SOCIOCULTURAL ASPECTS OF INFERTILITY IN A BLACK SOUTH AFRICAN COMMUNITY

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Abstract

An exploratory study was conducted to investigate (a) the views of infertility held by the black community in South African, (b) the impact of these views on community relations with infertile people and, (c) the ability of the community to act as social support for infertile people were investigated. The study also investigated the perceptions of available treatment options for infertility, and the implications of these perceptions to the mental health service provision for people who are infertile. A convenience sampling method and sampling to redundancy method were used to obtain seventy-six (76) members of the African community in South Africa. Semi-structured interviews were used to collect data. Open-ended and few close-ended questions were used to elicit meanings and to explore attitudes towards infertility. The data was organised into categories on the basis of themes elicited from the responses and domain analysis was conducted. Frequencies and percentages of theme responses were also used to analyse the data. The findings indicate that the community tends to pressurise women to reproduce. Women were held responsible for the couple’s reproductive failure. On the other hand, infertility in men is considered unacceptable such that it is kept a secret. The study also found that the inability to interact with infertile people or to give them social support is modulated by the community’s perceptions of the causes of infertility. For instance, social support is withdrawn in cases which infertility is attributed to adultery or a consequence of abortion; the community’s attitude is that the infertile are responsible for their reproductive failure. Thus, the findings indicate socio-cultural gender differences in infertility related stigma. Traditional African and Western intervention methods were reported. Implications of the research findings to psychological intervention strategies for infertility are discussed.
Keywords: Infertility, perceptions, stigma, community, African tradition, Black South African.

Résumé

Une étude exploratoire a été menée pour identifier (a) les opinions de la communauté noire en Afrique du Sud sur l’infertilité, (b) l’impact de ces opinions sur les relations de la communauté avec les personnes infertiles et (c) l’aptitude de la communauté de servir de source de soutien social aux personnes infertiles. L’étude avait également pour but d’identifier les perceptions sur les choix disponibles du traitement de l’infertilité et les implications de ces perceptions sur la fourniture des services de santé mentale aux personnes infertiles. Des interviews semi-structurées, avec des questions ouvertes et fermées, ont été effectuées avec un échantillon de soixante-seize (76) membres de la communauté africaine en Afrique du Sud. Les données ont été organisées en catégorisées sur la base de thèmes tirés des réponses et une analyse par domaine a été effectuée. Les résultats indiquent la propension de la communauté à exercer une pression sur les femmes en matière de reproduction. Les femmes sont tenues responsables de l’infertilité du couple. D’autre part, l’infertilité chez les hommes est considérée comme étant inacceptable au point d’être gardée comme un secret. L’étude a également trouvé que le manque d’interaction avec les personnes infertiles ou l’incapacité de leur apporter un soutien social sont modulés par les perceptions de la communauté des causes d’infertilité. Par exemple, le soutien social est retiré dans les cas où l’infertilité est attribuée à l’adultère ou est perçue comme la conséquence de l’avortement; l’attitude de la communauté est que ces personnes sont responsables de leur infertilité. Ainsi, les résultats indiquent des différences socio-culturelles sur le stigmate de l’infertilité basées sur le sexe. Il a été fait état des méthodes d’intervention occidentales et africaines traditionnelles. Les implications des résultats de la recherche sur les stratégies d’intervention psychologiques sur l’infertilité font également l’objet de la discussion.

Mots-clés: Infertilité, perceptions, stigmate, communauté, tradition africaine, noir sud-africain.

Introduction

Infertility, defined (in both men and women) as a failure to conceive after two years of regular unprotected sexual intercourse, or inability to carry pregnancy to live birth (World Health Organisation [WHO], 1991), affects 15% to 20% of people in South Africa (Martin, 1997). The
experience of infertility can be traumatic and debilitating for men and women, who, for cultural or personal reasons, view child bearing as central to their lives (Abbey, Andrews & Halman, 1991; Ndaba, 1994).

Tradition and religion commonly have a great impact on how children are valued and create norms informing and expecting people to reproduce. All over the world, children have personal and emotional value to an extent that men and women continue to be defined predominantly in terms of their reproductive capacities (Hilton-Barber, 1998; Miall, 1994). The cultural expectation is so strong such that couples are often asked “how many” and “when” rather than “whether” they will have children. Thus, infertility becomes a crisis not only for the couple, but also for the extended family and the society (Eupnu, 1995). Thus, the community serves as a lens through which infertility and other psychosocial conditions are seen (Barlow & Durand, 1995; Miall, 1994).

