>18</sup> to give different things like sheep, goat and 'mosobework'<sup>19</sup> to the Church. One of our neighbours vowed a goat to Angel Gebereal and then got a boy after a year. As they need an additional one, they vowed again and they got the second child.*

Such success stories were also told at the group interview with religious leaders. Aba Matiws, one of the religious leaders, shared his experience as follows:

*I was in 'Kirstos Semera'<sup>20</sup> monastery for ten years. Many women came there and vowed to Kirstos Semera by carrying her miracle book to have children. In the next year, most of them came back with a child to give the gift they promised. A few of them might not get children due to their lack of patience.*

Aba Matiws also remarked the importance of being patient by telling a particular story:

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<sup>18</sup> People present their gifts to the church during fests and the sheep and goats slaughtered to be eaten communally.

<sup>19</sup> Mosobework is a handicraft made by women which serves as a holy treasure in the church.

<sup>20</sup> A monastery named after a female saint in South Gondar at the costal of Lake Tana.

*One of my spiritual children has been married to his wife while she was a small girl. The husband educated her and she became a teacher. After a long time of marital life, they didn't get a child. Then they underwent medical tests and the doctors told them that the husband is infertile but the wife can give birth. After this, the wife requested her husband to break their marriage by saying 'I want a divorce I don't want to remain fruitless.' But the husband refused the divorce by saying 'I raised you and educated you starting from your childhood. I prefer to kill you first and then to kill myself rather than divorcing.' The wife asked me to persuade her husband for the divorce, but I advised them to stay together and pray for God. After a year, I saw a dream about them [...] that they will have a child and I told them and they become so happy, and they got a daughter now their daughter is an eleventh grade student.*

Another religious leader, Kes Haile-Mariam added:

*There is nothing impossible to God. If people patiently demand from God only, it is easy to get everything, including children. We can see in the Bible that Sarah and other infertile women gave birth during their old age [post menopause]. Many of the popular figures in the Bible such as Isaac, Jacob, Samson, St. Mary, and John the Baptist were born from couples who faced infertility problems at first and who received God's blessings for their faith in Him. The problem is that most people have no patience and do not stick to God only. They try sorcery, commit adultery, break their marriage, or lose hope in God. As religious persons, we advise people to be strong, to stay with their husband or wife, and pray to God as He has his own time.*

Religious explanations of the causes of infertility are common and infertility is perceived as the test of one's patient. Religious treatments of infertility are dominant and religious leaders have the power to say that infertility is only cured by God. We see that the advices of religious leaders and childless informants' strong reliance on God play an important role in keeping them hopeful. However, individual childless informants did not limit themselves to religious treatments only; they went far beyond the advice of the religious leaders.

### **5.3.2. Engaging in Extra marital Relations**

As described in the literature review, Tinsae (2009) found that infertile women who are in infertility treatment at Gondar hospital (Ethiopia) were at the risk of being infected with STDs and HIV/AIDS due to extra marital relationships by their husbands as well as by

themselves. However, in the case of my informants, no women mentioned extramarital relationship as a solution. However, one of the male childless informants, Mengistu, admitted that he had an extra marital relation:

*My friends advised me to try with other women and I have tried once without consulting my wife but I was not successful. After that, I restricted myself fearing of the new disease [HIV/AIDS]. They also advised me to divorce my wife and marry another, but I am not willing because now I am not even sure whether the infertility problem is with me or my wife.*

The existence of extra marital relation was mentioned by several people during focus group discussion. For example, a 75- year man explained: *“When we were young, having multiple sexual partners<sup>21</sup> was normal. Even being infected by STDs, gonorrhoea and syphilis, was considered as bravery. [... ] Those were the good days! But now, the principle is one-to-one due to this killer disease [HIV/AIDS].”*

In the past, engagement in extra marital relations was common not only for childless men but also for those who have wife and children. It was common for men to have children out of wedlock. A study by Deribew (2009, p. 5) revealed that the high rate of HIV/AIDS infection in Amhara region is triggered by wide spread concurrent sex. For example, the study found out that there were two common types of extra marital relations in Debre Tabor. The one was between married men and married, single or widowed women (*wushima*), and the other was between economically better-off who establish long term hidden affairs with economically disadvantaged young women (*kimit*).

### **5.3.3. Taking Contraceptive Pills**

Contraceptive pills are commonly known to prevent pregnancy. Contrary to this, some childless women took it to get pregnant as they are advised to do so by friends and family members. Some people think the pills make menstruation regular and the womb fertile.

In this respect, as mentioned earlier, Masresha took 90 pills for 3 months. But also other women tried such pills to conceive as Maritu recalled: *“My friends advised me to take the brown colour contraceptive pills. According to them, it makes the uterus thick and good for*

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<sup>21</sup> He explained later that their mistresses were usually those who are divorced or widowed.

*fertility. I took it for six months but it didn't work.” Abebu also mentioned: “My friends advised me to take contraceptive pills to get pregnant and I used to take it for some time although it didn't help me.” Mengistu had similar experience as Maritu and Abebu: “My wife took contraceptive pills to conceive as advised by her friends.”*

The experiences of these informants show us two things. First, the limited level of medical knowledge of people has led some to recommend/take contraceptive pills as a solution to infertility. As described earlier, most people in the study area are rural and have limited access to medical services and knowledge. Second, the active social support seeking behaviour of childless women of this study led them to accept every advice to get a child.

#### **5.3.4. Medical Treatment**

As mentioned previously, only three of my informants tried medical treatment. This can be explained by the inaccessibility of adequate health facilities in the vicinity, and the associated low level awareness of individuals about medical solution to the problem. Even for those who tried medical treatment, the time-consuming nature of the treatment and its unaffordable price became impediments to complete the treatment. Although childless men and women have limited awareness about the possibility of medical solutions to their problem, they are very eager to try anything possible to get a child. After I told one of my informants about test tube babies, she said to me: *“If you help me to get a child, I will pay you by selling whatever I have.”*

Dr. Fekade, the medical doctor interviewed, who is working in his private clinic in Debre Tabor and who wrote a small guide book about infertility and contraceptive in Amharic, talks about the low awareness level of people about medical solutions of infertility and the problem of infertility treatment:

*Some of the infertility problems can be treated even at health stations. Some can be complicated and some can be easily treated. However, the majority of the society in this region does not believe in medical solutions to infertility. I remember couples who cannot have a child for years due to simple problem which can be easily treated. After following medical advice and treatment for some time, they got a child and the husband thanked me later.*

On the other hand, he recognizes the problem of infertility treatment by saying: “*Most of the infertility treatments are very costly and time consuming. And the success rate of infertility treatment is very low even in advanced referral hospitals.*”

Childless informants of this study actively seek informational and concrete support from the church as well as from lay people to solve their problem. Thus they tried holy water, visited spiritual healers, engaged in extra marital relations, and took contraceptive pills. In Scheper-Hughes and Lock’s (1987) terms, the individual childless informants treatment experience represent the individual body: “...the various treats to health, well-being, and social integration that humans are believed to experience” (ibid, p.214). However, the childless women’s treatment choice is influenced by the existing dominant socio-cultural values and norms - the social body and political body. Although culture and religion are interwoven, religious treatments are the most used, and religious beliefs seem to be the dominant frame within which the women struggle to deal with their problem.

### ***5.3.5. Fosterage: Orphans Preferred***

As we have observed in the proceeding discussion, most of the childless women are inclined to attempt all kinds of remedies (except medical examination) as advised by friends, families, and other persons to have a child. Adoption is a widely practiced strategy for involuntary childless around the world (Jenkins, 2002). However, as shown in the literature review, studies found out that in many parts of Africa adoption is not considered as an acceptable substitution to real motherhood. Adoption or fosterage is rather seen as a partial solution to childlessness. Birth parents reclaim of their child, foster children’s disobedience for their adoptive mothers, and accusation of mistreatment and exploitation of foster children make it difficult for ‘real’ kinship relation to emerge and for fosterage to be a complete solution (Inhorn, 2003 and Gerrits, 2002). As a result foster children are usually seen as valuable sources of labour but they are less worthy in terms of social status, emotional satisfaction and old age security (Holloos *et al.*, 2009).

Although many of the childless informants of this study have strong desire to adopt orphans, formal/legal adoption is not practiced in the study community due to the extended nature of family. It is very common among childless people to foster or to take care of children of relatives and step-children. However, they do not have the legal right to claim the child as theirs and thus, fostering or care taking is often not permanent. Most of the time, childless

people foster children of their relatives from the surrounding villages. As the biological parents live near the foster family, the relationship between foster children and their biological parents still grows well. Out of my 19 informants, 15 of them have one or more foster child/children. Let's see the fosterage experience of the childless informants and the problems they encountered.

Debre, a 60- year woman, currently married to an elderly widower recalled: *"I raised my step-children and children of my step-children. I even breast feed some of them. Besides, I had many children who have grown up with me. However, when they grow, they start looking for their real parents."* Even if Debre raised small children by breast feeding, normally the responsibility of the biological mothers, she is not happy because the children prefer their biological parents as they grown up. Debre further explained the value of foster children by comparing with own children: *"For me, bringing up others' children is important only to support me in household activities and farming practices; not more than that. Your own children never let you alone when you become sick, poor, or old."* From this, we can see that the value of foster children is mainly attached to economic support and considered to be of lesser value than having own children.

Wude also complains about the problem of fosterage by saying: *"I tried to raise children of my relatives during their childhood, but they prefer their own parents after they grow up. Now I only have my little brother with me. He is grade 10 now and will join university after two years. I will be alone again then after."* Wude further explained the importance of adopting orphans in this way:

*Raising children has many benefits. You will not feel loneliness if you have a child around you. Children help their parents by fetching water, collecting firewood, keeping and feeding animals, and even replacing their father in farming when he becomes old. I prefer to adopt orphans in their early childhood, because they will not ask you for their biological parents when they grow up and they may see you as their own parents.*

For Wude, in addition to economic contribution of children to the household, they are important for inheritance of family's property and have emotional value. The only problem of fostering children, she feels, is undependability. That is why she prefers to adopt orphans.

Desta, a 60-year woman also sees the problem of fosterage in a similar way to the former informants:

*I brought up my step children and my husband's relatives even until their marriage. However, most of them do not visit us after marriage. One of them is now living idle in the town after not passing the Grade 10 national exam. She is doing nothing and I asked her to come here to live with us, but she refused because she hates to live in the rural area where we are.*

She emphasised the contribution of children in helping the parents by saying: “Everyone knows the benefit of children. To start from their simplest role, our animals are at home still now<sup>22</sup> because we don't have a child who can take care of them.” She also prefers orphans to avoid the loss of control over children. She says:

*If it was in the past, I prefer to adopt orphans in their early childhood because they have no one to go to and will be like your own children. Besides, it is easy to shape their behaviour as you want. But now I prefer the grown up ones since I don't have the ability to take care of small children.*

Maritu explained the problems of fosterage by saying:

*I have raised my brother's son and I educated him until grade 7. But it is difficult to bring up the children of others because you cannot make them disciplined as you cannot exercise full power to control them like real parents. If you try to discipline them, they will consider you as rude. And they will not live with your standard. They find any reason to leave you, they complain about being beaten and insulted and also they may complain as if you made them hungry and thirsty [...] it is completely a sin to raise other's children.*

During the focus group discussion, some participants said that childless women are cruel because they have not experienced labour pains. They refer to the following Amharic proverbs to emphasize the unkindness of childless people:

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<sup>22</sup> It is children's responsibility to keep animals in the grazing field starting from early in the morning till sunset. At the time of the interview (11:00 am), her cattle were at home.

“*The childless are baby slaughters*<sup>23</sup>” which means those who didn’t give birth are cruel; it is easy for them to mistreat children of others. This applies also to fertile women who are assumed to be cruel to the children of others.

