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THE EXPERIENCES OF INFERTILE MARRIED AFRICAN WOMEN IN SOUTH AFRICA: A FEMINIST NARRATIVE INQUIRY

BY

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DEDICATION

This is dedicated to my mother, for teaching me to stand firm in the face of adversity and for always being my most influential source of education…your teachings will remain with me for life.

SUMMARY

Tittle: The experiences of infertile married African women in South Africa: A feminist narrative inquiry.

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This study explores the experiences of infertile married African women in South Africa. The study explores the women's emotional experiences, their experiences of their relationships and the possible ways in which their culture may have influenced their experiences. The literature review gives an overview of female infertility, motherhood and feminism- from its conception to its current status in South Africa.

The study is carried out in a clinical setting where the participants are already attending an infertility clinic for treatment. Six black women participate in this study and they are all married and experiencing primary infertility. This study does not include women experiencing secondary infertility because although they may presently be infertile, they have previously experienced one or more successful pregnancies. Therefore, primary infertility is chosen as the focus of this study because unlike secondary infertile women, primary infertile women have never experienced pregnancy and childbirth and thus their infertility is more noticeable and severe.

The study is qualitative in nature and it is conducted within a feminist social constructionist research paradigm. This research paradigm is deemed to be more relevant in researching an issue pertaining to women, because feminist research enables social scientists to explore women's social history, women's perception of their own situation, their own subordination and their own resistance (Mies, 1993). Through social constructionism, the women are each able to make meaning out of their experiences and to include the influences of their culture, gender and social context in the construction of

their experiences. Furthermore, since feminist research perspectives have supported the process of telling sensitive human stories as research, a narrative approach is employed in gathering information regarding the women's experiences of being infertile. Thus, through telling their own self-narratives, the women are able to relate their experiences as well as the events that took place in their lives regarding their infertility.

Structural narrative analysis as well as content narrative analysis are employed in the analysis of the women's narratives. What emerges from their stories is the hope and the subsequent disappointment that follows from their countless visits and consultations with different health professionals, both western and traditional, as they search for pregnancy. It also emerges that in addition to their personal experiences, these women's marital and familial relationships, as well as their extended social relationships, also contribute to the emotional distress that they experience as a result of their infertility. Although most of the women mainly report negative experiences, there are also some who report positive experiences and some form of support in their lives.

It is hoped that the results obtained from this study will enable psychologists to intervene effectively and to work collaboratively with other health professionals towards delivering services aimed at assisting infertile African women medically, socially and psychologically.

Key Words

Female infertility
Feminism
Social constructionism
Narrative
Gender
Motherhood
Feminist research
Narrative analysis
Culture
Reflexivity

OPSOMMING

Titel: The experiences of infertile married African women in South Africa: A feminist narrative inquiry.
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Hierdie studie eksploreer die ervarings van onvrugbare, getroude vroue van ‘n Afrika-afkoms in Suid-Afrika. Die studie eksploreer die vroue se emosionele ervarings, hulle belewenisse van hul verhoudings en die moontlike wyses waarop die vroue se kultuur hulle ervarings beinvloed het. Die literatuurstudie gee ‘n oorsig van vroulike onvrugbaarheid, moederskap en feminisme – vanaf hierdie denkraamwerk se ontstaan tot die huidige stand daarvan.

Die studie word uitgevoer in ‘n kliniese omgewing waar die deelnemers reeds behandel word deur ‘n onvrugbaarheidskliniek. Ses swart vroue neem deel aan hierdie studie. Hulle is almal getroud en lei aan primere onvrugbaarheid. Hierdie studie betrek nie vroue wat met sekondere onvrugbaarheid gediagnoseer is nie, aangesien hulle reeds een of meer suksesvolle swangerskappe gehad het, ten spyte van die feit dat hulle tans onvrugbaar is. Primere onvrugbaarheid is gekies as fokus van hierdie studie aangesien die primere onvrugbare vrou, nie soos die sekondere onvrugbare vrou, nog nooit ‘n swangersap of ‘n geboorteproses beleef het nie en dus is hulle onvrugbaarheid meer opsigtelik en ernstig.

Hierdie kwalitatiewe studie word uitgevoer binne ‘n feministiese sosiaal-konstruksionistiese navorsingsparadigma. Die navorsingsparadigma word beskou as meer relevant in die navorsing van ‘n onderwerp wat vroue raak aangesien feministiese navorsing die sosiale navorser instaat stel om die vroue se sosiale geskiedenis, hul persepsie van hulle eie situasie, hul eie onderwerping en hulle eie weerstand, te eksploreer (Mies, 1993). Deur middel van sosiaal-konstruksionisme is die vroue instaat

gestel om betekenis te vind in hul eie ervarings, asook om die invloed te ondersoek wat hul kultuur, geslag en sosiale konteks op hulle ervarings het. Aangesien feministiese navorsingsperspektiewe die sensitiewe vertelling van die mens se stories ondersteun as navorsing, maak die navorser gebruik van ‘n narratiewe benadering om inligting te versamel aangaande die vroue se ervarings van hul onvrugbaarheid.

Strukturele narratiewe analise sowel as inhoudelike narratiewe analise word gebruik in die analise van hierdie vroue se vertellings. Temas wat opgesluit is in hierdie vroue se stories is hoop maar dan ook die teleurstelling wat volg na hulle herhaaldelike besoeke en konsultasies met verskillende geneeskundiges, beide westers en tradisioneel, in hul soektog vir swangerskap. Hierdie vroue beleef ook emosionele pyn en ‘n verlies aan ‘n gevoel van ‘n eie identiteit. Hulle voel ook dat hulle ‘n mislukkig is omdat hulle nie hul rol kan vervul as vrou maar ook as huweliksmaat nie wat gekoppel is aan hul onvermoe om kinders in die wereld te bring. Dit kom ook na vore dat addisioneel tot hulle eie ervarings, speel hierdie vroue se verhoudings met hulle eggenoot, hulle familie asook hulle uitgebreide sosiale verhoudings, ‘n rol en dra ook by tot die emosionele spanning wat hulle ervaar as resultaat van hulle onvrugbaarheid. Hoewel meeste van hierdie vroue hoofsaaklik negatiewe ervarings rapporteer**,** is daar ook sommige wat positiewe ervarings en ‘n vorm van ondersteuning in hulle lewe rapporteer.

Op grond van die studie se resultate word voorstelle gemaak ten opsigte van effektiewe sielkundige intervensies asook hoe sielkundiges saam met ander geneeskundiges kan werk om onvrugbare vroue van ‘n Afrika-afkoms te ondersteun op ‘n mediese, sosiale en sielkundige wyse.

Sleutelwoorde

Vroulike onvrugbaarheid; Feminisme; Sosiaal – konstruksionisme; Narratief; Geslag; Moederskap; Feministiese navorsing; Narratiewe analise; Kultuur; Refleksiwiteit

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CHAPTER 1

INTRODUCTION

1.1 Background of the study

This study explores the experiences of infertile married African women in South Africa from a feminist social constructionist perspective, employing a narrative form of inquiry. The study therefore takes into account the social and cultural processes involved in the women's constructions of their personal experiences. This study takes place in a clinical setting and the participants involved were already attending an infertility clinic at a local hospital in a township area.

The study focuses on women experiencing primary infertility. Primary infertility is defined as the inability to become pregnant or conceive after 12 months of unprotected sexual intercourse (Mazor & Simons, 1984). Thus, the study does not include women experiencing secondary infertility because although they may be presently infertile, they have previously experienced one or more successful pregnancies.

Although infertility is mainly a biological problem that may affect women of all races, this study focuses mainly on African women. In this case, African, also commonly referred to as Black, pertains to the native inhabitants of South Africa who speak indigenous languages (Abate, 1997). In this study, the words African and Black are used interchangeably to refer to the same group of people. This is due to the fact that, in South Africa, the group of people referred to as Africans is also commonly referred to as Blacks. Within the South African context, an African or a Black person pertains to the dark skinned people of South Africa who speak indigenous languages. Furthermore, Black people in South Africa have been anthropologically classified into four main ethnic groups, namely the Nguni (who consist of the Zulu, Swazi, Xhosa and Ndebele), the Sotho (who consist of the Southern Sotho, Northern Sotho and Tswana), the Tsonga / Shangaan, and the Venda (Nzimande, 1996). Although each group has its own culture,

Nzimande (1996) contends that these ethnic groups also show a remarkable degree of cultural cohesion with similar marriage and family structure, and therefore, research on these ethnic groups is usually reviewed broadly rather than focusing on each ethnic group separately.

Considering that the study is conducted within the South African context, and particularly on African women, their cultural aspects could not be excluded from the research. Culture is defined as an organised pattern of thoughts, values, beliefs and behaviour that is learnt and shared by a community (Visser & Moleko, 2001). It is a largely unconscious pool of information and set of decision-rules that tells its members how to perceive, comprehend, label, and understand -how to process- the input of the world (Goodenough, cited in Landrine, Klonoff & Brown-Collins, 1992). Therefore, although the study focuses on the individual experiences of infertile married women, it also explores the role that culture plays in shaping or influencing these individual experiences, because I am of the opinion that African women cannot be divorced from their culture, particularly when dealing with issues of marriage and reproduction.

1.2 Aims of the study

This study researches infertility among married African women. The aim of the study is to explore the experiences of these women, as well as the impact of the infertility on them. Thus, the psychological and social experiences regarding their infertility are explored. The research explores the women's emotional experiences, the experiences of their relationships and how the cultural meaning attached to infertility has influenced their experiences. It aims to explore how the women's constructions of female infertility and personal experiences are grounded in their socio-cultural context, thus explicating the social and cultural processes involved in the constitution of personal experiences.

1.3 Conceptualising the study

According to Boerma and Mgalla (2001), for clinical-epidemiological purposes, the World Health Organisation (WHO) Scientific Working group on the epidemiology of infertility defines infertility as the inability of a woman, man or couple to have conception after a period of two years of sexual exposure without contraceptives. Most clinicians, however, use a 12-month period of unprotected intercourse. Although infertility has generally been defined as a lack of conception after one year of unprotected sexual intercourse, over the years, this definition has become broadened to capture an inability to conceive, impregnate or carry a pregnancy to term and live birth. Thus, women who conceive but have subsequent miscarriages are considered infertile, just as women who are unable to conceive (Boerma & Mgalla, 2001). In addition, many textbooks for medical students and physicians differentiate between primary and secondary infertility. The former is the inability to become pregnant or conceive, while the latter is the inability to become pregnant or carry a pregnancy to term and live birth after one or more previous successful births (Upton, 2001).

For the purpose of this study, I focus on married women, who are married either in a legal and/or cultural manner. Marriage is defined as a socially approved mating arrangement, usually involving sexual activity and economic cooperation between a man and a woman (Popenoe, Cunningham & Boult, 1998). A legal marriage is one that has been formed after a woman and a man sign a legal marriage certificate, and a cultural marriage is one that is formed after a man pays lobolo, i.e. bridewealth for the woman. Regardless of the nature of their marriage, this study focuses mainly on those women who are experiencing primary infertility, meaning they have never been able to conceive. This is because women experiencing secondary infertility, unlike those with primary infertility, have experienced pregnancy and/or childbirth and motherhood. Although they may be struggling to fall pregnant or give birth again, they have previously had one or more pregnancies or children. In contrast to this, women with primary infertility have never conceived and thus, have never had any children. Therefore, I am of the opinion that these two groups of women may possibly experience their infertility differently. For

the primary infertile women, there has never been a previous pregnancy or childbirth; therefore their infertility is more noticeable and severe. For this reason, I have chosen primary infertility as the focus of this study.

According to Martin (1997), the incidence of infertility in South Africa was estimated to be 15% to 20% eight years ago. Recent estimates of the incidence and/or the prevalence of infertility in South Africa are difficult to obtain. This is because measuring the prevalence of infertility is difficult because it focuses on women who are still in their reproductive age span (women may still deliver a child before their menopause), and because it requires a delineation of a period of exposure to the risk of pregnancy (Boerma & Mgalla, 2001). Therefore, the demographic phenomenon of infertility is often overlooked. As Upton (2001) put it, individuals who are considered infertile are relatively invisible to policymakers and conventional demographic perspectives on fertility and sexuality in southern Africa. Local specialists in the field of reproductive health attribute the difficulty in obtaining the prevalence and incidence rates of infertility to the fact that individuals tend to consult different specialists in private practice and not in public institutions, where statistical records are usually kept (Futeran, 1989). Another problem could be due to the fact that Africans also consult with traditional healers, where records are not kept (Mabasa, 2002). In 2001, it was estimated that about 3 to 4 million women in sub-Saharan Africa are infertile (Boerma & Mgalla, 2001), but a distinction was not made between primary and secondary infertility.

Apart from race and culture, gender also plays a significant role in the way in which infertility is perceived and dealt with. Infertility may be due to the woman, the man or both. However, because the woman carries the child, she serves as the indicator of the infertility of the couple. Although the definitions of infertility clearly indicate that infertility concerns a couple system, most South Africans tend to view infertility as a woman's problem (Goosen & Klugman, 1996). To a certain extent, infertility in men is kept a secret in the black South African community (Mabasa, 2000) and it is believed that the man's virility depends on the fertility of a woman (Ngubane, 1977). Furthermore, literature regarding infertile couples indicates that regardless of whether it is the woman,

the man or both, who are infertile in a marriage, it is usually the women who suffer more psychological distress and guilt (Boerma & Mgalla, 2001; Mabasa, 2002; Mazor & Simons, 1984) and who are blamed and criticised by family, friends and society (Mathekga, 2001). Thus, the issue of the couple's infertility becomes mainly the woman's problem. In her study, Mabasa (2002) discovered that it was often the women and not the men who went to seek help for the couple's infertility problem. In addition to this, Mabasa (2002) further states that the division of Family Health and Mental Health from the World Health Organisation reported that reproductive health issues, including infertility, were accountable for many women seeking psychiatric and psychological services.

It is against this overall context of racial, cultural and gender differences and influences regarding infertility that this study is conducted. The study explores the social, gender and cultural processes involved in the construction of the experiences of infertile married African women.

1.4 Theoretical Paradigm

A paradigm serves a positive and constructive function for a science, acting as it does to encourage the continuing and progressively refined pursuit of knowledge through further articulation of the paradigm (Bohan, 1992). Science proceeds within a paradigm, the dominant model or worldview of a given scientific community (Kuhn, 1970). Thus, only those questions, methods, concepts, conclusions, and interpretations that are congruent with the fundamental assumptions of the paradigm can make sense to those enmeshed in its web of meaning (Kuhn, 1970).

This study is conducted within a feminist social constructionist paradigm. Social constructionism provides the opportunity and the conceptual tools for making sense of women's place in psychology to date and for constructing a women-inclusive psychology for the future (Bohan, 1992). This holds true to the present study, as it is conducted on women, in an attempt to give them a place and to make their voices heard in psychology.

Feminist social constructionism emphasises the importance of knowledge gathering as a personal activity, in which the researcher and the researched are recognised as in relation to one another (Gergen & Davis, 1997). Both must take into account their own experiences, gained from their own perspectives (Haraway, 1988). Thus, the researcher becomes part of the research process, rather than adopting the traditional research approach of showing an indifferent, disinterested, alienated attitude towards the research objects (Harding, 1987). This reflexivity enables researchers to participate with their participants in relationships with a high degree of openness, and to frequently reflect on their own position, with respect to the context of their work (Gergen & Davis, 1997).

Therefore, as a researcher, having decided to operate within a feminist social constructionist paradigm, I recognised the impossibility of assuming a neutral stance during this research. For this reason, and also in line with the reflexive nature of the feminist social constructionist paradigm, I have adopted a reflexive form of writing throughout this thesis, by referring to myself in the first person, 'I', and not as 'the researcher'. This has allowed me to frequently reflect on my personal involvement, not only with the participants, but also with the research project as a whole. Sharing a similar race and gender to that of my participants enables me to relate to them as both a black person and as a woman, and therefore my own personal experiences cannot be divorced from my interaction with the participants and with the research project as a whole.

1.5 Motivation for the study

This study is an explorative research project, and the purpose of such research is to gain insight into a situation, phenomenon, community or person (Bless & Higson-Smith, 1995). The need for such research arises out of a lack of basic information on an area of interest. I have developed a personal interest regarding the issue of infertility among African couples, particularly women. As a black young woman living in a South African township, I grew up being exposed to married African couples that were childless as a result of infertility. My curiosity arose as I came to realise that the couple's family and community members always conclude that it is always the wife who is infertile and as a

result, she is ostracised, rejected, disrespected and called names. Furthermore, I have always heard of insulting and derogatory names for infertile women in the Sotho language, but there has never been a name or a word for an infertile man. I have come to realise the pressure and demand placed on women to provide children for their in-laws as soon as they are married, and how much they suffer when they cannot produce any children in their marriage. Therefore, it is against this background that my interest developed more towards exploring the experiences of infertile women because it has always appeared to me that they are blamed and made to suffer more than their husbands.

During the literature review, I was faced with a lack of relevant information pertaining to this topic within the South African context**.** The available literature on infertile women is restricted in that the women who were studied and discussed were mostly white, middle class and urban. Therefore, a concentration on this limited population cannot be used to suggest a unified experience of infertility by other classes and races. Thus, the current study is based within the South African context and focuses on African women, thus giving them a voice in the field of scientific research, because they have been under-represented regarding research into the issue of infertility.

I hope that the results obtained from this study will enable psychologists to intervene effectively and to work collaboratively with doctors and social workers towards delivering services aimed at assisting infertile African women medically, socially and psychologically.

CHAPTER 2

INFERTILITY: ITS CAUSES, HISTORY AND IMPACT

2.1 Introduction

Although infertility is primarily a physical condition, it cannot be divorced from the psychosocial and cultural aspects that are inherent in our society. Thus, although the physiological processes involved in infertility receive attention in the present chapter, further attention is also paid to the psychological and cultural processes that may influence the way in which women experience infertility. Due to the fact that infertility has always existed, women's reproductive roles, as documented in history, are also discussed, so as to provide a picture of the way in which infertility was historically perceived within society and culture. The chapter then concludes by looking at how gender differences influence the way in which men and women react to infertility.

2.2 Biomedical determinants of female infertility

One third of all cases of infertility in South African women result from pelvic infections due to sexually transmitted diseases, another one third is due to hormonal imbalances and the remaining one-third result from unknown causes (Goosen & Klugman, 1996). Other genetic causes of female infertility, namely, "disorders of gonadotroph, disorders of female sexual differentiation, disorders of the uterus and female reproductive tract, disorders of the ovary and disorders of the pelvic cavity", have also been postulated by the European Society of Human Reproduction and Embryology in their article (ESHRE, 2002, pp. 441-442). Odendaal, Schaetzing and Kruger (1993) have also identified congenital or developmental factors, ovulation disturbances, tubal problems, uterine problems and vaginal-cervical problems, as other causes of infertility in women.

According to Williams, Bischoff and Ludes (1992) infertility in women is due to three primary biological causes. Firstly, the woman may not be producing and releasing mature eggs due to hormonal problems or ovarian cysts. Secondly, scarring or adhesions may

interfere with the fallopian tubes being able to properly transport the egg from the ovary to the womb. Thirdly, structural abnormalities or hormonal problems may result in the fertilised egg being unable to properly implant in the uterine lining.

However, people's social and cultural contexts have an influence on their understanding and explanation of the causes of infertility. Cultural understandings of conception and the meaning of witchcraft in everyday life may influence people's perceptions of the possible factors that may cause infertility. Thus, local and cultural perceptions of the causes of infertility can be different from those influenced by western medical understandings (Mabasa, 2002), and they are discussed below.

2.3 Cultural causal explanations for female infertility

Many African women attribute their infertility to sorcery and witchcraft (Ngubane, 1997). Many studies have found that infertility among Africans is usually attributed to witchcraft (Mabasa, 2002; Upton, 2001). Blood relatives, disgruntled or jealous neighbours, co-wives, past lovers or former husbands and in-laws, can use witchcraft. Women are usually seen as the ones who have been bewitched. In their study on infertile African women, Boerma & Mgalla (2001) discovered that women need to take care with regard to their menstrual cloth. Several women reported that a woman should not leave her cloth out in the open to dry after washing because anyone can steal it and bury it in a place where grass cannot grow, and this can block a woman's menses and thus, her fertility. Similar to this, in her study, Mabasa (2002) found that one of the emergent sub-themes related to witchcraft was the belief that a woman was not able to conceive because she had either lost her panties or had her panties stolen. According to these women, the witch performs a ritual on the panties to block the woman's reproductive ability. Some believe that this type of witchcraft works if the panties are worked upon when stained with the woman's menstrual blood (Mabasa, 2002).

Infertility induced by witchcraft is also believed to be the result of someone gaining access to a woman's postpartum blood, underwear, or the cloth used to clean the genitals after sexual intercourse. Thus, great care is supposed to be taken to safeguard these items,

as their use in witchcraft could block a woman's future fertility (Boerma & Mgalla, 2001). Fertility is also believed to be susceptible to other types of witchcraft medicines, which might be put into the food of an unsuspecting woman, placed at the crossroads where she is likely to pass, or placed on a chair on which she is likely to sit (Boddy, 1989).

The blood compatibility of the two people involved in sexual intercourse is also believed to be the cause of an inability to conceive. Both men and women believe that infertility is caused by incompatible blood of an infertile couple (Mabasa, 2002). This is believed to take place in the following way: the woman's blood gets mixed up with the blood of everyone she has slept with and the man's blood gets mixed up with the blood of everyone he has slept with. When these two people, in turn, have sexual intercourse, their separate 'bloods' have to fight it out and the man's blood battles the blood of all the men that the woman has ever slept with (Boerma & Mgalla, 2001). Thus, infertility occurs as a result of the separate bloods being incompatible and thus, unable to join together.

2.4 A historical background of women, motherhood and infertility

Since women, more then men, have been identified with their reproductive organs, the historical material that discusses infertility and the causes of infertility is almost exclusively centered on the female experience. Moreover, the female experience is further restricted in that the women who were studied and discussed were more likely to be white, middle class and urban (Valentine, 1988). Therefore, a concentration on this limited population cannot be used to suggest a unified experience of infertility by other classes and races. Rather, these writings can be used as an indication of the historical practices of women, motherhood and infertility, rather than their subjective experiences, because each woman experiences her own infertility differently.

Thus, below follows a historical account of women, motherhood and infertility as it has been documented in European and American history.

2.4.1 The Colonial period

In Colonial America, during the 17th and 18th centuries, a large family was an asset in a labour-intensive agricultural economy and fertility was associated particularly with women (Valentine, 1988). Colonial women of completed fertility had an average of eight children, making American fertility one of the world's highest (Grabill, Kiser & Whelpton, 1958). However, in spite of the value assigned to the reproductive abilities of women, colonial America did not idealise motherhood and a childless couple was not free to terminate their marriage in the hope of securing another spouse who might prove more fruitful (Valentine, 1988). The labour of the women was essential to the survival of the household and there were very few negative expectations of what was appropriate female work. Thus, the distinction between the gender roles of men and women was blurred by the economic demands of colonial America. Therefore, although childlessness might have been a distressful condition for a colonial woman, she was not without value in a society that depended on women for the extensive work necessary for survival (Valentine, 1988).

2.4.2 The Victorian period

By the middle of the 18th century, the subsistence of the colonial period was giving way to a commercial one. The social and economic roles of women were changing and new prescriptions for what was called 'true womanhood' dictated that proper women limit their activities to the domestic sphere. The asexual colonial role of parenthood was replaced by an expanded concept of motherhood, and the image of 'woman as mother' was reinforced. Motherhood had, in turn, moved to centre stage and in 1914, a joint resolution passed by the entire United States Congress declared the second Sunday in May as mothers' day and motherhood became the essence of femininity (Valentine, 1988).

However, associated with the notion of maternal instinct was the implication that women who did not become mothers remained unfulfilled. Even feminists believed that those women who passed through life failing in childbearing, could not be said to have lived to

the best purposes of a woman's life (Gordon, 1978). Infertile women were not only perceived as unfulfilled, but also as less feminine than other women. It was also believed that infertile women were particularly vulnerable to insanity, cancer and degenerative diseases, and they were judged to have brought their condition upon themselves (Harris, 1978).

2.4.3 World War II

World War II changed the roles of women in society. In order to fill the needs of the wartime economy and maintain a huge army, society turned to women. Whereas women had previously been criticised for leaving the domestic sphere, they were now praised for responding to their country's needs. The rate of female employment continued to increase in the post war decades and by 1960, twice as many women were at work as in 1940 (Chafe, 1974). The domestic sphere remained a central focus of women's lives, but it was no longer the only focus, and therefore more women had employment options outside the home, which had not existed before (Valentine, 1988).

2.4.4 Post World War II

Despite the radical change in the employment of women, the persistence of views about women's proper role continued into the post war period. These views were supported by Freudian psychology. An important disciple of Freud who more fully developed a Freudian position on women was Helene Deutsch. Her work became a Bible for psychoanalytic practitioners with a female clientele and gave new support to the cult of motherhood (Ryan, 1983). Deutsch argued that even female sexuality was part of the desire for motherhood. Therefore, she encouraged fertility as natural and as a protection against psychic loss in women, by stating that having many children was the best protection against this tragic loss of the mind (Ryan, 1983). Thus, based on this analysis, an infertile woman would presumably suffer psychological damage.

Women's magazines reflected this particular post-war preoccupation with maternity and essentially proclaimed that 'motherhood is a way of life' (Valentine, 1988). Advertisers in magazines and television targeted women as mothers and homemakers who would make increasing purchases for their expanding families. Thus, when women saw themselves portrayed in the media, it was more often than not in the clothing of motherhood. As a result of this, the trappings of a society that fully encouraged childbearing surrounded infertile women and they had good cause to feel excluded from the female experience of their generation.

From the above mentioned historical overview of women, infertility and motherhood, it is evident that the historical periods that defined women as biologically distinct and suited primarily to motherhood caused infertile women a lot of distress and made it more difficult for them to secure a positive image for themselves in society.