Therefore, the study draws from the general systems theory. The systems theory allows an analysis of the circular interaction processes, triangles, boundaries and beliefs in the complex system involving an infertile, a family and a variety of other groups that may impinge on the mental health of people faced with the problem of infertility (McDaniel, Hepworth & Doherty, 1992). The systems approach is characterised by the bio-psychosocial model. The model recognises that social, cultural and psychological factors are intrinsically part of the condition or a disease, and its treatment (Schlebusch, 1990).

Although infertility is essentially biomedical, psychological factors and social support systems significantly influence reactions to and adjustment to infertility (McDaniel et al., 1992; Ndaba, 1994; Schlebusch, 1990; Williams, Bischoff & Ludes, 1992). The nature of the extent of influence and reactions can be deduced from the following extract obtained in an article from Drum Magazine: “What made the suffering worse was the cruel responses from their families, friends and the community of Giyani in the Northern Province [South Africa]. People accused her of being a man in disguise. He was told he was a woman in trousers” (Hilton-Barber, 1998).

Therefore, to help people who find infertility to be distressing, mental health practitioners must first ask, what are the cultural definitions, values, rules and practices the society holds about infertility? What are the available social support resources for the infertile? Hence this paper did not focus on infertile individuals, but undertook two tasks within the context of black community in South Africa. First, it explored the community perceptions of infertility, including causal explanatory models and management options. Second, it considered the extent to which the perceptions held by community members might influence their interactions.
with and ability to act as a source of social support for people who find infertility distressing.

**Method**

Research Method

A qualitative research paradigm was used to gain in-depth unrestricted information on the black South African community’s frame of reference towards infertility. The method was field-based, community survey, using the social constructionist research orientation (Grbich, 1999; Terre Blanche & Durrheim, 1999). The form of inquiry was exploratory. Exploratory study was ideal for this study because little was written about African community’s perceptions of infertility in South Africa. Thus, the study attempted to develop a basic and broad understanding of infertility as a mental health construct.

Sampling Strategy

The population of the study was the black South African community from both the rural (56%) and urban (44%) areas, conveniently, from the Gauteng, Northwest and Northern Provinces. In this study, the indigenous black South Africans are referred to as a community or a society. The language groups involved were Northern Sotho, Tsonga, Tswana, Southern Sotho, Venda and Zulu. A convenience and redundancy sampling methods were used to obtain 76 (30 men and 46 women) participants from their homes. The exploratory nature of the research and the extensive use of open-ended questions used and, literature (Sobal, 2001; Miall, 1998; Miall, 1994; Miall, 1986) from other qualitative community surveys guided the size of the sample drawn.

The age of the participants ranged from 19 years to 76 years with a mean age of 42 years (SD = 3.9). Sixty-two (62%) percent of the respondents were biological parents, and the rest were childless by choice. The gender characteristic of the participants was seventy (70%) percent women and thirty (30%) percent men. The educational level ranged from illiterate to highly educated professionals. Forty-six (46%) percent had lower educational level, that ranged from junior secondary education to illiterate; thirty-six (36%) percent had senior secondary education; and eighteen (18%) percent had tertiary educational, they were professional such as nurses, teachers, oral hygienists and librarians.

Methods of Data Collection
The interviewing method was used to collect data. The researcher formulated an interview schedule to gather the participants' biographical information. The schedule consisted of items that asked the age, educational level, parental status, marital and domicile status of the participants. Semi-structured interviews were used to collect data. The characteristics of the sample are described under the sampling strategy above.

The interview schedule based on literature review and the standardised interview schedule developed by Miall (1994) was used to collect data. Open-ended and close-ended questions were used to elicit meanings and to explore attitudes towards infertility. The interview schedule consisted of items such as the following. (a) How prevalent is involuntary infertility in your area? (b) What makes people to be infertile? (c) How important it is for you to experience pregnancy and child birth/how important is it for you to biologically father a child? (d) Whether you have children or not, how important is motherhood/fatherhood to your belief of who you are as a person. What are the problems faced by people who are unable to have children? (e) What are your experiences about people who are unable to have children? (f) How available are you to people who are unable to have children?