“*The childless are advocates of punishing; the unmarried are advocates of divorce.*”<sup>24</sup> It is to say those who are childless encourage you to punish your baby because they don’t feel/know your baby’s pain; and the unmarried people encourage you to divorce because they do not know the benefits of marriage.

On this backdrop, we can understand why Maritu fears raising other’s children, as her trying to discipline them can be seen as cruelty by others. To avoid such problems, she also prefers orphans for adoption:

*I want to adopt an orphan because there is no one he or she knows to go and they see you as their real parent. Last week, my friend told me that one newly born baby was found thrown around the Muslim cemetery. I wish to be there. When I heard the news about a baby found in the bush or any other places, I wonder why don’t these people put the children in front of my door rather than throwing them away.*

Bertukan, an elderly divorced woman, also noticed the problem of fosterage as this:

*I brought up my step-children as mine. Last year, one of my step-daughters was infected by the new disease [HIV/AIDS] and no one was willing to touch her but me. I even wash her blood, unfortunately she died. But now, after we divorce, the other step-daughters are with their father<sup>25</sup> and they do not even greet me. Blood relation is the most important thing. Otherwise, they will forget you immediately, no matter how good you did for them.*

At the time of this interview a neighbour of Bertukan was there and she confirms the good things Bertukan did for her step-daughter when she was sick. The neighbour said: “*There was no one to enter the house because we all were afraid of the disease, but this woman took every care necessary for her sick step-daughter.*”

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<sup>23</sup> ያልወለደ አረደ።

<sup>24</sup> ያልወለደ ቀጭኑ ነው፣ ያላገባ ፈቻ ነው።

<sup>25</sup> The partners divided their house during divorce and they live side by side.



Abebu, an educated and employed woman who lives in town, was the only one who expressed positive views of and happy experiences with fosterage. She prefers to take care of children of her relatives rather than orphans for specific reason. *“I raised sons and daughters of my sisters. I brought them from rural areas. Most of them have graduated from university. I am very happy about them and I never saw them as the children of others. I didn’t adopt orphans because my relatives also need education.”* For Abebu, she is not the only person to benefit from fosterage. It is of great benefit to the children themselves because they get a better life and better education than they can get from their rural families.

As stated in the literature review, generational continuity is one of the major values of children (see Dyer, 2007 and Tinsae, 2009). Similarly, for the two childless men informants of this study, Hailu and Mengistu, the main reason why they wanted to have children is to have someone to carry on their family name. This cannot be achieved unless they get their own children. Hailu said: *“I have my step-son but I didn’t see him as my own because he is called in his father’s name, not in mine. So I need at least one child to carry on my name and to continue my generational line.”*

Mengistu fully agrees with Hailu’s argument:

*I have raised my relatives’ children but I didn’t consider them as my own children because they call their birth fathers as ‘father’ and not me even if they grew up with me. So I am always praying to God to get my own child so that I will be a real father and I will be called the father of such and such.*

There is a proverb that highlights the termination of childless individuals’ generational line after their death: *“An infertile and a house made of mud are the same<sup>26</sup>.”* This is to say as a house made of mud loses its base after some time; a childless will be forgotten immediately after death. Whereas a house made of concrete will stay for long time in the same way that the name of those who have children will be remembered after their death through their children.

As can be seen from the above cases, although most of the informants have foster child/children to cope with their childlessness, they do not feel happy about it. They wish to adopt orphans rather than to foster for two reasons: their inability to discipline the foster child as own (since it is considered as cruelty) and the foster children’s preference for their

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<sup>26</sup> መካንና የጭቃ ቤት አንድ ነው።

biological parents after growing up. However, for the two childless men informants of this study generational continuity is what is at the core, and nothing can replace this value. In Scheper-Hughes and Lock's terms (1987), these fosterage experiences of childless individuals can be referred to as the individual body. The different culturally constructed proverbs that are meant to refer to childless women as cruel could represent the social body. In the study communities it seems that real kinship emerges through blood relationship. It is possible to clearly see how the social body influences the individual body. The cultural values and norms related to the value of own children and foster children influences the individual childless women to feel unhappy about fosterage and to exert the maximum possible efforts to get own children.

#### **5.4. Discussion and Conclusion**

As we have seen in the forgoing discussion, there are different perceptions of the causes and treatments of infertility in the study area that can be explained based on Scheper-Hughes and Lock's (1987) three bodies approach.. Before examining the perceptions of infertility, it was appropriate to know how childless women come to know their infertility. Childless informants used different experience-based realization of their infertility. Taking a certain age limit and comparing themselves with their friends or partners who have a child could be a reference to identify ones infertility. The experience based realization of one's infertility could be referred to as the individual body. But even at this level, we can see the influence of social institutions and norms - the social body. The practice of early marriage has influenced childless women's thinking in that they considered themselves infertile if they pass age 15 without giving birth. Besides, the prevailing perception in the communities that considers the problem of infertility as women's problem has influenced women to accept their infertility without question.

Also regarding the perceptions of the causes of infertility, we can see the same dialectics between dominant socio-cultural values and individual women's experience. Childless women of this study mentioned a combination of religious, cultural, and medical reasons of their infertility. STDs, menstrual problems, and possession by zar spirit are experienced by some childless individuals as possible causes of their infertility. In addition to these individual experiences (the individual body), the perceptions of being uncircumcised and

having a closed vagina as causes of infertility are strongly related to the socio-cultural values, norms and practices of the communities.

As Deneulin and Rakodi (2011, p. 52) argue, religion is “one of the primary sources of values and morality for the majority of the world’s population”. Similarly, religion has a strong effect on people’s day to day life in the study communities as its influences are reflected throughout this chapter. Although childless women of this study tried different kinds of treatments or solutions, religious treatments were prominent. Religious treatments are strongly intertwined with cultural practices (the social body). In most cases, infertility treatments are evaluated as acceptable or not based on religious beliefs. Thus, we can say that religion influences and regulates individual treatment preferences as well as cultural values and norms - the political body which is “the regulation, surveillance and control of bodies (individual and collective) in reproduction and,...in sickness...” (Scheper-Hughes and Lock, 1987, p.209).

Folkman and colleagues’ (1986) coping theory also can be applied for this chapter. Generally, the coping strategies of childless women could be categorised as *seeking social support* (related to informational and concrete supports) and *planful problem-solving* (related to identifying different solutions and increasing the efforts to give birth). However childless men tend to use *distancing* strategy by relegating the problem to their wives and by being reluctant in seeking solutions.

In conclusion, childless informants actively search solutions and followed the advices of lay people and religious leaders. As infertility is a serious problem, childless people try all possible solutions unquestioningly. Despite all their efforts, none of my informants managed to get their own children. Consequently, they are exposed to different discriminations resulting from the perceptions of communities on childlessness. We will see the personal experiences of childless individuals in this regard in the next chapter.

## CHAPTER 6

### EXPERIENCES OF CHILDLESSNESS: STIGMA AND DISCRIMINATION

In chapter 5, I presented the perceptions of childless people, community members, religious leaders, and health workers about infertility, its causes, and solutions. This chapter mainly focuses on the experience of childless informants with a particular emphasis on stigma and discrimination.

Childless informants face stigma from other people and sometimes they stigmatize themselves. There is also a power relation between those who have children and who are childless. Thus, some of those who have children tend to think that they are more fortunate, powerful, and full person than the childless. As indicated in the theory chapter, the impacts of stigma are found to be multi dimensional and includes damaging self-esteem, loss of social status, creates grief, anger, social withdrawal and hopelessness (Deacon, 2006; Gray, 2002; Sartorius, 2006). However the stigmatized are not always passive victims of stigma but they actively resist it (Link and Phelan, 2001). Let's see which kind of stigmatizations that are most commonly experienced by the childless women's in the study community.

#### 6.1. Everyday Experience: Stigmatization

Many studies on infertility documented extensive stigmatization in relation to social, economic, and psychological aspects of childless women's life. Stigmatizations observed in other parts of the world include disrespect and social exclusion (Hollo and Larsen, 2008), name calling (Deribe *et al.*, 2007; Kimani and Olenja, 2001), mocking and evil eye accusation (Inhorn, 1996), denial of means of livelihood especially access to land (Feldman-Savelsberg, 2002), and in some instances physical violence (Riessman, 2000).

When I asked my informants if they ever faced mistreatment or any problem because of their childlessness, almost all of them said "Yes" with the exception of one informant, Asmarech, a 23- year woman who said: "*I haven't been mistreated due to my inability to conceive. My in-laws needed children badly but I could not make it.*" For others, it was very difficult even to tell what they faced. They simply do not want to remember and repeat it. Desta's (an elderly woman) expression is that much more representative than that of Asmarech: "*Can you*

*believe me if I tell you I was not insulted or had no problem? I don't want to mention it; I give it only to God."*

Childless women of this study faced stigma from their husbands, neighbours, husband's relatives and even quite a few of them from their own relatives because of their deviation from the "normal" standard of the society. There are also institutional practices that stigmatized the childless. The childless women are not only stigmatized by society however; they internalize the received stigma and felt worthless. The following sections discuss the different kinds of stigma that childless individual women and men experienced.

### **6.1.1. "Bad Words Remain in Your Brain Forever"**

As we have seen in the theory chapter, Scambler (1984) defined enacted stigma as the "intentional discriminatory attitudes and behaviours of 'normal' people towards the stigmatized" (ibid,p.215). The most common form of stigmatization faced by almost all informants is verbal abuses or insults. Childless women are insulted and intimidated by their husbands, neighbours, and even by their natal families. The common words used to insult childless women include 'barren', 'mule', 'waste', and 'useless'. This intentional discrimination of childless women is, therefore, enacted stigma.

In the following informants' accounts, we can see the derogatory words some people used to insult childless women and the pain inflicted on the women by these insults.

Debre, an elderly woman, who now lives with her fifth husband lamented when she recall how her ex-husbands stigmatized her:

*My two ex-husbands insulted me by saying 'you mule; you become fat by eating alone'. Even if I spent the whole day doing household activities and working in the farm, they didn't recognize my work. Rather, they thought I spent the day eating. As you see me, I am somehow plump by nature but I didn't eat more than others.*

Even if Debre accomplished her household duties properly, her inability to bear a child hindered her to get recognition from her ex-husbands. Besides, her physical appearance (being plump) was viewed as resulting from eating alone; that is not sharing food with children. Even if there are different family members in the house with whom she shares food, she was blamed for having no children to share with. As we will see, the blame for eating

alone is not special for Debre who have a plump body posture, but also for others regardless of their body size.

Bertukan, an elderly divorced woman, has somehow similar experiences as that of Debre. She recalled:

*One day, my husband insulted me by saying 'I am feeding a mule'. At that time, I became so mad and left my home even without sharing my property. I cannot tolerate insults by nature; I prefer he beat me. You know, you may forget the beat when the scar is cured. But it is not easy to forget bad words as they remain in your brain forever. After that no one insulted me, I don't know people may insult me behind my back.*

When Bertukan's husband insulted her by calling her 'mule', she got very angry and left the home without making formal (customary) divorce to get her share of the property and she never came back again. From her expression, one can understand how powerful the insults are to inflict pain and to bring devastating effects; she preferred being beaten to being insulted.

Both Bertukan and Debre experienced the insult of being 'mule' from their husbands. According to both childless informants and focus group participants, mule is the only animal known for not reproducing herself or giving birth. Thus, when a person calls a childless woman as 'mule', he/she wants to show that the childless woman lacks something to be considered as a proper woman or even as a human being.