2.4.5 An African cultural perspective on women, motherhood and infertility

Infertility is a problem that has always existed. People have attempted to solve it in a variety of ways, ranging from faith in miracles and magic, to a reliance on modern medicine. Every culture has had its set of customs and folklore for the relief of infertility (Johnston, 1963). The role of the male in reproduction was poorly understood and consequently, many primitive communities considered conception to be exclusively a woman's responsibility. Infertility may be due to the woman, the man or both. However, because the woman carries the child, she serves as the indicator of the fertility of the couple (Mazor & Simons, 1984).

Literature indicates that in African culture, infertility is mostly perceived as the woman's fault and not the problem of the couple. According to Ngubane (1997), in the African culture, a woman receives or takes in the seed that grows to be a baby- just like a seed of maize, which, because of the warmth of the fertile soil, germinates and develops to root. As long as the man is potent, he is not sterile. It is the woman who is said to be infertile, and the man's virility depends on the fertility of a woman.

Childbearing is an important factor in African marriages. Children are important for the whole kin group among Africans, to the extent that they are thought of as belonging to everybody in the system, not just to the parents (Mabasa, 2000). Childbearing and bringing up children serves to perpetuate the family name and to maintain the link between the ancestors and the living (Mabasa, 2002).

In African marriages, the practice of lobolo (bride wealth) has significant implications for the woman's ability to bear children. Ziehl (1994) postulates that the practice of lobolo implies transfer of a woman's reproductive rights from her family of origin to her family-in-law. From this perspective, lobolo is viewed as compensation to the woman's family of origin for loss of control over their daughter's present or future offspring (Mabasa, 2002). Thus, when a woman does not get pregnant fast enough, and the husband or the in-laws become impatient, they can decide to divorce her and they will claim back the lobolo they have paid for her (Boerma & Mgalla, 2001). However, in some cases, no divorce will be demanded and the infertile women may stay married. This takes place when the husband takes on another wife and the women live in polygamous unions.

A wife who is infertile is considered a loss to the in-law family because the children she bears are seen as the profit (gain) for the lobolo (bride wealth) they paid for her (Boerma & Mgalla, 2001). Thus, to have children is a profit and the inability to have children is a loss to a woman's family- in-law. The husband's family invested the family's capital (lobolo) in the woman so as to obtain her reproductive services; so practically, she owes children to her husband and to her husband's family. Therefore, a woman who is unable to produce children is faced with the reality of a polygamous marriage. The husband takes on another wife, who is fertile, and she bears him children. The fertile wife receives all the respect and attention, while the infertile one is ridiculed and neglected. Furthermore, infertile women have to cope with unfaithful husbands more often than other women have to, because these men are under pressure to prove their fertility outside their marriages (Boerma & Mgalla, 2001).

In contrast to the practice of men marrying other women to bear them children, in some South African ethnic groups, such as the Northern Sotho's, an infertile woman is allowed to marry a wife who can bear children on her behalf (Mathekga, 2002). These woman-to-woman marriages refer to a situation where the woman gives lobolo (bride wealth) to another woman who is fertile so that she can start a family through her (Kango-Male & Onyango, 1994). Thus, a barren wife can save her position in the family by obtaining a wife for her husband, with children of the union becoming hers. A similar practice to this one can also be historically traced back to Biblical times. The first book of the Bible, Genesis, tells the story of Sarah and Abraham. Sarah, long married to Abraham and childless, suggested having Hagar, her slave-girl, engage in sexual intercourse with her husband, Abraham, so she could bear them a child. Abraham agreed with his wife and engaged in sexual intercourse with Hagar, which resulted in the birth of a son, Ishmael.

Childbearing is an essential part of adult women's lives. One often needs to conform to the social pressure of parenthood in order to avoid the possible stigmatisation associated with infertility. In African cultures, a woman without a child is excluded from important cultural activities and seen as invaluable. For example, Mbiti (1989) postulates that an infertile woman cannot be involved in the naming of the child rituals because names are only chosen by women who have children. To add on to this, in her study, Mathekga (2001) refers to a news report on SABC 2 television channel news, following the marriage of King Letsie III of Lesotho, which stated that his new wife would not be given a royal name until she had given birth. This is another example of how the value of a married woman is based on her ability to give birth.

Another cultural practice that is exercised by many African cultures is that of naming the daughter in-law after she marries. Traditionally, when an African woman has been paid lobolo for, she is required to spend a specified period of time with her husband's family, and perform household duties as their daughter in-law. Upon her arrival to her in-laws' home, her in-laws give the woman a name and she is addressed by that name. For example, for the Southern Sotho people, a woman's in-laws would name her 'mma–mang - mang', which means ' mother – of – so – and – so'. This clearly has implications

for the woman in that she is expected to bear a child who will be given that name. Thus, if, for instance, her in-laws name her 'mmathapelo', which means 'mother-of-Thapelo', she is expected to bear a child and that child will be named Thapelo. For the infertile woman, who may never be able to fulfill this obligation, this creates a lot of frustration and distress on her part, as well as disappointment from herself, her husband and her in-laws.

From the above discussion, it is evident that a married African woman is faced with a lot of cultural expectations and obligations regarding childbearing. Her value as a wife is highly dependent on her ability to give children to her husband and to her family in-law. Thus, her infertility not only becomes an individual, personal problem, but it is rather a problem embedded in her socio-cultural context as well.

2.5 Gender differences in responding to infertility

Daniluk (1991) reported that couples who are infertile experience communication problems, which occur as a result of their difficulty in sharing feelings. The problem in communication can result in marital discord when the couple is not sharing the same feelings. Gender seems to play a significant role in influencing the different ways in which men and women experience their emotions and how they express their emotions in relation to infertility. Below follows a discussion on how men and women respond to infertility within a couple system.

2.5.1. Men's responses

Literature indicates that men do not appear to respond as negatively to infertility as their partners do. In terms of coping, infertile men appear to engage in denial, distancing, or avoidance (Mason, 1993) and these are strategies that may exacerbate marital tensions and prolong the pursuit of alternate solutions to the couple's childlessness. The crisis of infertility for a man also relates to failure to carry the family name forward, as this failure represents a mortality of the self and of the family (Ngubane, 1997). The one factor that appears to be associated with a more negative male response to infertility is the receipt of a male factor diagnosis (Leiblum, 1997). Men in infertile marriages characteristically

assume that their wives are the source of the couple's infertility, and they are often quite disbelieving when shared or male factor aetiology is diagnosed (Valentine, 1988). These men experience strong feelings of guilt, shame, anger, isolation, loss and a sense of personal failure (Mason, 1993). Infertile men also appear to remain considerably more isolated in this area of their lives, emphasising privacy relative to the couple's fertility struggles (Leiblum, 1997). Some men also tend to play a supportive role, attempting to exhibit strength and to restore equilibrium (Mabasa, 2002), while others avoid discussions about infertility as a way of maintaining peace and emotional balance (Mason, 1993). Furthermore, for many men, infertility has a direct negative influence on the sexual relationship within their marriages, whereby the goal of intercourse becomes conception rather than enjoyment (Ndaba, 1994). For this reason, men then tend to engage in extramarital affairs for pleasure, not for procreation.

2.5.2 Women's responses

According to Leiblum (1997), researchers who have examined sex differences in response to infertility have reported that women experience considerably greater psychosocial distress, more somatic difficulties, lower self-esteem, higher levels of depression, and greater interpersonal sensitivity related to their infertility. When fertility problems occur, women appear to attribute the cause of the infertility to their own biological failure, or to past behaviours or perceived transgressions, such as relinquishing a child for adoption, having an abortion, or having an extramarital affair (Daniluk, 1991). This self- attribution of responsibility appears to be evident, even when the couple receives an exclusively male factor diagnosis (Mason, 1993). Women perceive their inability to conceive as a reflection of their incompetence as women. They appear to be more sensitive to fertility-related stimuli (e.g. Pregnant women, babies, etc.) (Daniluk, 1991). This sensitivity was expressed by a man in a study done by Valentine (1988, p. 52) in the following way:

> " It didn't bother me as much as my wife because guys are not around children and mothers and females, talking about children and pregnancy and all that."

Furthermore, women being in patriarchal relationships where the children carry the names of their fathers may be depressed due to guilt feelings of failure to bear children for their partners (Mabasa, 2002). However, while women report more overt distress in response to their inability to produce a child, these women appear to more actively seek information and solutions to the couple's infertility problem than their male counterparts (Leiblum, 1997).

2.6 Conclusion

The biological, psychological and socio-cultural aspects of female infertility were explored in this chapter. Although infertility is a problem that has always existed, it appears that there is still a wide spread belief that it is mainly a woman's problem. For this reason women have carried, and are still carrying the blame and stigma of infertility within a marriage system, and as a result, they suffer more socio-cultural and psychological distress than their husbands. Due to this gender imbalance, this current research is conducted within a feminist social constructionist paradigm with the hope of understanding and changing the subordinate situation of infertile women in marriages. Therefore, a discussion on feminist psychology is the focus of the next chapter.

CHAPTER 3

FEMINISMS AND FEMINIST PSYCHOLOGY

3.1 Introduction

Due to the fact that this research project is carried out from a feminist perspective, it is of great importance that feminist psychology be explored in this chapter. Thus, an overview of the history and development of feminism and feminist thought in Great Britain and America, followed by the development of black feminism, are discussed. The chapter then focuses on the social construction of gender and ends with an overview of the issues surrounding feminism in South Africa.

3.1.1 Defining Feminism

The term 'feminism' first came into use in the English language during the 1980s, indicating support for women's equal legal and political rights with men (Bryson, 2003). Feminism is defined in Webster's New World Dictionary (1978, p.514), as (a) the principle that women should have political, economic, and social rights equal to those of men, and (b) the movement to win such rights for women. Collins English Dictionary (1979, p.534) defines feminism as a "doctrine or movement that advocates equal rights for women." For the purpose of this study, the concept of feminism will be applied in exploring the experiences of infertile women within their marriages, where they are usually seen as unequal, subordinate and oppressed, in relation to their husbands.

But what exactly is feminism? A general definition might state that it is the belief that women, purely and simply because they are women, are treated inequitably within a society which is organised to prioritise male viewpoints and concerns (Gamble, 2001). Within this patriarchal paradigm, women become everything men do not want to be seen to be: where men are rational, they are emotional; where men are active, they are passive, and so on (Gamble, 2001). Therefore, feminist emphasis on women's experience is

important as a political strategy that has given voice to women's oppression by, and resistance to, patriarchal prescriptions (Gavey, 1997).

Feminism is a woman-centered description and explanation of human experience and the social world (Belknap, 2001). It is active and seeks social change to end the neglect and subordination of women (Danner, 1989). The approach of feminism has been to attempt to answer the woman question, where partial and provisional answers intersect, joining together both to lament the ways in which women have been oppressed, repressed and suppressed and to celebrate the ways in which so many women have beaten the system, taken charge of their own destinies, and encouraged each other (Tong, 1989).

Black feminist bell hooks defines feminism simply as "the struggle to end oppression" (hooks, 1984, p.26). She compares patriarchy to racism and other forms of oppression and points out that for sexism to end, racism and other forms of oppression cannot remain intact (Belknap, 2001).

Finally, in its broadest sense, feminism constitutes both an ideology and a global political movement that confronts sexism, a social relationship in which males as a group have authority over females as a group (Collins, 2001). It seeks to modify or transform pre-existing gender relations to allow women and men equal rights and opportunities within a particular socioeconomic framework (Drew, 1995).

From the above definitions, it becomes clear that a concept which is closely related to the definition and understanding of feminism is gender, as it rests mainly on the differences between males and females. Therefore, what follows is a brief discussion of gender and how it is constructed in society.

3.2 The social construction of gender

Gender is one of the most salient categories by which people judge and evaluate others (Deaux, 1984). Gender is defined as culturally-determined cognitions, attitudes and belief

systems about females and males (Worell & Remer, 1992). The social construction of gender defines our knowledge, attitudes and beliefs about women and men (Worell & Remer, 1992). Thus, the characteristics that we attribute to gender are not true attributes of females and males, but are socially constructed categories that function to maintain female-male dichotomies and male-dominated power structures.

The study of the social construction of gender helps us to understand how gender is shaped and given meaning by the social structure of a society. Within the realm of feminism, the social relations of gender are ones in which women are treated as inferior and subordinate to men, and thus gender divisions are exploitative and oppressive (Alsop, Fitzsimons & Lennon, 2002). The social construction of gender creates in each of us a self-image of who we are as females and males and how we should behave. From this perspective, the cognition that "I am a woman" functions to activate a woman's entire experience of femaleness in society, and serves as a general schema that shapes women's current and future activities (Worrell & Remer, 1992). Gender also structures the expectations and behaviours of those with whom we interact, resulting in self-fulfilling prophecies that shape our behaviour to meet the expectations of important others (Deaux, 1984).

It is important to consider two major approaches to gender-related characteristics, those that exaggerate the differences between females and males, and those that overlook them (Worell & Remer, 1992). Hare-Mustin and Marecek (1988) refer to these two stances as alpha bias and beta bias, and maintain that bias towards either approach to gender is problematic for women. According to Hare-Mustin and Marecek (1988), alpha bias assumes an essentialist position, that there are real and enduring differences between the orientations, abilities and values of women and men. This position tends to dichotomise women and men, to support different roles based on their natural dispositions and to encourage separation. Essentialist views construe gender as resident within the individual, a quality or trait describing one's personality, cognitive process, moral judgement, etc. (Bohan, 1997). Therefore, essentialist views portray gender in terms of fundamental attributes that are conceived as internal, persistent, and generally separate

from the on-going experience of interaction with the daily sociopolitical contexts of one's life (Bohan, 1997). The basic assumption of essentialism is that gender is a permanent and stable feature of the individual (Gergen & Davis, 1997). It assumes that human beings have an underlying universal nature, one that is more fundamental than any variations that may exist among us and that it is in some sense always present - perhaps as genetic propensity - even if it is not discernible (Oyama, 1997).

On the contrary, beta bias overlooks or minimises differences between women and men (Hare-Mustin & Marecek, 1988). Minimising sex differences can frequently lead to disadvantaging women, such as assuming that they have equal access to resources and equal opportunities in relationships, employment and leadership positions (Worell & Remer, 1992), when it is actually not the case.

However, due to the lack of balance between the two major approaches to gender-related characteristics, many writers realised that more research and theory were needed in order to generate more knowledge that could assist in the development of less gender-biased and more balanced approaches to gender-related characteristics. Therefore, Worell & Remer (1992, p. 7) highlight four major outcomes of innovative research on women and gender, which are: (1) new information about women and their lives in contemporary society, (2) revised views of gender, sex, sex roles and gender related behaviour, (3) the rise of feminist theory, which serves as a guide to further research and practice, and (4) the applications of these innovations to professional practice.

As we use the term gender, it has several interconnected aspects. Firstly, gender is a feature of subjectivity. We identify and make sense of ourselves as men and women or boys and girls. Secondly, gender refers to the cultural understandings and representations of what it is to be a man or a woman. Thirdly, gender operates as a social variable, structuring the pathways of those so classified within society (Alsop, Fitzsimons & Lennon, 2002).

The use of the term gender has come under fire from within the feminist community for suggesting a false symmetry between men and women (Butler, 1993), for being unable to convey inequality and power, and for being politically benign (Evans, 1990). A distinction is usually made between gender and sex, by dividing the difference between men and women into two categories: sex differences and gender differences. Sex differences are biological differences, including differences in reproductive organs, body size, muscle development and hormones (Belknap, 2001). Gender differences, on the other hand, are those that are ascribed by society and that relate to expected social roles, such as professions, child-care responsibilities, wages (Belknap, 2001). Some feminists are of the opinion that most differences between men and women are gender differences, which are determined by society; they are not biologically determined. Moreover, socially based differences are rooted largely in inequality (MacKinnon, 1989) and because society creates these inequalities, society must also be the solution to restructuring the images and opportunities of women and men in order to achieve equality.

Women and men's different roles historically have been viewed as biologically based and unalterable (Evans, 1990). More recently, however, feminists assert that women's roles are learned and socially determined (Klein, 1984). Thus, it is important to examine and acknowledge how sex differences influence gender differences. West and Zimmerman (1987, p. 127) call for the need to understand sex and gender as they define sex as "a determination made through the application of socially agreed upon biological criteria for classifying persons as males or females." Thus, they point out that even sex is not immutable and is socially agreed upon biological criteria. On the other hand, gender, according to West & Zimmerman (1987, p. 127) "is the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category." Gender activities emerge from and bolster claims to membership in a sex category. Thus, gender is not simply an individual attribute, but rather is accomplished through interactions with others. It is viewed as both an outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental

divisions in society, the differences between males and females (West & Zimmerman, 1987).

Inherent in this distinction between sex and gender are the concepts of sexism and patriarchy. Sexism refers to oppressive attitudes and behaviours directed at either sex; that is, sexism is discrimination or prejudice based on gender, and directed primarily at women (Acker, 1990). Patriarchy, on the other hand, refers to a social, legal, and political climate that values male dominance and hierarchy (Acker, 1990). It is the ideology of male supremacy that results from the social construction of gender, which in turn justifies the social, economic and political distinctions between men and women (Bazilli, 1991). Central to the patriarchal ideology is the belief that women's nature is biologically, not culturally, determined (Epstein, 1988).

Understanding the distinction between sex and gender informs us that most differences between men and women and boys and girls are societally based (gender), not biologically determined (sex) (Belknap, 2001). However, childbearing, which is the central focus of this study, is both a societally (gender) and biologically (sex) determined attribute of women only, and this study examines how this may have negatively affected the lives of those women who are unable to bear children.

3.3 Feminist theory

The term feminist theory generally suggests a body of knowledge, which offers critical explanations of women's subordination (Stacey, 1993). It is an attempt to make intellectual sense of, and then to critique, the subordination of women to men. It does not seek to reinforce or legitimise, but rather attempts to undermine, expose, or challenge women's subordination (Stacey, 1993). Feminist theory offers some kind of analysis and explanation of how and why women have less power than men, and how this imbalance could be challenged and transformed (Robinson, 1993). A fundamental goal of feminist theory is to analyse gender relations: how gender relations are constituted and experienced and how we think or, equally important, do not think about them (Flax,

1990). The study of gender relations includes, but is not limited to, what are often considered the distinctively feminist issues: the situation of women and the analysis of male domination.

Cudd and Andreason (2005, p. 2) postulate the following three characteristics of feminist theory. Firstly, it sustains social criticism, by revealing subordination and the moral and political implications of that subordination. Since there are by definition those who benefit from others' subordination, it is essential that there be a way of proving that subordination exists and that it is morally unsupportable. Secondly, it provides a lens through which ideas and social practices can be analysed. Feminist theory has proven to be applicable across a wide variety of human thought and action, for it has shown that much of what we do, and how we conceptualise what we do is affected by gender. Thirdly, feminist theory offers visions of liberation, of what life, persons and society would be like without the subordination of women.

Feminist psychology arose out of a need for feminists to produce work about women's lives which is directly relevant to challenging women's oppression and improving women's position in society (Stacey, 1993). According to Worell and Remer (1992, p. 14), feminist psychology embraces the following five major tenets: (1) it recognises that the politics of gender are of central concern and are reflected in women's lower social status and women's oppression in most societies; (2) it seeks equal status and empowerment in society not only for women, but for all oppressed minority groups; (3) it values and seeks knowledge about women's experience; (4) it acknowledges that values enter into all human enterprises and that neither science nor practice can be value-free; and (5) it enables women to be committed to action for social and political change.

Feminists have produced diverse and competing theories about the general patterns of inequalities and the broader structures, belief systems and institutions that produce and organise particular experiences, in order to analyse, understand and hopefully, challenge women's subordination. These theories were produced as a result of the women's movements that took place in the United States. Feminist activities and movement

historians used the 'wave' model to describe the women's movement in the United States (Springer, 2002). Thus, it has become common place to refer to 'first', 'second' and more recently, 'third' attitudes or generations as if they were waves in the feminist critical tradition – from the suffragist movement of the 1920s, and into the newest recognisable phase of feminist thought, commonly understood as postmodernist (Howie & Tauchert, 2004). Therefore, below follows a discussion of the different 'waves' that make up the history of feminism, black feminist movement as well as feminism in South Africa.

3.4 First Wave feminism

The first wave is often dated to the publication of Mary Wollstonecraft's book, *The Vindication of the rights of woman,* published in 1792 (Cudd & Andreason, 2005). Mary Wollstonecraft was the first major feminist, and a *Vindication of the rights of woman*, written when the issue of the rights of man was bringing revolution to the United States, to France, and threatening even to shake the English parliament, was the feminist declaration of independence (Kramnick, 1975). Although there had been other feminist theorists, Wollstonecraft, who was a teacher and a writer in London, was the first to issue an outspoken rallying cry to middle-class women, especially mothers, as major influences on society. Wollstonecraft dedicated the *Vindication of the rights of woman* to the French minister, urging him that if women were excluded from the new French constitution, France would remain a tyranny (Donovan, 2001). Furthermore, having worked as a governess, and with sisters who ran a school, Wollstonecraft also stressed the importance of early moral and intellectual influences. In her opinion, all education for females was distinctly inferior to the education available for males (Wollstonecraft, 1980). Thus, although she accepted that most middle-class women would marry and remain at home, she wanted girls' education to prepare them for the possibility of economic independence, to give them freedom and dignity, rather than the ability to fascinate potential husbands (Gamble, 2001). She insisted that women had an independent right to education, employment, property and the protection of the civil law; this she argued was needed to ensure that women were not forced into marriage through economic necessity and that wives were not entirely dependent on the goodwill of their husbands (Bryson,

1992). In this way, she called for women to have access into the great enterprises of public life, and not be confined to the domestic sphere (Donovan, 2001).

Many other feminist writers came forth in Europe and America after Wollstonecraft as the 1950s generally saw a major resurgence of feminist activity. The specific injustices faced by mothers in unhappy marriages were one of the important issues highlighted during the feminist activities. According to Sanders (2001), in the nineteenth century, the status of a married woman was defined in such a way that within the marriage, the very being or legal existence of a woman was suspended, or atleast incorporated or consolidated into that of the husband, under whose wing, protection and cover she performed everything. To protest this issue, 25 000 women in England signed a petition in favour of married women's property ownership, and this resulted in limited legal rights being introduced by the Matrimonial Causes Act of 1857 (Donovan, 2001). The Matrimonial Causes Act was mainly concerned with divorce, since access to divorce was unequal for husbands and wives. Therefore, this Act transferred jurisdiction for divorce to the law courts and improved the position of women in divorce cases (Gamble, 2001). In 1882, there were 18 more acts released concerning married women's property, of which the most significant was the 1870 Act (Sanders, 2001). This allowed married women to keep their earnings and to inherit personal property.

Apart from marriage and divorce, education and employment spheres also underwent numerous changes as a result of the feminist movement. Initially, women's employment opportunities developed in areas that were seen as an extension of their 'natural' sphere as mothers and carers: teaching, philanthropy, nursing, and work on school boards (Sanders, 2001). However, the feminist movement's attack on the then current state of women's education and employment opportunities resulted in women being accepted into universities and being awarded degrees fully equal to men's; women being admitted into medical school and gaining new opportunities in public and clerical work (Donovan, 2001). Furthermore, the outbreak of the First World War in 1914 released women into new areas of work, especially nurses, to support the war effort. Thus, women's

participation in the war had come about by historical accident, and the new challenge was to educate them for active and responsible citizenship (Sanders, 2001).

First wave feminism marked the first outbreak of the feminist movement. Although some of the greatest reforms of women's social and legal position before those of the late twentieth century occurred in a few decades of the nineteenth century, many of those women who were active campaigners were ambivalent about the extent of their own feminism, and overanxious to distance themselves from unconventional lifestyles and behaviours (Gamble, 2001). Moreover, they seemed to be more concerned and focused more on the plight of intelligent middle-class single women. Thus, this made their contribution to the feminist cause narrowly specialised as they concentrated on a special group of women, to the exclusion of others. After the First World War, developments slowed down again until the next major outbreak of feminism in the 1970s, which is discussed below.

3.5 Second Wave feminism

The divergence of views in the early 1970s signals both the complex origins of second wave feminism and its internal divisions. According to Friedan (1965), to women born after 1920, feminism was dead history. It had ended as a vital movement in America with the winning of the final right to vote, and therefore, there was a period of relative inactivity in feminist theory and politics (Valian, 1998). Thus, in the 1960s, the onslaught of feminism was now resurgent, after being temporarily halted by a fifty-year counter-offensive. The symbolic beginning of the second wave is assumed to be 1968, but a change in emphasis can be detected throughout the 1970s from the earlier liberal agenda of equal pay and opportunities to a broader set of political goals (Saulnier, 1996). As the second wave of feminism gathered mass momentum during the 1960s, 1970s and 1980s, it generated a complex set of values, political positions, and strategies regarding the social changes needed to empower women to achieve equality with men (Spanier, Bloom & Boroviak, 1984).

The second wave movement is sometimes characterised by its efforts to move beyond the first wave and its focus on the political and legal sources of women's inequality. Second wave feminists maintained that, although important, political and legal equality were not enough to end women's oppression (Radcliff, 1980). In their view, sexist oppression is not simply rooted in legal and political arrangements; its causes are all pervasive and deeply embedded in every aspect of human social life – including economic, political, and social arrangements, as well as unquestioned norms, habits, everyday interactions and personal relationships (Cudd & Andreason, 2005). Moreover, second wave feminists criticised first wave for not going far enough in its economic reforms. They argued that feminism must demand full economic equality for women, rather than simple economic survival (Radcliff, 1980). Furthermore, they scrutinised areas of social life that were previously seen as political – such as the institution of marriage, motherhood, heterosexual relationships and women's sexuality – with the aim of radically transforming these aspects of both the personal and political life (Saulnier, 1996).

A central theme of the emerging second wave feminism was the process of 'consciousness-raising' - the move to transform what is experienced as personal into analysis in political terms, with the accompanying recognition that 'the personal is political'; that male power is exercised and reinforced through personal institutions such as marriage, child-rearing and sexual practices (Gamble, 2001). Thus, commitment to a female revolution in consciousness via the process of consciousness-raising became a defining characteristic of women's liberation groups. Furthermore, women's liberation groups held conferences, and the four main demands formulated at these conferences, for equal pay, equal education and opportunity, 24-hour nurseries, and free contraception and abortion on demand, signaled the double focus which also marked second wave feminism; on women as an oppressed social group and on the female body with its need for sexual autonomy as a primary site of that oppression (Thornham, 2001).