Procedure

The interviewers visited participants in their homes where verbal and written requests were used to obtain consent. The participants were assured of their anonymity and confidentiality. This was immediately followed by the conduct of the interviews in the participants' homestead. Six postgraduate students in Psychology (Honours students in Psychology) from the different language groups similar to those of the participants and the researcher conducted the interviews. The students were requested to assist on the basis that they had training on interviewing skills as part of their curriculum. The students went through the interview schedule with the researcher, discussing and clarifying meanings before they went into the field. The interviews were either conducted in English or in the first language of the participants according to their preference and level of literacy. The interviewers transcribed the interview notes in verbatim and translated into English. Then, the interviewers formed two separate groups, one group back translated the interview notes to the African languages and the other group translated the back translation again into English in order to ensure reliability of the translations (Denzin & Lincoln, 1994).

The researcher read the translated data several times in order to gain an understanding and to develop theme patterns. The data was organised into categories on the basis of themes elicited from the responses and,
content analysis was conducted. In order to ensure validity and
generalisability, work was cross-checked through the methods of member
checks. An independent qualitative researcher reviewed the data and
identified similar themes (Denzin & Lincoln, 1994).

Results

The themes obtained were summarised into major categories of (1) Causal
explanatory models for infertility, (2) gender bias on the view of infertility,
(3) the stigma of infertility, (4) the impact of infertility, (5) management
strategies, and (6) social support.

1. Causal Explanatory Models for Infertility

The given causal explanatory models for infertility were (a) biomedical, (b)
supernatural, (c) psychological, and (d) mythical.

The following biomedical causal factors were elicited from responses.
Damage to the reproductive organs due to infections of the reproductive
system caused by illegal abortions, sexually transmitted diseases,
prolonged use of contraceptives, chemicals and, complications of
circumcision from traditional initiation schools. Drug abuse, long distance
truck driving, promiscuous behaviour and, complicated surgery and
childbirth also damaged the reproductive organs resulting in infertility.
Other biomedical explanations were hereditary factors, low sperm count,
impotence, immature ovaries, irregular menstruation, cancer of the cervix
and, anomalies of the reproductive organs.

The supernatural explanations indicated that infertility was causes by
witchcraft, God's will and being cursed. The emergent psychological
causal theme indicated that infertility was caused by stress. Infertile
couples were unable to bear children because they were 'tense'. The
Cultural myth elicited, as causal factors for infertility were incompatible
blood group and poisoned blood. Another emergent theme involved
respondents being noncommittal, indicating that they did not know what
cause infertility.

2. Gender Bias on the View of Infertility

Views of infertility were biased towards women involved in relationships
where there was infertility problem. The emergent themes were (a) that
women in infertile relationships carried the diagnosis, (b) the secrecy of infertility in men and, (c) the stigmatisation of women in infertile relationships.

There was a tendency to perceive infertility as a woman’s problem in a couple that had infertility. It can be observed from most of the findings of this paper that there was a false impression that the research was asking questions on infertility in women, which was not the case. Women in an infertile couple system were presumed to have the infertility problem even before the couple went for diagnostic tests. “...in some cases the woman would be taken to a traditional healer who will confirm that it was indeed a woman who had a fertility problem” (65 years old; female; domestic worker).

Although infertility affected both men and women equally, infertility in men was usually kept as a secret. Patriarchal influences made the reproductive capabilities of men to be unquestionable. Hence men were protected from carrying the diagnosis of infertility. Thus, women in infertile relationships were subjected to infertility related stigma while their male partners were exempted.

3. The stigma of infertility

The stigmatising themes were as follows. (a) Infertile women could not achieve adulthood status, (b) infertile women had a deviant personality, (c) beliefs that infertility was due to one’s faulty behaviour, (d) the dehumanising nature of infertility, (e) the beliefs that infertility was caused by tension and, (f) having pseudo-pregnancy.

Infertility made it difficult for infertile women to achieve adulthood status in which they could be accorded respect and are engaged in adult-related community events. There was a belief that infertile women were short-tempered and impatient. Infertile women were extremely clean such that they did not tolerate children who visited their homes and messed up their houses. They tended to alienate themselves from family and friends. It seemed infertile people lacked parenting skills, were rude and abusive to children. “The person can be extravagant, trying to justify the extravagant behaviour by saying: that was the money that was going to be spent on a child. Such people try to substitute children with something material like expensive clothes” (27 years male).