The blame that one eats without yielding fruits is explained in different ways. Wude and Maritu have bitter experiences in this regard. Although Wude has been living with her first husband for 22 years, her brothers-in-law made life hard for her. She recalled her experience:

*My brothers-in-law are my neighbours and they are the only problem for me. They insult me day and night by saying 'your stomach only carries your faeces'<sup>27</sup>. They made me hate myself. I usually cry; that is why my face looks like this [showing black spots on her face]. Thanks to God we have enough wealth to live, but bad words hurt*

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<sup>27</sup> ሆድኝ ያለ ፈርስኝ ምን ይሸከማል

*me a lot and make me underweight. They also always push my husband to divorce me and marry a child-bearing woman.*<sup>28</sup>

Maritu has quite similar experiences to Wude. She remembers the insults from neighbours and her husband: *“In the past, some neighbours including my husband used to insult me. Most of the time, they used to say: ‘There is nothing important from your eating; you only throw it in the toilet’. Nowadays, people got used to my infertility.”*

Although the word *“faeces”* is a taboo word in the community, Wude’s brothers-in-law used it to devalue her and to say she is totally useless. Maritu’s neighbours and husband also made similar allusion although in an indirect way. Besides the emotional pain, being stigmatized in this way may be seen to affect one’s health, like Wude who thinks that her bodily problems (black spots on her face and becoming underweight) comes from the grief and sorrow she feels. This internalization of stigma is what Scambler (1984) calls felt stigma.

As mentioned in the literature review, childless women in some African communities are accused of being a witch or having an evil eye due to their uncontrollable envy of other’s children (Inhorn, 1996; Pearce, 1999; Orji *et al.*, 2002). One of the informants of this study, Worke, had similarly experienced an evil eye accusation by her neighbours:

*Some people believed that I have an evil eye. No one told me this directly but I know it by their actions. For example, when I reach in my neighbours’ home while they breastfeed, they automatically stop feeding or they hid the child with their “netela”<sup>29</sup>. I remember one day, my neighbour’s baby was sick. The parents thought I gave the baby an evil eye. After some days, I found my dress torn<sup>30</sup> by somebody. When I saw that my dress was torn I understood I was suspected [to be responsible] for the baby’s illness. They know my family; I do not belong to the evil eyes [people].*

As Hodes (1997, p. 32) noted, “Ethiopians believe that some people carry the evil eye (*buda*) who have the ability to look at substance [people] and poison it.” In the *Amhara* region, the “evil eye people” (*buda*) are completely segregated from the community and work in handicrafts as potters, blacksmiths, and weavers (Reminick, 1974, p. 280).

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<sup>28</sup> During the interview, Wude’s brothers in-law were together harvesting their products around their village. The five of the brothers (including her husband) live near each other and there is no other house around.

<sup>29</sup> *Netela* is a locally made cotton-scarf.

<sup>30</sup> If someone is suspected of casting an evil eye and made someone ill, burning piece of cloth of the suspect is assumed to be a solution; people think that the smoke of the cloth cures the sick.

Worke personally believe in the existence of people who have an evil eye and with power to cause illness to people. However, she claims that she does not belong to such a group of people and her neighbour's accusation of her as casting an evil eye and causing their baby's illness is groundless.

### **6.1.2. "For Whom are You Working"**

In addition to various kinds of verbal abuses and insults, childless informants are also discouraged to work hard and to own real property due to the absence of children to inherit their wealth after their death. The idea is that people are doing everything for the sake of their children. Debre's experience is evidence of this: *"When I quarrel with my neighbour over our land border, she said to me 'why do you worry about land? You do not have a child to inherit it; for whom are you keeping it?' At that time, I felt hopeless and burst in tears."*

Fanta, aged 28, also complained about her brothers' interest to take over her land:

*I faced problems especially from my brothers. They always talk about their privileges. They do not care about me. They want to inherit my land when I am alive; they are too selfish. They frequently say 'for which child of yours are you keeping your land? It is proper to give it to us'.*

As we can see in the above two informants' accounts, land holding is considered as proper only for those who have children. When people say *"for whom are you keeping the land"*, it is to emphasise the absence of legitimate transfer of property from parents to own children.

In addition to the discouragement for possession of land and other property, childless women are also discouraged to work hard to improve their personal life. Berke, aged 31, remarked her experience like this:

*I usually try to make myself busy. I planted cabbage, carrot, and potato in my garden and I keep digging and watering them. By doing this, I reduce stress and loneliness and at the same time, I get a sustainable income by selling them. However some friends and family members discourage me from doing so. They usually say 'for whom are you working like this? If I were you, I wouldn't make myself so tired'.*

In the study community, as in most rural parts of Ethiopia, women are involved in farming activities (mostly helping the men) in addition to having the sole responsibility for all the



household tasks. Childless women are not exceptional in this regard; they work hard in their house as well as in the farm. But some people want to comment on every move of childless women. During informal conversation, a mother of a childless woman stressed the irrelevance for childless woman to work hard by saying:

*My daughter doesn't have a child but she is working hard; even harder than those who have very many children. I and my relatives always advise her to relax and visit churches and monasteries instead of working hard and accumulating wealth because no one is there to inherit her property. But she refused and now she is building a big hotel in Bahir Dar [the capital city of Amhara Region].*

Childless women are discouraged to work hard and accumulate real property in the absence of legitimate successors. In contrast and as I will show in the next section, childless women are under a strong pressure to work harder than other women in communal work as people believe that childless women haven't lost energy in pregnancy or giving birth. This may seem to be a contradiction to the preceding argument, but is an illustration of the fact that in people's belief, childless people are totally different from the "normal" people in every aspect of life.

### **6.1.3. "Tireless Women and Aggressive Men"**

In the study community, childless women and men are perceived as physically different from other women and men. While childless men are perceived as aggressive, childless women are considered as having more energy for work. Therefore, childless women are encouraged to take on communal duties that require a lot of energy as they are considered to have extra energy compared to those women who have children. Almaz lamented her experience of being seen as physically stronger than women who have children:

*If there is a religious or other festival, women around the neighbourhood gather together to prepare food and drink. At that time, if I said I am tired, other women replies 'You didn't lose energy by getting pregnant and by giving birth; what makes you tired?' Also if I have a fever and told them so, they start mocking me by saying 'It may be the hair of your foetus.' At this time, I feel so disappointed and I challenge God by saying 'it was better not to create me'.*

In addition to the labour abuse she faced from her neighbours, the teasing and the dirty jokes hurt Almaz to the extent of hating herself and questioning the importance of her existence in this world. Surprisingly, Almaz's neighbours didn't show her any sympathy even when she feels sick.

Yemata, now living in the town, has the same experience as Almaz. She remembered what happened when she was in the village with her second husband:

*When I was in the rural village, insults like 'barren' and 'mule' were common. But what surprises me most was that some people think infertile women are physically stronger than other women. During my second marriage, three of my brothers-in-law lived near to us and we used to celebrate holydays together. At the time, we women (wives of my brothers-in-law), were responsible for preparing food for the feast. By then, if a job requires extra effort, the women say 'Yemata will do it'. If I say I am tired, they say 'why you are tired? You didn't lose energy in pregnancy, labour, and breastfeeding'.*

Mengistu, one of the male informants, also observed his wife being mistreated by his sisters:

*While I go to the market with my wife, I usually carry things that we have to sell. At that time, my sisters say 'Give it to your wife; she has to carry it, there is nothing coming out of her.' I feel so sorry for her. Even if she did her best at home, no one think about her being tired. They consider her as stronger than other women in the house.*

Studies from different parts of Africa stressed out that femininity or full womanhood is achieved through child bearing. For example community members in Kenya used different derogatory terms to refer to childless women as "hard" and masculine (Kimani and Olenja, 2001, p. 208). Similarly, childless women in Egypt were viewed as not quite female but rather as pseudo-males or masculine (Inhorn, 1996, p.59). This seems a bit different from my case because childless women are considered to have more energy than other women. This is related to the perception that childless women do not waste energy in pregnancy, giving birth, and breastfeeding, but not to an idea about maleness. Due to this perception childless women are seen as tireless and exposed to labour abuse.

In the study communities, infertility is believed to be mostly as women's problem. That is why childless women carry the lion-share of the blame compared to childless men. However, we can not underestimate the stigmatization of childless men. The two childless male informants of this study are also stigmatized and accused by their neighbours of "eating alone" which means that they live without sharing the food to children. They are also insulted as "barren" (like the women informants). The male informants are also associated with aggressiveness (which is not the case in female informants).

Hailu, one of the childless male informants said: *"If I disagree with neighbours, they insult me by saying 'you barren; you become aggressive by eating alone.' I usually try to avoid conflicts in fear of such painful words. However, even if others initiate a conflict, I am the one to be labelled as aggressive."*

The other male informant, Mengistu, has exactly similar experience to that of Hailu:

*When there is disagreement between me and my neighbours, they use painful words to silence me by saying 'you do not have any relative except your stomach.'<sup>31</sup> And others say 'you become aggressive because you are eating alone'. I remember one day one of my neighbours used my pasture for his animals. As a result, we quarrelled but he blamed me for being aggressive.*

In relation to the cases of these two male informants, their state of childlessness is used by their neighbours to silence them during disagreements and conflicts. Even if almost all of the childless informants have extended family and foster children at home, they are accused of 'eating alone', something which refers to the lack of their own children. As we saw in the previous section, a childless woman is also accused of 'eating alone'. However, the result of eating alone is perceived differently for women and men. A woman's eating alone is associated with her physical appearances (being plump or fat) whereas for men it is associated with their behaviour (becoming aggressive).

In addition to being aggressive, childless men are also perceived as losers. There is one commonly known anecdote that underscores this point. Childless men as well as focus group participants recounted the anecdote for me:

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<sup>31</sup> ያለ ሆኗህ ምን ዘመድ አለህ

*A father of a child wagered with the childless man by saying: 'If we throw our clubs (sticks) outside the house, then my stick will come back home and yours will not. Then they put their sticks outside the house. After a while, a child saw two sticks outside, recognized his father's stick, and brought it home. This way, the father with a child won the childless one.*

The anecdote is told to show the superiority of fathers over childless men. Fathers are perceived as advantageous and more powerful because they have children who are concerned about them and who provide help at any time in contrast to vulnerable or helpless childless men. Hailu, one of the childless male informants, didn't forget the expression of one of his neighbours on what a loser Hailu is: *"Even a stone becomes two, three, or more when it is crushed, but you have nothing."* This expression shows us that even if a childless man has the same or better standard of living in the community, he is considered as having nothing since he is unable to continue his generation.

From the above informants' accounts, we have seen that childless individuals are discriminated in several ways. Due to intentional stigmatisation from others, childless women experienced feelings of grief, sorrow and unworthiness. While this is related to the individual body in the three bodies' approach of Scheper-Hughes and Lock (1987), the social body is reflected in the symbolization of childless women and men. The childless men are symbolized as aggressive while childless women are perceived as having an untiring body. The physical strength of childless women is assumed to arise from saving energy related to childbearing. Thus, childless women are expected to do more laborious jobs and not to get tired. Besides, the strong symbolisms that associate childless women with animal ('mule') and "fruitless" make the women to experience heartbreaking emotional feelings (individual body).

#### **6.1.4. Discrimination after Death**

As stated in the literature review, a study in Southern Nigeria found that the body of a deceased childless woman was often thrown into the bush or the forest to be eaten by animals because of fear of reincarnation (Pearce, 1999, p. 73). Another study from the same country found that even if earlier practice of throwing away infertile women in the forest no longer exists, their funeral becomes small-scale and quiet due to the absence of children to cover the burial expenses (Holloos *et al.*, 2009, p. 2065). As I mentioned in the introduction chapter,

funeral is a big ceremony in Ethiopia. In my study area, childless people are buried in the same funeral places (usually church compounds) as other people. However, the funeral ceremonies of infertile people are normally very quiet. Besides, according to some informants and focus group participants, the body of the deceased is buried in a different position.