Second wave feminists set the terms of the current equality and difference debates, agreeing that the liberal political slogan 'equal but different' mystified the fundamental fact that masculinity is 'always already' valued over femininity, and men are guaranteed

a form of sanctioned domination over women (Howie & Tauchert, 2004). Feminism, then, sought both to voice women's immediate and subjective experience and to formulate a political agenda and vision (Gamble, 2001). As a conscious political movement, which sought to unite women through a sense of a shared oppression- however differently articulated- manifest at the level of the personal and subjective as well as the social, second wave feminism was characterised as much of the search for an over-arching theory as it was by activist struggles (Thornham, 2001). Other feminist theorists have described the way in which feminist activism 'opened a space' for them to rediscover themselves as women and thence to theorise that identity and its possible transformation (Donovan, 2001).

During the thirty-year period since the beginning of the 'second wave', feminism has acquired an academic voice both within and beyond Women's Studies, but as a political identity, it has fractured along lines of multiple differences between women (Thornham, 2001). Similar to first wave feminism, second wave feminism has received criticism for being representative of mainly a white middle-class sector, thus ignoring the differences of women from other race and class. Therefore, Springer (2002) notes quite logically that it is only common sense, based on the first wave and second wave analogies, for those seeking to define a new direction of feminism to call it the 'third wave'.

3.6. Third wave feminism

The term third wave feminism as we now know it signals a new generation of feminists. The third wave has been overly eager to define itself as something different from previous feminisms (Gillis, Howie & Munford, 2004). For this reason, although feminism was expanding, there remained a noticeably growing lack, and therefore, a need for more black women to be represented by the values and ideologies of feminism. Therefore, inserting Black women into the public record of feminist activism and the wave model challenged the notion that black women were not also concerned about gender related issues. As a result, there was the emergence of the 'third wave black feminism', which is first discussed broadly, and then within the context of South Africa.

3.6.1 Black feminism

For decades, the women's liberation movement reflected white, middle class bias in its objectives and aims, and its membership and leadership treated the interests of black women as secondary to their own by excluding them from the movement's agenda (Simien, 2004). Black feminism thus emerged as a response to feminist theories and white bourgeois women's movements that omitted serious examination of racism, and the general concerns of black women and other women of colour (Hamer & Neville, 2001). Black feminism acknowledges the link between the struggles for freedom from racism and sexism in black women's lives. Since elite white men and their representatives control structures of knowledge validation, white male interests pervade the thematic content of traditional scholarship (Collins, 1990). As a result, black women's experiences with work, family, motherhood, political activism, and sexual politics have been routinely distorted in or excluded from traditional academic discourse (Collins, 1990). Therefore, using the term 'black feminism' disrupts the racism inherent in presenting feminism as a for-whites-only ideology and political movement (Collins, 2001). Furthermore, inserting the adjective 'black' challenges the assumed whiteness of feminism and disrupts the false universalism of this term for both white and black women.

The historical suppression of black women's ideas has had a pronounced influence on feminist theory. Theories advanced as being universally applicable to women as a group, on closer examination appear greatly limited by the white, middle-class origins of their proponents (Collins, 1990). In her book, Walker (1983) writes of her experience of sharing an office with a prominent white feminist who exposed superficial interest in black women's ideas yet compiled an ontology of women writers, from which black women were noticeably absent. Similarly, white women who possess great competence in researching a range of issues omit black women from their work, claiming that they are unqualified to understand the 'black woman's experience' (Collins, 1990). Black women who were aware of feminism were publicly quieter than they might have been, apparently finding no comfortable place for themselves in the movements and eventually forming

their own networks and organisations (hooks, 1990). Therefore, in order to make their voices heard, black feminists in the 1970s expended disproportionate amounts of energy attempting to legitimise themselves in the eyes of white and black communities (Springer, 2001). Black feminists' writings of the 1970s and 1990s refuted the idea that working against gender oppression is somehow counter to antiracists efforts (Springer, 2002) and therefore an attempt should be made to strike a balance between adequately theorising race and gender oppression (Springer, 2001).

Many contemporary black women are ambivalent about identifying themselves as feminists, though most celebrate historical black feminist traditions (Taylor, 2001). This could be due to the misconception that many people continue to link the feminist movement exclusively to the activism of bourgeois white women and not to the struggles initiated by blacks for freedom, justice and equality (Taylor, 2001). Thus, not only were women of colour in fact overlooked in feminist movements, but their exclusion was also reinforced when white women spoke for and as women (James & Sharpley-Whiting, 2000). Therefore, during the tail and on the eve of the second wave of feminism in the 1970s, and on the eve of the third wave in the 1980s and 1990s, countless numbers of black women activists developed a distinctly feminist consciousness that gave them an agency to strive for empowerment on their own terms (Taylor, 2001). Collectively, their feminism was more expansive than the agenda put forth by white women, in that specific social, economic and political issues facing black communities were incorporated into a theoretical paradigm that is today called black feminism. Thus, when black women advocate black feminism, their discourse recognises how systems of power are configured around maintaining socially constructed categories of both race and gender (Collins, 2001). In addition to this, since economic differences are the main determinants producing variations in their lives, black feminists attack racism, sexism and poverty simultaneously (Taylor, 2001).

Another distinguishing factor about black feminism seems to be the emergence of a concept referred to as the 'strongblackwoman', which is a central and unique feature of black feminism. The standard of the strongblackwoman is situated in the history of

slavery and the ways that black women were expected to persevere under any circumstances (Springer, 2002). Morgan (1999) writes 'strongblackwoman' as one word and abbreviates it to SBW, signifying the transformation of a stereotype into an accepted and recognisable identity trait for black women. This linguistic move solidifies the idea of 'strong', 'black' and 'woman' as non-separable parts of a seemingly cohesive identity (Springer, 2002). In this title, there is no room for being just one of the three identities at any given time, instead, there is an expectation in the black community that black women will be all three, at all times. Furthermore, because of the myths about black womanhood being rooted in slavery, it is also assumed by many that if a black woman goes through hardship she can 'handle it' because of her super-human strength, and she does not require support like other women (Taylor, 2001). The stereotypical image of the 'strong' black woman was no longer seen as dehumanising (hooks, 1981), it became the new badge of black female glory (Springer, 2002). When the women's movement was at its peak and white women were rejecting the role of breeder, burden bearer, and sex object, black women were celebrated for their unique devotion to the task of mothering, for their 'innate' ability to bear tremendous burdens, and for their over-increasing availability as sex objects (Colins, 2001). hooks (1981) postulates that usually, when people talk about the strength of black women they are referring to the way in which they perceive black women to be coping with oppression. They ignore the reality that to be strong in the face of oppression is not the same as overcoming oppression, thus, endurance is not to be confused with transformation.

Although some black feminist writers advocated the concept of the strongblackwoman during its emergence, many other feminist writers have come forth since then and deconstructed this concept. One such writer is Joan Morgan, who came forth and deconstructed the strongblackwoman image for what she believes it is: " a way for black women to deny emotional, psychic, and even physical pain, all the while appearing to keep it together - just like their mothers appeared to do" (Morgan, 1999, p. 97). When feminists acknowledge in one breath that black women are victimised and in the same breath emphasise their strength, they imply that though black women are oppressed, they manage to circumvent the damaging impact of oppression by being strong – and that is

not the case. Thus, rather than striving to live up to the image of the strongblackwoman, Jones (1994) calls for a redefinition of the self as key to recuperating an image of black women that is not detrimental to their individual and collective well-being, an image that allows them to claim the right to imperfections and vulnerabilities without fear of being a discredit to the black woman's image.

Over and above, the most central theme of black feminist thought is that because black women experience both racial and gender oppression that result in needs and problems distinct from those experienced by white women and black men, they have to struggle for equality both as women and as black people. Thus, focusing on gender as a structure of power that works with race should provide the much needed space for dialogues among black women, among black men, and between black women and men (Collins, 2001). Furthermore, although black feminist thought may originate with black feminist intellectuals, it cannot flourish isolated from the experiences and ideas of other groups. By advocating, refining, and disseminating black feminist thought, other groups - such as black men, white men, white women, and other people of colour- can further its development (Collins, 1990). Black women intellectuals can play an important role in the production and dissemination of black feminist sources because not only do they have the gender and racial understanding, but they also have greater access to resources that can enable them to represent the voices of other black women and to form coalitions with other groups.

Third wave black feminism bears much relevance to the situation of women in South Africa, especially bearing in mind that this project is based exclusively on black South African women. Therefore, it is only fitting that the issue and state of feminism in South Africa be explored.

3.6.2 South African Women and Feminism

While it is true that through most of history women in most parts of the world have had to struggle, in South Africa that struggle has been monumental over the last 50 years

(Reynolds & Richards, 2003). What emerges from this unique historical overview of women's lives over this period is the way in which South African women have fought for change, bridging the gap between hope and reality. In South Africa, women of all races and creeds have had to struggle to make their voices heard, but more so those who were deliberately marginalised by law (de Lille, 2003). Therefore, considering that this research is based on South African women, it is important that the history, as well as the current status of women in South Africa be discussed below, followed by a specific focus on black South African women, because this research project is exclusively carried out about them.

In April 1994, South Africa held its first fully democratic elections, marking the official transition to majority rule and the end of Apartheid and white supremacist rule in the country. Women of all classes and races, women from urban and rural areas, women from all religions of South Africa, played a significant role in the struggle against apartheid (Meer, 1998). During the transitional period leading up to the elections, South African women inserted gender demands into the debates around issues of majority rule, ensuring that a post-Apartheid state would indeed face gender-specific demands (Seidman, 1993).

Although in the 1994 elections many women believed that their husbands or their employers had to make their decisions for them (Zondo, 1994), many changes have taken place over the years which have enabled women to make their own choices and decisions, and to have their voices heard. These changes include the many laws that have been passed in the past decade that impact favourably on women, such as in the workplace, thus affording them equal opportunities according to the Constitution. In domestic life, laws granting equal custody and guardianship of children, the right to claim maintenance from the fathers of their children, the prevention of violence against women Act, the rape in marriage Act, the abortion Act, and the abolition of marital power in community of property marriages (Suzman, 2003), are some of the laws that have been introduced in South Africa so as to support and empower women. In addition to this, black women married by customary law, also now have full legal status (Steyn, 1998).

The political sphere, which has historically been a largely male-dominated area, also underwent drastic changes over the years, as more women were included in politics. According to Suzman (2003, p. 8), the representation of women in the political arena after the 1994 elections was as follows: the speaker of the National Assembly was a woman; 30% of MPs were women; there were 8 women ministers in the cabinet and 8 women deputy ministers; 18 members of the Permanent Council of provinces were women and the chairperson was a woman; there were many women in the provincial and local legislatives; two women judges in the constitutional court, the highest court in the land; one woman judge in the Supreme court of Appeal in Bloemfontein and there were 20 women judges in high courts throughout the land.

Since the 2004 elections, South Africa has had 131 women in parliament – the eleventh highest total in the world (Gouws, 2005). Furthermore, according to Gouws (2005, p.67), the political representation of women in the political arena following the 2004 elections is as follows: Women now constitute 32.75% of the National Assembly; of the nine provincial premiers, four are women; there are ten women ministers and twelve deputy ministers, with women holding some of the most powerful ministerial posts in government; at provincial level the representation of women increased from one hundred and two in 1994 to one hundred and thirty nine in 2004. Finally, the most significant representation of women in politics occurred in June 2005 when the president of South Africa appointed a woman as his deputy president, thus historically making her the first female deputy president of the country.

However, what life was like for women in South Africa for the last fifty years, where they are now and where they are hoping to be, cannot be restricted to considering gender as the only relevant factor (Reynolds & Richards, 2003). Inevitably, the subject of race intervenes in determining the past, present and future status of white, black, coloured and Indian women, and especially that of black women living in the rural areas under customary law (Suzman, 2003). Despite the passing of several laws that improved the status of women during the Apartheid era, black women were almost invariably excluded (Reynolds & Richards, 2003). While white, coloured and Indian women were able to vote

for the ‘own affairs’ tricameral parliament from 1983, black women only received the right to vote in 1994 (Suzman, 2003). Thus, a South African feminism needs to develop a historical-contextual approach with emphasis on different kinds of gender oppression in the country (Bazilli, 1991). In short, while all women are oppressed, they are not oppressed equally. There is inequality within inequality, and there is a need for the recognition that although all women are oppressed, they are not oppressed in the same way.

Historically, the difference between the lives of women from different racial backgrounds has been great, and differences still exist in terms of socio-economic status. As a result of the systematic privileging of whites within the economy, white women belong predominantly to the middle upper classes, whereas black women tend to belong to the working class (Steyn, 1998). An illustration of this class stratification is that 89% of people employed in domestic service are black women working for white women (Steyn, 1998). Thus, not only do black women suffer oppression by gender, but by race and class as well. For this reason, in the black community, most women have tended to subordinate the struggle for gender equality to the greater struggle for racial equality (Hendricks & Lewis, 1994). This has resulted in the majority of black South African women resisting to be labeled as feminists. Those women who have called themselves feminists have been, for the most part, white, middle-class, left-wing intellectuals (Winter, 1993), and their tendency to speak on behalf of black women has been resented in South Africa, as it has been elsewhere (Ginwala, 1991).

Therefore, what is needed, is the establishment or the reconstruction of a South African feminist movement that is fully inclusive of the diversity of South African women. A South African feminism needs to develop a cultural-contextual approach with emphasis on the different kinds of gender oppression (Bazilli, 1991). Thus, two major themes emerge early in the process of reconstructing a South African feminist movement: the need for an integrated, democratic process, and the role of culture (Steyn, 1998). Advocating a democratic feminist process, Cock (1991) is of the opinion that in putting women on the agenda, we in South Africa will have to go out and talk to people to find

out what their needs and demands are. This will be an advantage in that it will enable us to avoid much of the elitism and class-bias which has weakened the women's movement in the advanced industrialised societies of the north (Cock, 1991). A second major area articulated by theorists is the role of culture in reconstructing a South African feminist movement. The question of rights for women within South Africa is closely linked to cultural issues, and this interface is probably one of the most difficult the feminist movement has to address. The different cultures in South Africa have impacted on women in different ways, and the right to practice one's culture and the right to equality are often in direct conflict, a conflict that is most pronounced in the issue of customary law (Steyn, 1998). Under African customary law, when a woman is married, she becomes part of an extended family, she is not allowed to own property, her children are regarded as part of her husband's clan, and she cannot be legally married unless her husband-to-be has paid 'lololo' (brideprice), which sets her economic value (Pillay, 1994). Thus, the requirements that adherence to customary law should be out of free and informed choice (Pillay, 1994) and that customary law should be subject to the right of equality (Murray, 1994) have been important victories for women in the fight against oppressive practices.

Finally, just as feminist issues are being inflected in terms of the cultural realities in South Africa, so too, are cultural issues being explored through the framework provided by feminism (Steyn, 1998). Numerous examples of such interrogation of local cultures are found in articles published in Agenda, a South African feminist journal, which explores, among others, issues of gender and bodies, sexuality and marriage. Although the primary objectives of such articles are to raise awareness around feminist issues and to interrogate South African cultures in terms of feminist concepts, another major objective is to educate South African women about each other, and thus to overcome some of the ignorance brought about by enforced separation and cultural chauvinism (Steyn, 1998).

3.7 Conclusion

From the above, it is evident that there is a need for the development of a more inclusive, broad-based South African feminism. Furthermore, there should be a commitment to treat all cultures equally in the quest to promote gender equality. Therefore, just as much as the feminist movement should not focus mainly on white women, it should also not focus only on black women and culture, to an extent that other South African women are marginalised and excluded. A South African feminist movement should acknowledge that, apart from gender discrimination, South African women have to deal with many other different and overlapping issues, which need to be integrated into the feminist struggle so that they can be able to identify with and relate to the concept of feminism.

This research aims to achieve an inclusive South African feminism as it focuses on black women in an attempt to integrate their experiences into the feminist psychology movement so that they can also be able to identify with and relate to the concept of feminism. It explores the culturally and socially constructed experiences of being infertile as a black married woman and this is in keeping with a tenet of feminist psychology, which is to seek knowledge about women's experiences. Focusing mainly on black women implies that, in addition to their gender, the women's race and culture can also be overlapping issues that may significantly affect their experiences, and are thus taken into consideration when exploring the women's experiences.

CHAPTER 4

RESEARCH METHODS AND PROCEDURES

4.1 Introduction

Feminist scholars have noted that science reflects the social values and concerns of dominant societal groups (Harding, 1987). As such, research projects in the social sciences have often ignored women and issues of concern to women (Campbell & Schram, 1995), therefore women's lives and experiences have not been adequately captured through the traditional scientific lens. In light of this, the current research is based on an issue of concern to women, infertility, and a feminist research approach is employed in researching their experiences regarding this issue. Feminist research highlights the oppression of women, pursuing concepts of empowerment and emancipation (Mabasa, 2002). Therefore, for the purpose of this study, in order to gain an understanding of the experiences of infertile married African women, an exploratory form of inquiry is employed, with the use of narrative and feminist social constructionist research paradigms. Below follows a discussion on the research paradigms that are used in this study; firstly feminist research, followed by the narrative and the social constructionist research.

4.2 Feminist research

A research project's direction and shape are affected by many factors, including the research question, background of the researcher, and the theoretical position adopted (DuBois, 1983). Thus, the theoretical position adopted for the current project is a feminist approach, which I believe is a more relevant approach, in exploring the experiences of infertile married African women. Furthermore, as an advocate for feminism and as an African woman, my background as a researcher places me in an advantageous position regarding the research project, because to a certain extent, I can have a better relation to some of the issues raised by the participants.

Feminist methodological interventions focus on experience, amongst other things, in terms of whose experience is represented and validated within research (Harding, 1987).

It is through women's own experiences, and especially through their life crises, that they are able to view and to understand the world around them (Hammersley, 1993). Research using feminist methodology refers to research questions that are pertinent to women, are of interest to women, and are developed out of political struggles (Hammersley, 1993). Thus, it is hoped that through the exploration of female infertility, an issue that can be considered a crisis in some women's lives, women will be able to gain more insight into the way in which they view and understand the world around them.

Riger (1992) articulates the value of a variety of epistemological orientations in the psychology of women, namely feminist empiricism, feminist perspective theories and social constructionism, as they offer a variety of understandings of women's experiences and gender. Furthermore, feminist psychology may also provide a conceptual framework within which women may explain discrimination, and it may help one to connect with others who can help problem-solve in response to discrimination (Cressy, Harrick & Fuehrer (2002).

Feminists have been meticulous in their efforts to examine, identify, expose, and redefine the numerous points of contact between the ideology and practice of patriarchy, on the one hand, and gender and sexual assumptions, practices, and beliefs on the other (Gergen, 1988). Feminist research enables social scientists to explore women's social history, women's perception of their own situation, their own subordination and their own resistance (Mies, 1993).

Grbich (1999) identifies five enduring principles common in feminist research, and these principles influenced this research project. Firstly, there is a need to centre the social construction of gender, as gender is viewed as a construct that identifies certain characteristics as appropriate to one sex. It is usually expected for women to bear children and to bring them up, so much that maternal involvement with children is a characteristic that is often more socially emphasised than paternal involvement, and this may cause the experience of infertility to be much more distressing for women than for men. Secondly, an acceptance that women are oppressed. Thirdly, there is a non-

exploitative, egalitarian and emancipatory relationship between the researcher and the participants. In keeping with this, the relationship I develop with the participants, as a researcher is one that is open and unrestricted, so as to allow the women to speak freely about their experiences and hopefully, become liberated through the process. Fourthly, there is an exposure of the researcher's position, experiences, emotions and values, and how these factors influence the researcher's view of reality, and how this reality is handled during the analysis and interpretation of the realities of the participants. Thus, the researcher becomes part of the research process and assumes a subjective insider's position. This position is achieved by appreciating the experiences of the participants, and it involves sameness of life experiences, such as being of the same race, sexuality and sharing the same experience of oppression (Grbich, 1999). Therefore, my identities as a member of a similar black community, same ethnic group and same female gender group, influence my interaction with the participants and enable me to respond to them personally, without hiding behind the façade of an objective researcher. Fifthly, the representation of findings should address issues of power, honesty and ownership. In this study, these issues are addressed within a social marriage system, where the women are infertile and can therefore not fulfill the socially expected gender role of motherhood.

When a man is infertile, there is a tendency for his wife to get the blame, because men can be protected from blame by patriarchal ideology (Boerma & Mgalla, 2001). Thus, feminist research not only attempts to understand, but also to emancipate the informants, in this case, infertile women. It serves the interests of dominated, exploited and oppressed groups, particularly women (Mies, 1993). The researcher becomes part of the research process, rather than adopting the traditional research approach of showing an indifferent, disinterested, alienated attitude towards the research objects (Harding, 1987).

Fonow and Cook (1991) discuss four themes of feminist research. The first theme, reflexivity, is characterised as a process by which the nature of the research process is examined critically. This allows for the voice of the researcher to be heard in the form of creating some form of commentary on the ongoing representation of the work. The second theme, an action orientation, addresses the fact that feminist research is aimed

towards the goal of liberation. Specifically, the transformation of patriarchy and the empowerment of women should be the goals of feminist research. The third theme of feminist research is the need to pay attention to the affective components of research. Used through "caring and emotionality" (Fonow & Cook, 1991, p.12), this theme pays specific attention to negotiating unpleasant feelings (Cressy, Harrick & Fuehrer, 2002). The final theme is the "use of the situation at hand" (Fonow & Cook, 1987) as a focus of inquiry. The authors claim that feminists are "particularly adapt at recognising the opportunities available in unforeseen settings to study otherwise-hidden processes" (Fonow & Cook, 1991, p.12).

This research embodies these four themes. Reflexivity takes place throughout the research process as the researcher and the participants interact, share and make meaning of their life experiences through their narratives. This research also has an action orientation in that the creation of knowledge and greater understanding of the personal lived experiences of the infertile women is hoped to be empowering and ultimately, liberating to them in their marriages. Through the dialogues with the researcher, the women will be telling their stories and attempting to make meaning out of their personal experiences of being infertile. This acknowledges the affective component of feminist research, as highly emotional experiences are revealed and discussed. Finally, apart from being faced with a lack of literature on this topic, I also recognised the opportunity available at an infertility clinic to explore the experiences of infertile married African women, and thus used 'the situation at hand' as a focus of research.

4.3 Narrative social constructionism

Narrative approaches have been central to feminist interpretive research, both in terms of deconstructing cultural beliefs about women and generating new knowledge about women's lives (Smith, 2000). Therefore, feminist research approaches support the process of telling sensitive human stories as research. Adopting a narrative, social constructionist worldview offers useful ideas about how power, knowledge, and 'truth' are negotiated in families and larger cultural aggregation. It can be considered to be more

important to approach people with attitudes supported by social constructionist ideas than it is to use any particular 'narrative technique', because in this way, the researcher allows the participants to construct their own 'truth' about issues pertaining to their lives, and thus allowing for the inclusion of influential socio-cultural meanings (Cressy et al., 2002). Social constructionist orientations provide useful understandings of the politics of making meaning about individuals' interactions and experiences (Gergen, 1985). According to social constructionist epistemologies, the process of negotiating social identities occurs through socially constructed meaning, evolving through shared discourse. Crossley (2000) tells us that social constructionist approaches have encouraged the deconstruction of personal accounts as a means of explicating the social and cultural processes involved in the constitution of personal experience.

Freedman and Combs (1996) postulate the following four ideas that relate to this worldview. Firstly, realities are socially constructed (Freedman & Combs, 1996). In other words, people, together, construct their realities as they live them. Thus, although infertile women individually construct a model of reality from their own individual experiences of being infertile, these realities/experiences are influenced by their interactions with their husbands, families and society because within these interactions, their experiences are constantly constructed and modified into what society holds to be true, real and meaningful.

Secondly, realities are constituted through language (Freedman & Combs, 1996). An understanding of language is essential for any understanding of the reality of everyday life. Language is used to represent external reality, and our internal representations are accurate reflections of external reality. Therefore, for the infertile woman, her internal representations of her experiences may be a reflection of her external reality; she may use the language used by those around her in order to give an account of her own experience. However, it is hoped that the conversations these women will have during this research project will create an opportunity for them to develop new language, with which they can negotiate new meanings for their negative experiences, feelings, thoughts and beliefs, thus giving them alternative views to reality.

Thirdly, realities are organised and maintained through narrative (Freedman & Combs, 1996). In striving to make sense of their lives, these infertile women are faced with the task of arranging their experiences of events in sequences across time in such a way as to arrive at a coherent account of themselves and the world around them. This account can be referred to as a self-narrative, and it is through telling their own self-narratives that the women in this research are able to relate their experiences as well as the events that took place in their lives regarding their infertility.

Fourthly, there are no essential truths (Freedman & Combs, 1996). There are many possibilities for how any given experience may be interpreted, but no interpretation is 'really' true. Thus, the experiences or ideas that the women may have about themselves, as women and as wives, and about their infertility, may not be essential truths. Instead, like other constructions, they may have been formed through their social interaction with the people around them and within their respective cultural contexts.

According to Terre-Blanche & Durrheim (1999), the social constructionist approach assumes that reality consists of people's subjective experiences of the external world and that such subjective experiences can be understood through interacting with and listening to their stories. Thus, by employing a narrative technique, I intend to listen to the stories that the infertile women tell regarding their experiences of infertility. The importance of child bearing remains a particularly powerful theme in the narratives of many individuals (Upton, 2001). Through narrative, we try to make sense of how things have come to pass and how our actions and the actions of others have helped shape our history. In narratives, the representation and interpretation of experience is guided and shaped by shared culture and understanding, and the narratives therefore transcend particular histories and life circumstances and become representations of shared cultural models (Mogensen, 1997). Narratives are stories that provide information about people in relationship with one another, and provide an explicit forum in which individuals make meanings out of their life experiences. In addition to personal narratives, stories can evolve from cultures, thus providing a framework for interpreting collective experiences (Cressy et al., 2002).