Infertility was seen as a consequence of a woman’s faulty behaviour. The attributed faulty behaviours included such actions as having history of abortion, prolonged use of contraceptives and promiscuity. Viewing infertility as a curse was stigmatising in that the infertile person was at fault and, infertility was a form of punishment from the supernatural being.
Thus, infertile women were called by derogatory names such as *mumba/nyumba/moapa* in Tshivenda, Xitsonga and, Northern Sotho respectively. This means a cow that is unable to reproduce (T. A. Mabasa, personal communication). There was a belief that women were handicapped by infertility. Infertile women were also dehumanised to a level of a car tyre as indicated in the following narrative. “Pressure from the in laws also had a contributory factor on the side of the infertile woman, the in laws will say nasty remarks that our son is pumping a tyre that does not get full” (52 years old woman, grade 8).

The view that tension caused infertility, that pseudo-pregnancy as a result of reproductive failure and of a wish to conceive, was stigmatised as indicated in the following narrative. An infertile woman “needs to have a relaxed mind because she is always preoccupied with the desire to conceive and, that could lead to an imaginary pregnancy. Eventually that imaginary pregnancy could make one to become a talk or a laughing stock” (19 year old woman with senior secondary education).

4. The Impact of Infertility

The following themes emerged as ways in which the respondents viewed the impact of infertility. (a) Identity crisis (b) emotional problems, (c) family conflicts, and (d) divorce.

Infertility denied women from identifying themselves as parents. There was a belief that “a person was only called a parent after having her own baby” (21 years old female teacher). Couples faced with the problem of infertility could also not identify themselves as families because, it was only biological parenthood that “made couples to have a real family” (woman graduate). Moreover, a family without biological children was incomplete. A woman was considered a ‘real’ woman after childbirth. It was not enough for women to read about pregnancy and childbirth in magazines. One had to have a ‘taste’ of pregnancy and childbirth. Pregnancy proved that a woman would be able to carry gender role expectations such as taking care of the child since she would have gone through the hardships associated with pregnancy and childbirth. Biological motherhood elevated the identity status of women. Biological motherhood meant that a woman would be respected and counted among other mothers, who also experienced pregnancy and childbirth. Moreover, the elders were only proud of a woman who could bear a child. Biological fatherhood proved manhood and provided a sense of authority and being in control. Failure to achieve biological motherhood/fatherhood led to identity crisis.

Emotional problems were common among people faced with the problem of infertility. Infertility led to anxiety, shame, frustration, loneliness, isolation, worry, and depression. Consequently, some infertile
people were suicidal while others resorted to alcoholism. The infertile tended to be impatient, selfish and, jealous type of people. They were so stressed to an extent that they became withdrawn and aggressive. The feelings of rejection in the society made people who were infertile to hate themselves. Societal pressure influenced criminal behaviour where infertile women were forced to steal other people’s babies.

Infertility led to marital problems. Couples blamed each other for the problem of infertility. There was a decreased expression of affection and a feeling of rejection in a couple’s relationship. Their husbands physically abused infertile women. Couples tended to fight, quarrel, and engage in extramarital affairs. Some couples ended up divorcing due to infertility. The resultant marital breakdown was attributed to socio-political changes, as illustrated in this response: “These days it is divorce, but during our times, men were advised to look for someone who can bear them children” (52 year old woman).

It seemed that the family functioning became disturbed in the sense that there was usually no one to fulfil the roles played by children. There was a resultant lack of a mediator when there were conflicts between a couple, a lack of guidance from children, and, a lack of assistance in household chores. Infertility also resulted in loss of kinship. Infertility caused a strained relationship between an infertile woman and her in laws. The in laws pressurised the infertile woman to bear them grandchildren. The absence of a biological child led to the infertile woman being ridiculed and insulted by the in laws. The in laws believed that an infertile woman was troublesome and critical of the household because she did not have children to keep her busy.

5. Management Strategies

Western and African traditional medicines, counselling and, faith healing were perceived as available treatment options. Traditional marriages and adoption were considered as alternate management options. Themes relating to the acceptance of the infertility condition and preventative measures for infertility were also elicited.