A woman in the focus group discussion emphasised it:

*Usually, the funeral of infertile people is very quiet. Children and grand children made the funeral of their parents warm. Besides, daughters are supposed to carry the ornaments of their mother, especially her cross during the funeral. There is no such ceremony for a childless woman because there is no child to carry her ornaments and say 'my mother'.*

It is a common practice in the study area for children to express their bitter sorrow carrying the ornaments and putting on the cloths of their deceased mother on the funeral ceremony. Childless peoples' funeral ceremonies are quiet not only due to the mere absence of children and grand children themselves, but also due to the reluctance of other people to go to the funeral. People do not find it worthwhile to attend the funeral of a childless because there are no children of the deceased to observe who is coming to and who is absent from the funeral of their parents. There is a proverb that stresses this point:

*My childless woman is dead; let's go to the funeral;  
First I have to eat my lunch, and then prepare my dinner,  
I will go thereafter; late and relaxed;  
Who is there to observe my being late, herself or her child?<sup>32</sup>*

The previous discussion shows us that childless informants of this study faced overt stigma and derogatory comments from other people and thus, some of them deeply felt and internalize it. In addition to this individual level stigma, there are also discriminations related to burial ceremonies of the infertile which signifies the existence of institutional discriminatory practices or structural stigma as described by Link and Phelan (2001).

One of the childless informants remarked: “*Infertile people are treated differently not only when they are alive in this world, but also when they die; they are buried upside down.*” All

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የሰላሳውን በልቸ፤ እራሱን አቡከቸ፤ ሙሄድ እሄዳለሁ ብዬ ጠርቶ ጠርቶ፤  
32 አሰን ታላቅን ብዬ ልጄን ያላቸውን ብዬ?

childless informants and focus group participants who mentioned this practice had heard about burial of infertile women “upside down” from others, but they didn’t see it by themselves. There was no consensus among focus group participants why childless women are buried differently (“upside down”). The varied explanations include: to show that they lived a pitiful life in this world, have no children to be proud of them, failed to taste the curse of women (labour), and didn’t taste the Virgin Mary’s experience in giving birth.

As mentioned in the introduction, there are religious rites for the dead called ‘*teskar*’ celebrated on the fortieth day and ‘*fitihat*’ (absolution) on the day of death every year afterwards. Children or relatives have to take something to the church so that the priests will remember the dead in their prayers. Childless people, especially those who have no close relatives, have to undergo these religious rites when they are alive since there is no one to prepare this ceremony after they die.

## **6.2. Coping Strategies**

We have seen in the literature that childless people in most African societies tried to cope with the problem of infertility mainly by seeking traditional and religious treatments (see Okonofuaa *et al.*, 1997; Koster-Oyekan, 1999; De Kok, 2008) and by fostering/adopting (see Hollos *et al.*, 2009; Gerrits, 2002). Similarly as presented in chapter 5, childless informants of this study used problem-focused coping strategies for their infertility by trying various treatments and by fostering.

The problem of infertility not only deprives the childless women of giving birth, but also challenges their life as a human being due to the stigma. This section presents the coping strategies of informants to deal with external problems of stigma and internal emotional problems. As we will see, informants mainly seem to use emotion-focused coping to regulate stressful emotions. Among Folkman and Colleagues’ (1986) lists of ways of coping escape-avoidance, self- control and seeking social support were the most widely used ways of coping by childless informants of this study. In the following subsections I will present the different coping strategies of childless women.

### **6.2.1 Avoiding Public Gatherings**

To escape unnecessary and disappointing comments related to their childlessness, some informants tried to avoid being with people by not attending festivals or local associations.

This is related to escape-avoidance way of coping as described by Folkman *et al.* (1986). For example, Fanta point out: *“I usually avoid attending festivals like weddings, baptism, and zikir<sup>33</sup>. I don’t want to stay around at family gatherings, but sometimes I go there for the sake of my husband.”*

On such festivals, women and men often take segregated seats and the children normally stay with their mothers. Women’s talking often focuses on children since they come with their small children. This is a terrible time for childless women since they have nothing to talk about. It becomes even worse if the gathering is among family members, as the husbands’ families often hurt the woman by reminding her childlessness.

Amsale, who is married to a teacher and lives far from her husband’s family, recalled:

*My husband and I are living far from our families so we are at peace because no one is around. The problem is when we go to our families for different festivals, at that time we will be disturbed. On each occasion we visit them, they will not leave us without throwing words that remind our childlessness. For example, when we attend a baptism ceremony, people say ‘when is your turn?’ No one understands our problem.*

Migration is also one option to avoid stigmatization of childlessness. As Mengistu, one of the male informants, mentioned: *“Sometimes, I wish to migrate to other places where people do not know me. However, I ignore this idea while I think about my old parents here as there is no one to take care of them.”* The fact that Mengistu suppressed his interest to leave his village for taking care of his old parents and this also shows us how children are always responsible for taking care of their parents.

### **6.2.2 Pretending as if Nothing Happened**

Some childless women of this study tried not to let others know their feelings which is self-control way of coping (Folkman *et al.*, 1986). For example, Wude who has abusive brothers-in-law didn’t want to expose her sadness to them: *“I usually cry a lot until my pillow becomes wet and I get some relief then after wards. If I can’t cry I will have a headache. I cry when no*

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<sup>33</sup> Zikir is a religious association named by the names of saints and angels.

*one is around me; I don't want to be seen sad as this gives happiness to my enemies [brothers-in-laws]."*

Yemata also prefers not to share her problems with people due to the fact that the advice she gets from people doesn't bring a concrete solution to her infertility:

*When I face challenges related to my childlessness, I just keep silent; I don't want to consult anyone since no one can solve my problem. Is it possible for anyone to make my womb fertile? So what is the need to talk? I usually pretend as if nothing happened and I try to look happy. If you look sad and always complain about your problem, people load too many things on you in the name of advice; I don't like it at all.*

Bosena prefers to pray when she faced problems rather than talking with people:

*I usually go to Church when I have problems. Sometimes, I pray to God to give me the strength to pass such difficult moments. Sometimes, I sit there for a long time; I like the silence at the Church. Afterwards, I forget everything and feel somehow relaxed when I return home.*

As shown in the previous chapter, religious explanations for the cause and treatments of infertility are popular. However, only Bosena uses praying, which is a positive reappraisal coping strategy, to regulate her emotional problems.

### **6.2.3. Consulting Friends**

Contrary to those informants who chose to hide their emotions, others share their problems and accept sympathy and advise to regulate their stress. According to Folkman and colleagues' (1986) this way of coping refers to seeking social support. Debre and Maritu got some help by sharing their problems with friends. Debre explained the importance of sharing problems with friends as this: *"I have many good friends. I share with them whatever bothered me. By nature, I am free and open to share ideas even with strangers. This helps me a lot; otherwise I would have been dead by now. I have had many horrible experiences."* For Debre sharing problems with friends is important to the extent that she thinks that it has saved her life.

Maritu also remarked: *"Most of the time, I am not concerned about what people say. When I feel bad, I just make coffee, invite my neighbours, tell them what was happening, and then I*



*forgot everything.*” Neighbours drink coffee together; and take turns to invite each other. The coffee ceremony<sup>34</sup> might take an average of one hour and it is a good opportunity for women to chat.

Sometimes friends’ advice may not bring the intended positive result, however. Almaz feels that she doesn’t get a convincing advice from her friend:

*I used to share my problems with my friend when I feel bad, but my friend usually said ‘don’t worry, having children means nothing’. I know and she knows having children means everything and is the solution to all my problems. Later on, I decided not to talk about my problem.*

Almaz’s friend tried to simplify the problem. But the way she reduces having children into ‘nothing’ was not proper in a community where having a child defines women’s identity.

### **6.3. Special Supporters of Childless Women**

We have seen in the previous chapter that friends and relatives of childless informants participate in seeking solutions. Some recommend particular holy waters and others participate in making a vow. Apart from the wide range of stigma and discrimination, such supports give some hope to childless individuals. In this section, I will present the special persons (supporters) in the lives of childless women.

A few childless women get a special support from their husbands. This strong mutual understanding and support was observed particularly in those couples who have managed to stay together in marriage despite childlessness. For Wude who has been married to a priest for 22 years, her husband is the special person in her life:

*Without the support and advice of my husband, I would have been in my grave until now. He is always advising me by telling me about the patience of Abraham and Sara in the bible. When his brothers annoy me, he says ‘don’t worry about others as far as I am with you, I will be with you throughout my life whether you give birth or not’. My mom is also my helper in this regard. She gave my little brother for me to escape my loneliness.*

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<sup>34</sup> The full process of Ethiopian coffee ceremony: washing coffee beans, roasting them in a coffee roasting pan, grinding, putting the coffee powder with water, boil it and serve. It has 3 rounds, the first serving is called “*abol*”, the second serving is “*tona*” and the third is “*bereka*”. Coffee is usually served with snacks.

Masresha, lived for 29 years with the same husband, point out:

*My husband, my sister, and my brother support me. But I most appreciate my husband's support. It is not a surprise if your relatives supported you because you share the same blood with them. But it is difficult to get a support from your husband who is a complete stranger for you unless children created relatedness.*

According to Masresha, children create relatedness between partners of a couple, which means that childless couples are strangers to one another. This makes it difficult for a childless woman to get a sympathetic husband, herself being an exception in this regard.

Childless women and men are also assisted by friends in different ways. Bertukan, an elderly and one of the poorest women among my informants, explained the support of her friend in this way: “*My neighbour, who is also my friend for a long time, encourages and advises me to be strong especially after I became divorced. Even if she has many small children and she has no income except her husband's, she shares whatever she has with me; food, coffee [...]*”<sup>35</sup>

Bertukan has various problems; she is a divorced woman who has no means of income. She is also getting old and has some health problems. In addition to the emotional support and advice, she gets material support from her friend. Without the support of her friend, her childlessness could have a devastating effect.

Abebu, who is a government employee, appreciated her mother's and sister's support:

*My mother and my sister are my special supporters. I lived 32 years with my mother. She is not only my mother; she is also my friend. I discuss everything with her. In addition to my mom, I had a wonderful sister. I never bought clothes and ornaments with my salary. She used to buy them for me. She tried everything to make me happy. She also paid for my infertility treatment. She died last year; my being childless is nothing compared to losing my priceless sister [crying and showing me the picture of her sister posted on the wall].*

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<sup>35</sup> Bertukan and her neighbour were together during the interview and the neighbour said: “I am poor too if I have something I want to support my friend. She has no one and I feel so sympathetic to her.”

If a childless woman gets support and encouragement, children might not be the only priority. Abebu's experience shows us that having an understanding and supportive family is more important than having a child.

#### **6.4. Discussion and Conclusion**

We have seen that in many cultures, full womanhood is achieved through being a mother and consequently infertile women usually carry the blame for reproductive failure (see Ombelet *et al.*, 2008). In this study area too, we have seen that motherhood/fatherhood is the most fundamental value of the communities and it is perceived as the main purpose of one's being. Those who are unable to give birth are considered as humans of lesser value. The consequence of such a perception is that childless individuals become the targets of all rude insults and impolite treatments. For example, childless women and men are accused of eating alone; without sharing food with children. One reason that makes motherhood extremely important in this area is the values attached to children. They are considered as God's blessing, legitimate successors of their parents and, as we will see in the next chapter, binding forces of marriage, and sources of labour and old age securities.

Douglas (2005, p. 78) argued that "the physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society." In this research too, there is an interplay between the individual experiences of childless women and the cultural ideas about their body. Because of their inability to bear a child, childless women of this study are devalued and marked with verities of stigma. The common type of stigma that childless women experienced is enacted stigma which includes overt comments and derogatory words. They are insulted as 'barren', 'mule', 'plump' and 'waste'. In addition, women's body is perceived as tireless as it doesn't experience pregnancy, labour, and breast feeding. On the worst encounter, childless women are accused of eating without yielding fruits. All these strong symbolization of the infertile body and the different kinds of stigma represents the social body - the body as a symbol. As stated in the theory chapter, stigma has such consequences as disbelief, shame, terror, grief, anger, social withdrawal, hopelessness, and lack of prospects (Gray, 2002). Similarly, due to the enacted stigma and the absence of the main societal role (motherhood), childless women of this study develop felt stigma. As a result, some of them feel hopeless, and some even question the importance of their mere

existence. The distressed feelings that childless women experienced constitutes the individual body in the three bodies' approach of Scheper-Hughes and Lock (1987).