Romeo and Steward (1999) articulate the empowering benefits of a narrative methodological approach in constructing women's individual identities against patriarchal hegemonic master narratives. In many situations there are master narratives that develop and effectively define the rights and duties of those subordinated by this narrative. Thus, I am of the opinion that the master narrative regarding a married couple's fertility is that the woman is expected to bear children for her husband and should the couple fail to reproduce, the woman is usually held responsible, regardless of who the infertile person is, within the marriage. Another master narrative is that women are expected to reproduce and therefore failure to do so is a reflection of their failure as women and they in turn suffer a lot of psychosocial problems as a result of their infertility.

Within the African context, the interpretations and experiences of infertile married women are guided and shaped by their cultural understanding of the phenomenon of infertility. The women's narratives provide a means of exploring how constructions of female infertility and personal experience are grounded in culture, as well as how their individual experiences transform and participate in the creation of the shared knowledge of infertility, its causes and its treatment.

Below follows a discussion of the research methods and procedures that were undertaken during this research, from the selection of the participants, to the analysis of the data as well as the ethical considerations that had to be adhered to throughout the research process.

4.4 Sampling

I employed the method of non-probability sampling. This type of sampling involved three processes, (i) specifying the target population; (ii) choosing the sampling procedure, and (iii) determining the sample size (Barker, Pistran & Elliot, 1994), and they are discussed in detail below.

4.4.1 Specifying target population

The initial sampling procedure involved identifying a group from which the participants were selected. The target population in this case is African women who are married, and who have been diagnosed as infertile, meaning they have been unable to become pregnant or conceive after 12 months of unprotected sexual intercourse. Furthermore, the women chosen have also never experienced pregnancy or childbirth, thus making them primary infertile. The women who participated are between the ages of 21 and 40 years. This age group is targeted because women are expected, by society, to fulfill their reproductive roles from the adult age of 21 years, and therefore those women who fall pregnant at this age no longer fall under the category of 'teenage pregnancies'. The age of 40 years is used as the cut off age because it is the average age when women become menopausal and this not only decreases the probability of falling pregnant, but it also increases the risks involved with pregnancy. Kern (1982) reports that by age 35, only half of all women can conceive and this figure is reduced to three to four percent by age 44. From a medical perspective, later pregnancy is seen purely in terms of increased risks (Mazor & Simons, 1984). I am thus of the opinion that women would experience more distress regarding their infertility before the age of 40 years, because then they will still have higher hopes and better biological possibilities of falling pregnant, as opposed to when they are over the age of 40 years.

4.4.2 Sampling procedure

I employed the judgemental sampling procedure for the study. This sampling method is based on the judgement of a researcher regarding the characteristics of a representative sample (Bless & Higson-Smith, 1995). The strategy is to select participants that are judged to be typical of the population under investigation. For this study, the characteristics of a representative sample are the following: married African women, between the ages of 21 and 40 years, who are experiencing primary infertility. The women are recruited from an infertility clinic at a local hospital in a township area in South Africa. This particular infertility clinic is selected because it is within a well-known hospital that is situated in a township. Therefore, the patients who utilise the

services of the hospital are mainly black residents from the township and other surrounding residential areas. This is therefore an appropriate hospital to use for this research because since I am exclusively looking for black women as participants in this study, it is easy to locate them at this clinic because it deals mainly with black women.

The women were first informed by the nurses at the clinic about my research and then requested to participate. However, the nurses did not explain my research in detail to the women as a group because they told them that if they were interested in participating, they could see me for further clarification and explanation. The women who were interested then came to see me individually in the designated interview room at the clinic. After introducing myself to them, I provided them with a thorough explanation of the research and what it entailed, and then inquired if they were interested in participating further. All the women who came to see me agreed to participate in the study, and each one had to sign a consent form before the interviews could proceed. However, because the sisters informed all the women who came to the clinic for infertility problems about my study, this meant that all the women came to see me in the interview room, and it was only after finding out individually from them that I discovered that some had previously had a child or children and were therefore experiencing secondary infertility. Since this was an exclusion criterion for my participants, I had to turn away some women and explain to them that I was only looking for women who have no children and have never fallen pregnant before.

4.4.3. Determining sample size

The sample size consists of 6 women, who were each interviewed once. The lengths of the interviews varied according to the time it took for no new themes to emerge, i.e. for the interviews to reach saturation. Saturation can typically be obtained with a sample size of 5 to 10 for rich protocols (Barker et al., 1994). All the interviews were recorded on tape. Ending the interviews was guided by the fact that no relevant new information seemed to be emerging, and the significant themes were well established and validated by their repetitive nature and the length of time the participants devoted to them.

4.5 Pilot Study

Basson and Uys (1985, p.95) define a pilot study as a "sample scale study using a small sample of the population, but not the ones who will eventually be part of the sample group." It is often very useful to assess the feasibility of a research project, the practical possibilities to carry it out, the correctness of some concepts, the adequacy of the method and instrument of measurement by doing a pilot study (Bless & Higson-Smith, 1995). For this study, a pilot study was conducted on 4 women during the first week of collecting data. The results of the pilot study are not analysed to form part of the results of the main study. The pilot study assisted me in trying out the interviews with the women and giving me experience in conducting them and knowing when and how to intervene and ask for clarity or more detail.

The pilot study interviews also enabled me to familiarise myself with the whole data collection procedure as well as with the allocated interview room at the clinic. Therefore, after these interviews, I realised that I had to adjust the volume of my tape recorder to a certain level so as to improve the quality of the sound; and I also rearranged the seating positions in the interview room because during the pilot study the participants sat near a window and this compromised the quality of their voices on the tape recorder.

Finally, because the sisters initially requested all the women who had come to the clinic for infertility problems to participate in the study, during the pilot study I ended up also interviewing 2 women who were experiencing secondary infertility because I only found out half-way thorough their stories that they had actually had children before. Therefore, this informed my decision in the subsequent weeks when I then decided to first ask each woman who came to the interview room if she had had a biological child or children before experiencing infertility. This meant I could eliminate women experiencing secondary infertility without having to go through a very detailed explanation about my research, and in this way I saved time, as well as recording space on the tapes by not interviewing women who could not be part of the sample group.

4.6 Data collection

The research is qualitative in nature and data was collected by means of semi-structured interviews. Semi-structured interviewing is a qualitative data-gathering technique and it maximises the discovery and description of participants' individual experiences (Raymond, 1979). For a researcher, the basic source of evidence about the narratives of participants is the interview (Mishler, 1986).

Feminist researchers find interviewing appealing because for one thing, it offers researchers access to people's ideas, thoughts, and memories in their own words, rather than in the words of the researcher (Reinharz, 1992). Interviewing also allows the interviewer to envision the person's experience and hear the multiple voices in a person's speech (Reinharz, 1992). Thus, by also exploring the social influences regarding women's experiences of infertility, I was able to also hear the voices of the women's husbands, families, societal and cultural ideologies, as they may also have an impact on the women's experiences of being infertile.

The semi-structured interview also allowed the women interviewed to expand on the topic as they saw fit, to focus on particular aspects and to relate their experiences (Bless & Higson-Smith, 1995). I, the interviewer, would then intervene to ask for clarification or further explanation. I also brought in questions to probe on certain issues, and I was also free to formulate other questions as judged appropriate for the given situation during the interview. The guideline questions I used were aimed at obtaining the following themes: (a) history of infertility; (b) initial reaction to infertility; (c) husband's and in-laws' attitude towards her; (d) how she and her husband cope with the infertility; (e) her causal explanations of infertility: cultural versus western; (f) treatment options she has considered/tried thus far: cultural versus western; and (g) how she views herself as a woman.

Rubin (1976) also postulated that women tend to discuss their feelings about their lives, their roles and their marriages more freely when men are not present. Thus, the women

were interviewed individually, in the absence of their husbands, so as to maximise freedom in expressing their personal experiences in detail.

The initial phase of the interview focused on eliciting demographic information, such as age, length of marriage, duration of attending infertility clinic, and so on. Beginning with these type of questions helped both the participants and I to ease into the more sensitive information regarding the topic of infertility. The middle phase of the interview focused on the story regarding their experiences of being infertile. This was elicited in the following manner: Could you please tell me your story about your infertility? The final phase focused on probing for more explanations and further details regarding the stories told. I also used the guideline questions so as to elicit information on unexplored issues.

What followed from the interviews was the transcription phase. There are various ways in which researchers can transcribe their interviews, and the method or style of transcribing that was chosen for this research project is discussed below.

4.7 Transcription

Before the recorded interviews could be used for data analysis, they had to be transcribed first. The transcription process is intended to be detailed so as to give a precise account of the experiences and stories of the women. Thus, I included silences, emphases, expressions like “uhm”, discourse markers like “you know” or “so”, and non-verbal cues in the transcription. Riessman’s (1993) general advice is to begin with a rough transcription, a first draft of the entire interview that gets the words and other striking features of the conversation on paper (e.g. crying, laughing, very long pauses, etc.). Then the researcher can go back and re-transcribe selected portions for detailed analysis.

Several symbols are used in the transcribed stories, and these appear as follows:

- Brackets [ ] signify the addition of a missing word or phrase by the researcher
- Parentheses ( ) indicate the addition of a descriptive or explanatory word or phrase by the researcher

- Three dots … show that there was a pause in the flow of speech
- Three dots in brackets […] indicate the omission of a word or sentence
- Quotation marks signify dialogue reported by the narrator (Lieblich, Tuval-Mashiach & Zilber, 1998).

4.8 Translation

The interviews were mainly conducted in Sotho, with the exception of a few English words or sentences which either the participant or I used due to a lack of, or a lack of knowledge about, a similar word in the Sotho language. After the interviews had been transcribed, they were then directly translated into English so as to minimise data loss. Although language specific utterances such as ‘Eish’ and ‘Hai’ cannot be translated into English, they are also included in the translated interviews, but they are left as they are. Furthermore, other language specific words, such as ‘moopa’, ‘muti’ and ‘ntate’ are also left as they are in the translated interviews, and they are presented in single inverted comas, e.g. ‘moopa’, followed by English explanations/translations placed in brackets next to them, particularly when they occur within a sentence that is used as a quotation in the discussion of findings. Brislin (1980) refers to this practice as ethnographic translation, which introduces the importance of context in translation. Its purpose is to elucidate the cultural context of the source as well as the participants’ language versions. Thus, the concern is on how the people themselves (not the anthropologist studying them) use the terms and the context in which the terms are used. Therefore, although it is important to remain with the factual content during the translation, in some cases the concern is also to capture the particular personal and cultural aspects that participants bring to the situation.

After the interviews had been transcribed and translated, they were then analysed, and the way in which the process of analysis was carried out is discussed below.

4.9 Data analysis

The process of data analysis was carried out by an ongoing integration of narrative structural analysis and narrative content analysis. Riessman (1990) considers narrative analysis as a formal methodological approach and has applied such approaches to studies of personal relationships. He suggests that the unpacking of structure is a significant early stage in analysis. To avoid the tendency to read a narrative simply for content, and the equally dangerous tendency to read it as evidence for a prior theory, Riessman (1993) recommends beginning with the structure of the narrative. The purpose of the structural analysis is to learn something about the speaker that might not have been apparent from examination of content alone. Thus, structural analysis focused on the structure of the plot, the sequencing of events and inclusion of different characters, its relation to the time axis, its complexity and coherence and the feelings evoked by the story (Lieblich et al., 1998). Therefore, during the process of analysis, I looked at the plots or the structure of complete life stories. This I did by answering questions such as: How is the story organised? Does the narrative develop as a comedy, tragedy, irony or romance? Does the story ascend towards the present moment in the narrator's life or descend towards it from more positive periods and situations? How does the story allow for the inclusion of different characters in the narrator's life? (Lieblich et al., 1998).

The elements of a well-constructed narrative include a story (or ongoing plot), a clearly defined objective, a series of events that progress towards that objective and relations of sequence and causality among those events (Bruner, 1991). For the purpose of this study, a clearly defined objective for infertile women attending an infertility clinic is for them to receive treatment that will hopefully enable them to be fertile. The process of analysis helped to explore the series of events that progressed towards them being at an infertility clinic, and if and how these events and experiences led to them seeking help from an infertility clinic.

On a content level, data was further analysed by the thematic content approach to narrative analysis. According to Lieblich et al. (1998), the thematic approach may be

adopted when the researcher is primarily interested in a problem or a phenomenon shared by a group of people. This holds true to this research, in which I am primarily interested in infertility as an experience shared by a group of married African women. I employed Lieblich et al.'s (1998) process of narrative analysis, which took place in the following manner:

1. I read the material several times until a pattern emerged, usually in the form of focus of the entire story. I read carefully, empathetically, and with an open mind. There were aspects of the life story to which I wished to pay special attention, but their significance depended on the entire story and its context.
2. I placed my initial and global impression of the case into writing. This entailed noting exceptions to the general impression as well as unusual features of the story such as contradictions or unfinished descriptions. I also noted episodes that seemed to disturb the teller, or produce disharmony in her story. This was done by noting moments during which the participant became tearful, or looked away, or took lengthy pauses in the middle of relating an event.
3. I then decided on special content for the themes I intended on using. A method I used for the selection of themes was to read the story as openly as possible and to define the major content themes that emerged from the reading. I frequently distinguished themes that warranted a special focus by the length of time devoted to them in the story, their repetitive nature, and the amount of detail the teller provided about them. In practice, the process of defining content themes was a circular procedure that involved careful reading, suggesting categories, sorting the sub-themes into themes, generating ideas for additional themes or for refinement of existing ones.
4. What followed then was to sort the material into the themes, and this entailed assigning separate quotations or utterances to relevant themes. While the utterances were sometimes from a single story, most of the themes included utterances by several different individuals, reported verbatim.

5. I also paid attention to where a theme appeared for the first and last time, the transitions between themes, the context of each one, and to episodes that seemed to contradict the theme in terms of content, mood or evaluation by the teller.
6. In drawing conclusions from the results, the contents collected in each theme were then used descriptively to formulate a picture of the overall content regarding the experiences of infertile married African women. Some of these contents are reported verbatim while describing the themes so as to allow the respondents' own expression by representing what they were saying in close proximity to their actual words.

Analysis of the narrative as a whole may also be enhanced by the researcher's personal perspective and evaluative impression (Lieblich et al., 1998). Sensitivity on the part of the reader, for instance, to the detail and degree of emotion with which each event is described or to discrepancies between different descriptions of the same event may provide useful clues (Lieblich et al., 1998). Introducing this subjective element into the analysis of data enables a kind of relationship between the researcher and the object of research, which decreases objectivism and allows for reflexivity (Harding, 1987). Reflexivity is a tendency for the researcher to reflect upon, to examine critically and to explore analytically the nature of the research process. The researcher's experience is not just unimportant or secondary to the research process and should thus have a place in the reporting of the research (Moch & Gates, 2000). For this reason, I, the researcher, have also told my own story in the presentation of the findings, thus allowing my voice to be heard regarding how I experienced the research process.

The analysed data is presented in the following two chapters that focus on the discussion of the findings.

4.10 Ethical considerations

Neuman (1997) is of the opinion that ethics begin and end with the researcher and that the researcher's personal moral code is the strongest defence against unethical behaviour. Thus, below follows a discussion concerning the ethical considerations adhered to in this study.

4.10.1 Permission

Permission to interview the women attending the infertility clinic was first granted by the Chief Executive Officer of the hospital concerned (See Appendix A), and then finally by the Head of the Gynaecology Department and the head of the infertility clinic (See Appendix B).

4.10.2 Informed consent

The participants were required to sign a consent form before participating in this study. A written consent form was given to them to read before they signed it, so as to make them fully aware about what the research entailed (See Appendix C). The content of the consent form was also verbally explained to the participants thoroughly in their own language, Sotho, so as to prevent any misunderstandings. Permission was also granted by the participants for the interviews to be recorded. In this regard, prospective participants were able to make a free and informed decision about whether or not to participate in the study (Barker et al., 1994).

4.10.3 Anonymity and confidentiality

Anonymity refers to the principle that the identity of an individual is kept secret (Neuman, 1997). Therefore, although the women wrote their names on the consent forms when signing them, they were assured that under no circumstances would those names be divulged in the thesis. Furthermore, because the interviews were recorded, they were also

reassured that the interviews would only be listened to by the supervisor and other authorised people who are involved with this study, and then they would be destroyed once the study has been completed.

4.10.4 Psychological Harm

Harm in psychological research usually comes from stirring up painful feelings or memories, threats to one's self-image and embarrassment (Barker et al., 1994). Discussing a sensitive issue such as infertility stirred up painful memories and feelings in the participants. Although some women became tearful, none of them became too psychologically distressed to continue with the interview. However, in order to ensure that they were not psychologically harmed, after ending the interview and switching off the tape recorder, I debriefed each of the women individually. I also informed the women about the psychological services available to them at the hospital's psychology department, especially because I had confirmed their availability when I telephonically spoke to the head of the psychology department at the hospital.

4.11 Conclusion

This chapter has presented an overview of the research methods and procedures applied in this study, as well as the ethical considerations that had to be adhered to throughout the study.

Since feminist research aims to improve the situation of a marginalised group – women – by giving 'voice' to their concerns, it is hoped that having employed feminist research in exploring infertility among these married African women, the findings of this research will contribute towards the improvement of the situation of the women affected by infertility.

The women who participated in this study are introduced in the next chapter. The discussion of the findings from the analysed data is spread over the next two chapters.

Therefore, the findings from the structural narrative analysis are firstly discussed, and these are then followed by the findings from the content narrative analysis.

CHAPTER 5

FINDINGS: STRUCTURAL NARRATIVE ANALYSIS

5.1 Introduction

This chapter first introduces the six women who participated in this study. The background information of the women is briefly provided, so as to present an idea of the individual characteristics of the six women.

This chapter then focuses on the structural analysis of the six narratives of the women who participated in this study. The structural analysis approach, as proposed in chapter four, is applied in the analysis of the narratives of the women who participated in this study. Therefore, as proposed in the previous chapter, the narratives are analysed according to their structure of the plot, their sequencing of events and inclusion of different characters, their relation to the time axis, their complexity and coherence, and the feelings they evoked (Lieblich et al., 1998). Finally, an abstract of each story, which is discussed later, is then included at the end of each analysis.

Below follows an introduction of the participants, followed by a discussion of the framework within which the process of structural narrative analysis is carried out.

5.2 Meet the participants

This section introduces the women who shared their stories with me. Due to confidentiality and anonymity issues, the women's names may not be revealed in this thesis, therefore the women have each been given a numerical name so as to hide their identity. Thus, the women have been named Woman 1, Woman 2, Woman 3, Woman 4, Woman 5 and Woman 6, and their biographical information is discussed individually below.

5.2.1 Woman 1

She is a 31-year-old northern Sotho speaking woman who has never been pregnant before. She has been together with her husband for almost 9 years. Academically, she studied until Grade 11 and then worked at a restaurant for 2 years. She is currently a housewife. Her husband has 2 children with 2 different women. She says when she met him, he already had the first child whom he'd had while he was still in high school. The child stays with the mother in another town, therefore, she and her husband do not have any contact with them. As for the second child, whom he supposedly had during their marriage, she seems uncertain about the child's existence because she heard rumors about it in her community but did not confirm it with her husband. The couple is currently living alone together.

5.2.2 Woman 2

She is a 30-year-old northern Sotho speaking woman, who is ethnically a Shangaan. She has never been pregnant before. She has been married to her husband for about 5 years. Academically, she studied until Grade 7 and then dropped out of school due to economic reasons. She currently works as a domestic cleaner. She is in a polygamous marriage and she is a second wife. Her husband has 3 children with the first wife - he already had 1 child when she married him and then the other 2 children he had after he was married to her. She stays alone with her husband in the surrounding township and the other wife stays back in the village with the children.

5.2.3 Woman 3

She is a 30-year-old northern Sotho speaking woman who has never been pregnant before. She has been married to her husband for 4 years. She studied until Grade 12 and she is currently a housewife. She lives with her husband in the surrounding township.

5.2.4 Woman 4

She is a 31-year-old northern Sotho speaking woman who has never been pregnant before. She has been together with her husband for 7 years. She studied until Grade 12 and works as a cashier at a supermarket.

5.2.5 Woman 5

She is a 38-year-old woman who is ethnically a Zulu, but she converses in both Sotho and Zulu. She has been together with her husband for 13 years. She studied until Grade 12, and then studied further to obtain a secretarial diploma. She is currently working as a secretary for a government department. Her husband has a child with another woman. He had this child while he was married to her.

5.2.6 Woman 6

She is a 38-year-old Setswana speaking woman. She has been together with her husband for almost 15 years. She has a BA degree in teaching and an Outcomes Based Education (OBE) teacher's diploma. She previously worked as a college lecturer and she now works as a high school teacher. Her husband has a child with another women, whom he had before they met and started a relationship.

5.2.7 Summary

The women's ages range from 30 years to 38 years. All these women live in the surrounding township area where the hospital's infertility clinic is situated. Although Woman 2 and Woman 5 belong to the Shangaan and Zulu ethnic groups respectively, they can both speak Sotho. Since they also reside in a predominantly Sotho speaking township, they did not indicate any discomfort or difficulty in conversing to me in Sotho because they understand and speak the language. Therefore, all the interviews were conducted in Sotho.

5.3 Framework of analysis

The stories are analysed within the framework of structural narrative analysis as proposed by Lieblich et al., 1998. This framework is discussed below.

5.3.1 Structure of the plot

In plot analysis, the focus is on the narrative as a whole, but variations in structure are of most importance (Lieblich et al., 1998). Plotting of a narrative can be accomplished by repeatedly reading the story to identify the structure it takes. The way in which a range of plots are divided appears to depend on the particular perspective or interest of the researcher. Therefore, in my analysis of the plots, I have chosen to divide the narratives using a combination of the different types of plots proposed by Northrup as well as by Gergen and Gergen. Northrup (1963, p. 47) proposed that four basic narrative structures give form to human experience: (1) the romantic, in which an aspect of life is configured as a quest or a pilgrimage to some desired end, (2) the comic, in which progress toward the goal occurs through evolution or revolution, (3) the tragic, in which one falls away or declines from some achieved goal, and (4) the ironic, in which events overwhelm the person. On the other hand, Gergen & Gergen (1986, p. 27) propose three prototypical narrative forms and describe them in the following way: In the progressive narrative, progress towards the goal is enhanced; in the regressive narrative, it is impeded; and in the stability narrative, there is no change. Although some plots are constructed by combining these narrative forms in various ways, some may only use one.

5.3.2 Sequencing of events and inclusion of different characters

This section looks at the way in which the whole story is told, from the beginning to the end. It focuses on the way in which the narrator sequences the events in her story, how she describes an event, how she goes back to the event later in the story, and so on. It also looks at how and when the narrator includes or introduces the different characters in her story, their actions and their voices.

5.3.3 Relation to time axis

This section looks at what Labov (1982) referred to as orientation. This looks at how the narrator, whilst telling the story, orientates the listener to the time and place of the event been told.

5.3.4 Complexity and coherence

This section focuses on the complexity and/or coherence of the story in terms of the characters in the story as well as the events being discussed. It looks at how coherent and/or complex the story is.

5.3.5 Feelings evoked by the story

This section looks at the emotions that are evoked by the story, both within the narrator and the listener.

5.3.6 Abstract

Labov (1982) refers to an abstract as a summary of the narrative and sees it as one of the important elements of a narrative during its analysis. Therefore, in addition to Lieblich et al.'s (1998) framework of analysis, I have also borrowed form Labov's idea of including an abstract in the analysis of a narrative and added one at the end of each analysed story.

Below follows a discussion of each of the individually analysed stories.

5.4 Woman 1's story

5.4.1 Structure of the plot

Her story develops as a tragedy, characterised by some unhappy and sad events. It appears that after she achieves the goal of being married, her life story declines away

from that positive period in her life, particularly as a result of her inability to conceive. From the time she discovered her infertility problem, she narrates a regressive story in which life events are problematic and move her character away from happiness.

5.4.2 Sequencing of events and inclusion of different characters

Woman 1 begins her story by taking me back to the time when she met her husband and how long they have been together for. Before marriage, she never thought she had a problem because she was still young, therefore she only realised her infertility problem after she was married.

What follows from there is her consultations with different doctors and the medical tests she underwent. She consulted with traditional doctors as well, and with all these doctors she consulted, she still could not be told what her problem is. It seems because the doctors could not tell her what her problem is, she turned to her own culture to gain an understanding of why she cannot bear children. Thus, she takes me into her cultural and ancestral world, telling me the story of what she understands to be the cultural cause of her infertility.

What follows then is the inclusion of her husband and the role he plays in this story. Her husband's character is that of a man who, as a result of his infidelity, made another woman pregnant. She takes me through the events leading to her husband impregnating another woman, as well as the events that followed after the incident. Her husband's character is introduced into the story as a 'bad' character as he is introduced as the man who cheated on his wife and made another woman pregnant. But then she proceeds to talk about him as currently playing a positive role, in that he is now supportive of her and her inability to fall pregnant.

The story then proceeds to include her in-laws, their religion, and how supportive they are of her; as well as her own sisters, who are also supportive.

She then brings in her interaction with children, how they visit her during holidays and how she spends time with them. From there, she then speaks about the times when she wishes the most that she could have a child, which is when she fights with her husband and they end up not being on speaking terms, as well as when she sees women her age who are pregnant.

Although she speaks of her hope and faith in God to bless her with a child one day, she also tells of her fear of her husband leaving her for the woman he made pregnant, although he has reassured her that he will not leave her for another woman just because she cannot fall pregnant.

She talks about her husband's first child, and it appears she has not displayed an interest in that child. She says she doesn't know how old the child is, he/she is probably in high school, the child stays far away and she does not know him/her or his/her mother.

She proceeds to speak about her in-law family's support and how they treat her well, probably because they can see she does not have parents.

She then returns to the earlier theme/role of her husband and the events surrounding him making a child with another woman. She speaks of her uncertainty about whether there really is a child or not, although when she asked her husband about it, he told her he only slept with another woman because he wanted to see if he can make children.

From this emerges yet again, her fear of her husband possibly leaving her for the other woman who has made him a child.

She then speaks about her expectations and the disappointments she experiences during some months when her periods are late and she hopes she is pregnant, only to realise her periods are just late and she is still not pregnant. There are times when, even during sex with her husband, she silently hopes that it could be the time when she falls pregnant.