The reported western medical treatment included cleaning the womb, artificial insemination, surrogate, and test tube babies. The reported traditional medical treatment involved the use of herbs and performance of rituals by traditional doctors and herbalists. Traditional healers tended to slaughter a goat to appease the ancestors as part of the treatment. Infertile persons sought counselling from Social Workers. Faith healing was also an emergent theme. It was perceived that infertile people should pray for a child from God.
Women in infertile relationships would usually have a child with someone in the extended family, like the husband's brother or an uncle. An elderly in the family usually advised this. The husband was usually not informed about such decisions, and he would assume that the children were biologically his. Men tended to marry a second wife who will bear them children. When medical treatment fails adoption was considered as one of the options that infertile couple had. There was an indication that medical practitioner did not inform infertile couples about an option of adoption when the medical treatment failed. The emergent themes on the forms of adoption were that an infertile couple should ask a close relative to give them a child who will be raised as the couples' own, and that relatives could voluntarily give a childless couple their own child. The child was usually obtained from those poor relatives who could not afford to raise their child.

There were reported negative opinions regarding the relationship between infertility resolution and adoption. There was a belief that it was difficult to raise some one else's child, especially if there were not close relations. In that regard, an adopted child was viewed as not ones own. Infertile couples would always be regarded as childless, irrespective of whether they adopted or not. Adoption was stigmatising to an extent that people who adopted would be laughed at. It would be painful for the adoptive parents when an adopted child requested to know the 'real' parents. Adoption was considered a risk for an adopted child because the adoptive father could sexually molest him/her. Relatives could harass the adopted child, constantly reminding the child that he/she was not a blood relative.

Positive aspects of adoption related to the belief that in adopting a child, one would be contributing to the life of an abandoned child. Adoption prevented loneliness and boredom. It was suggested that adoption should be done while the child was still young, preferably under six years of age, to enable bonding. An infertile couple could accept the condition of infertility, and choose to remain childless. However, it seemed that acceptance of infertility was difficult to achieve because of beliefs in faith healing as illustrated in the following narrative. "My advice to people who are unable to have children is to keep on dreaming for a miracle despite the reality of their physical health, you will never know what fate holds for you. Dreams and desires must be complemented with prayers, one should never lose hope".

Measures suggested to prevent infertility and its impact were as follows. Couples should go for premarital counselling to prepare them about the possibility of infertility and to make the couple aware of each other's value system, which could help them deal with impact of infertility. There was an expressed need to educate people about infertility. Education
should be geared towards attitude change. Confronting the view that infertility was caused by witchcraft. Communities should form organisation to educate the youth about consequences of prolonged use of contraceptives, which was believed to cause infertility. Again, the community members should avoid taking their children to the traditional initiation schools for the initiation ritual. Instead, they should consult modern medical doctors for the initiation.

People needed to have frequent visits to specialists in reproductive health for check-ups. People should seek treatment when infected with sexually transmitted diseases. The medical profession was challenged to find the cure for infertility. Thus, making infertile people happy.

6. Social Support

The findings indicated that the respondents were willing to provide the different types of social support to infertile people. For example, instrumental social support (allowing own child to be sent for chores by an infertile person), information or affirmation support (giving advice), and emotional support (communication of love). There was an indication that infertile persons should not be rejected, but be accepted because, every person was good in God’s eyes, and, because infertility was not their fault.

Those infertile people whose infertility was attributed to the consequences of prolonged use of contraceptives, and to the damage of reproductive organs due to either sexual transmitted diseases or abortions were considered not eligible for social support. The implication here was that the infertile person was suffering the consequences of his/her own faulty behaviour, thus, deserved to be infertile.

The societal members had difficulties in interacting with people who were infertile. The difficulties were due to the perceptions that infertile people need not be shown that one care about them because they enjoy being alone, are easily angered and, are intolerable. Some respondents avoided topics that involved children while interacting with people who were infertile. There was a concern that infertile people would feel guilty, depressed, inferior, scorned and shy if the conversation involved children. Other respondents included topics that involved children in their interaction with infertile people. The reasons for including children related topics in conversations are indicated in the following narrative. "I usually interact with infertile persons like I do with any other person because, if I interact with them differently, they will notice, and this might make them feel uncomfortable. I think it is best to also discuss topics which include children so that they will get used to the idea that there are children in this world" (68 years old female, illiterate).
Discussion

The findings suggested that causal explanations for infertility were biomedical, supernatural, psychological and mythical in nature. This was in contrast with other studies where causal explanations of infertility were found to be biomedical in western cultures (Dunkel-Schetter & Stanton, 1991; MacCormack, 1994; Miall, 1986) and supernatural in African cultures (Kayongo-Male & Onyango, 1994, Greil, 1991, Brand, 1989). The societal members’ view that infertility was caused by stress differed from scientific studies where heightened emotional distress experienced by infertile couples was considered more a consequence of infertility than a cause (Dunkel-Schetter & Stanton, 1991; Moller, 1991). The societal view that infertile couples were unable to bear children because they were tense seemed to be stigmatising.