As indicated above *enacted stigma* is more noticeable than *felt stigma* in my study communities. Contrary to this, a study by Greil (2002, p. 106) on infertile women in Western New York found out that felt stigma is more common than enacted stigma since most of his respondents perceived infertility in terms of the failure of their body. In small communities where everyone knows each other, the social pressure on individual's life is obviously strong. This might be one reason that my informants faced strong social ostracism and stigma. In addition to enacted and felt stigma, there is *structural stigma* which is mostly visible in relation to the funeral and burial ceremonies of childless individuals. The funeral ceremonies of childless individuals are very quiet and the burial of their body is positioned differently from that of other people.

In relation to discriminators on infertile women, many studies found that mothers and sisters-in-laws are the most discriminators of childless women (Inhorn, 1996; Mekdes, 2008; Hollos and Larsen, 2008; Hollos *et al.*, 2009). However, this is not the case in relation to my informants. Surprisingly, no one mentioned stigmatization coming from mothers-in-law but from their husbands, neighbours, brothers-in-law, and brothers.

The existence of stigma and discrimination doesn't indicate that childless informants of this study are totally passive. Rather, they have their own coping strategies to deal with the challenges related to their childlessness. *Self-control* (hiding their feelings), *seeking social support* (consulting with friends and neighbours and accepting sympathy), and *escape-avoidance* (avoiding to attend public gatherings and living far from families) are commonly used as ways of coping.

Stigma and discrimination are not the only consequences of childlessness and the associated perceptions. There are also other consequences that affect the overall wellbeing of childless women. In the next chapter I will present the social, economic, and emotional consequences of childlessness.

## CHAPTER 7

### SOCIO-ECONOMIC AND EMOTIONAL CONSEQUENCES OF CHILDLISSNESS

In the previous chapter, we have seen the multi dimensional impact of stigma and discrimination on the childlessness individual's lives. This chapter deals with consequences of childlessness beyond the issue of stigma, it focuses on the social, economic and emotional consequences on individual childlessness women's lives. It is indicated in the literature that children have multiple values in African communities (see Dyer, 2007). Children create marital stability, they are old age securities and economic supporters, and they grant proper gender identity. Children confer parents' social status and they have religious and emotional values as well (see Pearce, 1999; Kimani and Olenja, 2001; Runganga *et al.*, 2001; Inhorn and van Balen, 2002; Dyer *et al.*, 2004; Hollos *et al.*, 2009).

Childless informants of this study also confirm such values of having children. Recognizing the incalculable values of children, childless people try to cope with their infertility problem and get children. Their coping strategies are strongly related to the communities' and their own perceptions about the causes and treatments of infertility, the resources they have, and their age. Besides, female body and aging is another factor that affects ones coping. All these factors in turn influence informants' future social expectations. The following sections discuss different socio-economic and emotional consequences of being childless.

#### 7.1. Marital Instability

It was indicated in the literature review that in many African communities, creating marital stability is one of the major values of children and childless marriages are incomplete and insecure (see Dyer, 2007). Remarriage, polygamy, abandonment of wives and divorce were found to be prevalent in childless marriages (see Inhorn, 1996; Pearce, 1999; Orji *et al.*, 2002; Deribe *et al.*, 2007; Hollos and Larsen, 2008; Hollos *et al.*, 2009). In a similar fashion, most of the informants of this study have been divorced more than once. The following informants' accounts will show us the impact of childlessness on marital relationships.

Yemata, who divorced two times and is now married to an elderly widower, recalled her marital history:

*I was a kid when my first marriage was broken off so I do not have a special memory of it. However, I will never forget the second marriage as long as I am alive. We had love and we spent more than eight years together. One day in the morning, my father and my brother came to my house and I asked them why they came suddenly. They said 'don't you know that your husband called us to share your property and to take you home? He wants divorce.' I became mad and I didn't know what to do. What still hurts me a lot is that we divorced on Thursday and he got married on the next Sunday. It was good if he had told me that he wanted the divorce, but he made it in that way. After that, I promised not to marry again as I decided to become a nun. I refused many proposals and I stayed five years alone with my family. After a long time, my relatives pushed me to marry my current husband. He doesn't need me to give birth as he had already many children, and he is rich as all of his children are living in America. That is why I finally decided to marry him.*

A divorced woman usually has limited options: remarriage, migration to towns and cities, or living with her parents. However, the last option is socially unacceptable and is almost impossible since it makes the divorced woman dependant on her parents. That is why Yemata broke her promise not to marry again. In addition to family and social pressures, Yemata decided to marry the man because he is economically well off and his children are living in America. People who have children abroad especially in Europe and America, are considered as lucky since their children send them sufficient money.

Abebu, economically well-off divorced woman, recounted her unsuccessful marital life:

*I have been divorced three times and two of my husbands divorced me because of my infertility. They were wealthy and I also equally contributed to the wealth. However, I ended up with divorce without sharing my wealth. After that, I decided to live alone and I have been living alone for the past 32 years. Even if it was easy to marry again, it is difficult to have a sustainable marital life as no one allows me to stay [in marriage] unless I give birth. I am lucky to have my own salary and a good standard of living. That is why I decided to live alone. Those infertile women who didn't have their own means of survival have two options: to marry again or be engaged in prostitution. Here in Debre Tabor [the capital city of South Gondar], there were lots of infertile women engaged in prostitution. However, most of them have passed away due to HIV/AIDS. I know the prevalence of the disease as I am working in the health*

*sector. If I haven't had my own income, I could have continued in marrying and divorcing and my destiny might have been to be infected with HIV/AIDS.*

In addition to her tragic marital history, Abebu raised two important points. One is economic independence, which is the key for women to decide the life they prefer. She is the only government employee among my informants and the only one who has her own stable income. Since she has economic independence, she decided not to marry again and no one could change her decision. The other point is the vulnerability of childless women to HIV/AIDS. As mentioned in the literature review, it has been documented that childless men and women are more vulnerable to HIV/AIDS since they are engaged in divorce, remarriage, and extra marital relations in search for own children (Favot *et al.*, 1997 ; Tinsae, 2009).

According to Maritu, divorce is to be taken for granted if a marriage is childless: *"I am living with my third husband. The first one divorced me because I couldn't give him a child. The second one died. If not, I am sure divorce was inevitable with him too."*

Worke, who is divorced four times, has quite similar ideas to Maritu: *"My first husband was a priest and we had a good life together except being childless. However, he sacrificed even his priesthood<sup>36</sup> for children and divorced me. After him, I have married many times but divorce was my destiny as I cannot produce children."* This case also shows that having children is more important than having a good life or a prestigious social status such as priesthood.

Bosena is the only one among my informants who initiated the divorce herself. She has an inherited land and wealth from her family, which gives her economic confidence to live independently. So she decided to divorce her second husband because of his extra marital relation from which he had a child. She recalled:

*My first marriage was not counted because I was only 12. I used to run away several times when I missed my mother and then my family returns me again to my husband's home [...] finally we divorced. With my second husband, [laughing] I divorced him because he got a child from another woman without my consent. However, we are remarried now because he promised me not to have a relation with other women again.*

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<sup>36</sup> Note that if a priest divorces, he will lose his priesthood as per the Church's rules.

Contrary to Bosena, quite a few informants consider it to be good if their husbands get children with other women because it can save their marriage. Berke's experience confirms this: *"My husband divorced me because of my failure to give birth. After he divorced me, he got children from another woman and then remarried me. Now we are living in peace because he got children and they are living with us."*

Almaz, who is married three times, also says: *"My first husband died; my second husband divorced me because I couldn't give birth. He married me again after he got three children from another woman. However, we are now divorced again for other reasons and I am living with my third husband."*

From the above cases, we can see that the marriage of a childless woman may become more stable if she lets her husband have children with other woman. Although this practice has a positive effect on binding the marriage, there is a possibility of being infected with STDs and HIV/AIDS as the man goes here and there seeking children.

Debre, an elderly woman who divorced repeatedly and is now living with her fifth husband, described her infertility and her marital story in a different way from other informants:

*Being infertile has two dimensions in my life. When I was young, I have lost my wealth due to divorce because sometimes I just ran away from my house without sharing any property. This made me poorer and poorer. At my old age, I have no one to support me. My only choice is to marry an old widower having many children and who wants no more children. My current husband and the one before chose me due to my infertility status. At this time, my position is more as a servant than as a wife. I even didn't have sexual intercourse with my current husband for years because he is too old.<sup>37</sup> No one takes care of me and is concerned about my wellbeing. My step-children come to my house only to check whether I care properly for their father or not. Even if I have been taking care of their father for the past 18 years, they do not consider me as a mother; not even as a distant relative. I am afraid now what they will do to me if their father dies.*

For Debre, in the absence of other options to get means of subsistence, being infertile became an advantage in making her the preferred marriage partner for old widowers who do not want

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<sup>37</sup> Debre's husband is 87 years old and has a visual problem.



any more children. These findings are confirmed also in an Egyptian study which found out that childless divorced women are considered as desirable only to ‘deviant’ men for example, widowed men with young children who need a step mother, old men (widowed or divorced) who want a woman to take care of them until they die, or men with some other mental, physical, or behavioural defect (Inhorn, 1996, p.122). Some of the husbands’ of informants of this study have visual, hearing, and other health problems due to old age. Although it is difficult to find a desirable husband for most of the childless informants, marriage is one coping strategy in the absence resources to live independently.

Focus group discussion participants mentioned an Amharic proverb that refers to the wish of childless woman saying: “*don’t forget me; take me back and forth [in marriage].*”<sup>38</sup> This is to show that the marriage of a childless woman is fragile; she wishes to marry and divorce because of two reasons. First, she cannot live alone and has no other option than marriage. Second, she can share her husband’s property in each divorce. However, some of my informants didn’t get their share of property as we have seen above. They simply ran away from their husbands due to the discriminations, without formal divorce and property sharing requests.

In some exceptional cases, we can find strong marital relationships between childless partners. The experiences of Wude and Mengistu might be good examples of this. Wude (married to a priest) said: “*I am infertile and his family consistently pushes him to divorce me. However, we have 22 years of marriage because we love each other. Besides, as my husband is a priest, he will lose his priesthood if he divorces me.*”

Mengistu and his wife don’t know who is infertile from a medical point of view. Following the pressure from his friends and families, he tried once to have a child from another woman but he was not successful. Now he lives with his wife withstanding the social pressure. He himself explained it: “*Even if my family and friends pressured me to divorce her and marry a child-bearing woman, I cannot accept their idea because she is a very good woman for me. We have spent seventeen years together.*”

For Mengistu, inability to bear a child is not a sufficient condition for divorce even if his wife cannot give him a child, as far as she holds desirable qualities as a wife. This shows that if the

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society has shared the perception of Mengistu, divorce and other related consequences of childlessness could be averted. In the study communities childlessness is stigmatized because of the multi dimensional values associated with children and the social values related to motherhood/fatherhood. If voluntary childlessness had been accepted in the society as an option, involuntary childless people could have not been discriminated in a way like this.

## **7.2 Economic Consequences and the Problem of Old-age Security**

As described in the literature review, in the majority world children contribute to the household through cooking, fetching water, tending livestock, as well as farming (Lancy, 2008). Children also support their aging parents in the absence of social support systems for the elderly (Inhorn and van Balen, 2002). Most of the childless informants of this study confirm that they are economically disadvantaged because of the absence of children's labour contribution in the household. Although most of the informants have foster children, foster children cannot replace the value of their own children. As informants claim, foster children are not reliable because they prefer their own biological parents when they grow up. Besides, having one or two foster children might not be sufficient in the labour intensive agrarian economy. In the following informants' accounts, we can see how their day-to-day activities become problematic due to the absence of children's help.