She speaks of her past involvement with children, and takes me back to how, when she was younger and still staying at home, she participated in raising her siblings as she was older than them, secretly wishing they could have been her children, because she loves children and has no problem with them.

She concludes her story by expressing her hope for the success of the treatment; mentioning all the tests and examinations she has undergone up to now, and how she is still enduring the treatment to see what will happen.

5.4.3 Relation to time axis

The story that she narrates seems to be ordered along a time axis. She tries to provide an orientation as to when each event occurred by giving the year when her mother passed away, for example, and the year when her husband supposedly made another woman pregnant.

5.4.4 Complexity and coherence

Woman 1's story is not complex, but there is a lack of coherency in that she starts to speak about something and does not really finish it, and then later on during the story she goes back to that earlier issue and supplies more information. There are also gaps and uncertainties in her story, particularly regarding her husband's second child. As a result of the incoherency in her story, it remains unclear to me whether or not her husband actually has a second child or not. She speaks of her husband's first child, whom she's never met before, but then also mentions that her husband had made another woman pregnant while they were married, but she'd heard rumors that the woman had had an abortion, so she is still not sure if her husband actually has a second child or not. She and her husband separated for a while, but even after they got back together, it seems she did not thoroughly ask him about that incident.

5.4.5 Feelings evoked by the story

My emotional connection with this woman was minimal, and this can be due to the fact that, this being my first real interview after the pilot study, I was more focused and concerned about getting the content that I was looking for. I realise this may have had an influence on her side in the sense that there were times when I felt she was separating her emotional aspects from the content she was giving, probably because of the nature of our relationship.

However, although she discussed everything in a monotonous voice, there were moments when her body language and her facial expression gave away some emotional aspects. For example, she would look away or look down and remain silent for a while; or she would start fidgeting with her fingers (I remember noticing that this happened when she spoke about her love for children and how she helps out with her sisters' children; and also when she spoke about how her husband might leave her for the girl he made pregnant). Although I noticed this, I found myself consciously avoiding going deep into the emotional aspects, but rather still trying to obtain more content around the issue. At the end of the interview when she asked if she would be seeing me again, I realised that there might have been some connection between us, or her speaking to me had had some positive effect on her because she indicated an interest in wanting to see me again.

All in all, I can say that this interview was more intellectual than emotional. The most I felt during the interview was sympathy for the woman, and I found myself wanting to reassure her that hopefully things would work out for her and she would have a child.

5.4.6 Abstract

This is a story of a woman who is struggling to fall pregnant and is currently attending an infertility clinic in the hope of trying to receive treatment that can enable her to fall pregnant. Hers is a story about past events that occurred in her life, particularly in relation to, and after finding out about, her infertility. Her narrative develops in the form

of a tragedy in that she mostly relates certain events that caused her to be unhappy or sad. Her narrative takes me through the periods and situations, mostly unpleasant, which took place in her life until the present moment, when she is attending an infertility clinic. She brings in the other characters that are also part of her story, the doctors, her husband, her in-laws, her family, by including the nature of their relationships to her and the role they play in her life. She passively includes their voices, possible thoughts and feelings regarding her infertility.

5.5 Woman 2's story

5.5.1 Structure of the plot

Her story develops as a regressive tragic plot in which there are events related to her infertility, which cause her character to decline or move away from happiness. Thus, from the time she realises her infertility, her life story is characterised by negative experiences.

5.5.2 Sequencing of events and inclusion of different characters

Her story begins with her telling me about how long she has been married to her husband for and how she initially did not think she has an infertility problem, thinking it is only taking time for her to fall pregnant. She speaks of her in-laws and says she thinks they know about her problem because they know she usually goes to hospitals.

What follows then is her telling me that her husband has 3 children, some of which he had while he was already married to her. In order to explain to me how it came about that her husband had children with another woman while he was still married to her, she enters into a somewhat complex description of the nature of her marriage, which leaves me feeling rather confused. My confusion is caused by my lack of understanding about whom he has children with and whom he is married to, so she then clarifies to me that she is in a polygamous marriage and so her husband has a first wife with whom he has 3 children.

She then tells me how she wonders if she has been bewitched or if people have done this to her. She speaks of the many doctors she has consulted, both western and traditional, as well as the explanations and diagnoses they gave her.

She then speaks of the pain she feels when she thinks of her infertility, as well as how she does not feel like, or identify herself as, a woman because she does not have children.

She tells of her friends and especially her younger sisters, who all have children, one having as many as four. This, she says, hurts her because even children have children but she does not have any children.

Her story then goes back to the beginning, to the year when she first realised she has an infertility problem, and how she had not realised it before she was married.

What follows then is her speaking about her fear that her husband might possibly find a third wife and have a child with her, because she cannot give him a child.

On a more positive note, she talks about how her younger sisters encourage her to keep going to the doctors so she can be helped, although she is not so sure if she can be helped because she has already tried so many treatments.

She then mentions how she sometimes worries about this issue so much that she sometimes cannot even eat. One of her concerns is whom is she going to leave her possessions to if and when she dies because she does not have a child who can inherit her belongings.

Although she does not report any problems between her and her co-wife and her co-wife's children, she is not sure about her in-laws and what they could possibly be saying about her infertility behind her back.

She then speaks of how differently her and her co-wife are treated. Particularly when there are family gatherings, the elder women make her work harder than the other wife because she does not have children to look after, and they also speak to her as though she is only a girlfriend and not a wife. In addition to that, they also constantly ask her when is she making a child and this hurts her because she knows she has an infertility problem.

She then goes back to speak about her fear of seeing the other wife pregnant with her fourth child while she still cannot have even one child. When comparing herself to the other wife, she feels inadequate as a wife because the other wife keeps on giving the husband children but she cannot give him even one child.

Although she says that when her co-wife is pregnant her husband treats both of them in the same way, she mentions that sometimes when he is with her, he rushes off to the other wife if he gets a phone call saying she is sick or one of the children is sick, and this leaves her feeling like she is less important than the other wife because she does not have any children.

She then speaks about their sex life and how this infertility problem affects their sex. Sometimes, during sex, her and her husband can believe that her egg has been fertilised, only to find out weeks later that she is still not pregnant. She speaks of how she is sometimes too afraid to tell her husband when she is not pregnant because she does not want to disappoint him, since he is trying so hard, while the problem is with her. She fears that her husband is probably tired of always sleeping with a woman and she does not fall pregnant, because then there is no reason why he married her.

She then goes back to her fear of her husband possibly finding a third wife who will bear him children as soon as she arrives, whilst she has been married to him for so long but has not given him a child.

She ends her story on a hopeful note, saying she keeps telling herself that when the time allows she will have a child.

She then concludes by questioning, almost as if seeking reassurance, if she and her husband are going to be helped at the hospital. She says the interview has been helpful in that it will get her to seriously think about issues that she had not thought about before.

5.5.3 Relation to time axis

Woman 2's story orientates me to the time when certain events took place in her life. She mentions when she and her husband were married and she can also trace the time when she first became aware of her infertility problem back to a specific year, although then she did not regard it as a problem because she was still not married.

5.5.4 Complexity and coherence

Although her story is coherent, there is a complexity in the way she introduced her husband, his children and first wife into the story. This was unclear to me, and I can imagine that just as I was a bit frustrated with trying to understand, she was probably just as frustrated by the questions and wrong assumptions I made in an attempt to understand the complex nature of her marriage. However, she then cleared out the misunderstanding and complexity by explaining to me that she is in a polygamous marriage.

5.5.5 Feelings evoked by the story

This woman engaged quite well with me and seemed to acknowledge her fears and have an understanding of her experiences and heartache. She tried very hard to conceal her pain and prevent herself from crying, instead of crying, she would look away or lower her voice and start speaking slowly.

I sensed some feelings of inferiority as she compared herself to the other wife who now has 3 kids, as well as to her younger siblings who also have kids. This woman clearly believes that her duty in her marriage is to provide a child for her husband, and thus, her failure to do so makes her feel worthless and useless. I somehow got the feeling that for

her, it is more about having a child for her husband far more than for herself. This perhaps could be due to the marital situation she's in, being a second wife and having to watch the first wife having children, as well as fearing that her husband could take on a third wife who will also bear him children. Her polygamous marriage also seems to place her in a position where there is constant comparison between her and the other wife, with the other wife being preferentially treated by the in-laws because she has children. This seems to perpetuate her feelings of inadequacy and inferiority.

5.5.6 Abstract

This is a story of a woman who is struggling to fall pregnant and is currently attending an infertility clinic in the hope of trying to receive treatment that can enable her to fall pregnant. Her narrative develops in the form of a tragedy in that she mostly relates certain events that caused her to be unhappy or sad. Her story is about her experiences of being infertile in a marriage where she is constantly being compared to her co-wife, who already has three children. She takes me through her fears, her feelings of inadequacy when compared to her co-wife and her fear of her husband taking on a third wife to give him children. She tells a story about past events that occurred in her life, particularly in relation to, and after finding out about, her infertility. Her narrative introduces me to her culture of a polygamous marriage and the struggles and unfair treatment she has had to endure from her in-laws because she is the infertile wife in the marriage. She brings in the other characters who are also part of her story, the doctors, her husband, her husband's first wife and their children, her in-laws, her family, by relating the nature of their relationship to her and the role they play in her life, by including their voices, possible thoughts and feelings regarding her infertility.

5.6 Woman 3's story

5.6.1 Structure of the plot

Her story develops as a romantic plot, in that she configures her religion, which is an aspect of her life, as a search for a desired end, in her case, motherhood. In this way, her

story progresses towards a resolution or an acceptance. This she does by relating her faith in God from the beginning of the story, and how it helps her through the experience of infertility, and then ultimately ends with the assertion that even if she never has biological children, something may come up and she may have to spread God's purpose so that she can find children in spirit.

5.6.2 Sequencing of events and inclusion of different characters

The story begins with her telling me how long she has been married to her husband for and then bringing the story to the present by saying she just found out today that she has an infertility problem. She then tells of how she has been to many doctors who could not find anything wrong with her, and how it is probably due to the fact that they are not specialists. Therefore, she has now come to see Dr X who is a specialist and who has been able to tell her that she has an infertility problem.

She speaks of how her husband initially refused to believe that there is an infertility problem, and how he eventually ended up opening his heart and going with her to doctors, where they discovered that the problem is not with him but with her. She had taken it upon herself to tell him that she thinks there is a problem, before he could ask her, because she was expecting to fall pregnant but it wasn't happening, and she was worried about her age and realised she should start now to seek help. She tells of how she indicated to her husband that she thinks she may be the one with the problem because being a woman, she knows that women tend to have problems related to their wombs.

She then introduces her in-laws into her story, and speaks of how she does not spend time with them since she realised that she has an infertility problem, and says she has therefore not spent long enough with them for them to ask her about her infertility.

She tells of how it causes her a lot of stress when she sees someone her age or younger than her carrying a child, because then she asks herself when will it happen to her.

She then speaks more about her own character, the type of person she is, and the amount of faith she has in God. She mentions how she avoids allowing other people to see that she has a problem because she never wants them to know.

Her faith in God is then brought back into the story, and she says that although her infertility causes her a lot of stress, it does not do so to a point where she loses hope. She trusts in the Lord and tells herself that what happens will happen. Furthermore, in addition to trusting in the Lord, she also believes that if she does not have biological children, she may find spiritual children through carrying out God's purpose. She also brings in a character of a woman she knows from church, whom she feels is also an example of how the Lord knows when what will happen, because although this woman was medically not supposed to be pregnant again, she is actually currently pregnant, thus giving her hope.

She then takes me back to when she first joined the 'born again' Christian church with her husband, and how the decision was not easy for them. Together they decided to both leave their homes and families to start their own life because when they first started with this church, their families did not understand most of their religious behaviour.

As she speaks about her family, she tells of how even her mother has not been able to approach her and ask her about her infertility problem. She is aware that her mother wants to ask her but she does not want to give her the chance to ask her because she feels that if she does, then she will be constantly interfering in her business.

The theme of secrecy and a fear of letting people know about her problem are then re-introduced at this point. This time she speaks about their church, that although they pray for people's problems, she cannot tell them in church that she has this kind of a problem because then some people in the church may go out and tell other people about it.

Her faith and trust in the Lord is then introduced again, as she speaks about her patience and how she is prepared to wait for the Lord to answer her for as long as it takes, regardless of how much older she may become.

She then speaks about other people around her, particularly those who are parents, and tells of their unpleasant experiences of parenthood with their children, and how when she thinks of those negative kinds of stories regarding parenthood, she tells herself that she is better off alone, without children.

She then speaks about her belief in the power of God, and how everything happens because of him. According to her, one should always pray to the Lord, even when doctors touch a person, he/she should pray to the Lord to open up the doctors' minds and enable them to use all the knowledge they have in order to help you.

She then brings her story to the present moment, and tells of how better and differently she feels about her problem now that she has spoken to me about it. She speaks about herself again, and how she is the type of person who always goes into prayer when she has problems, but because we shared things during the interview, it brought up her religious spirit and thus, improved her mood. She also tells of how she has gone through many hardships in her life and feels that at her age, she cannot be running to people to seek help, instead, she has been given the strength to do everything through Jesus.

She ends her story by bringing in her husband again, and tells of how he is always very supportive of her and how he sometimes scolds her when she allows stress to overwhelm her, and he reminds her not to go to bed without turning to the Lord for strength.

5.6.3 Relation to time axis

Apart from relating that she only received a positive infertility diagnosis on the day of the interview, she does not relate her story along a time axis. Thus, she does not tell me when certain events happened.

5.6.4 Complexity and coherence

The story is characterised by a lot of incoherency. For example, she relates how she has been finding her strength in her faith in God and turning to Bible scriptures to help her through her inability to conceive. She also mentions how she has always avoided her family and husband's family since she realised her infertility problem. However, she tells me during the interview that she has just found out for the first time on the day of the interview that she has an infertility problem. Thus, although she claims she only found out today, it seems she had already been aware of and dealing with her inability to reproduce even long before the day of the interview. There is also incoherency and irrelevance in the way in which she responds to certain questions or relates certain events.

5.6.5 Feelings evoked by the story

Her religious belief came across very strongly and repetitively in everything she said. She reported the cathartic experience of the interview in the end, as she told me that before she came into the room she had been very stressed out, but because she had gone deep into her story and we had shared it together during the interview, it had raised her religious spirit and she now felt better than she had before the interview. However, it was difficult to identify the feelings evoked by this story, both within me and within her because of the strong religious content of her story. I found it difficult to break through the religious barrier and explore the underlying feelings evoked by the story.

5.6.6 Abstract

This is a story of a woman who is struggling to fall pregnant and as a result she has come to seek help from an infertility clinic. Her story takes me back to when she first suspected she has a problem, the doctors she consulted and how she ended up being here at this particular infertility clinic. Hers is a story that is based a lot on religion and how she draws her strength and hope from prayer. Although she admits to being stressed about her infertility, it is something that does not seem to control her life in that she says every

time she feels the stress overcoming her, she turns to her faith in God in prayer, and that helps her cope.

Her story is one that does not have many characters as it is mainly about herself, her husband and God. She seems to distance herself from people by excluding them from her problem and ensuring that nobody knows that she is experiencing infertility.

Although she speaks of her experiences and briefly mentions her family and her in-laws, all her experiences and events are always linked/related to God and her faith in him. It appears that her religion is all she has, the only thing she can hold on to. Although she speaks about her husband being very supportive, his character does not come through strongly in the story regarding the role he plays in her life. She only portrays her own roles in the story as both a wife and as a Christian. She is struggling to fulfill her role as a mother, and she does not mention a positive role of being a daughter, a sister, or a friend. Her world is dominated by God and religion, with her husband fitting in somewhere in the background.

5.7 Woman 4's story

5.7.1 Structure of the plot

Her story develops as a tragedy as she relates negative experiences that took place in her life ever since she discovered she is infertile. She relates a regressive narrative that shows a decline in her life from the time she discovered her infertility problem.

5.7.2 Sequencing of events and inclusion of different characters

The story begins with her saying that she is not sure if she is infertile or not because she has been to many gynaecologists who have not really given her a diagnosis, but she herself has found something hard inside her vagina and she experiences a lot of pain during her periods, so she suspects that maybe this hard swelling may be the cause of her infertility. She also goes on to mention that this hard thing she has sometimes even

affects her sex with her husband because sometimes if he does it in a rough manner, then she experiences pain.

She takes me back to the year when this problem started and brings in her husband by telling his age and that he does not have children at all.

Her sex life is then brought back into the story again, as she speaks of how she and her husband sometimes worry about her feeling pain when they are having sex, because of the hard swelling she has inside her vagina.

Her husband's character is then brought into the story again, this time regarding his own fertility tests that he has undergone. She tells of how he has also had his sperm tested, but they have not been told the results of the test yet, unless if the results have been written in his file, so she does not know what his results showed.

She then introduces her family and her family in law, and the supportive and advisory role they play regarding her infertility, by encouraging them to go to church and also suggesting places they can go to for help.

She then brings in the traditional healers she has consulted, and their voices are heard through the causal explanations they gave her regarding her infertility problem. She speaks of one in particular who gave her traditional herbs to try out and told her she has 'sefola' (sores) inside, on her uterus. Then she brings the story to the present, where she is no longer consulting with traditional healers, but is now only going to church and coming to the hospital for assistance.

She then introduces her friends and tells of how it hurts her when she is around them because they sometimes talk about what their children do, and that hurts her because she knows she has a problem with her fertility.

She brings me back into her relationship with her husband by saying that the times when she wishes the most that she could have a child, are the times when she and her husband fight, because then she feels insecure about his feelings for her.

Her sense of feeling differently from other women is then introduced when she says she thinks she is not like other women because she even experiences a lot of pain during her periods, so much that she does not even go to work.

She brings the story to the present, and tells of how her trying to have a child has become the only thing she is focusing on in her life, and how she cannot think about anything else in her life.

She then takes me back to when she started coming to this particular hospital for treatment, and that she was told that her tubes are blocked and she would therefore have to undergo a surgical operation to unblock them.

Her relationship with her husband is then brought into the story again, as she goes back to explain why she mostly thinks about having a child when she fights with her husband. This, she says, is because then she feels he doesn't love her that much because she does not have a child. She also tells of her fear of her husband possibly finding another woman, and thinks that atleast if the relationship ends when she does have a child, then she would have given him a child, and if he leaves her, he may come back because of the child.

She then goes back to her in-laws, and this time speaks particularly about her mother-in-law. She tells of how she usually asks her for a grandchild, and how this bothers her because she also wants a child herself but she knows she has an infertility problem.

She then introduces the people who stay in the same residential area she stays in, and how when they fight with her and her family, they use her infertility to hurt her by calling

her derogatory names used for infertile women, such as ‘moopa’ (a derogatory Sotho word used for a barren woman).

She ends her story by speaking of her hopefulness for the situation that she is in to change, and also asks about the possible nature and outcome of the treatment she is about to receive at the clinic, and whether she will have to undergo the same tests she has already done in the gynaecology department.

5.7.3 Relation to time axis

Her story is ordered along a time axis as she orientates me to the time her infertility began, when she married her husband and how long they have been together for, as well as to the time when she first started attending the infertility clinic at the hospital.

5.7.4 Complexity and coherence

Her story is neither complex nor incoherent. She relates a simple story and gives a coherent account of the events and experiences in her life. When asked for clarity, her answers are relevant and to the point.

5.7.5 Feelings evoked by the story

This woman somehow left me feeling like there is so much she had not said to me. This could be because when she walked into the room, her body language, her posture and her voice somehow gave me the impression of someone who is heavily burdened, but as we engaged in the interview, she did not seem to give away too much. She usually spoke softly, and although she maintained eye contact most of the time, she tended to look away or look down, particularly when she spoke about something which could have been emotionally distressing for her, (this I noticed when she spoke about her fear of her husband possibly leaving her; and when she spoke about the girl who called her ‘moopa’).

5.7.6 Abstract

This is a story about a woman who is struggling to fall pregnant and is thus attending an infertility clinic in the hope of receiving treatment that can help her. Her story takes me back to when she first discovered that she might have an infertility problem, and takes me through the events that followed, such as the treatment options she tried. She narrates the nature of her relationship with her husband and tells of how she feels during the times when they fight. She talks about their sexual relationship as well as her fear of him possibly leaving her for another woman without her having been able to make him a child.

Although her in-laws do not seem to be that much a part of this story, she does bring in the role of her mother-in-law, and introduces her character as that of someone who is constantly asking her for a grandchild, and thus putting pressure on her. Being around her friends also seems to be a problem for her, because of the pain she feels every time they speak about their children and the things their children do, while she knows that she cannot have children. Her story does end on a somewhat hopeful note in that she says she does have hope that things will change.

5.8 Woman 5's story

5.8.1 Structure of the plot

Hers is a regressive narrative with multiple characters and themes. She also presents a combination of a tragic and an ironic plot – tragic in that she relates unpleasant events that cause her misery, and ironic in that these events overwhelm her.

5.8.2 Sequencing of events and inclusion of different characters

This woman begins her story by speaking about when her infertility problem first began as well as how long she and her husband have been married for.

She then speaks about her husband's child with another woman, and the fact that he had this child while they were already married.

From this, she introduces her in-laws into the story, and tells of how they make her life difficult. She informs me of the nature of her relationship with her in-laws, and tells me about the things that they have done to her to make her life difficult. She proceeds to focus for quite a lengthy time on her in-laws' characters, and speaks about her husband's paternal and maternal aunties, as well as his mother. She takes me back to past incidents that have occurred, and informs me of the negative actions and words that her in-laws have done and said to her, as well as how she feels they may also be influencing her husband by telling him bad things about her, and this all happens only because she is infertile.

She then speaks more about her husband and the fact that he had a child with another woman while they were married. She takes me back to a time when she had actually considered taking her grandmothers' advice to find her husband another woman with whom he could have a child. She speaks more about this by taking me through her culture, and tells of how her grandmothers had suggested she finds her husband another woman to bear his child, because it is an acceptable cultural practice amongst the Bapedi ethnic group. She tells of how that even though she discussed this with her husband and even considered doing it, she did not really like the idea and therefore they ended up not going through with it.

She then takes me back to the events surrounding her husband's affair with another woman and subsequently having a child with her. She brings in all the role players, i.e. her husband's aunties, who were involved from the beginning of the affair, as well as when and how they told her about the child.

She then tells me about the events that took place subsequent to the affair. She left her husband after she found out, but when he asked for forgiveness and wanted her back, she went back to him. She also tells me about the other woman and how they were not on

good terms with one another when she first found out about her, although they are now getting along with each other.

She speaks about the current nature of her husband and the other woman's relationship. When she asked her husband about the other woman whom he slept with, he said he did not love her; all he wanted from her was to see if he could have a child or not.

She then speaks about her husband's relationship with his child, and how she watches them playing together and wishes that the child could have been hers, because no matter how much she may love him, she will always be reminded that he is not her biological child.

Her story then takes me through her consultations with different doctors as well as the diagnoses she was given. She also speaks about the traditional healers she consulted and how they told her that she has 'sefola' (sores, on her uterus).

She then speaks about her relationship with her husband, and says that although he handles the whole infertility issue well, there are times when he fights with her about it, and he is the one who even convinced her to come to this clinic for treatment because she had become too tired of trying and no longer wanted to come.

She then speaks about her own family, the support they give her and the way in which she can turn to them when her in-laws bother her. She also tells of how she spends time with the children in her family, and each time she does that, she wishes they could be hers. She also wishes to have a child the most when she is around women who talk about their children, or when she sees people walking around with their children or also when she sees children's clothes in shops.

Her story then takes me back to her relationship with her husband and the fights that they sometimes have. She mentions that her husband brings up her inability to have children

when they fight, because he wants to hurt her feelings. She tells of how she does not feel like a complete woman because she has not experienced the pain of giving birth.

Her story then takes me into her innermost world, where she reveals her private thoughts and emotions. She speaks of how she is not coping with this situation, so much that she feels it would be better if she just died, because then she would rest and take a break from thinking about having a child as well as from her in-laws. She tearfully speaks about how she thinks of taking her own life, but then says she will not do it because she is afraid of taking her own life and she does not even know how she would do it.

Her story then goes back to her relationship with her husband and she tells of how he is sometimes supportive of her, especially when he sees her crying, and he has told her not to take his aunties seriously because they are drunkards.

Her husband's aunties are then brought back into the story and she tells of how painful it feels when they call her derogatory names and ridicule her in front of people. She takes me back to the beginning of her relationship with them and says it was good, but things changed after she consulted a traditional healer regarding her infertility problem, because then the aunties accused her of trying to bewitch her husband.

After she speaks about how badly the aunties treat her, she then introduces her own aunty, her sister, her friend and a previous social worker as her sources of support. Her friend is going through a similar infertility problem, so they talk about it and help each other. She also mentions a social worker that she used to see whom she says helped her.

Although she ends off her story saying she is willing to try the current infertility clinic's treatment and she hopes it will succeed, she also mentions that she is tired of all the doctors she has been to and when she considers her age, she doubts if she can be helped.

5.8.3 Relation to time axis

This woman relates her story along a time axis as she tells me the time and the years when certain events took place, and tries to also orientate me to the different characters in her story.

5.8.4 Complexity and coherence

She relates a complex but coherent story. The complex characters, the events and themes that emanate from her story create its complexity.

5.8.5 Feelings evoked by the story

I found myself feeling the woman's anger, pain and frustration as she related her story regarding her in-laws and the way in which they treat her. I really felt sympathetic towards her because it seemed like her whole life is no longer private as there are people interfering and accusing her of all kinds of negative things, all because she is infertile. This infertility seems to have also negatively affected the way in which she perceives herself as a woman, because she mentioned that she 'does not feel like a woman' because she cannot bear children for her husband.

She was emotionally expressive and she seemed to have been experiencing these difficulties for quite a long time, to a point where she felt like just giving up. It concerned me when she mentioned that she is not coping, so much that she has even thought of just ending her own life. Although she was tearful most of the time, she maintained eye contact, and at some point her eyes looked as if she was reaching out to me to help her.

When she left the room, I was really emotionally overwhelmed by everything that had been said and done during the interview. This woman and her story stayed with me, in my head and in my heart, even long after the interview had ended, because I kept on

replaying her story in my head and feeling the anger, the pain and the frustration she may have probably been feeling as well.