One significant finding of this study was the manner in which women in infertile relationships were stigmatised, and, at times made to doubt their identity status as adult members of the community. It seemed the society viewed the woman’s reproductive failure as a threat to kinship and to a sense of security that children brought in old age. The resultant anxiety and anger was manifested in the form of blame, derogation and humiliation of women in childless marriages. Consequently, the psychological effects of infertility could be overwhelming for infertile women.

While women were pressurised and held responsible for couple infertility, men infertility was wished not to exist and, was usually kept as a secret. The cultural belief that infertility was a woman’s problem could be attributed to the traditional gender role expectations where the primary role of women was to reproduce. The patriarchal South Africans tended to exonerate men from and apportion to blame women for infertility. As much as infertility in men was handled with secrecy, to protect men from humiliation, such secrecy could have negative psychological consequences for the infertile men. According to Miall (1994) maintenance of secrecy might be very stressful and heightened a sense of shame.

These gender differences on the view of infertility were in contrast with what often happened with infertile women in matrilineal kinship structure, like the Macua people in Mozambique. In that situation, the family of origin supported the infertile women in search for a solution. For the same reason, her husband and in-laws did not repudiate her ( Gerrits, 1997). Unlike in patriarchal organised South African society, which blamed women for infertility, the Macua men in Mozambique regularly were considered to be the ones who caused the infertility to an extent that the woman and her family took decision to divorce.
The same community members, who tended to stigmatise infertility, recognised the emotional consequences of infertility. The community members seemed willing to be available for infertile people. Infertile people were not supposed to be rejected because everyone was good in God’s eyes. Implying that infertile people were at fault in the eyes of the society. Hence, infertility due to abortion and sexually transmitted diseases was considered to be some form of punishment for the infertile people’s faulty behaviour. The societal members did not provide social support to those infertile persons whose infertility was attributed to ones faulty behaviour. That finding caused concern because, 85% cases of infertility in Chris Hani Baragwanath hospital was due to sexually transmitted diseases (Goosen & Glugman, 1996), implying that the majority of South Africans from the interviewed community were likely not to receive social support.

Help seeking behaviour was pluralistic in the sense that the types of treatment sought for infertility included counselling, modern medical, African traditional and, faith healing. The current socio-cultural model was neither purely traditional nor western. Therefore, the reported traditional forms of sexual unions approved in marriages geared towards procreation no longer hold. For instance, black South African women no longer wanted to be in polygamous marriages as an alternate options for infertility management (Lundgren & Paulson, 1997). Hence, infertility usually led to divorce. Adoption as an alternate management option for infertility was undesirable. There was a belief that it was impossible for infertile persons who adopted to feel like real parents.

Infertility needs to be seen as an important reproductive health issue by policy makers and programme makers. However, South Africa is still a developing country with many challenges such that she could not afford to introduce advanced technologies such as in vitro fertilisation in public health. This is available in private clinics at a price not affordable to many. Moreover, new reproductive technologies presented ethical and moral challenges. Thus, preventive interventions could have more impact than the curative ones.

The findings suggested that infertility treatment should not only focus on the infertile couples, but should also include community-based educational programmes geared towards attitude change, gender sensitivity, and empowering women in matters concerning reproductive health. Psycho-educational programmes should confront cultural prejudices that infertility was a female affair. The psycho-educational strategies need not be focused on one area but encompass broader perspective. The existing programs such as humane treatment in HIV/AIDS prevention programmes could include infertility-related issues.
Conclusion

The study explored the current community constructs of infertility and how the held constructs influenced social support offered to infertile people. One significant finding of the study was that women in infertile relationships were blamed for infertility without medical evidence, while infertility in men was handled with privacy. Causal explanations and types of treatment sought in the community were included both the traditional African and western aspects. The results showed that the community was able to act as a source of social support in cases where infertility was not attributed to the person's faulty behaviour. Mental health practitioners have a responsibility to educate the society to be sensitive and where possible, be supportive to those whose hopes for biological parenthood have not been realised.

References