Wude pointed at the gap that children are supposed to fill in the household division of labour:

*We have no problem in household activities as I can do everything. We are only three so my day-to-day activity is not that much labour-demanding. The problem is to keep the animals in the pasture. My little brother, who is living with us, is a 10<sup>th</sup> grade student and has to spend half the day at school. So when he goes to school in the morning shift, the animals have to stay at home until he returns. If he is in the afternoon shift, the animals will be at home in the afternoon.*

We have stated in the introduction chapter that people in the study community are engaged in mixed farming for subsistence. Keeping the animals in the pasture starting from early in the morning till evening is the responsibility of children, especially boys. Even though parents' motivation to educate their children is increasing, children have to help their parents at least half a day after or before school. Thus, we can imagine how difficult life can be without children.

Mengistu, one of the male informants, described the labour intensive nature of farming and burden of farming and animal husbandry without children's labour contribution:

*Farming demands more manpower throughout the year starting from ploughing, seeding, weeding, and harvesting. So farming is very difficult without the support of children. Besides, keeping the animals is the sole responsibility of children. For example, foxes killed my sheep repeatedly because there was no one to protect them.*

Fanta has no foster child and because of this her every day activity is tiresome and her social life is poor:

*I usually work the whole day; cleaning the house and the animals' shelter, fetching water, cooking, and the like. I cannot participate in social activities with other women who have children. For example, it is difficult for me to attend church on Sundays, to visit sick people in the neighbourhood, and to attend funerals.*

In the household activities, girls help their mother in fetching water, cleaning, and cooking. Besides, daughters are expected to keep the house when their mothers are out. Thus, it will be difficult to get time to participate in social activities for childless women like Fanta.

The focus group discussions participants of this study confirm that childless people are economically disadvantaged and they have difficulty in securing their old age. A male focus group participant explained:

*Childless people are the same as people who have no eucalyptus tree. If you educate your children, they become your old age security. Similarly, if you have eucalyptus tree, you can cut and sell it; it can be your source of income. It is hard to survive without eucalyptus tree and children. For example, there was an old childless woman in our village of Arga [calling her name and asking participants if they can remember her]. As there was no one to take care of her, the village community decided to take care of her on a monthly basis. So she used to move from one home to another every month. The worst thing was that people were concerned only with feeding her but not keeping her clean as we do for our own parents. I remember her hair was full of lice.*

In the above explanation, the man emphasised educating children as the future economic security of parents and he tries to compare educating children with planting eucalyptus tree.

In the study area, the eucalyptus tree is a multi-purpose tree as it is used for firewood and to construct houses. As a result, most of the farmers grow this tree since it is a good source of income and it can grow again within few years after they cut it. Similarly children are supposed to help their parents financially after they accomplish their study and have a job. Besides, he provided a good example of how having an old age security is a problem for poor childless woman.

Having resources such as arable land makes easier to cope with economic hardship and the problem of old age security. For example, for those childless people who have an arable land, securing their old age is somehow easier. If the childless individuals have land, they can ask someone to take care of them until their death and in exchange the caregiver inherits the land. A female focus group discussion participant illustrated this:

*Infertile people are economically weak. For most of them, having cattle is very hard because they don't have children to herd the cattle. At old age, infertile people have no one to take care of them. Most of the time, they give their land to a person who can take care of them until their death.*

The following Amharic proverb (funeral poem) illustrates the discussion above:

*What does a childless woman have, except her belt?  
Her home will be abandoned after her funeral.<sup>39</sup>*

This is said to show that childless women are the poorest of the poor and due to the absence of legitimate successors (children) her home will be empty immediately after her death.

### **7.3. Emotional Consequences of Childlessness**

Literature shows that infertile individuals and couples experience high level of emotional distress (Jordan and Revenson, 1999; Pottinger *et al.*, 2006). Emotional satisfaction is one of the reasons to have children (Dyer, 2007). In addition to the socio-economic rationale behind having children, children are considered as sources of personal happiness, purpose of life, and offering companionship for their parents (Dyer *et al.*, 2002; Runganga *et al.*, 2001;

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Sahleyesus, 2005). The following sections present the emotional consequences of infertility as reflected through the childless women's reaction for children and pregnant women.

### 7.3.1. "I Love Children"

We have seen that most of the informants have fostered a child or children. This section is about childless women's reaction to children in general (fostered or not) based on their replies to the questions: *what is your relation with children in general? What do you feel when you see any young children?*

Almost all of the informants said they love children and have good relations with them. Debre expresses her relation with children in this way: *"I like children very much and I feel happier when the children of my neighbours come and play in my house. I usually give them whatever I have; 'injera'<sup>40</sup>, 'kollo'<sup>41</sup> or bread."*

Another informant, Berke says: *"I love children and I kiss them even if I didn't know who they are. I kiss even when they are unclean."* In the study community, it is common to admire and kiss a child. People usually say: *"How a cute baby! 'entf entf entf'<sup>42</sup>."* What makes Berke special, as she said, is that she kisses every child although he or she is dirty.

Fanta emphasised how she attempts to make a good relations with children and the positive outcome of it: *"I think no one hates children. For me, children are innocent and can be good friends if you are close to them. They say no bad words and tell no gossip. In the neighbourhood, I am known for caring for children. In turn, they help me by taking messages to my neighbours."* Fanta loves children and she enjoys their innocence. From her good relation with children, she also gets rewards and help from them, like delivering messages. In the absences of modern technologies children, are preferred for delivering messages in the scattered neighbourhood.

Abebu also developed a good relation with children and she often plays the role of a mediator between her friends and their children:

*Children are like white paper; they accept whatever you gave them. If you like them, they like you and if you hate them, they also hate you. Generally I like children and*

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<sup>40</sup> Injera is a typical Ethiopian food which looks like a big pancake and is made of a local cereal called "teff"

<sup>41</sup> Kollo is roasted cereals usually used as a snack.

<sup>42</sup> A person say "entf" three times to protect the child from evil eye.

*they also like me. My friend's children usually tell me if they have conflicts with their parents. Then I try to settle the issue with their parents so that the children will not be punished.*

A few informants have more problematic relationship with children although they didn't link this problem with their childlessness. Alemitu thinks children don't like her: "*Children ignore me; they afraid me; they also despise me; I don't know the reason.*" On the other hand Masresha doesn't like children at all:

*To be honest with you [...] I don't like children. I treat them harshly so they are afraid of me. They start to run when they see me while playing in the field. If I catch one of them, I usually punch him/her. When children are disturbing at home, their parents call my name to scare the children.*

### **7.3.2. "I Feel Jealous when I see a Pregnant Woman"**

Studies found out that in the case of inability to have own children, being around other people's children and pregnant women could evoke feelings of frustration, sadness and jealousy and thus some childless women tried to avoid contacting children and pregnant women (Lalos *et al.*, 1985; Pottinger *et al.*, 2006). Contrary to loving children and having a good relation with them, some of the childless women in this study said that they feel jealous and became emotional when they see pregnant women. Let's have a look at to some of the informants' reactions.

A 38- year woman, Worke, recalls her reaction with pregnant women like this:

*I become upset when I see pregnant woman; my eyes stuck on her belly. I remember one day, I went to Bahir Dar for my sister's wedding. When I pass by a shop, I saw a doll wearing a beautiful dress of pregnants. I stopped there and started staring at it. Some people laughed at me because they considered me to be a rural woman who cannot differentiate a doll and a woman. But the story was different; I stood up there to see the belly of the doll.*

Both Fanta (aged 28) and Tibebe (aged 35) say that they lose comfort when they see a pregnant woman. Fanta point out: "*I feel very jealous when I see a pregnant woman. My eyes stuck on her and I feel something running in my stomach [...] like throwing up.*" Tibebe also stated: "*I become very jealous when I see pregnant women. Sometimes, I even want to cry.*"

Some informants do not want to see pregnant women and to hear about pregnancy related topics at all. For example Berke, aged 31, who said she loves every child unconditionally (see the previous section), doesn't want to see a pregnant woman: *"I feel jealous when I see pregnant women and especially if the pregnant woman is my friend. The worst thing is that all my friends become pregnant one after the other every year. Where can I go now not to see a pregnant woman?"*

Alemitu, aged 38, has similar sentiments: *"I feel very jealous when I see pregnant women. I usually avoid contacting them. Sometimes, I change my way when I see a pregnant woman coming in my direction."*

Almaz, aged 30, also remarked: *"I even don't want to hear the news that someone is pregnant in the neighbourhood. Surprisingly, my neighbours want to talk about this issue. The major topic during the coffee ceremony is usually who is pregnant and who gave birth recently."*

As shown in the above sections, although most of the childless women regardless of their age asserted a positive feeling towards children, relatively younger women (aged 28-38) feel uncomfortable by the sight of pregnant women and by pregnancy related conversations.

### **7.3.3. "Time is out now"**

The female body and aging are of course closely interrelated and age has a great influence on how the women cope with the emotional distress related to the problem of infertility. We have seen above that informants within reproductive age said they feel jealous when they see pregnant women. However, informants who are near to or already in their menopause stage said that are presently indifferent, but recalled bad feelings in the past (when they were young). In this regard Desta, a 60- year woman, said: *"I never thought about pregnancy and related things after I stopped seeing women's custom [menstruation]."*

Yemata is only 40 but has already entered menopause. She says: *"In the past, I used to be very upset when I saw not only pregnant women or children, but also 'ankelba'<sup>43</sup>. What worries me now is not my childlessness, but my health. I have a deep pain around my stomach."*

Bertukan, an elderly divorced woman currently without means of survival, recalled:

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<sup>43</sup> "Ankelba" is locally made leather used to carry small children on women's back.

*Of course you can feel something when you see pregnant woman while you are young. This feeling of mine vanished after I lost my hope of giving birth due to my age. Now, time is out. When you become old like me, it doesn't give you meaning. What makes me worried now is my health; my eyes are too weak. I don't know what will happen next.*

These post-menopause childless women do not worry about becoming pregnant as do young women. For such elderly women, their worries are old age security and their health, as most of them have different health complications.

#### **7.4. Future Expectations of Childless Women**

After all the ups and downs childless informants have been through, they have set their own plan for how to lead the rest of their life. To know their expectations of the future I posed the questions: *“Do you believe you will have a child in the future? If not, what will your life look like in the future, what is your options and plans?”* Let's see their replies.

##### **7.4.1 Hoping to have Children in the Future**

Folkman *et al.* (1986) mentioned wishful thinking or hoping for a miracle as a coping strategy. Some relatively young childless women of this study are inspired by success stories of others. As a result, they believe their story will also be changed one day. Berke, aged 31, has a strong belief in God and thinks that one day He will help her to have a child. She said: *“When I heard about people who gave birth after a long time of childlessness, I also believe I will give birth one day as nothing is impossible for God.”*

Fanta, aged 28, also stated: *“When I hear news about people who give birth using the holy water, I also hope I will get a child one day.”* As most of the informants believed infertility is God's Will and the consequent solutions are spiritual treatments, almost all informants tried holy water. The miracles of holy waters and other spiritual solutions are told by community members and religious leaders. These stories give hope to childless women like Fanta that they will have a child in the future.

Bosena, aged 37, says: *“I know infertile people who gave birth after a long time of trial. I also think about a day I may give birth. I always ask God when my turn is.”* Bosena



personally knows a couple who got a child after long time of childlessness and she is hopeful that one day she might also get a child.