5.8.6 Abstract

This is a story of a woman who is struggling to fall pregnant and is currently attending an infertility clinic in the hope of trying to receive treatment that can enable her to fall pregnant. Hers is a story about past events that occurred in her life, particularly in relation to, and after finding out about, her infertility. Her story develops both as a tragedy and as an irony, and is filled with many events in which she is ridiculed, hurt, ostracised and disrespected. Her story seems to evolve mainly around the main characters, her husband's aunties, and it seems like all the main and negative experiences and incidents that have taken place in her life stemmed from her interaction and relationship with her husband's aunties.

This is a woman whose sense of self seems to have been taken away from her, and the role she is expected to play as a wife and as a mother is constantly under attack from her in-laws. Hers is a story of a burdened woman, whose infertility has become more of a family problem involving many characters, instead of just a marital problem between her and her husband. Furthermore, she is not only facing pressure from her in-laws, but she thinks that biologically, she does not have much hope of falling pregnant because of her age. Her situation has at times become so overwhelming that she has even considered committing suicide because she feels that then she will be able to rest, but because she is afraid to do it and also does not know how she would do it, she is certain she will not take her life.

5.9 Woman 6's story

5.9.1 Structure of the plot

She presents a tragic plot, which begins with a progressive narrative in which she moves toward a goal and achieves a high position, i.e. her studies and her career, but then there

comes a regressive episode, i. e. her infertility, in which there is a rapid fall. Her life story is one of a woman who worked very hard all her life to achieve both academic and professional recognition. However, once that had been achieved, her struggle with infertility began and this led to the regressive move away from her goal or her happiness.

5.9.2 Sequencing of events and inclusion of different characters

Her story begins by her telling me about when she was still at school and how, although she was aware that she was not falling pregnant, it did not bother her then that she could not have a child. She then talks about her relationship with her husband and how it was when they first met, and how, despite the fact that she stopped using contraceptives, she realised that she was not falling pregnant. She then speaks about all the different doctors and treatments she tried, all to no avail. She also introduces her husband's daughter, whom he had before he met her, and tells of how after years of not seeing her father, she came looking for him and found him. The story then brings me to the present, where she is now seeing this current doctor, and she tells of how she heard about him and came to the clinic. She also then speaks about how she is now worried about her age because she realises she is getting older, and she has also noticed that lately she is short tempered and irritable because of worrying about her infertility.

She then speaks about her financial situation and says that because she is working and has a permanent position, she can afford to have even more than one child.

She brings in her family and her in-laws, and tells of how she sometimes feels there may be people saying negative things about her behind her back, particularly when they see her holding another person's child because she does not have her own.

She then brings in her colleagues at school and says they call her derogatory names, but her family and in-laws treat her well. She speaks about her in-laws and how they have a family member who is also infertile, and so therefore, she thinks they are afraid to behave negatively towards her whilst they themselves have an infertile person in their family,

who even went and adopted a child. She then links this to her own unsuccessful attempt to adopt a child, and her decision to first try out the current treatment from the clinic before she tries to adopt again.

She then tells me about the different people and places she has approached for help, such as her church and traditional healers, in an attempt to fall pregnant, but nothing has worked.

She says she does not feel like she is a woman, and feels she is not fully playing the role of a woman because she does not have a child, but her husband is very supportive towards her through all of this.

She then speaks about how lately she just wants to sit alone and be away from people, and she avoids being around people, particularly women, because she is afraid that they may start talking about their families and husbands and eventually, children, and then she would have nothing to say.

Although her husband has not tried to have a child with another woman outside the marriage, she says a doctor once suggested to her that they try a surrogate mother, but she and her husband did not like the idea and so they never went through with it.

She brings back her stepdaughter into the story, and says she has a very cute baby who makes her wish she could be her own, and when she saw her she even thought to herself that even children have children but she is struggling to have a child.

She then brings in her hopefulness in the story, by speaking about her church and how they often offer them encouragement, as well as her faith in the fact that a black doctor is treating her at the moment.

She then speaks about situations that make her feel the most that she wants to have a child, such as when she is with family members and they all have their own children, and

also when she is in church and sees women carrying their children, then she wishes that she could also be holding her own child as well.

She brings in her sources of coping, being her work and her husband's support. She also turns to her younger sister as well as her husband's sister for support.

Her identity is then brought into the story, as she speaks of how she feels differently and wonders why she is not like other women. She wishes to atleast fall pregnant, even if she does not carry the baby to term, because then she can atleast console herself with the fact that she once fell pregnant, even though she never gave birth.

She speaks about the school holidays; saying that they are the loneliest period because then she is at home the whole day and other people are also with their children, so it is during those times that she wishes to have a child the most.

Her husband is then brought again into the story, and although he is supportive, she feels that he cannot compare himself to her regarding the couple's infertility, because unlike her, atleast he has a child, even if he did not bring her up, she is his child.

Her stepdaughter is then brought into the story again, and she speaks about the positive relationship they have with one another. However, although they have a good relationship, she says she still feels the empty space of not having her own child, because no matter what she can do for her stepdaughter, she will always know that she is not her biological mother.

She then concludes her story by talking about her possessions and how hard she and her husband worked to attain them, but now that she does not have a child she is worried about who will inherit them in the event that she dies.

5.9.3 Relation to time axis

She does not order her story along a time axis. The only time she orientates me to is the time when she and her husband met and married.

5.9.4 Complexity and coherence

Although there is a complexity of issues she raises in her story, it does not leave me with any confusion or uncertainty because she relates these issues in a coherent and detailed manner.

5.9.5 Feelings evoked by the story

This was a very emotional interview, both for her and for me. This woman was highly in touch with her feelings and she could express them very well. The story she told evoked many painful feelings within her and she was tearful throughout most of the interview. It seems her struggles and experiences are more internal than external, in that she reported minimal negative experiences or treatments from people in her life; her focus was more on herself and how she feels as an infertile woman. I sensed her frustration and helplessness, and how, despite all her achievements, she regarded herself a failure as a woman for not falling pregnant. I could feel her pain and helplessness as she desperately tries to have a baby but with no success.

5.9.6 Abstract

This is a story about a woman who is struggling to fall pregnant and is thus attending an infertility clinic in the hope of receiving treatment that can help her. This woman's story does not have many characters that are making her experience negative and difficult. Rather, hers is a story of an internal struggle she is constantly having with herself, being an achiever and a successful person, and now having to fail at achieving the one last thing she misses and wishes for the most - motherhood. She is becoming more socially

withdrawn and seeks to avoid situations where the subject of motherhood will be brought up, because she feels she will then have nothing to contribute to the conversation.

Although she has a stepdaughter with whom she is very close, she still feels the emptiness of not having her own biological child. She is a woman who tried virtually everything to have a child, and thus gives a sense of having placed her ultimate hope of succeeding into this current doctor at the infertility clinic.

5.10 Conclusion

Tragic plots characterise the narratives of most of these women, and this can be understood in light of the painful issue that was being discussed. Struggling with infertility is not expected to be a pleasant experience for women, especially when they are married and are thus expecting and expected to have children with their husbands. From the time these women realise their infertility problem, they relate regressive narratives as they reflect back to the unpleasant and negative events that occurred in their lives up to the present moment at the clinic.

Multiple characters are also included in the women's stories. Their husbands, their families, their in-law families, their friends, their colleagues, their community members and the health professionals they consulted with, are each introduced into the stories and the women orientate me, the listener, to their roles in and their influence in their life stories. Some of the women also introduce God and ancestors as characters in their stories, and relate the role that they also play in their life story.

The women do not always sequence the events in the order in which they happened, rather, they relate events as they came to mind and would then occasionally take me back to other events that led to an event they had just related, so as to orientate me to the situation being described. This inability to sequence their stories in chronological order can be related to the difficulty that some of the women experienced in remembering when certain events happened. Thus, although some women manage to order their stories along

a time axis, other women are not always able to provide an orientation as to when each event occurred.

Very few of the narratives are either complex or incoherent. Those that are complex are made complex by the intricate web of many characters, events and themes that are brought up by the women as they tell the stories. On the other hand, those stories that are incoherent are made incoherent by the contradictions, irrelevance and the 'missing gaps' that characterise them.

Since infertility is a sensitive issue, a wide range of emotions is evoked by the stories that the women tell and while some women try to suppress overt displays of them, others are tearful. However, most of the women verbally express their emotions, both past and present. Although some stories evoked some emotions in me as well, there are some stories during which my emotional response or connection to the women was minimal.

Finally, since the purpose of structural analysis is to learn something about the speaker that might not have been apparent from examination of content alone, it is hoped that this chapter has provided a picture of the six women who shared their stories with me. To avoid the tendency to read a narrative simply for content, Riessman (1993) recommends beginning with the structure of the narrative, which is what the purpose of this chapter was. The unpacking of structure was carried out as the first stage of analysis in this chapter. The second stage of analysis is carried out on a content level and the results are discussed in the next chapter. Thus, the process of data analysis is carried out by an integration of narrative structural analysis and narrative content analysis. The content of narratives is very important during analysis, and therefore the next step of analysis relates to what Lieblich et al. (1998) referred to as holistic-content analysis, which takes into consideration the entire story and focuses on its content. The themes that emerged from the content analysis of the six women's narratives are discussed in the following chapter.

CHAPTER 6

FINDINGS: CONTENT NARRATIVE ANALYSIS

6. 1 Introduction

This chapter discusses the content of the narratives of the women as they take me through their experiences of being infertile. The stories take me to the beginning when the women first found out about their infertility problem and the consequent events that occurred in their lives relating to their infertility. The stories inform me about the causal explanations for their infertility, as well as how they have experienced their infertility, both individually and socially. The chapter then goes on to discuss the women's coping and management strategies, and concludes with the story of the researcher's experience of the research process.

Below follows the themes that emerged from the content narrative analysis and these are discussed against the background of available literature.

6.2 Causal explanations

Once a couple realises and acknowledges that they could possibly be faced with an infertility problem, what usually ensues is a frantic search for a causal explanation or a diagnosis, so as to understand what could be causing the infertility problem. As Cornwall (2001) put it, some move from healer to prophet to herbalist to hospital, desperately seeking some resolution, driven by hope, uncertainty and despair. This is consistent with the findings of this study, as the women involved also went through a period of searching for a causal explanation for their infertility, and for some it was either biomedical, cultural, religious or a combination, and these causal explanations are discussed below.

6.2.1 The doctor said

All of the women interviewed had been to see a doctor or a specialist, either privately or at a local clinic or hospital. These women were given a diagnosis by the doctor so that they could understand what the cause of their problem is. As Woman 4 reports: *"They were telling me that my tubes are blocked so they have to do an operation to unblock them."* Tubal abnormalities occur in approximately 20% of all infertile women (Wood & Paterson, cited in Pepperell, Hudson & Wood, 1980). Although this was a finding done from a study conducted more than two decades ago, it is consistent with recent findings of a study carried out by Day (2001) where he found that the most common explanation of female infertility concerned tubes that might have been blocked. According to Day (2001) this reasoning is probably widespread in society, for women's magazines and health care suggest that tubal damage may develop from sexually transmitted infections, such as gonorrhoea or chlamydia, which are major causes of infertility. Furthermore, Ndaba (2002) found that studies done in Kenya, Ghana, Sub-Saharan Africa and Gabon indicated that tubal blockage is the most common cause of infertility in southern Africa. Thus, consistent with these findings, half of the women in this study report having been told that their tubes are blocked.

6.2.2 The traditional healer said

Out of the 6 women interviewed, 5 of the women report that they had consulted with a traditional healer as well, sometime before coming to the current clinic. Although some of the women were not provided with a clear explanation as to what is causing their infertility, two of the women report that they had been told by the traditional healers that they have 'sefola', of the uterus, that is, sores on the uterus. 'Sefola' is a Sotho word for a condition that is believed to be passed on to someone when that person steps on some muti (traditional medicine) that another person has placed for her/him in her/his path. This condition usually manifests as deep sores on the legs, and usually, in its severest form, the person may need to have their leg or legs amputated. However, for these women, according to their traditional doctors, this condition has affected their uterus and

thus caused their infertility, as Woman 4 reports: *"Another one (traditional doctor) told me that I have 'sefola' (sores) on the uterus"*.

6.2.3 It's the ancestors

For one woman, who had been to doctors and traditional healers and been told that there is nothing wrong with her, a cultural explanation seemed to make better sense to her. Although she claims not to have any idea what the cause of her infertility may be, she does have a cultural explanation for her understanding of the problem and thus attributes it to the ancestors. Misfortune and illness can be seen as a result of the ancestors' displeasure with the living (Mabetoa, 1986). Meyer, Moore and Viljoen (1997) state that ancestors serve an all-important intervening medium and contact with God for Africans. Thus, for everyday existence, the ancestors are therefore very important and they form an inherent part of daily African functioning. Woman 1 explains an ancestrally related cause of her infertility in the following way:

Woman 1: " Ag, the thing is the idea that I have with me, it is ancestral things. So at home I am the last-born child, so my mother passed away long time ago, […]. When my sister got married, she got married at my father's house, so the time I got married, there was a problem, because I am the last-born, so why did I get married at my grandmother's house, because I had to go and get married at my father's house. So, the big thing that I think is wrong with me, is that it (my infertility) is ancestrally related…"

6.2.4 I am not sure what is causing it

The uncertainty of a diagnosis can be caused by doctors saying that they cannot see anything wrong and can therefore not give you a diagnosis. This is the case for Woman 1, who went to see doctors and says she was told there is nothing wrong with her; therefore she has no idea what the problem could be. Although it is painful to accept an infertility diagnosis, it is usually helpful to infertile couples because it provides an explanation to their infertility (Leiblum, 1997). Thus, although Woman 1 has concluded on her own that

her infertility problem might be ancestrally related; she still has uncertainty regarding her diagnosis because both western and traditional doctors have not given her a diagnosis.

Woman 1: " Ah, they tell me I do not have a problem because my tubes are open, my womb is clean, so I don't have an idea as to why I cannot have children."

Furthermore, the uncertainty of a diagnosis may also be brought about by unclear explanations given by doctors. This seems to be the case with Woman 3, because after she underwent X-Rays and medical examinations, it seems although the doctors attempted to tell her what her problem might be, she still remains uncertain.

Woman 3: "What was there is that, let's say when the womb appears like this, they cannot see what it is supposed to look like at the corner. Now the doctor can see that this thing is not on the level it is supposed to be on, so maybe that's where the problem is."

From the above, it appears that the process of searching for a diagnosis or a causal explanation for infertility is usually a lengthy one, which involves countless medical consultations and investigations. For black women however, it is evident that a western biomedical diagnosis alone does not provide sufficient explanation regarding the causes of their infertility, and therefore additional culture-specific resources such as traditional healers and ancestors are included in the formulation of a possible causal explanation to their infertility. This seems to provide a broader understanding of their problem, particularly in cases where they were not given clear or definite biomedical diagnoses.

6.3 Realising when an infertility problem began

For a process to take place, it has to have begun somewhere. Therefore, for these women, the process of experiencing or dealing with infertility began after they realised that despite engaging in unprotected sex with their partners/husbands for a certain period of time, they were still not falling pregnant. For most of these women, it was the realisation of not falling pregnant that began the process of them seeking explanations and help from traditional healers, religion, doctors, medical specialists, and presently, the infertility

clinic that they were recruited from. According to Needleman (1987), once a couple realises they are infertile, they usually experience it as a crisis, as they suddenly find out that they cannot have children naturally and have always taken it for granted that they will be able to have children.

Thus, below follow the narratives of how and when the story of infertility began for each of these women.

6.3.1 Back then it was not a problem

Although Woman 1 only began to seek treatment for her infertility after she was married, she traces her infertility back to before she was married. What is interesting is the way in which she differently perceived her inability to fall pregnant before and after she was married. As Woman 1 puts it in her interview: *"Before I got married, I did not have a problem with not bearing a child. Maybe I was still growing up so at that time I did not realise there is a problem."* Therefore, although she realised her inability to fall pregnant even before she was married, it was only after she was married, thus, within the context of the marital system, that she started perceiving her infertility as a problem.

Woman 6 also tells a similar story to this one. She met her husband about 15 years ago, and during their relationship, although she was not using contraceptives and they were engaging in unprotected sex, she was aware of the fact that she was not falling pregnant. *"I stopped going to the clinic after I met him, and we were not using any protection, but then I did not know I have an infertility problem."* Thus, for her as well, she only began identifying her infertility as a problem when she and her husband were ready to have children within their marriage.

6.3.2 We thought it was only taking time to happen

After 5 years of being married to her husband, Woman 2 says that although they were aware that they were not having children, they thought it was only taking time for them to

be pregnant. *"All this time I did not think it is a problem, I though it is only taking a while but it will happen, my husband also thought so."* It is also unclear as to when exactly during their marriage did she acknowledge she has an infertility problem because although she realised all along that she was not falling pregnant, she thought it was only taking a while for it to happen.

6.3.3 Before he could ask, I told him there is a problem

On the day of the interview, Woman 3 had just received a positive infertility diagnosis from the specialist at the clinic. Although after being with her husband for 4 years and not falling pregnant, she was still under the impression that she does not have a problem because the previous doctors she had seen had not given her a diagnosis. However, although she does not give a precise account of how long ago she realised there was an infertility problem, she reports that she decided to be the first to tell her husband that she suspects there is a problem, before he could ask her. *" Because you expect something to happen, so I thought that before he could ask, I told him I see a problem."*

6.3.4 I cannot say if I am infertile or not

Despite having received both a western and a cultural diagnosis, Woman 4 still has difficulty defining herself as infertile. *"The thing is, I don't know if I am infertile or what…"* However, she says that since 2000, she realised that despite sleeping with her husband without using any contraceptive method, she was not falling pregnant.

6.3.5 We were sleeping together, but nothing was happening

Woman 5 traces her infertility problem back to 13 years ago after she and her husband were married. She says that after she met her husband, they slept together and expected to have a child, but nothing was happening. *" I can say this problem started after I met the man I married. You know after you marry, you sleep together, and even if you do not*

plan, but you atleast expect a child to be born. So since we met, from around 1992, but nothing has happened."

Looking at their stories about when their struggle with infertility began, it becomes clear that what all these women have in common is that for all of them, what serves as an indicator of an infertility problem in their marriage is the fact that after sleeping with their husbands for more than a period of no less than four years, without using any method of contraception, they are still not falling pregnant. According to Machelle (1979), even before an actual infertility diagnosis is made, the couple is undergoing feelings of anxiety, uncertainty and inadequacy. For most of these women, it seems that even earlier on in their relationships, there is already an awareness or a suspicion of their infertility, because even though they are not using contraceptives, they are not falling pregnant, but it is only later on in their marriages when they and their husbands expect to have children, that they acknowledge their infertility and begin to see it as a problem which has to be dealt with.

This delayed realisation of an infertility problem can be attributed to the fact that women never expect or are never prepared for the possibility of being infertile in adulthood. As a result of the socialisation process and our parents who are our role models, we are led to believe that we too will be parents one day and are never prepared for the possibility of not being able to have children (Needleman, 1987). As Menning (1980) put it, children are raised with the belief that they will be parents one day and they must therefore prevent the possibility of an illegitimate pregnancy. Therefore, some of these women grow up using contraceptives to prevent illegitimate pregnancies, and even when they are not falling pregnant earlier on in their lives, they do not identify it as a problem because they are either still growing up or they just assume that it is taking time for them to fall pregnant.

6.4 Individual experiences

Individuals have their own personal ideas and feelings about things, events and people, and this may suggest individual differences in similar experiences (Krech, Critchfield & Ballachey, 1962). Thus, although these women are all experiencing infertility, each one has her own story to tell about her individual experiences. Therefore, below follows a discussion of the individual experiences of infertility reported by the women.

6.4.1 It hurts

The emotional pain that comes with infertility is often unavoidable. It is usually women who mainly experience the heartbreak of infertility (Gill, 1998). In this research, half of the women report how emotionally painful the experience of being infertile is to them. Woman 5 reports this emotional pain in the following way: *" My heart hurts, sometimes I even want to cry."*

6.4.2 I do not feel like I am a woman

Motherhood is usually identified as an essential part of being a woman, to an extent that women without children are usually portrayed as unfulfilled and incomplete (Anderson, Steward & Dimidjian, 1994). Therefore, women who are unable to have children experience a sense of being incomplete as well as a lack of identity: *" The thing is, I don't feel like I am a complete woman because I don't know the pain of being in labor."(Woman 5)*

6.4.3 I feel different from others

Issues that face those with an infertility problem may include the fear that they are 'abnormal' (Read, 1995), in other words, they may not see themselves being as 'normal' as fertile women are. This is narrated by two of the women who feel they are not like other people and tend to question their difference:

Woman 4: " I feel hurt…for me it looks as if I am not like other people. I even see with some of my periods, they come out lightly, and then I say but how am I?"

Woman 6: " Now when nothing happens totally then I ask myself what kind of a person am I, and what kind of people are others, when nothing happens with you."

6.4.4 I worry and stress a lot

Infertile women have to constantly worry about the success of their treatment and how this could impact on their marriage (Valentine, 1986). Some of the women in this study narrate that they are constantly very worried about their infertility. Woman 2 reports how she sometimes worries so much that she does not even eat: " *…but when I am sitting alone, I become worried about this issue of a child, you'll find that sometimes I don't even eat because of worrying."*

Even more severe, Woman 5 reports how she sometimes wishes she could just die because she constantly worries about her infertility and cannot seem to cope with it: " *No, I am not coping." I always worry a lot of the time. I mean I should die, just like that. Atleast I will rest. I will no longer think about having a child,"* and Woman 6 reports that her infertility is so stressful that she now does not even want to be around people: *" And now it is beginning to stress me out up to a point that where I am starting to, it's like I become short tempered. Mm. I'm irritable. The thing is, I always want to be alone, I don't enjoy being with people."*

6.4.5 It is painful to see other women pregnant or with children

For the infertile women, seeing and being around other women who are pregnant or who are with their children acts as painful stimuli. These women suffer pain, loneliness and sadness when they see other women with their own children (Brandon, cited in Becker, 1990).

As two of the women put it, when they see a woman who looks as old as they are, pregnant or carrying a child, they each wonder when they will have their own child:

Woman 1: *" Its like, it bothers me when I see, maybe a woman my age who is pregnant, that is when I ask myself when will it be me."*

Woman 3: " You know, the thing is like when I see…someone carrying a child. It is like…and a lot of times, when I see someone carrying a child I tend to look at her and say 'maybe she could be my age or younger than me, but what about me?'"

Somewhat different from this is the experience of Woman 2, who is in a polygamous marriage. Being a second wife, her fear is more about the possibility of the first wife falling pregnant again, because seeing her pregnant will be painful for her: *" If she (the other wife) gets another child…I will have to see her pregnant again and that does not feel right."*

Furthermore, certain social contexts that infertile women find themselves in also make their experiences of infertility painful for them as they expose them to seeing other women with their children, as two women indicate in the following way:

Woman 5: " When I am sitting with people, other women, you find them talking about what their children do. You know, even when I walk in town and you find people are walking with children, or I go into a shop and I see children's clothes, then I wish that eish, if only I had a child."

Woman 6: "Yes, it is often when we are now, when we are together as a family, either from my husband's side or my side, and then everybody is complete with their family. The thing is then we also feel jer (an expression), if only we could have been holding our own (child). Or in church, you also feel as if you could be holding your own thing in your arms."

And for Woman 4, the experience of being around women who have children is made even worse by the women talking about their children: *" Your heart feels sore when you*

hear someone talk about my child this and this, he/she did this and this, whilst you know that you have this kind of a problem."

Therefore, for all these infertile women, whether it is seeing a total stranger in the street or a co-wife, there is a common painful experience that is aroused by seeing other women pregnant or with their children. Certain social contexts as well, where there are women and their children, also cause infertile women pain.

6.4.6 I am getting older

Because age has biological implications on a woman's infertility, half of the women report that they are worried because they realise they are getting older but they are still not falling pregnant. Because there is an age-related decline in fertility, women over the age of 40 usually believe that they are less fertile than they were at a younger age (Kern, 1982). As Woman 5 puts it: *" And now I also consider my age, I don't have hope. 38!"* This is also the case with two other women who report that they are worried about their chances of falling pregnant decreasing with their age.

6.4.7 I am not fulfilling my role

Reber (1995, p.674) defines a person's role as "what is expected of him or her by others and ultimately, after the particular role has been thoroughly learned and internalised, by the person him or herself." According to Brandon (cited in Becker, 1990), childbearing has been viewed as a valuable gender-specific role to women. Therefore, women who are unable to bear children experience a pervasive sense of personal failure (Tremayne, 2001). Woman 6 narrates this feeling of being a failure in fulfilling a woman's role in the following manner: *" So you know, I also take that feeling that, eish, I am not playing the role of a woman, I am not playing it the way I should because the one important thing that a woman misses, I cannot have, so that is the problem."*

6.4.8 I am called derogatory names

Half of the women report having been called 'moopa' by some people they know. 'Moopa' is a Sotho term that is ordinarily used to describe a cow or an animal that cannot reproduce (Upton, 2001). Therefore, infertile women are dehumanised and insulted by being referred to as infertile animals, as Woman 4 reports: *" Yes, her family does not get along with my in laws, so they got a child to call me a 'moopa' and hurt my feelings, because they know it is going to hurt me to be called a 'moopa'."* Similarly, in her study carried out in Nigeria, Cornwall (2001) found that an infertile woman could be insultingly referred to as 'agan', while there is no term in their language, Yoruba, that describes a man who is potent but infertile. This is a similar situation in South Africa, where there is no Sotho term that describes an infertile man, but there is a derogatory term for an infertile woman.

6.4.9 Who will inherit my belongings?

As it is usually customary for parents to leave their belongings to their children when they pass away, two of the women are concerned about whom to leave their belongings to because they do not have children who can inherit their belongings from them, if it happens that they pass away. Woman 2 reports this concern in the following way: *" Because I am working, I have things, so you'll find that, if I die, then who will my things be left with? There is nobody I can leave them for because I do not have children."* A similar finding is reported by Boerma & Mgalla (2001) where they found that many African men are concerned with their livestock and the production of descendants who will sustain the family corporation.

It is evident from the above findings that infertile women undergo negative individual experiences regarding their infertility. The emotional turmoil, characterised by constant worrying, increased stress and heartache, makes this an unbearable experience for them. These women experience a lack of identity and feel they are not fulfilling their roles as women. Furthermore, apart from having to deal with dehumanising and insulting names

from the people around them, these women have to deal with the additional pain that is aroused by seeing other women who are pregnant or who are with their children. The future also poses fear and uncertainty for these women, because not only do they realise that they are growing older and this may gradually decrease their chances of ever falling pregnant, but they also realise the probability that they may one day die without having had any children and then there will be nobody left to inherit their belongings from them.

6.5 Marital experiences

Infertility within a marriage affects both husband and wife, regardless of who carries the infertility diagnosis, because it is socially expected for a married couple to have children. Therefore, infertility represents a significant loss to a couple desiring a child, as it implies a loss of pregnancy, genetic continuity, potential children, a life goal, parenthood and control over one's own body (Laurence, 1989). Experiences of infertility may be similar or different for men and women within a marital system, however particular focus is herein made on the experiences of the women within the marital system. Therefore, below follows a discussion of the women's experiences of their infertility within their marriages.

6.5.1 He slept with another woman

Although male fertility and an ability to produce children are rarely, if ever, questioned (Upton, 2001), men in infertile marriages often feel pressure to impregnate other women so as to prove their own fertility (Boerma & Mgalla, 2001). Therefore, this often leads to issues of infidelity within marriages, as men engage in sexual relationships outside their marriage so as to prove their fertility. The following two women report a similar experience with their husbands:

Woman 1: " When I asked him about it he said he wanted to see whether or not he can make children."

Woman 5: So this man (her husband) had a relationship with that woman, and then there was a child, and I didn't know all that time."

6.5.2 I left him…but came back

The marriage can sometimes be under a lot of strain as a result of issues related to the couple's childlessness. Couples may also fail to share their anxiety with each other and this can lead to a breakdown of communication and an increase in marital problems (Menning, 1980). For two women in this study, the marital problems became so much that at some point they left their husbands, but they did return to them after they (husbands) asked for forgiveness and asked them to return to them. Woman 1 reports this in the following way: *" We broke up for 3 months, then he came and asked for forgiveness and wanted me again."*

6.5.3 The other wife

For Woman 2, being a second wife in a polygamous marriage where the first wife already has three children raises issues of inadequacy for her. She reports that she is fearful of the possibility of the other wife falling pregnant again whilst she is struggling with infertility. In a study in western Africa, Brandon (cited in Becker, 1990) also found that women who are in polygamous marriages and are unable to bear children live with the pain of seeing other wives bearing children for their husband. Woman 2 reports her fear in the following way: *" Some days I am worried about what if the other wife gets a fourth child whilst I still don't have anything."*

6.5.4 We sometimes fight

Some women report that the issue of not having a child comes to the fore when they fight with their husbands. Woman 1 reports the loneliness that she feels during the times when they are not on talking terms with her husband after they fight with each other. According to her, it is during those times that she wishes she had a child because then she would have someone to talk to: *"Maybe, I don't know, when I fight with my husband, that's*

when I think of a child and say 'If a child was here, I would…' , because it is possible that you don't talk to each other for two days in the house, so you'll find me saying 'If there was a child here, I would talk to him/her.'"

For Woman 4, the reason for longing for a child when she and her husband fight is because during those times, she feels that if they had a child together and it happened that he left her, atleast he would return to her for the sake of the child. Brandon (cited in Becker, 1990) supports this finding by asserting that women who are unable to bear children do not have any security in their relationships with men, because it is only through biological reproduction that ties are created between a man and a woman. Woman 4 reports this insecurity in her relationship in the following way: *" Then I don't think he loves me that much because I don't have a child…and atleast if there is a child when we fight, even if he leaves, atleast when a child is here, he will come back because of his child."*

Woman 5 narrates a different experience regarding the fights she has with her husband. For her, her husband brings up her childlessness during their fights and verbally attacks her about it so as to hurt her feelings. Mason (1993) reported this display of anger by men in infertile marriages towards their wives. Woman 5 narrates her experience as follows: *"Ah, he handles it, even though he sometimes fights. About this issue of me not having children, you find that sometimes he does not take it well…yes, because now when you fight you want to hurt each other with words. So he knows that this issue does not sit well with me."*

6.5.5 He might leave me for her

Some of the women report their fear that their husbands might leave them for women who can give them children. Woman 1 and Woman 2 feel that because they cannot bear children for their husbands, they might leave and find other women outside who can bear children for them:

Woman 1: *" No, he still loved me…eish, but the thing is when you have found someone outside who made a child and the other one is unable to make a child, then it is obvious that you will end up leaving her and taking the one who has a child."*

Woman 2: " Yes, sometimes I think he will go out and make a child with another woman because I am unable to do so (give him a child) and so there is nothing I can help him with."

For Woman 5, the fear of her husband leaving is mainly caused by her in-laws, as she reports that they encourage her husband to leave her because she cannot bear him children. Men's families are quick to reject wives who fail to reproduce and to encourage their 'son' to find another woman (Laurence, 1989). Woman 5 narrates her experience in the following way: *" Then another one (in-law aunty) mentioned right there that T (husband) has a child with another woman, and they want him to leave me because I am not a woman, I am a fool, so and so…"*

6.5.6 We do not talk about it

Daniluk (1991) reported that couples who are infertile experience communication problems, which occur as a result of their difficulty in sharing feelings. Woman 1 narrates how she stayed with her husband all the time and he did not tell her that her infertility hurt him, it was only after he made a child with another woman that she realised her infertility bothered him:

Woman 1: " That is why I am saying, he, ntate, (respectful way of saying my husband) when I stayed with him all this time, he did not tell me that my inability to have a child hurt him. We told ourselves that it would happen when the time came. Until he saw a girl outside, and made a child with her, that is when I realised that this thing (my infertility) bothers him."

Although Woman 5 tells a somewhat similar story, hers is more about her husband bringing up her infertility in a moment of anger to insult her when they are fighting, so as to hurt her feelings:

Woman 5: " Even at home, you know when my husband and I are angry with each other, you find him bringing up the fact that I cannot have children, just to hurt me."

6.5.7 I must be the infertile one

When fertility problems occur, women appear to attribute the cause of the infertility to their own biological failure (Daniluk, 1991). This is the case with two of the women, who assumed they are the ones who have an infertility problem in the marriage, before the couple even went for medical investigations. When Woman 3 first approached her husband about their infertility, she immediately assumed she must be the infertile one because, as she puts it, women tend to have problems with their wombs: *" Like I say, we women have things with our wombs, so I just took it that the problem has to be with me."*

Similarly, despite the fact that Woman 4 still does not know her husband's sperm test results, she has just assumed that she must be the one with a problem in the marriage: *" They have not told him his results, for his sperm, I don't know if they wrote it in his file or what."*

6.5.8 Our sex life is affected

Infertility affects a marriage not only emotionally, but sexually as well. Lovemaking becomes a clinical experience and preoccupations with infertility overshadow the marital relationship (Valentine, 1986). As a result, sex is no longer pleasurable as couples associate sex with reproduction, and sexual problems may occur (Laurence, 1989). Two of the women report how they would sometimes think about falling pregnant and actually hope that their husbands have impregnated them during sexual intercourse:

Woman 1: " You know, even when my husband and I are sleeping together (having sex), I sometimes feel something happening inside me, and then I tell myself that maybe this time he has made me pregnant."

Woman 2: " Yes…sometimes I feel as though those things (sperm) have entered the egg. And men themselves, isn't it that they can feel it when they ejaculate, so you'll find that sometimes he will even tell me that he is sure he ejaculated inside me, but then after some weeks I will still be like this."

Woman 4 tells a similar story about her sex life being affected by her infertility, but she reports that because of the hardness she has discovered inside her vagina, which she suspects contributes to her infertility problem, she and her husband worry about her experiencing pain if he touches that hard swelling in her vagina during sexual intercourse:

Woman 4: "No, it is just that there is something hard inside, the thing I suspect is making it difficult for me to have children, so you find that when we are busy, if he does it roughly, then it feels painful inside. So you find that when we are doing it (sex) we are worried that I don't feel pain."

6.5.9 I can feel I am not his child's mother

Goody (1982) postulated that no matter who cares for the children on a day-to-day basis, biological mothers can continue to 'hold on' to their children in the longer term because they have an unbreakable biological bond with them. This is supported by the stories of two infertile women whose husbands have children with other women. Although these infertile women may care for their husband's children and love them, they are constantly aware of the painful reality that they are not their biological mothers, and this is an entrenched feeling that they are aware of, regardless of the positive nature of their relationships with these children:

Woman 5: " When he (husband's child) plays with his father, that's my husband, you know they will be laughing and playing, and you can see he is happy, so I look at them and say 'if it was my child we would all be happy together.' Because you know, even if you can love a child, but if you have a problem giving birth to your own child, you feel that even if I can love him and take care of him, he is still not my child. You do not forget that."

Woman 6: " Atleast I…even if she (stepdaughter) does not fully fill it (the space inside her), because I know she still has a mother, who is her mother, her biological mother…so, I am positive when she is like that towards me but what remains is that she is not my child, so even if I can do anything for her that satisfies her, still, she is not my child."

6.5.10 …But he is supportive

Although there are men who have little empathy for their wives and offer no support, not all are heartless bystanders who simply seek out another woman if their wives fail to match their expectations (Cornwall, 2001). Three of the women report that, despite whatever problems they may have in their marriages as a result of the infertility; their husbands are supportive towards them:

Woman 3: " It's like he (husband) does not want to see me stressed out. And at a time when I can feel the stress coming over me, he scolds me, and says you know what, I ask you not to put the Lord under the bed when you sleep please."

Woman 5: " He also supports me sometimes, especially when he sees me crying. And even about his aunties, he told me not to stress myself out over them, they are drunkards. So we try."

Woman 6: " …but my husband is very supportive, that is why he came with me like this, and he supports me everywhere, a lot, and everywhere we go, we go together, he does not remain behind."

From the above, it is evident that infertility has adverse effects on a marriage. The infertile woman has to overcome her husband's infidelity and live with the constant fear of him possibly leaving her for a woman who can bear him children. Furthermore, the infertile woman whose husband has a child with another woman lives with the constant feeling and reality of the fact that no matter how much she may play a motherly role in the child's life, she is not the child's biological mother. The marital couple may also

experience communication problems as they do not discuss their feelings regarding the infertility, and this can lead to marital conflict, and eventually, marital breakdown.

An infertile couple's sex life may also be negatively affected by infertility. Sex may no longer be spontaneous and pleasurable when a pregnancy is desperately sought and the anxiety may be great (Needleman, 1987). This may lead to sexual problems and tension, especially if the couple does not communicate about it. Finally, and on a more positive note, infertile women's husbands may play a positive and supportive role in their wives' lives, and this may help to ease the burden of dealing with infertility.

6.6 Familial experiences

Most people are members of atleast two families during their lifetime, namely the family in which they grow up and the family in which they are parents. However, in addition to this, after marriage, women, and even men, become part of the family into which they marry. The loss of an ability to conceive brings with it the secondary losses for the couple's families, whereby the families are confronted with the loss of grandchildren, nieces and nephews (Laurence, 1989). Therefore, couple's families also experience losses as a result of the infertility of the couple. However, since the infertile woman does not have a family in which she is a parent, the two families of which she is a member of, namely her family of origin and her in-law family, are discussed so as to hear the women's stories regarding their experiences of infertility in relation to these families.

6.6.1 Family of origin

The family is a largely self-sufficient system and thus provides for most of its members' physical and emotional needs (Popenoe et al., 1998). Thus, although the women in this study are all married, many of them are still in contact with their families of origin, particularly their mothers and siblings, and therefore, these interactions also contribute to their stories.

6.6.1.1 My family is supportive

According to Popenoe et al. (1998), apart from socialisation, a second major function of the family is to provide love and affection for its members. For the infertile woman, this love and affection can be displayed in the form of support, as Woman 5 reports her family members' supportive role in the following way: *" Ah, at home they are supportive, they don't have a problem. Even when my husband's family bothers me, I cry to them."*

6.6.1.2 Even children have children

The family members may also unintentionally evoke painful feelings for the infertile women when they are in contact with young female family members who already have children, especially before marriage. The infertile women experience mixed emotions of envy and bitterness when they realise that the young women in their families, whom they regard as children, now even have children before them. According to Buga, Amoko and Ncayiyana (1996), children are so highly regarded in certain black communities that adolescents may be inclined to prove their fertility and decide to become pregnant before they are married. Thus, it may be common for infertile women to see young family members who are pregnant, and this may painfully remind them of their own infertility. Woman 2's younger siblings all have children, and woman 6's stepdaughter, who is also young, has a child, and they narrate the experiences of being around them in this way:

Woman 2: " You'll find my heart feeling sore because children have children, but I do not have children."

Woman 6: "And she (stepdaughter) has a child, she came to us already having a child, a beautiful one, and you find me thinking that even children have children but we cannot (have children)."

6.6.1.3 I raised all the children at home

It is often common practice for older siblings in African families to play a parental role towards the younger siblings in the family (Kango-Male & Onyang, 1994). Woman 1 reports a similar experience in her family where she participated in the raising of other children in her extended family and says that at times she even wished that they could be her children:

Woman 1: " Yes, I love children a lot, I don't have a problem with children. I raised all the children at home. And you would even find me wishing that they could have been mine. I don't have a problem with children at all, I love them."

6.6.2 The in-laws

In-law relationships force an individual to form intimate, familiar relationships with non-blood kin whom she/he did not directly choose to make part of her/his family (Papp, 2000). Therefore, married women become part of their husbands' families and interact with them during the course of their marriages. This has implications then for the infertile women, in that the in-laws may expect them to have children, and failure to do so may result in either negative or positive experiences, which are discussed below.

6.6.2.1 When are you having a child?

According to Ziehl (1994), in African marriages, the practice of lobolo implies transfer of a woman's reproductive rights from her family of origin to her family in-law. Therefore, the husband's family has earned the right to expect a wife to bear children for them after she marries into their family. This places a lot of pressure on infertile women because, as two of them put it, they are constantly asked by their husband's mother or by the older women in their husband's family, about when are they going to have children:

Woman 2: " And then you'll find these older women on his side (of the family) asking you when you are making a child, and at that time there'll be people you are sitting with, so it doesn't feel right because you are with people and you don't know what to say."

Woman 4: " No, she (mother-in-law) does not ask that much, but when she sees me she likes talking about it, and it stresses me out because I also know that I want a child. And now she is also stressing me out and telling me that she wants a grandchild."

6.6.2.2 They treat me badly

Woman 2 reports that the older women from her husbands' side of the family do not speak to her as though she is a wife just because she does not have a child. Only by becoming a mother is a woman regarded as a 'wife' by a man's family (Cornwall, 2001) Therefore, the infertile woman may be faced with an indefinite period of being treated as though she is not a wife, as Woman 2 illustrates in the following way: *" There are some things, like when there are feasts at my husband's home, you'll find that the older women do not converse with you like they do with women who have children, it's like, you are nothing or you are still a girlfriend just because you do not have a child…things like that."*

For Woman 5, the treatment she receives from her in-laws is so bad that they say malicious things to her directly and even blame her past behavior for her infertility. According to Cornwall (2001), there are usually perceptions that infertility is a possible outcome of women's earlier transgressions regarding their sexual behaviour. In support of this perception, Woman 5 reports that her in-laws blame her infertility on her earlier sexual behaviour with men: *" The thing is my husband's family always interferes in our business. His mother, maternal aunties, paternal aunties, everybody, likes coming to us and they usually say bad things about me. Even last week, one was saying that I used to do things with men before I married my husband, so that is why I cannot have children."*

6.6.2.3 They treat me well

Although half of the women report a positive experience regarding the way in which their in-laws treat them, they also provide reasons that could possibly explain why their in-laws are treating them well. This could be because research usually indicates that infertile women's family in-laws treat them negatively (Grabill et al., 1958; Mabasa, 2000; Mabasa, 2002; Mathekga, 2001), therefore those women experiencing positive treatment from their in-laws provide explanations as to why they think that, unlike other infertile married women, they are being treated well by their in-laws. Two of the women narrate that their in-laws treat them well because of their association with church:

Woman 1: *" With my in-laws, my mother-in-law is someone who goes to church regularly, so…the Sabbath church, and in this church, they follow the Bible so, I don't know how to describe her, she treats me well, she cries with me. She wishes that I can have a child, there are no bad words, and it is also the same with my husband's siblings*."

Woman 4: " They (her in-laws) just tell us to go, we attend the Zionist church, they tell us to go there, maybe it will be all right."

For Woman 6 however, the reason she provides for her in-laws' positive treatment towards her is that they also have an infertile woman in their own family, therefore, she thinks they would be afraid of treating her badly when they have an infertile family member themselves:

Woman 6: " …but where I am, at home, they are supportive, because even where I am married, on my husband's side, there is one woman and she has even been to adopt, because she has the same problem that I have. Now, the thing is, I think they are afraid that they might point a finger at me whereas they also have someone like me in their family."

What emerges from the above discussion is the fact that although infertility may be a couple's problem, it also affects the families of the woman and the man involved in the marriage. It appears that the socialisation of women to eventually become mothers may

begin earlier on in their families of origin, where young women may play a parental role in raising the other children in the family. Although infertile women may be hurt by, or be envious of, younger female family members in the family who already have children, they can also receive a lot of support from their families.

The in-law family also has a significant influence on the experiences of infertile married women. In African marriages, the woman is expected to bear children for her in-laws, therefore an infertile woman's failure to do so causes her distress as she is constantly pressurised and reminded by her in-laws that she should have a child. However, not all married infertile women narrate negative experiences of their in-laws because there are some who actually report that their in-laws treat them well.

6.7 Extended social networks' experiences

Almost all behaviour is oriented towards other people, for we are constantly aware of the effects that our actions and reactions have upon others. As people, we are almost always involved in social interaction, the process in which people act toward, or respond to others in a mutual and reciprocal way (Popenoe et al., 1998). Therefore, infertile women also come into contact with other people and through their interaction with them, these people contribute to the women's experiences of being infertile. Certain social contexts such as friendship circles, work, church and the community may have an influence on certain experiences of the infertile women, and these are discussed below.

6.7.1 Friends

Friends remain important throughout our life span. Friends often serve as a buffer against stress, are a source of support and contribute to a person's feelings of self-esteem (Antonucci, 1990). Most of the women in this study report that their friends have children and that they spend time around these children, but none of them report having been treated negatively by their friends. In fact, for Woman 5, her friendship experience is an even more positive one because she has a friend who also has an infertility problem, and

therefore they talk about it and help each other, as she reports in the following way: " *And this friend of mine also has a problem of infertility, so we also talk about it and help each other."*

6.7.2 Colleagues

The work context is also a possible place where infertile women, just like anybody else, come into contact with their colleagues. Work provides opportunities for social interactions outside the family (Craig, 1996), therefore women come into contact with their colleagues and their interactions with them can also influence their experiences of infertility. Woman 6's story takes me to her work place as she relates her negative experience of being called derogatory names by her colleagues at work:

Woman 6: " You know those names, often those (derogatory) names, it is at work where they will be saying that I am a nyopa, you know… what do they say it is in the language used here, moopa? Yes, moopa, and things like that…" She further reports finding the situation at work so unpleasant that she even chooses to be alone when she is at work, rather than to be around her colleagues.

6.7.3 Church

Church is also another social context in which people interact with one another. The crucial role of the church is to help infertile couples move beyond an experience of barrenness and find meaning and purpose in life (Gabobonwe, 2004). In keeping with this, Woman 3 reports that going to church has made her aware that she can find meaning in life by carrying out God's purpose: *" I tell myself that I may not have biological children but then something may come along and I will have to carry out God's purpose so that I can find children in spirit,"* and Woman 6 reports the hope that is instilled in her by the church: *" And at Church they are promising us that the Lord will not promise you bread and then end up giving you a stone or what."*

6.7.4 Community

A community is a cluster of people located in a particular geographic area whose lives are organised around daily patterns of interaction (Popenoe et al., 1998). These patterns involve such activities as work, shopping and recreation and such institutions as education, religion and government. Infertile women and their husbands are part of communities and their interactions with the members of their community may have an influence on the way in which they experience their infertility.

Woman 1 is still uncertain as to whether the woman her husband lived with really did fall pregnant or not, and if she did, whether she had an abortion or not. This is due to the fact that this is information she received from the rumours that had been going around in her community when she returned to her house because she used to stay at her employers' house for certain periods of time. Therefore, the community's involvement was such that rumours were going around about her husband, but she seems to have not confirmed them because she reports that she has not fully discussed the issue with her husband:

Woman 1: " There were rumours that he stayed with someone, and that girl that he stayed with…I don't know if its true, that she was pregnant, but I don't know where it ended because there were also rumours that her family took her to have an abortion."

For Woman 4, her experience in her community is that of a young girl who had been sent by older people in her family to go and insult Woman 4 about her infertility. The people in their community who did this did it so as to humiliate and hurt her because they do not get along with her and with her family in-law.

Woman 4: " There are such people, in fact where we live, this other girl had a fight with me, so she sent children to me to tell me that I cannot have children. Yes, her family does not get along with my in laws, so they used a child to hurt my feelings, because they know it is going to hurt me to be called a 'moopa'."

From the above, it is evident that because women interact with other people in their social networks, these interactions have an influence on the way in which they experience their infertility. Friendships provide the most positive experiences for these infertile women, and the church also instills hope and faith in them. The work place and the community are the two social contexts that cause negative experiences for two of the women, as they are called derogatory names and have rumours being spread about them regarding their infertility and marriage.

6.8 Management of infertility

"In both traditional and western ethno-medical systems, an important aspect of the management and perception of infertility is that it is seen as just that: manageable," (Upton, 2001, p.356). Infertile couples usually manage their infertility by seeking treatment from different resources available to them. When couples start to have treatment they may find that they have many differing responses to it (Becker, 1990). There may be a sense of excitement that something is happening at last; there may be a fear of what the effects of the treatment may be on them or their spouse, either physically or emotionally (Becker, 1990). Seeking treatment can also involve having to consult with a number of medical professionals and undergoing countless procedures that may aid in the diagnosis and prescription of treatment. This is the case with many of the women in this study because they consulted with different medical professionals and underwent a number of investigative procedures.

6.8.1 Visits to clinics and hospitals

All of the women report having been to doctors, either privately or at hospitals and clinics, and currently, they are all attending the infertility clinic where this study is conducted. In order to be given a diagnosis and hopefully, subsequent treatment, most of these women had to undergo many medical tests and procedures, and for some this seemed to be a tiring and endless process, with no positive results. As Becker (1990) put it, progressing through treatment stages seems to have a 'roller coaster' effect on infertile

women, with emotions swinging from hope to despair, from pain to joy, but they still do not give up. This is illustrated by Woman 1 in this way: *" …I have gone for the sonar, the x-rays, they took my blood, so many things. But we will see, we will endure the treatment and see what happens"*

In addition to the procedures that they have to undergo, financial difficulties are also experienced (Laurence, 1989) and they may sometimes not afford to undergo certain other medical procedures, as it is the case with Woman 6: *"I have been to doctors, Lerato, I went for…I come from operations, this thing IVF, in X (city), I should have also come to Y (city), but then I didn't have money, they wanted R30 000."*

6.8.2 Visits to traditional healers

Traditional healers play an integral role in the understanding and treatment of illnesses for many African people. They form a link between the living and the spiritual world of the ancestors (Mabetoa, 1986) and are thus in a position to also mediate between the living and the ancestors and provide culture related explanations and treatment to illnesses that African people struggle with. The essential role of traditional healers is supported in this study where five of the women report having previously consulted a traditional healer. Therefore, along with four other women, Woman 2 reports her consultation with traditional healers in the following way: *" Yes, I went to them, and they gave me 'ditlhare' (traditional medicine)…"*

6.8.3 Praying for a child

Three of the women report praying for a child, with Woman 3 reporting that it is something she does oftentimes, and on her own, whilst Woman 4 and 6 report that they go to the Zionist church to pray for a child. The Zionist church usually comprises of faith healers (Mabetoa, 1986), and they reinterpret Christian teachings within an African context (Popenoe et al., 1998). Furthermore, Zionist churches offer a level of intimacy and care which cannot be matched by larger mainline congregations (Kiernan, 1990).

Therefore, two of the women report having specifically gone to the Zionist church to pray for a child:

Woman 4: " They (family) just tell us to go, we attend the Zionist church, they tell us to go there, maybe it will be all right."

Woman 6: "…and church, I attend the ZCC church and they will keep on giving me tasks to carry out, and I do but nothing is coming right."

Although Woman 3 does not affiliate herself with a specific church, her Christianity and strong faith in God's power come across in the following way: " *Mm, because I understand that for everything to happen, it is through God's strength. Even when a doctor touches you, and when you go to a doctor, you must pray that the Lord must give him, open up his mind so that he can take out all his knowledge, and be able to, so that everything he touches on your body can heal."*

6.8.4 The family is involved

The family usually becomes involved at some point during the couple's management of infertility and tries to assist them by giving them advice. The crisis of infertility experienced by couples evokes many different feelings and they are usually extremely vulnerable and can be hurt by lay advice of how to try and achieve pregnancy (Laurence, 1989). Woman 5 received such advice from her grandmothers regarding how to solve her childlessness according to their culture. However, she only considered it but did not go through with it. According to her, her grandmothers told her to find another woman to bear a child for her, as it is culturally permissible to do so: " *So they (her grandmothers) said according to their culture, that is Sepedi, a woman can look for another woman, and then that woman makes children for her. But it has to be atleast a woman from your family, you see, that is, it must not be someone from outside, it must be like a cousin or a sister."*

From the above, it emerges that infertility treatment appears to be a very stressful experience for most women as they are faced with countless visits to medical professionals. Furthermore, these women are subjected to endless medical examinations and treatment procedures, which raise their hopes but then lead to despair when they realise they are still not pregnant. Apart from medical doctors, the church and traditional healers also play an essential role in the management of infertility, particularly when the hospitals and clinics fail to deliver.

The management and treatment of infertility is not a once off event, rather it is a process that lasts for an indefinite period as each failure to fall pregnant subsequently leads to more re-visits to the hospitals or clinics.