Maritu and Wude decided not to give up thinking about getting a baby, but admitted that they might stop thinking about it when their biological age of child bearing ends. Maritu: *“I never give up until my menstruation stops; I hope I will have a child one day.”* Wude has a similar hope: *“I never give up as long as my menstruation comes. Even when my menstruation becomes late by two or three days from the usual time, I thought I become pregnant, but I feel disappointed when it comes again.”*

From the above cases, we can say that the future expectation of some childless women is closely related to their age. This is due to the knowledge that conception is determined by menstruation.

#### **7.4.2. Accepting Childless Life**

It seems the previously mentioned consequences of childlessness are less severe in the cases of educated and economically independent women. Education and sustainable income give informants a more positive image of and hope for their future. That is why the few such informants accepted their childlessness more easily and decided to live with it. For example Asmarech, who is studying at secondary school, has a positive vision of her future: *“When I finish my education, I have a plan to marry and I hope I will give birth. If I fail to do so, it is not a matter of life and death; I will simply adopt children since I will have a reliable income.”* Having an education and income might reduce the strong motivation to have own children. Unlike most of the informants, who saw fostering as problematic in many ways and perceived foster children as less valuable, Asmarech has a positive view of adopting children.

A government employee, Abebu, reinforces the significance of income to have a secured life: *“I am left with few years to retire. My pension will be enough for me. I am not worried about how to live the rest of my life.”*

#### **7.4.3 The Church as a Social Welfare Institution**

In the absence of social support systems for the aged, children are responsible for supporting their parents (see Inhorn and van Balen, 2002). That is why most of my informants said they badly need the support of children in their old age and when they become sick. This is not surprising in a country where there are no social security programmes and strong welfare

institutions especially designed for rural communities (see introduction). Consequently quite a few informants have no hope that they will be able to lead a sustainable life and thus plan to spend the rest of their life in religious places (monasteries). The decision of these informants seems logical since monasteries provide care for their elderly members. Although the primary purpose of monasteries is not to provide old age security, the aged and sick persons at monasteries are not discriminated, they get sufficient treatment and are not obliged to work (Mahibere-Kidusan, 2009). It is customary in the study community that if people are not happy with their life, they depart from their family and go to monasteries.

Bertukan, an elderly divorced woman and currently experienced a visual impediment, said:

*I am 60 now and live alone. In the past, I depended on my husband's income, but I am divorced now. I tried to earn some money by spinning and selling "fetil",<sup>44</sup> but my eyes are too weak to do that. I have decided to go to a monastery and to become a nun. I believe that is the best place for a person like me; I will spend the rest of my life there.*

Bertukan tries to earn a living but her eyes are deteriorating and that is why she prefers to go to a monastery.

Debre, who is married to an elderly man, has the same plan as Bertukan:

*As you can see, my husband is too old and will pass away within few years. After that, I will find a church and I will become 'akabit'.<sup>45</sup> As I told you before, my step-children will not give me a day to stay here. They are waiting for the death of their father to throw me out of the house.*

Even if Yemata is only 40 and married to a rich man, she also has a similar plan with the above two informants: *"I am not lucky enough to have a happy life in this world. In the future, therefore, I want to build a good house for the other world; I want to live for my soul. I want to be a nun and to spend the rest of my life by doing spiritual things."*

These informants' decision to spend their life in religious places seems to primarily arise from the absence of old age security and lack of other life options. However, not all poor

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<sup>44</sup> Fetil is cotton thread which is used to make traditional clothes.

<sup>45</sup> Akabit is a woman who stays permanently in the church by providing church services such as fetching water, collecting fire wood, grinding cereals and cooking.

childless women see the religious places as the last resort. For example, the future of Desta and Tibebe seems solely depends on their husbands' life. Desta, an elderly and handicapped woman, stressed: *"I have no one for me. I always pray to God to understand my situation and protect me from illness. I want to die before this old man<sup>46</sup> because my step-children will take care of me as long as their father is alive."* Although Desta presently feels somehow safe, she is not certain about how her step-children will treat her after the death of her husband. Tibebe has the same plan as Desta: *"I hope my step-children will take care of me together with their father."*

As discussed in chapter 5, religious rituals are the major sources of treatments and tried by most of the informants. Here also, religiosity is a way of coping especially for the most marginalized of the childless women. They consider the church as a social welfare institution.

## **7.5. Discussion and Conclusion**

As discussed in chapter 6, childless informants of this study receive overt ostracism and stigma from families, neighbours, and the community at large due to their deviation from "normal" life (motherhood in particular and parenthood in general). As a result, childless women strongly desire to have at least one child to be considered as full woman and to avoid the emotional crises of being childless. In addition, childless informants have serious problems related to marital instability and old age security. Most of the informants divorced more than once due to their inability to bear a child. Tilson and Larsen (2000) found that young age at marriage and childlessness significantly increase the risk of divorce in Ethiopia. Infertility studies in African communities also documented well the problem of childlessness and marital instability (see Inhorn, 1996; Pearce, 1999; E.O. Orji *et al.*, 2002; Deribe *et al.*, 2007; Hollos and Larsen, 2008; Hollos *et al.*, 2009). Studies in many African communities found that polygamy is often practiced in childless marriages; the husband may take another wife if one is unable to bear a child. However, as polygamy is unacceptable in my study area, divorce is more prominent.

As stated in the introduction, two types of marriages are practiced in the communities: customary and religious. In religious marriages, divorce is prohibited and is not flexible. Of the two childless women married to priests, one of the husbands preferred to stay childless

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<sup>46</sup> The husband of this informant has visual as well as hearing problems due to old age.

but the other preferred divorce and lost his prestigious status of priesthood. Customary marriage is the most widely practiced type in the study area for its flexibility. Of the 17 childless women interviewed, 15 were married through the customary marriage and 15 of them were divorced at least once (see Table 1).

The other consequence of childlessness has to do with economic hardship and the problem of old age security. In rural parts of Ethiopia, children are sources of labour in the household. Informants reported lack of help in household work, farming, and tending the cattle. Old age security is also a major problem and worry of childless informants in the absence of welfare institution to take care of the aged people. It was noticed here that one's choice of coping strategy is influenced by resource and age. Thus, poor or/and old childless women worry more than the economically self-sufficient and young ones.

Childless women in this study have shown different reactions to pregnant women and children. With some exceptions, almost all informants regardless of their age said they love children and have normal relations with them. This is in contradiction with community members' perceptions that considered childless women as pitiless for children. On the other hand, some childless women experienced feelings of jealousy and other bad emotions towards pregnant women and consequently they tried to avoid being by the sight of pregnant women. These feelings and emotions have an age dimension; it is inversely related to women's age. While women of childbearing age have strong envious feelings, women of post menopause stage feel normal. Thus for younger childless women of this study, avoidance is one way of coping to emotional disturbance.

We have seen in the theory chapter that Folkman and colleagues (1986) distinguishes eight ways of coping. Childless women in this study employed different coping strategies concerning their future, although their coping strategies are culturally specific. Age and economic status are the crucial factors that shape ones coping strategy. Naturally female reproductivity diminished over time thus the most common coping strategy used by women of childbearing age is wishful- thinking or hoping for a miracle. They believe they will have a child in the future through spiritual treatments. Whereas some other informants especially the aged and the destitute ones planned to go to monasteries and work to the benefit of their soul.

## CHAPTER 8

### CONCLUDING REMARKS

Infertility is a global problem affecting men and women equally. However, we have seen in the literature that in many societies of Africa, infertility is perceived mainly as women's problem (see Inhorn, 1996; Kimani and Olenja, 2001; Deribe *et al.*, 2007). This perception in turn has its own consequences on the overall life of childless women. In many African communities, childless women are exposed to severe stigmatizations due to their inability to give birth; it is assumed that their body has failed to conceive (Ombelet *et al.*, 2008). This study has attempted to explore the socio-cultural perceptions of infertility and the implications of these perceptions on the lives of childless women in South Gondar, Ethiopia. Relevant documents related to infertility were reviewed and qualitative data was collected from childless individuals, community members, religious leaders and health workers through in-depth interviews, focus group discussions, and group interview. The qualitative data was analyzed into major themes such as: perceived causes and treatments of infertility, social support and stigma, socio-economic and emotional consequences of childlessness on women's lives, and the coping strategies of childless women. Under these themes, theoretical frameworks of the three bodies' approach, social stigma theory, and coping theory were used to explain the cases of childless individuals.

In this chapter, I will present the major findings of the study. We will see the findings with respect to the perceived causes and treatments of infertility, the reasons why childlessness is a serious personal and social problem, and the coping strategies of childless women to deal with infertility-related challenges.

#### **8.1. Different Perceptions of Infertility**

In the study area, there were different perceptions among childless individuals and community members of the causes and treatments of infertility. To begin with, there are very limited medical ways of knowing one's infertility. Hence, informants have their own experience-based ways of recognizing their infertility status; most of which seem logical in the absence of medical check-ups. The practice of early marriage (below 12) strongly influenced women's perceptions here; they were forced to start sex at a very early age and to think about their infertility if they do not give birth soon. In other infertility studies, it was

found out that starting sex at early age is a possible cause of infertility (Ericksen and Brunette, 1996, p. 216). In my study, many childless women mentioned age 15 as an appropriate age limit to give birth in normal circumstances. Thus, a 15 year girl can consider herself infertile as other persons (specially her husband and relatives) start to complain that she is becoming late at giving birth.

Once a person is known to be infertile, mostly non-medical explanations are provided as causes and practiced as treatments of infertility. There are spiritual, cultural, and medically accepted explanations of causes and treatments of infertility. Spiritual explanations of infertility are found to be very dominant and almost all informants tried spiritual treatments. Most of the childless women believed that their having or not having children is God's Will. However God's Will is interpreted in different ways; some women associate it with punishment of their wrong deeds and others with predetermination. Religious leaders, however, argue that infertility is not a result of sin and that God doesn't predetermine our destination. They say it is to reveal/manifest the wisdom of God as He will later show His miracle by curing the problem or even by giving a blessed child after long time of childlessness; a test of one's patience in staying with God despite problems. Although community members mentioned that childless women do visit individuals possessed by spirits of Zar in search of a solution, childless informants didn't often mention it as a solution since it is associated with sorcery and sinful acts. However, zar spirit is also assumed to be a cause of infertility.

In addition to spiritual explanations, some community members believed that infertility is caused by certain factors which are more related to specific cultural understandings of the female reproductive body. These culturally accepted factors include having closed vagina and being uncircumcised. The health worker revealed that the problem locally mentioned as closed vagina can be treated with minor surgery. Consideration of being uncircumcised as a cause of infertility is against the literature which shows that circumcision can cause infertility (Inhorn, 2002). Taking contraceptive pills is also perceived by some informants as treatment of infertility; something which shows the limited medical knowledge of the informants.

Medical knowledge is not totally absent, however. The potentials of STDs to cause infertility are well recognized causes of infertility by most of the childless women and community members. Some childless informants had been infected by the virus of STDs (gonorrhoea and

syphilis) which they suspected to be the cause of their infertility. It is a common practice for husbands of childless women to be engaged in extra marital relations in search of children. Although extra marital relationship is practiced by men as a solution, it is at the same time a cause of being infected with STDs. Another medically related factor that was mentioned as a cause of infertility is irregularity or absence of menstruation.

The various treatments mentioned by informants and community members include: spiritual (mostly from God's blessings and in some instances from zar spirit), extramarital relations (of husbands), taking contraceptives, fosterage, and medical. However, medical treatment of infertility is the least practiced among the informants due to the inaccessibility of health facilities in terms of distance and cost, and the low level of public awareness about medical solutions.

Although childless women prefer to adopt orphans, it is not possible to get orphans due to the extended nature of family in the study area. Instead, fostering children of relatives and step-children is a common coping strategy. However, many of the childless informants were not happy about it for two reasons: foster children's preference of their biological parents when grown up and community member's perception of childless women as cruel when they try to discipline their foster children.