6.9 Ways of coping

Infertility is seen as a crisis for married women because it implies failure to fulfill the reproductive role expected of them. This may lead to unpleasant and negative feelings for these women and they may develop coping strategies in an attempt to deal with the experience. Coping strategies are conscious rational ways for dealing with the anxieties of life (Reber, 1995). The infertile woman may be anxious as a result of her experiences of being infertile and the unknown outcome of the treatment. Because the infertile woman has to live with her infertility everyday, she finds ways of coping with her situation.

6.9.1 The Lord will provide

When all else does not work, it is only by faith that one is humbled to realise that we are not masters of our own fate (Gabobonwe, 2004). Thus, after countless treatments and failed attempts at pregnancy, infertile women may turn to their faith in God for hope and for strength. Some of the women report that their faith in God is their source of strength and a way of coping. These women are hopeful that in time, their prayers will be answered and they will have children, as Woman 1 reports: " You know, I tell myself that

God knows everything. He will bless me one day[…]" and Woman 3 also reports: " …And then I tell myself that when He (God) says I must be patient, I am still waiting for Him. And even when I am still waiting for him now when I am 30, and then I reach 33 and still nothing has happened, you know, even at 33 I will still tell myself that 'I'm still waiting for you', until I reach 40 years, until those times when I reach menopause. It's like I keep encouraging myself by saying that because my faith says just that."

6.9.2 I bury myself in work

Work is a way in which individuals satisfy many of their psychological and social needs (Blignaut, 1993). This is the case with Woman 6 who uses her work as a way of coping. For Woman 6, burying herself in her work helps to keep her mind off things, especially the issue of infertility: *"And then at work, when I am at work, a lot of things leave my mind. And even during the breaks, there will be some work (to do)."*

From the above, religious faith and work are identified as coping strategies for two of the women. Faith seems to instill hope for things to change in the future. It also enables one to endure the present experiences knowing that the Lord will intervene in the future and improve the negative life situation brought about by infertility. Another coping strategy reported is work because through keeping busy with work, one is able to focus on other things and therefore not constantly think about infertility.

6.10 Available support

People going through a life crisis may require support from other people in order to assist them in dealing with their experiences. Support refers to the connections an individual has to significant others who may offer assistance (Visser & Moleko, 2001). Woman 5 and Woman 6 single out certain members from their own family, the in-law family as well as a friend as people who play a supportive role in their lives:

Woman 6: " I go to my family, I have my husband's sister, who is also very supportive, and from my side I have the one who comes after me."

Woman 5: " Yes, my sister and aunty know about it. And this friend of mine also has a problem of infertility, so we also talk about it and help each other."

It is evident that support is an essential part of human survival, especially during stressful and negative life experiences. Support may build an infertile woman's self-esteem and make her feel valued and accepted despite her feelings of inadequacy as a result of her infertility. It is comforting for these women to know that there are people in their lives who are available to give them support during times when their experiences of infertility become unbearable.

6.11 My story: The researcher's experience

Innovative feminist research methods are characterised by an awareness of the personhood and involvement of the researcher (Reinharz, 1992) through what is called personal reflexivity. Personal reflexivity is a kind of disciplined self-reflection on who we are, how our identities – as individuals in society, members of particular ethnic or religious groups, gendered beings and feminists – influence our work and in turn, how our work influences these aspects of the self (King, 1994). Thus, as feminist researchers, we constantly engage in a process of self-reflection and acknowledge our involvement with the participants. As researchers, we are as much a part of the research process as the participants are; therefore we have our own experiences of the research process, which inform our interactions with the participants, and our interpretations of their stories. Krieger (1991) argues that the researcher experience is present, no matter how much researchers try to ignore the presence of the researcher within the research report. The researcher experience is fundamental to qualitative research and should thus have a place in the reporting of the research. In fact, reporting holistic findings demands the inclusion of the researcher experience (Moch & Gates, 2000). Therefore, a discussion follows below on how I experienced the research process as a researcher.

6.11.1 My emotions

The research I have described was not just an intellectual journey for me, but also essentially an emotional one. Emotions were prime movers in the selection of the research initially, as a result of the strong emotions I hold regarding issues involving the empowerment and emancipation of women. This research evoked deep emotions in me, but it also created a platform for the release of deep emotions on the part of the women who participated. The women expressed feelings of sadness, pain, frustration, despair and hopelessness. Some of the women broke down and were tearful, and others attempted to suppress their emotions by looking away, remaining silent or becoming restless in their seats. During these emotionally distressing moments, I became aware of my own uncertainty as to which role to assume – that of a researcher or of a psychologist. As Cannon (1992) put it, interviewers use emotion to judge how to pace the interview, how far to go at what point, and typically, when to draw back from issues that are causing distress. They do this not so much by means of training, but by their understandings of the usual courtesies of everyday interaction and their general competencies as social beings in an unstated process, which has received little attention in research literature (Cannon, 1992). During the more emotional part of the interviews, I allowed the women to talk as they saw fit and left the flow of the interview to them. This meant that I would join in their brief silences as they tried to suppress their emotions, and if I needed to intervene and ask a question, I did so in a lowered empathetic voice so as to maintain the intimacy already created, whilst at the same time requesting information.

A very wide range of emotions was expressed by the women, and in responding to these emotions sympathetically, I personally experienced a wide range of emotions as well. A lot of the times I felt helpless and overwhelmed by the emotionally charged atmosphere in the interview room, and it was at these times that I felt uneasy about the fact that as much as I sympathised with the women, I had to remind myself that I was there to collect information for an academic purpose. Thus, once sufficient information had been provided, I let the emotions pass and using common sense, I attempted to end the interviews with as much composure as I could gather.

6.11.2 My identity

My identities as a woman and as a black person came into play throughout this whole research process – from selecting the topic, reviewing the literature, doing the field work, the analysis and reporting of the findings. During the literature review, my background as a black South African woman informed the way I understood the texts I read and how I chose to include them in the study.

My identities also came to the fore during the interviews as I was directly interacting with the participants. Terre-Blanche and Durrheim (1999) state that research participants are more wiling to divulge information to researchers with whom they can identify. As a result, some researchers employ certain strategies that may promote identification during their interaction with their participants. For instance, Owens (1986) reports that during his research on infertile men, although he was single, he wore a ring on his wedding finger to give the impression that he could understand his participants' concerns as a husband and as an aspirant father. Similarly, in her study on infertile couples, Mabasa (2002) reports that there was some discomfort when she informed her participants that she has a child. Therefore, in an attempt to identify with them, she often found herself disclosing about her aunt's infertility. The experience of identifying with my participants was different for me because the women I worked with did not place me in a situation where I felt I needed to identify with them as wives or as women pursuing motherhood. This could be because they were older than me and probably did not perceive me as being married or old enough to be struggling with infertility.

However, the age gap between the women and I had implications on how I interacted with them. Since there was an age difference of atleast five years between the women and I, it meant I had to draw from my identity as a young black person and be respectful in the manner in which I addressed them, using words such as 'sesi' (older sister) and 'mama' (older woman). Thus, although I maintained my professionalism as a researcher, I was consciously aware of the manner in which I addressed the women and posed certain questions to them, particularly those related to sex, because of the discomfort they may

have felt when discussing such private matters with a youngster. My identity as a young black person enabled me to slip back towards the Sotho vernacular and use euphemisms and culturally acceptable words during the interview.

6.11.3 Requests for help

There were many requests from the women for me to provide assistance, usually in the form of explaining procedures and what the treatment entails. This may be partly because the women associated me with the infertility clinic and had therefore concluded that I should know how the clinic works. Therefore, my final question of 'whether there was anything they wanted to add or ask' at the end of the interviews was answered by requests to explain about the process of treatment, and testing or whether they would see me again. For a researcher to suggest that she/he does not know the answer to such questions can undermine credibility in the eyes of the respondents who have some expectations that the researcher understands the process she/he is researching (Carter & Delamont, 1996). Therefore, I answered these questions to the best of my knowledge, but always made it clear to the women that they should ask the nurses and the doctors for clarity or for more information because I was only there to carry out the research.

6.12 Conclusion

This chapter provided more insight into, as well as a better understanding of the women's experiences of being infertile. It appears that for all these women, the struggle with infertility begins when they start consulting with different western and traditional health professionals so as to obtain an explanation about their inability to conceive. Prior to seeking medical assistance, it seems these women are already aware of the fact that they are not falling pregnant even though they are engaging in unprotected sex with their husbands, but they find reasons and explanations for this rather than immediately assuming they have an infertility problem.

Once these women have been given a diagnosis or an indication of the presence of a reproductive problem or failure, what seems to follow is a wide range of emotions, ranging from denial, anger, hopelessness and extreme emotional pain. They experience an identity crisis and feel incapable of fulfilling their roles as women and as wives. In addition to all of this, these women have to endure their husbands' infidelity as they sleep with other women to prove their own fertility. Therefore, their marriages suffer emotionally and sexually as a result of their infertility.

These women have to further deal with the treatment they receive from their own families and from their husbands' families. Although some may be treated well and receive support, others have to live with the insults and the derogatory names they may be called by their husband's families. These families may exert pressure on them to conceive and their biological inability to do so may be a constant reminder of their failure.

As these women persistently seek help from different health professionals, their emotions alternate between hope and despair, and some turn to their religion and church for help. Through all of this, some of these women come to derive their own ways of coping with the experiences of their infertility, and others turn to their husbands' and families' support as ways of coping.

CHAPTER 7

CONCLUSION

7.1 Introduction

The feminist researcher's role is to be the teller of someone else's story or account, the medium through which women's voices are to be heard (Smith, 1987). In this chapter, I conclude this project by first reflecting back on the women's stories that I told in the previous two chapters. This I do through a continuous integration of the findings that emerged from the structural narrative analysis and the content narrative analysis of the six stories that were told. What follows then is a discussion of the possible ways in which psychologists can intervene and assist women experiencing infertility. I then propose suggestions and recommendations for further research on this topic, based on the limitations of my study. The journey then ultimately ends with my concluding story, which is a reflection of my experiences throughout this research project.

7.2 Reflecting back on the women

As I near the end of this journey, I first have to reflect back on the stories that the six women who participated in this project shared with me. Although each narrative was different and unique in its own way, the process of structural and content analysis yielded some similarities that necessitate an integrated concluding discussion about the stories.

7.2.1 Their stories

I was introduced to the stories of the women during the interviews as they each individually narrated their experiences of being infertile. As I listened to their stories, I noticed how each woman had her own way of telling her story – from bringing in the different characters in her life story and sequencing the events that took place since she discovered she is infertile. I realised that some women were more articulate than others when telling their stories. Later, when reviewing their biographical information, I realised that those women who had been the most articulate during the interviews were also the

ones with higher levels of education than the other women, and this led me to conclude that these women's higher academic levels had probably enabled them to articulate their stories better than the way in which the other women had articulated theirs.

The narrative process of telling their experiences was difficult for some of the women. Some were missing memories and some jumbled the historical sequencing of their experiences. One common factor with all the women was their inability or difficulty to recall when their struggle with infertility began. Therefore, some gave estimates of when they think they first realised their infertility, and while others also attempted to estimate, there were some incoherencies with their estimated duration of infertility and other events that they related in their stories. However, I let this pass because although they could not trace back their infertility to a specific date, they were all certain that they had been struggling to fall pregnant for over two years, thus confirming their infertility.

As I interviewed and listened to the women, I was also overly conscious of some of my own reactions to what they were saying. Therefore, I had to consciously control the tone of my voice as well as my facial expressions when they would, for instance, speak about their husbands' infidelity, because I was aware that they could have been sensitive to what may have come across as a negative reaction or disapproval from me. Thus, if I needed to ask for more clarification on issues such as their husbands' infidelity, I would try hard to pose my questions in such a way that they would not perceive me as being judgmental or disapproving.

At the end of the interviews, some of the women commented on the cathartic experience of the interview, reporting that they felt better after talking about their infertility and that the interview had raised some issues that they had not really thought about before.

7.2.2 Their emotions

The women experienced a wide range of emotions whilst telling their stories and some of them expressed them verbally whilst others displayed them mainly through tears. The

emotional pain, coupled with stress and constant worrying, makes infertility a disheartening experience for these women. They feel incomplete and abnormal as a result of their reproductive failure, and thus feel they are not fulfilling their roles, mostly as wives, but also as women. As some of the women realise their increasing age and the negative biological implications that come with it, they become envious of and try to avoid confrontation with pregnant women or families with young babies. The stigma attached to being infertile is a further issue that these women have to deal with as they are called derogatory names and dehumanised because of their infertility.

Through all of their emotional displays, the women tried hard to narrate a comprehensive sense of their experiences, with some trying to suppress their emotions by speaking with tears in their eyes, looking away, becoming silent or speaking with shaky voices or becoming restless in their chairs. At the heart of most of their stories were feelings of loss, pain, suffering, betrayal, helplessness and a lack of a sense of identity.

7.2.3 Their relationships

From the structural as well as the content analysis, it emerged that networks of inter-relationships characterise these women's lives and some of these relationships are harmful while others are helpful. Marital relationships may become very strained and the infertility of the woman may damage or disrupt the relationship. Infertile women live with the fear of an actual or emotional abandonment by their husbands, as they may leave them for women who can bear them children. Apart from this fear, some of these women remain in marriages with their husbands, despite their infidelity because these husbands justify their behaviour by claiming that they only slept with other women to prove their virility. For some of these women, sex with their husbands becomes an activity with a definite goal of pregnancy. Their sex lives may be characterised by an endless cycle of hoping for a pregnancy, followed by the subsequent despair of realising they have not conceived.

Infertility also has implications for women's relationships with their wider families. Having children ensures family continuity and may gain women respect and status in their in-law families. While some women receive positive support from their families, husbands and friends, some are ridiculed and disrespected by their family-in-laws and their communities.

7.2.4 Their search for help

Infertile women seem to wait as long as possible before seeking treatment. Their quest for treatment begins with countless visits to doctors, specialists, traditional healers and faith healers. The process of treatment is a long and tiring one, beginning first with a search for a causal explanation or a diagnosis for the infertility. Since a vast number of fertility tests and diagnostic procedures are usually carried out mainly on women, during this time, women are expected to expose themselves for investigations and to reveal details of their sexual lives and their private wishes and fears surrounding their desire for a child.

For some women, receiving a diagnosis, (in this study, mainly tubal blockage), informs their decisions and planning regarding the further management of their infertility. However, in addition to searching for western medical explanations, these women also turn to traditional healers for help. Traditional healers usually attribute the causes of illnesses to either witchcraft or ancestors. Consistent with a finding in this study, it is believed that ancestors may allow an illness to strike so as to warn a person in connection with some negligence relating to traditional or ritual obligations. On the other hand, placing medicine on a path so that the victim steps on it and becomes ill may be another way to cause illness. One condition that is caused in this way is 'sefola', which some women in this study report has been diagnosed by their traditional healers. Therefore, consistent with this finding, traditional etiology of infertility provides alternative explanations and the traditional treatment thereof is mainly through traditional herbs or sometimes a ritual practice.

Faith and religion also play an important role in infertile women's search for help, and thus they engage in a series of prayers for a child and turn to their faith in God as a source of strength and hope.

7.3 How can a psychologist intervene?

Having conducted this research as a psychologist, it is important to note areas where psychologists can intervene and contribute towards helping the women in their search for biological motherhood. Therefore, I have identified two roles through which a psychologist can participate in helping the women; that of a psychotherapist and of a psycho-educator.

7.3.1 As a psychotherapist

Infertility does not appear to be experienced as a single, identifiable event, which can be resolved and then forgotten. Throughout the life cycle, these infertile women seem to experience reminders of their infertility during investigations, treatment, family gatherings and events celebrating children's graduation, marriage and grandparenthood. Therefore, helping infertile women to face the biological, emotional and social implications created by the status of infertility can be a positive major contribution by a psychologist. It has been recognised that psychologically, infertility creates a condition conceptualised as the crisis of infertility (Denber, 1978). This state is an emotional condition that gives rise to feelings of loss – loss of health and self-esteem, as well as feelings of mourning, depression, guilt and frustration. The job of the psychologist then is to intervene in the emotional aspects of infertility and alleviate the stress aroused by the condition. The psychologist can recognise and acknowledge the feelings evoked by the situation of infertility, offer support, and help women to restore a sense of self-esteem. This can be achieved by helping infertile women to view the infertility problem separate from their identity by externalising it rather than internalising it. This may encourage them not to define themselves as inadequate or incomplete women just because they are infertile.

Before engaging in therapy with infertile women, it is important to note that when infertile women seek help, they are mainly driven by their hope and longing to have a child. Therefore, because a psychologist should not and cannot hold out the promise of pregnancy as her/his goal of therapy, it is important to clarify this matter to the women at the beginning of the intervention, so as to not raise their expectations. Rather, therapy should aim to enable the women to achieve a resolution of the state of longing to have children and being unable to. Furthermore, during the course of treatment, a psychologist should be aware that although there may still be hope for some women to fall pregnant, either spontaneously or as a result of medical or surgical intervention, this may not be the case for other women and they may have to live with the knowledge that they may never become mothers. The psychologist should then help these women to resolve these feelings of hopelessness and loss, and to attain an acceptance of life without pregnancy and/or childbirth.

7.3.2 As a psycho-educator

Women may not always approach a psychologist with the intention of beginning a course of psychotherapy. As it was evident in this research project, a lot of the women who approached me asked me many questions related to their treatment procedures and did not necessarily ask me for or about psychotherapy. This uncertainty and lack of knowledge regarding treatment procedures also contributes to the women's feelings of helplessness and loss of control. For this reason, the psychologist working at an infertility clinic can also assume a psycho-educational role in such cases by providing education and creating awareness about available medical tests, reasons for them to be carried out and an overview of the possible treatment procedures. Improving the women's knowledge about their medical aspects of infertility may provide them with a sense of empowerment and control. However, although a psychologist working with women experiencing infertility should be able to answer basic questions about reproduction, infertility tests and treatment, she/he should always respect the limits of her/his expertise and convey this to the women, advising them to obtain more information from health professionals who specialise in that field.

7.4 Further research

Similar to many other research projects, the limitations of this study as well as the findings provide a point of reference from which further research can be carried out.

The sample group used in this study was selected purposefully and can therefore not be passed on as a representative sample of the infertile population of married African women in South Africa. The women who participated were mainly from a township area, but there are other infertile married African women residing in villages, rural areas and urban area. Thus, although the findings of this research may provide insight into and an understanding of the experiences of infertile married African women, they cannot be generalised to the broader population and other contexts of infertile women.

This study indicated that women pay a heavy price for not being able to fulfill the reproductive expectations of their husbands. However, we cannot make comparative assumptions based on the findings of this study and conclude that women suffer more emotional distress as a result of their infertility. Therefore, further research can focus exclusively on married men's emotional experiences of male infertility. Furthermore, this study yielded information regarding how the infertile women's husbands experience and handle their infertility. However, because the women provided this information, it may not be an accurate portrayal of the men's experiences of being married to an infertile woman. Thus, in order for us to have a fair and an in-depth account of 'the other side of the coin', research should be carried out on fertile married men to explore their experiences of being married to infertile women.

Further research can also investigate the availability of support structures for infertile women, as well as their efficacy. Since infertile people are invisible in society and do not know how to contact each other (Menning, 1980), research into the availability of support groups for infertile women/men/couples can assist in creating a broader pool of referral for infertile people to go and receive the necessary support they may require. Furthermore, research can also focus on how infertile women experience the services

rendered at their infertility clinics as well as the health care providers working there. This can enable us to gain knowledge about how infertile women, in particular, view the services rendered to them at the clinics, so that all the necessary improvements or infrastructures can be put into place in order to make the experience of visiting the clinics more worthwhile for the women. This suggestion stemmed from my realisation during this research, of how many women were unsure of the basic services at the clinic, and how others, for some reason, did not have enough motivation to keep returning to the clinic to continue treatment.

7.5 My concluding story

The longing for a child that women experience is something that no rationalising explanation can ever make sense of. Women have always been defined by events related to their reproductive functions – the experience of pregnancy, childbirth, parenting and the eventual launching of their children into the adult world and preparing for grandparenthood. The expectation of married women to become mothers is seen as a normative or mandatory quality of motherhood in society. Thus, women go through their married lives striving for motherhood, along with the sense of identity, achievement and status that it comes with. In this ideological context, women's decisions are not so much about whether or not to have children, but about when to have them, how many to have or at what point in their marriage to have them. Therefore, realising that having children may be hindered by reproductive failure comes both as a shock and as disbelief to infertile women.

Infertility is a complex concept, which results in childlessness, in fewer children, or in women having children only after a delay, after medical investigations or adoption. For those women experiencing primary infertility, the search for pregnancy and subsequent childbirth may be even more intense and through desperation and longing, their thinking becomes adjusted from wanting several children to just wanting one child, or even more severely, just wanting the experience of pregnancy, even if there may be no subsequent successful birth.

The negative image of female infertility is a theme that I have become increasingly aware of during this project, both from the literature review, as well as from past and present research projects, including this one. The terms for infertile women, like barren and 'moopa', are derogatory and dehumanising, implying a failure not merely in reproductive terms, but also in womanhood. In fact, as I work more on this research project, I realise that even using the word 'infertile' implies an inability and an inadequacy, almost as if declaring women as incompetent and emphasising their failure reproductively. This may be the reason why some women, regardless of how long they have been failing to fall pregnant, still say 'I am not sure if I am infertile or not', thus, tentatively refusing to take on the label of infertility because of the negative intensity of its meaning. Therefore, as I progress through this project, I am aware of how, despite my continued use of the word infertile, I have come to prefer and have become more comfortable using the word childlessness, as it merely implies a lack of children, without implying any reproductive inabilities or defects. In my opinion, the use of less derogatory words, both medically and socially, can be the first step towards deconstructing the negative image of childless women.

Another step towards deconstructing the negative image of childless women can be through deconstructing the narratives about motherhood in an attempt to reconstruct a more inclusive meaning of motherhood. Women are expected and supposed to become mothers, as motherhood is highly valued symbolically as the key to adulthood and fulfillment. As such, childless women are often asked to explain themselves and seek help for their reproductive problems in contrast to women who have children, who are rarely asked to explain their conformity to the norm of motherhood. Thus, childless women come to realise that by failing to comply with one of the most salient features of being a woman, they open themselves up to accusations of not being normal and woman enough. These feelings of failure extend into their roles as wives, as they live in constant fear of being left by their husbands because they cannot provide them with children. Furthermore, some women whose husbands have children with other women outside the marriage sometimes find themselves assuming a parental role with these children. Although some of these women may have positive relationships with their stepchildren,

they are also aware of the fact that these children are still not their biological children and can therefore not replace their need for biological motherhood. The difficulty of filling the empty space that childless women feel may be one of the reasons why they persistently continue in their endless attempts to achieve biological motherhood.

From this, it appears that as a result of society's emphasis on pregnancy and biological motherhood, women feel they cannot identify themselves as mothers or fulfill the role of motherhood if they have not given birth to the children they are involved with. This calls for a need of a more inclusive social construction of motherhood, one that can enable childless women to become mothers, even if they are unable to become pregnant and give birth. Thus, we need to create opportunities for the development of new language with which we can negotiate new meanings for motherhood. In this way, we can reconstruct a different reality in which motherhood can be achieved through alternative ways of parenting – such as child care, baby sitting, foster mothering, step mothering or being a committed aunt. This can be a huge step towards eradicating the negative images of biological-childlessness and most importantly, allowing for alternative ways in which mothering practices can create possibilities for childless women to assume the social identity of 'mother' and enjoy some of the experiential and emotional benefits of motherhood.

Finally, I have to conclude this story by expressing my thoughts and experiences regarding my position as a feminist researcher. Embarking on this project as a first time feminist researcher meant I was venturing into the unknown. As anticipated, there were academic and intellectual challenges, but these did not surpass the emotional challenges I also encountered along the way. As Carter and Delamont (1996) put it, because the theory and practice of feminist methodology has placed considerable emphasis on the emotions, it has been widely claimed that an emotional element must inevitably be present within research at every stage – planning, implementation and writing up. In this project, emotions were prime movers in the selection of the research topic and they constantly informed the way in which I read and understood the literature, participated with the women during the interviews and analysed their narratives.

Many feminist researchers believe that only women should research women's issues (Kremer, 1990), firstly in the belief that understanding and empathy will facilitate disclosure and identification of issues and secondly, due to the belief that women have been oppressed and their needs gone unrecognised in a male dominated research and real life world. Being of the same gender with the women, the empathy and identification I experienced whilst working with them came to the fore. As I listened to and analysed their stories, I found myself constantly engaging in a process of self-reflection as a woman. Although I am unmarried, without a child and younger than the women I interviewed, I could still place myself in their position and genuinely imagine what it may feel like to be married and to reach their age and then realise I cannot bear children. This meant that although I empathetically listened to the women's stories, I had to avoid being emotionally biased or imposing my feelings on the women's stories by constantly separating my own reactions from the stories they told me.

As a South African woman conducting feminist research on South African women within a South African context, I have become aware of the multiple discourses in literature regarding the need for and the availability of a purely South African feminism. As I have become more acquainted with Agenda, a South African feminist journal, I have gained a better understanding of what differentiates or constitutes South African feminism. With particular reference to black South African women, an acknowledgement of the role of race, culture and socio-economic status is essential in the process of reconstructing an integrated and relevant South African feminism. Gender, culture, race, family, religion, education and socio-economic factors may affect or are affected by behaviour and therefore must all be considered if one intends to investigate the whole human experience in feminist research (Pateman, 2000). This is evident in this research as the women's stories carry themes of their culture, their families and their religion, and their educational levels, which influence the way in which they articulate their experiences. However, as I near the end of this research project, I conclude that although feminism may be different for different women in different contexts, its main objective for all women is their emancipation and empowerment, by giving voice to their experiences and concerns through feminist research.

Finally, since feminist researchers are honest enough to articulate personal growth motives, their emotions and indeed a basic intellectual curiosity in their research (Smith, 1987), I have to conclude by expressing my hope that this research will make a significant contribution towards psychology as well as towards issues pertaining to black South African women and infertility. I believe that this research project can serve as a starting point for my further growth and development as a feminist researcher, as I continue dedicating such research efforts to all those black South African women, whom feminism, in its past and present existence, has never touched or has failed to help.

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