As infertility is a serious problem, childless informants of this study actively seek informational and concrete support from the Church as well as from lay people to solve their problem. Thus, while many of them tried holy water and related religious treatments, some visited spiritual healers and took contraceptive pills. However, the childless women's treatment choice is influenced by the existing socio-cultural values and norms. Although culture and religion are interwoven in the study area, religious treatments are the most used.

## **8.2. Why Childlessness is a Serious Personal and Social Problem**

The empirical findings of this research showed that childlessness is a very serious personal and social problem in the study area due to three main reasons: the stigmatizing effect of being childless, the multidimensional values of children, and poverty or lack of resources.

### ***Childlessness and stigma:***

Before I went to the study area for data collection, I have read studies on the stigmatisation impact of childlessness in many African communities and I believed I had a good level of knowledge about the problem. However, I fully understood what being childlessness means during my fieldwork. When the informants recalled their personal experience, all their appearance, tears, disappointments, degraded self esteem, and feeling of hopelessness were well over my imagination and awareness. As Goffman (1963, p.3) argued, bodily signs or behaviours that depart from the “ordinary and natural” are deeply discrediting and the person is reduced from “a whole and usual person to a tainted and discounted one”. Similarly, childless women in the study area are exposed to social stigma due to their inability to fulfil the role of motherhood. Perception of the reproductive body that connects eating with the purpose of reproduction is a starting basis for stigmatization. Thus, childless individuals are accused of eating alone; without yielding fruits. Childless women are also symbolized as mule due to lack of experiences in pregnancy, labour, and breast feeding. In addition to the stereotypical perception of the infertile body, childless individuals often experienced verbal abuse and are discouraged from achieving personal prosperity. Besides these intentional discriminatory behaviours - enacted stigmas (Scambler, 1984), the study also found out that there is a structural stigma - institutionalized practices (Link and Phelan, 2001) related to funeral and burial ceremonies. In Scheper-Hughes and Lock’s (1987) terms, the strong symbolization and labelling of the childless women with various types of stigma could be referred to as a social or symbolic body. Because of the enacted and structural stigma on childless women and their inability of achieving the vital role of motherhood, some women developed feelings of hopelessness and worthlessness (felt stigma). This felt stigma can be related to the individual body. These dialectics show us the strong link between the individual body and the social body.

### ***The value of children:***

Although it is difficult to measure the value of children, this research found out that children have social, economic, and emotional values for their parents. Creating marital stability is one major value of children. As experienced by most of the informants of this study, childless marriages are prone to repeated divorce and remarriage. In addition, childless women lose their wealth during divorce and it is difficult for them to find the desirable partner; they are mainly accepted by old widowers who already have their own children. This is consistent with Inhorn’s (1996) findings.



Children are also economic supporters, old age security, and legitimate successors of their parents. While male children help their parents in farming and in tending the animals, female children help their mothers in the household. As a result, childless informants experienced lack of helpers. In the absence of old age security systems, children are responsible for taking care of their aged parents; thus childless informants are worried about their future. Above all, having own children is a necessary condition to achieve full womanhood and manhood. My findings regarding the values of children overlap strongly with the findings of Dyer (2007). In the study communities, substitute mothering such as fosterage can't replace the value of 'real' motherhood or fatherhood for different reasons. The need for biological generational continuity, foster children's preference of their biological parents and the perception that associate the childless women as pitiless for others children made fosterage undesirable for childless informants of this study. Such kinds of fosterage problems are also found in other studies conducted in Africa (see Inhorn, 2003; Gerrits, 2002).

***Lack of resources:***

This study found a disparity about the severity of childlessness between those who have resources and those who have not regarding their experiences and their future expectations. Economically marginalized childless women worry about not having helpers in their old age. The absence of old age security programs in the rural societies aggravates their situation. As children are sources of labour in rural households, childless informants usually consider themselves as the most disadvantaged and unlucky creatures. On the other hand, the few childless women in my study who have resources such as arable land, sustainable income, and education expect a better future in terms of old age security even if they did not manage to get their own children. Thus, it seems that poverty is one factor that aggravates the problem of childlessness in the study area.

### **8.3. Dealing with the Problem of Childlessness**

Scheper-Hughes and Lock (1987) noted that the beautiful, strong, and healthy body is the culturally and politically "correct" body in many societies although the indicators may vary. In my study communities, it seems that the 'fertile body' is the culturally and politically "correct" body. A simple evidence for this argument is the culturally constructed vocabularies and proverbs (mentioned in this study) to devalue childless women and refer to

childless body, to explain unkindness of childless women, and to show the generational termination of childless people.

Among the childless informants of this study, no one challenges the value of motherhood and prefers to lead a child free life voluntarily. However, they developed coping strategies to solve or stabilize internal emotional problems as well as external challenges related to their infertility. This study found out that the choice for a particular coping strategy is influenced by the sex, age, and socio-economic status of informants. Women easily accept their infertility and actively seek informational as well as concrete support from lay people and religious leaders. However, for the few men in my study, it seems harder to accept their infertility status and to seek solutions. Thus, these childless men tried to distance themselves from the problem and prefer divorce and extra marital relation as a solution. Concerning age-based differences, women of reproductive age have strong hope and are engaged in wishful thinking of becoming a mother in the future. In addition they tried to avoid visual contact that remind them of their childlessness or hurt their emotions. Elderly women, on the other hand, are more worried about their health condition and for not having supporters in their old ages. They have emotional stability and many of them plan to devote the rest of their life to religious activities. In general, childless women of this study have employed different coping strategies starting from seeking solutions to solve the problem of infertility, to managing stressful situations related to stigma and discrimination. Among the eight ways of coping identified by Folkman *et al.* (1986) only confrontive coping was *not* used by childless women. As shown in the theory chapter *confrontive coping* includes strategies like aggressive efforts to change the situation, trying to find the responsible person that caused the problem and expressing anger towards the person who caused the problem. These specific strategies didn't work in the case of my informants since the cause of infertility is mainly associated with God's Will.

*What does a childless woman have except her belt?*

*Her home will be abandoned after her funeral.*

(Amharic funeral poem)

## **8.4. Recommendations**

My finding showed us the perceived causes and treatments of infertility are mainly non-medical. Even some perceived solutions to infertility are medically identified potential causes of infertility. Consequently, childless women are exposed to severe stigmatizations which make their lives bitter. Therefore, averting the stigmatization problem calls the attention of responsible bodies to exert a great deal of effort in creating awareness on the medical causes and treatments of infertility. As Orthodox Christianity is widely accepted in the study area, the Ethiopian Orthodox Church and related religious institutions can play a pivotal role in this regard. The study also found out that most of the childless women have practical economic problems to get medical infertility treatments and to secure their old age. It will be good if responsible bodies should give due attention in developing short term plans and programs that create affordable and accessible medical treatments for infertility and that guarantee old age security for the socially disadvantaged elderly childless women.

This research has achieved its objective in identifying the socio-cultural perceptions of infertility and the implications of these perceptions on childless women's lives in South Gondar, Ethiopia. However, it will be very interesting if future research can be conducted combining the problems of both primary and secondary infertilities to know if secondary infertility has the same impact as primary infertility. From the experience of the two male informants of this study, we have seen that infertility has a negative impact on men's life too. This signals the significance of future research on childless men to explore their life experiences and to see if they face similar stigma as do childless women. It will be also interesting to do a study in polygamous societies to see if the pressure to bear a child for a childless wife is as strong as we saw in this study where monogamous marriages are predominant.

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# APPENDIX 1: Interview Guide

## I. In-depth interview for primary infertile women

### A. *Background information:*

- Where are you coming from?
- Do you have formal schooling? If yes, up to what level?
- What is your religion?
- What is your occupation?
- What was your age at first marriage?
- Who arranged the marriage?
- How was your marriage ceremony?
- Do you have married siblings?
- Have you been divorced, if yes, why? And how many times?
- If the reason of your divorce is your being infertile, do you hope of remarrying another to give birth?

### B. *Infertility and its causes:*

- When do you start thinking about being infertile?
- How do you know you are infertile? Have you undertaken an infertility test?
- Is there other person in your family who is infertile?
- What do you think are the reason of your being infertile? Starting from childhood, bad luck, problem with your husband, taking contraceptive, having abortion before, having sexually transmitted disease before,
- Have you tried anything to conceive?

### C. *Social support and stigma:*

- Have you faced any discrimination from your husband, your husband's family, or your family?
- What are the particular words and expressions used by people to insult you?
- Is other people talking about you behind your back or talk directly about your problem?
- Is there any one that supports you?
- With whom you discuss your problems
- How your being childlessness affect your economy positively/negatively?
- What will be your reaction when you faced internal emotional problems or external discrimination due to your being childless?
- Have you consulted the priest? What is the opinion of the church/mosque about infertility?

### D. *Fosterage or adoption as a solution:*

- Do you have foster or adopted children? If no, why? If yes, do you feel the foster or adopted children as yours?
- What do you think about the benefit of fostering or adopting children?
- What kind of children do you want to adopt: orphans, children with blood relation; children at early age, grown up children?
- What is the value of own children?
- What do you think about the age in which people badly need the support of children?

### E. *Care taking:*

- What is your relation with children?
- What do you feel when you see any other children or pregnant women?
- Have you engaged in giving care for children in your family or neighbourhood? If no, why?

***F. Futurity:***

- Do you have a plan to adopt children?
- Have you heard about the probability of fertility success in other infertile women?
- Do you believe you will have a child in the future? if yes how? If no, why not?
- What life will be like in the future, what is your options and plans?
- What do you feel about yourself?
- Do you have any question?
- Do you want to add anything?

***Thank you very much for sharing me your life experience!***

**II. Semi -structured interview with health workers**

- What looks like the general trend of family planning initiatives in the region?
- What is the overall situation of the problem of infertility in this area?
- Do people come in the health centre seeking for infertility treatment?
- How does the community treat infertile women?

***Thank you very much for your contribution!***

**III. Group Interview with religious leaders**

- What do you think are the causes and solutions of infertility? (According to religion)
- Do you think there is permanent infertility?
- Is there a problem of infertility for men?
- Do women come to religious places seeking for infertility treatment? Could you give me an example and its result (success/not)
- How does the community treat infertile women?

***Thank you very much for your contribution!***

**IV. Focus group discussion with community members**

- What do you think are the causes of infertility?
- What do you think the treatments of or solutions to infertility?
- Could you give me examples/proverbs that said for infertile women/men?
- Who do you think mostly infertile? women/men?
- How does the community treat infertile individuals?

***Thank you very much for your contribution!***

## APPENDIX 2: Sample Contact Summary

<p><b>Contact summary form (adapted from Miles and Huberman, 1994)</b></p> <p>Site <u>Kirarm Eyesus</u> Contact date <u>25.5.2010</u> Summary date <u>25.5.2010</u></p> <p>Contact type <u>in-depth interview</u> Contact name <u>Debre</u></p>
<p>1. Main issues/themes that struck the researcher in this contact:</p> <ul style="list-style-type: none"><li>• Infertility has some sort of advantage for poor childless woman as it makes her a preferred wife for old widowers.</li><li>• Infertile women are buried differently (upside down) from other people.</li></ul>
<p>2. Summary of information gained from this contact:</p> <ul style="list-style-type: none"><li>• divorced 4 times</li><li>• unhappy about her current step-children</li><li>• wants to discuss her problems with friends</li><li>• tried holy water and other spiritual treatments to conceive</li><li>• planned to spend the rest of her life in religious places, if her current husband passes away</li></ul>
<p>3. Anything else that is interesting in this contact:</p> <ul style="list-style-type: none"><li>• She is free and open to talk about the issue and sometimes she makes fun out of her experience.</li></ul>
<p>4. New/remaining target questions</p> <ul style="list-style-type: none"><li>• Why infertile women are buried upside down?</li></ul>